

COPING PATTERNS OF WOMEN BREAST CANCER SURVIVORS IN KIGALI-RWANDA A PHENOMENOLOGICAL STUDY

Olukemi Olufunmilola ASEMOTA

Mount Kenya University, School of Business and Economics

Avenue-De-la-Paix Opposite Belgium School, P.O. BOX, 5826,

Kigali Rwanda

ooasemota@gmail.com/ooasemota@mku.ac.ke

(+250) 785 273 442

Abstract

Breast cancer is one of the leading causes of cancer deaths amongst women worldwide. Most women diagnosed with breast cancer live throughout life with some challenges and thereby adopt some coping mechanisms in order to minimise their ordeal. This study examined the coping patterns exhibited by Women Breast Cancer Survivors (WBCS). A phenomenological research design was employed with the snow ball approach for data collection. Ten (10) WBCS were interviewed with average age of 40 years. The results show that WBCS shared common four coping patterns, namely: spirituality, support from family and friends, the medical team, the use of prosthesis. Other emerged sub themes were: disease removal not organ removal, and socialising with other victims of breast cancer. The results showed that women who survived breast cancer always have a story to tell on their coping patterns despite the debilitating physical and emotional traumas of living with breast cancer.

KEY WORDS

Coping strategies, disease removal, environment, family support, friends, personal Characteristics, prostheses, spirituality

1.0 INTRODUCTION

Globally, cancer is a major public health concern and burden, accounting for one in eight deaths overall, which is more devastating than Acquired Immune Deficiency Syndrome (AIDS), tuberculosis and malaria combined (Boehringer Ingelheim, 2009). More importantly, a substantial number of cancer sufferers experience significant reductions in their quality of life due to physical pain, mental anguish and economic hardship (Boehringer Ingelheim, 2009). Cancer has become a great public health problem, with significantly high associated deaths and disabilities (Alemayehu, 2012, Asemota, 2014). It is the second leading cause of death in developed countries and, it is one of the three leading causes of death for adults in developing countries (Boehringer Ingelheim, 2009). There are over 200 different types of cancers but four (4) cancers: lung cancer, breast cancer, prostate cancer and large bowel cancer account for more than half of all cases (Boehringer Ingelheim, 2009). Boehringer Ingelheim (2009), indicate that out of the 12.4 million new cancer cases reported in 2008 , the most common cancers in terms of incidence were lung (1.52 million), breast (1.29 million) and colorectal (1.15 million).

Breast cancer is one of the leading causes of cancer deaths amongst women worldwide

(Harandy, Ghofranipour, Montazeri, Anoosheh, Mohammadi, Ahmadi, Shokravi and Niknami,

2010; Mukwato, Mweemba, Makukula and Makolela, 2010, Okorie, 2012and Asemota, 2014).

Okorie (2012) ascertained that breast cancer is a major cause of deaths among women aged 30 and above and women in both high- and low-income resource countries. Further, breast cancer constitutes a major public health issue globally, with over one million new cases diagnosed

annually, resulting in over 400,000 annual deaths and about 4.4 million women living with the disease and it affects one in eight women during their lifetimes (Okorie, 2012).

1.1 Problem Statement

Before the 1994 Rwanda genocide against the Tutsi, there was a cancer registry located at the only public University Hospital in Butare (CHUB), (Harvard Global Equity Initiative, 2010). From that period up to 2010 there was a general lack of adequate national cancer register, showing cancer prevalence and/or incidence rates, in Rwanda (Harvard Global Equity Initiative, 2010). The Challenge facing Rwanda is that even with the opening of a cancer centre, at Butaro, some patients' concern of having to travel to other countries for chemotherapy, radiotherapy

and/or surgery treatments offered by Oncologists (cancer specialists) have not been addressed (Harvard Global Equity Initiative, 2010). Moreover, the Butaro Cancer centre is only able to provide some expertise treatment such as chemotherapy, palliative care, screening, diagnosis and surgery for cancer patients (Namuwaya, 2012a, 2012b). Furthermore, breast cancer awareness is still low in Rwanda and the East Africa region (Alemayahu, 2012, Asemota, 2014).

Given this information, it is in Rwanda's best interest to more effectively and systematically provide public health services to cancer survivors, especially because of the loss of the most productive people (Asemota, 2007, 2014) due to the several forms of cancers endemic in the country. It is on this premise that the study is conducted to investigate how women breast cancer survivors have been coping despite inaccessibility to adequate medical care, and Oncology specialists, in Rwanda. The study examined and described phenomenologically, what it was to experience being a victim of breast cancer in the midst of inadequate and up-to-date medical

facilities and expertise. Cancers incidence, mortality and survivor rates information, in Rwanda, are sparse and incomplete, where estimates for most common types of cancers within Eastern

Africa countries, are similar to those of Rwanda. The common adult cancers in Rwanda are Kaposi's sarcoma, breast cancer and chronic myelogenous leukemia (CML), (Harvard Global Equity Initiative, 2010).

1.3 RESEARCH OBJECTIVE

The main objective of this study was to examine the coping patterns of women breast cancer survivors in Kigali, Rwanda.

1.4 RESEARCH QUESTION

What are the coping patterns adopted by women survivors with breast cancer?

2.0 LITERATURE REVIEW

Various studies had been conducted to investigate how people cope with cancer and the attitudes exhibited by the victims. Dunkel-Schetter, Feinstein, Taylor and Falke (1992) identified five patterns of coping in a sample of 603 cancer patients, which are: seeking or using social support, focusing on the positive, distancing, cognitive escape-avoidance and behavioural escape-avoidance. The relationships of these coping patterns to socio-demographic characteristics, medical factors, stress appraisal, psychotherapeutic experience, and emotional distress were tested using correlational and regression techniques (Dunkel-Schetter et al., 1992). DunkelSchetter et al. (1992) found that coping through support, focusing on the positive, and distancing were associated with less emotional distress, whereas using cognitive and behavioural escapeavoidance were linked with more emotional distresses.

2.1 Patterns of Coping with Cancer

Overall, coping with cancer by focusing on the positive seems to originate more from personal characteristics. The Institute of Medicine (2001) reported that coping efforts were important moderating factors on the impact of stress on health. They defined coping: “as volitional management of stressful events or conditions and regulation of cognitive, behavioural, emotional, and physiological responses to stress”. In their book (Health and Behaviour: The

Interplay of Biological, Behaviour, and Social Influences), the Institute of Medicine (2001) categorises proposed coping responses to include: coping to solve a problem against coping to manage emotions; cognitive against behavioural coping; approach against avoidance coping, and coping aimed to achieve (primary) control over the stressor (the source of stress) against (secondary) control over response to the stress (emotions). The Institute of Medicine (2001) also ascertain that breast cancer patients who learn to use more direct and confrontational coping strategies were less distressed than those who used avoidance and denial techniques. Furthermore, a “fighting spirit” about the illness led to probability of longer survival periods.

Research suggests that the belief that one has control over the cause of the disease leads to poor outcome, whereas belief in control over the course of the disease leads to better outcome (The Institute of Medicine, 2001).

2.1.1 Cancer stage

Dunkel-Schetter et al. (1992) further opine that situational factors, like site of cancer, stage of disease, time since diagnosis, and whether patient is undergoing treatment; have other possible impacts on coping behaviour in cancer patients. They believe that persons with more acute and

severe medical conditions were likely to apply very many and different coping strategies, than those with less acute and less severe disease status.

2.1.2 Age

Although, socio-economic factors like age, marital status, and educational level of cancer patients were important for coping, Dunkel-Schetter et al. (1992) found that older and less religious cancer patients found it more difficult to adopt positive attitudes. This is so because, the use of social support structures were strongly correlated with many specific types of individual characteristics. That means social support is a coping method, which could be helpful to a wider range of cancer patients. Dunkel-Schetter et al. (1992) indicate that age was inversely related to three methods of coping with cancer and bivariate tests were positively associated with coping by dancing. Older age may reduce perceptions of cancer as threat and perceptions of the number of coping options one has. A greater understanding of the impact of cancer on older individuals compared to younger individuals is valuable, from psychosocial intervention, which derives from disproportionate occurrence of cancer among the elderly (Dunkel-Schetter et al., 1992).

2.1.3 Spirituality and Religious beliefs

Religious coping activities (prayers) have shown to help breast cancer survivors give meaning to life (Levine, Aviv, Yoo, Ewing, and Au 2009, and Gall and Cornblat, 2002). Focusing on the positive was common among very religious and younger individuals. Catholics focused most on the positive followed by Protestants, and more than Jews, while those with no religious preference, coped the least (Dunkel-Schetter et al., 1992). In bivariate tests, being employed played positive reinforcement, which was in contradistinction with the degree of stress experienced (Dunkel-Schetter et al., 1992).

2.1.4 Personal characteristics

Of the personal characteristics studied, age, education and religious inclination proved valuable in explaining how people coped with cancers. For example, more-religious people in the sample were more likely to use methods of coping involving cognitively reframing in their stressful situations (Dunkel-Schetter et al., 1992). Overall, coping with cancer through focusing on the positive seems to derive more from personal characteristics (age or religion) of individuals than from situational factors (disease state or degree of stress), (Dunkel-Schetter et al., 1992). Using bivariate tests, coping through focusing on the positive was characteristic of individuals not in treatment and those currently in remission (Dunkel-Schetter et al., 1992).

2.1.5 Social support

By contrast, use of social support was strongly correlated to greater perceived stressors from cancer, which was associated in bivariate tests with more functional limitations, more frequent worries about cancers, and higher levels of education (Dunkel-Schetter et al., 1992).

2.2 Theoretical Literature

2.2.1 Roy Adaptation Model

Henderson et al. (2003) study on coping strategies among African American Women with breast cancer employed the Roy Adaptation Model, which says individuals are capable of responding to their dynamic environments. The environment, considered by Henderson et al. (2003), is categorised, into: focal, contextual, and residual stimuli. The focal stimulus is described as what immediately confronts the individual diagnosed with breast cancer. The contextual stimuli according to Henderson et al. (2003) are factors that contribute to the focal stimuli such as,

demographic factors like age, marital status, educational level, income and length of time since diagnosis. The residual stimuli are unknown environmental factors that affect the individual's adaptive system (Henderson et al., 2003). Another theory that is apt and useful in explaining coping strategies is the Lazarus Theory of Stress and Coping. This was reported by Halstead and Fernsler (1994) in their study that cancer survival is a stressful experience requiring coping for the maintenance of equilibrium. In their study, Lazarus' Theory was used to assess the effectiveness of coping strategies by long-term survivors. Due to the environmental impact (physical and psychological), coping strategies are vital to adaptation (Henderson, et al, 2003).

Graves (2001) used social cognitive theory to enhance quality of life for Breast Cancer survivors. Therefore, this study is guided by: Self-Regulation Theory, Cognitive-Relational Theory of Stress and Coping. Consequently, the theoretical concepts of coping in this study can be examined using the process approach.

2.2.2 Process Theory

The process theory (Henderson et al., 2003), shows the relationship between the individual and self, the individual and others around (peers, support group, family members, siblings, husband and significant others, the individual and the disease). They categorised breast cancer coping mechanisms into four major categories, namely:

(i) Fighting spirit and problem solving

This category of breast cancer patients fully accept a diagnosis of cancer, have an optimistic attitude towards it and are determined to fight it (Henderson et al., 2003; Lazarus, 1993).

(ii) Denial and escape-avoidance

This group of cancer patients do not accept the reality of diagnosis. It reflects: “efforts to manage stress that change over a period of time and are shaped by the adaptation context out of which it is generated” (Henderson et al., 2003; Lazarus, 1993). This set of patients either rejects the diagnosis of cancer or denies/minimises its seriousness. Denial is encountered many times in the work with cancer patients (Lazarus, 1993). They would, for example say: “Well, I don’t think that experts always know what’s going on and just to be on the safe side, they prefer to treat breast lump as something serious” (Henderson et al., 2003).

Henderson et al. (2003) explain coping mechanisms as innate or using the Roy Adaptation model of Lazarus; that its operation might be situational. Further, denial as a theoretical concept in patients’ coping with cancer, is defined in terms of “what” patient denied and to what extent?

This could vary according to patient and over different intervals (Lazarus, 1993).

(iii) Stoic acceptance

The patient accepts diagnosis but does not seek further information, and attitude becomes: “I knew what he was going to say. I was quite prepared. I know that it’s out of my hands – what will be, will be. It’s pointless worrying” (Henderson et al., 2003; Lazarus, 1993).

(iv) Helplessness/hopelessness

The patient is overpowered by knowledge of diagnosis and her daily life is disrupted by preoccupation with cancer and dying (Henderson et al., 2003; Lazarus, 1993).

3.0 METHODOLOGY

A qualitative, phenomenological, research design was utilised for the study through snow ball approach, for in-depth information from the informants (Asemota, 2014). The snowball approach was used to select informants who linked the researcher to other breast cancer survivors. Snowball technique is defined by Robson (2002, p.265) as where: “The researcher identifies one or more individuals from the population of interest. After they have been interviewed, they are used to identify other members of the population, who are themselves used as informants, and it goes on until desired number of informants are achieved”. The phenomenological approach explored the real experiences of persons involved, by gaining a deeper insight and understanding of the phenomenon and tries to bring out the common themes or dissimilarities among the informants as they present their stories without any biases (Groenewald, 2004).

3.1 Target Population

The population for this study were women who had survived breast cancer disease in Kigali

Rwanda. The target population for the study was estimated between 90 and 100 informants. The population of the study was obtained from President of the Conquer Breast Cancer Association in Kigali, Rwanda. The period of diagnosis for the women under study spanned from 2007 to 2013 (inclusive), with ages from 25 to 55 years. The chosen age range is critical in order to widen the scope (inclusion) of the different categories of women (married/unmarried, those in child-bearing age/those that had completed bearing children, those that had breast cancer before getting married), but most importantly, the focus was on women who survived breast cancer diagnoses and treatment (Asemota, 2014).

3.2 Inclusive criteria: The researcher involved only women with breast cancer from different age groups. The two key informants, who were the executives of the Conquer Breast

Cancer Association (CBCA), were also included in the study, to act as links with policy makers and the Ministry of Health personnel, in order to advocate for women breast cancer survivors (Asemota, 2014).

3.3 Exclusive criteria: Non-women were excluded from participating in the study. The study was conducted to answer the research question: What are the coping patterns adopted by women survivors with breast cancer? (Asemota, 2014).

3.4 Data Collection

Approval letter of research authorisation was obtained from Mount Kenya University, Kigali Campus and thereafter permission was sought with the President of CBCA and a list of members with their phone numbers was released for contact with any willing prospective informants. Willing informants were contacted through informed consent on agreed date, time and place. Digital voice recorder could not be used because informants preferred their responses to be written by hand. Hence the researcher utilised field notes and the interview guide questions were administered with informants in agreement with the place of their choice. It was only one research assistant, who assisted in the interpretation of the interview guide questions. Data were gathered through semi-structured interviews with ten (10) informants from different sociodemographic variables such as age, (young/older women), marital status (single/married), educational level (educated/not educated), length of time since diagnoses (Asemota, 2014).

3.5 In-depth interview process

Each interview began with request for demographic information such as informant's level of education, marital status, number of children, age, nature of work, and length of service. Following the demographic section of questions, there were open-ended questions that permitted women to discuss issues that relate to their coping mechanisms exhibited thus far in managing breast cancer. The interview duration time ranged from one hour to two hours, using the field notes. The interview was validated by the informants to ensure that their stories have been captured the way they were told by clarifying the contents from the informants immediately after the interview (Asemota, 2014). A data analysis spiral was employed for data analyses (Leedy and Ormrod 2010, Asemota, 2014).

4.0 FINDINGS AND DISCUSSIONS

A total number of ten female breast cancer survivors were interviewed on issues that relate to how their coping styles were demonstrated amidst the challenges of managing the disease. Seventy percent (70%) interviewees were married, 20% were single and 10% were widowed, with ages between 25 and 55 years, and their average age was 40 years. From the data analyses, four major themes and two sub themes emerged on the coping patterns of WBCS, which were: spirituality, support from family and friends, medical team and use of prosthesis. Sub themes were: disease removal not organ removal, and socialising with other breast cancer victims at CBCA, Kigali. The informants' demographic data is displayed in Table 1.

Journal of Business Management Science

Table 1: Informant’s demographic variables

Code	Age Now	Marital status	Children Number	Education	Nature of work	Home and/or location	Year diagnosed
001	43	Married	3	Bachelor’s degree	Administrator	Urban/Kigali	2008
002	48	Married	4	College of Education	Nurse	Urban/Kigali	2012
003	55	Married	3	Bachelor’s degree	Retired Senior Civil Servant	Urban/Kigali	December, 2011
004	25	Single	None	Bachelor’s degree	Nurse	Rural but moved to Kigali	August, 2013
005	48	Widow	3	Diploma	Nurse	Urban/Kigali	2011
006	41	Married	>12	Primary	Farmer	Rural	2013
007	45	Married	2	BA Marketing	Project Manager	Urban/Kigali	2009
008	46	Married	3	BA	Consultant	Urban/Kigali	2007
009	30	Single	1	Primary	Civil servant	Urban/Kigali	2009
010	40	Married	3	Master’s degree	Researcher	Urban/Kigali	2013

Source: Asemota, 2014

Table 1 indicates that women breast cancer survivors ages, ranged between 25 and 55 years, while the average age was 40 years. This result also corroborates other findings that breast cancer is more, a disease of older women (Park, 2007; Dunkel-Schetter, et al., 1992; Wells and

Horm, 1992; Gorey, Luginaah, Bartfay, Fung, Holowaty, Wright, Hamm, and Kanjeeikal, 2011). 70% interviewees are married, 20% are single and 10% are widowed, the number of children ranged between 0 and >12 with the average number of children greater than three (3). The above table also shows that 20% interviewees attained primary school and the remaining 80% attained post-secondary and/or university education. Furthermore, 40 % interviewees were diagnosed of breast cancer more than five (>5) years ago, and the remaining 60%, were diagnosed less than five

(<5) years ago. The foregoing information also corroborates the findings of other researchers, that higher levels of education and high income breast cancer patients had better survival rates (Park, 2007; Dunkel-Schetter, et al., 1992; Wells and Horm, 1992; Gorey, et al, 2011), due to better diagnoses and treatment, or more awareness and early detection of the disease or a combination of them, all (Asemota, 2014).

4.1 Main themes

4.1.1 Spirituality and religious beliefs (through prayers and trusting God for help)

All the women that participated in this study had the courage to live through the ordeal of breast cancer utilising various methods of coping mechanisms. Popular among these coping mechanisms are: getting closer to God through prayers and trust. Some of the responses below are a demonstration of adopting their religious beliefs as coping mechanisms (Asemota, 2014):

“Yes, it has strengthened my faith and trust in God. I am always ready to help others in need of help especially people with breast cancer, to give them moral support. I managed not to give it time and God has helped me through”. “I solved the difficult times through prayers to God and fellow Christians who visited me also prayed for me”. “My belief in God that He allowed it for a purpose has helped me cope”. “I believe that God can heal me, and change the situation and because of this, I was not depressed”. “I believe God can help me conquer the breast cancer”. “God might have made me go for the test on time”. “But now I believe that nothing is impossible. Eventually, I have accepted my situation. I go to church, I pray and I believe that God is with me”. “I develop the ability to still be happy and live life to the fullest, not moody and not alone. I am still grateful to

God, despite all I have gone through.” Other things that helped me and still helping me cope is my belief in God and I believe I am cured now. I believe also that God can help me conquer breast cancer, totally”.

4.1.2 Support from Family members (Husband, children, and boyfriends)

4.1.2.1 Coping patterns of older women

All the women derived support from either their husbands or children or their boyfriends (single women). For those married women with children, they were able to cope through the emotional support offered by their husbands and their children. This is evident in one of the quotes, cited below (Asemota, 2014):

“My husband has been good and kind”. “Other strategies I adopted for coping was to discuss freely with my children on things relating to cancer”.

4.1.2.2 Coping patterns of Younger women (Asemota, 2014)

“My boyfriend helped me accept my situation. He is always there for me, by saying: “You lost one breast, not your life”. ”This gives me courage and confidence to have reasons to live. I am ready to share my story with others who are experiencing the same predicament like me .My boyfriend helps me to accept my situation”.

“Life is still good. However, with some challenges, but I have to keep on living.

4.3 Support from the Medical team and the Ministry of Health (Asemota, 2014)

“A doctor who gave me medicine comforted me. Medicine helped me cope with the new situation”. I followed Doctors’ instructions and prescriptions, strictly”. “I had quick

treatment because of support from the Ministry of Health, which sponsored my medical bills up to 90% costs and my office too, while I only paid my air ticket to India”.

4.4 The use of prosthesis (Asemota, 2014)

All the women both young and old accepted that the use of prosthesis has helped them cope, in the area of dressing.

“And also I use prosthesis to complement my dressing where I had mastectomy”.

“Yes, mastectomy sometimes affects me when I look at the mirror. But, the situation cannot be undone. I am planning to have prosthesis, then breast reconstruction in Europe”.

4.5 Sub-themes

4.5.1 Disease removal and not organ removal (Asemota, 2014)

“What matters to me is not organ removal but the disease is being removed. I had no option except mastectomy which is the Z- option. No woman would like to lose her breast. It is what gives the feminism status”. “I was positive”.

4.5.2 Support from Conquer Breast Cancer Association (Asemota, 2014)

Some women obtained support from Conquer Breast Cancer Association (CBCA) in Kigali. .

“What helped me to cope amongst others was support from CBCA. At CBCA through discussions and sharing information with others that have similar problems, has helped me greatly to cope with my situation and I have positive attitude to life. I did not lose my job. I am still working as a nurse. Since I have accepted my situation, life generally had become easier for me”. “It offers forum among breast cancer survivors to relate their experiences, challenges and how they can successfully manage their lives. Members meet once in a month, although it is not every month and draw strength from one another when they share their stories”.

Based on the analyses and findings emanating from this study, it is evident that women with breast cancer share common coping patterns ranging from spirituality support from the family members, the medical team and the Ministry of Health, the CBCA, the use of prosthesis and self determination to live. The study also revealed that regardless of socioeconomic status of the informants, they all thought of death at the early onset of their diagnoses. But, after successful surgeries, their coping patterns and perception to life improved and the thoughts of death, disappeared (Asemota, 2014). Analyses of data further show a common treatment in the form of mastectomy, radiotherapy and chemotherapy (Asemota, 2014). Henderson et al. (2003) study on coping strategies among African American Women with breast cancer employed the Roy Adaptation Model, which says individuals are capable of responding to their dynamic environments. The environment, considered by Henderson et al. (2003), is categorised, into: focal, contextual, and residual stimuli. The focal stimulus is described as what immediately confronts the individual diagnosed with breast cancer. The contextual stimuli according to Henderson et al. (2003) are factors that contribute to the focal stimuli such as, demographic factors like age, marital status, educational level, income and length of time since diagnosis. The residual stimuli are unknown environmental factors that affect the individual's adaptive system

(Henderson et al., 2003). Another theory that is apt and useful in explaining coping strategies is the Lazarus Theory of Stress and Coping. Halstead and Fernsler (1994) reported that cancer survival is a stressful experience requiring coping for the maintenance of equilibrium. Hence,

Lazarus' Theory was used to assess the effectiveness of coping strategies by long-term survivors. However, due to environmental impact (physical and psychological), coping strategies are vital to adaptation (Henderson, et al, 2003). Graves (2001) used social cognitive theory to enhance quality

of life for Breast Cancer survivors. Coupled with the above shared experiences, informants revealed that they are able to cope and demonstrate positive attitudes to life as a result of their successful surgeries. They have also learnt that in life, the unexpected could happen and people should never give up. Family support, the medical team and friends have been sources of encouragement to some of the informants, which helped them to cope successfully with breast cancer (Asemota, 2014).

5.0 CONCLUSION AND RECOMMENDATIONS

The results show similar coping mechanisms of acceptance of their situations after each successful initial stage of treatments, were conducted. However, in the course of these challenges, all the women were able to develop some coping mechanisms that helped them survived and are still helping them to survive their ordeal. These coping mechanisms vary from attitudes and behaviour such as: *“getting closer to God, paying more attention to their health than before, sharing with other survivors at the Conquer Breast Cancer Association meetings, and accepting their situations and have learnt to continue living positively with their lives”*

(Asemota, 2014). These findings also corroborate, the Mubuke studies conducted in 2013.

Women’s stories in this study indicated that social support constituted a vital source of coping mechanisms. Support from significant other(s), such as: *“spouses, boyfriends and children”*.

Many of the women deeply cherished the social support they obtained from their co-workers, family members, church and religious groups. One informant specifically mentioned the efforts of her medical team, in offering succour during her ordeal. Other supports, as narrated by the

informants, were obtained from friends and other members of their family, reading books on health and faith (Asemota, 2014).

The research findings revealed that no matter the socio-economic status of women, or their marital status or educational levels, all women in this study shared some common coping patterns after diagnoses with breast cancer. Therefore, some recommendations for increasing breast cancer survival rates are hereby suggested (Asemota, 2014):

I. Increase Sensitisation programmes for both men and women

The Ministry of Health and Ministry of Gender and Family Promotion should be at the forefront of increasing awareness of sensitising the Rwanda populace on cancers, especially breast cancer.

II. Psycho-social support

Although all the women developed coping mechanisms that suited their lifestyles, none of them mentioned receiving psycho-social support. In view of this gap or lack, there is need for counselling support, psycho-social support, financial support, and medical support from the Ministry of Health and other non-governmental organisations in managing breast cancer,

holistically.

III. Advocacy

There is need for more advocacies on increasing access to screening, widening the scope of insurance coverage to include breast cancer, as well as devote more funding to breast cancer patients.

IV. Capacity building: There is a need to encourage potential medical students to pursue courses in Oncology, oncological nursing and other courses relating to managing cancers, especially breast cancer.

REFERENCES

Alemayehu, G. M. (2012). Ethiopia: Breast Cancer Awareness Month.

http://indepthafrika.com/ethiopia-breast-cancer-awarenessmonth/#.UI42bG_Mju0

Retrieved 29/10/2012

Asemota, O. O. (2007). Impact Assessment of HIV/IDS on Namibian

Education Sector. A paper presented at the 5th International Conference Entrepreneurship and Innovation held at the Polytechnic of Namibia, Windhoek, Namibia, pp. 317- 323, 24 – 25 October.

Asemota, O. O. (2014). Coping and Attitude Investigations of Women Breast Cancer

Survivors in Kigali, Rwanda. Master of Public Health (International Health and Development), Mount Kenya University (Unpublished Thesis)

Boehringer Ingelheim (2009, May). Fact Sheet: The Global Burden of Cancer. Retrieved from: dl.groovygecko.net/.../shirehealth/04/Global_Burden_of_Cancer.pdf .

Dunkel-Schetter, C., Feinstein, L. G., Taylor, S. E., & Falke, R. L. (1992).

Patterns of Coping with Cancer. *Health Psychology*, 11(2), 79-87.

Gorey, K. M.; Luginaah, I. N.; Bartfay, E.; Fung, K. Y.; Holowaty, E. J.; Wright, F. C.;

Hamm, C.; & Kanjeekal, S. M. (2011). Effects of Socioeconomic Status on Colon Cancer Treatment Accessibility and Survival in Toronto, Ontario, and Francisco, California, 1996 - 2006. *American Journal of Public Health. Research and Practice.* January. 101(1), 112-119.

Graves, K. D. (2001). *Quality of Life Intervention for Breast Cancer Survivors:*

Application of Social Cognitive Theory. PhD Dissertation. Virginia Polytechnic

Institute and State University, Blacksburg, Virginia.

Retrieved: [http://scholar.lib.vt.edu/theses/available/etd-](http://scholar.lib.vt.edu/theses/available/etd-02252002152824_unrestricted/KGPDFdissertation.pdf)

[02252002152824_unrestricted/KGPDFdissertation.pdf](http://scholar.lib.vt.edu/theses/available/etd-02252002152824_unrestricted/KGPDFdissertation.pdf)

Groenewald, T. (2004). A phenomenological research design illustrated. *International*

Journal of Qualitative Methods, 3(1), 1-26. Article 4. Retrieved:

http://www.ualberta.ca/~iiqm/backissues/3_1/pdf/groenewald.p

Halstead, M. T., & Fernsler, J. I. (1994). Coping strategies of Long Term Cancer

Survivors. *Cancer Nursing*, 17(2), 94-100. Retrieved from:

<http://www.ncbi.nlm.nih.gov/pubmed/8020003>

Harandy, T.F., Ghofranipor, F., Montazeri, A., Anoosheh, M., Mohammadi, E., Ahmadi,

F., Shokravi, F. A., & Niknami, S. (2010). Health –Related Quality of Life in

Iranian Breast Cancer Survivors: A Qualitative Study.

Harvard Global Equity Initiative (2010, June 1-2) Cancer Care in Rwanda. Global Task Force on Expanded Access to Cancer Care and Control in Developing Countries.

Retrieved from: <http://isites.harvard.edu>

[/fs/docs/icb.topic761161.files/Cancer_care_and_control_in_Rwanda_](#)

[FINAL%202%200_PRINT_FINAL.pdf](#)

Henderson, P. D., Fogel, J., & Edwards, Q. T. (2003). Coping Strategies Among African American Women with Breast Cancer. *Southern Online Journal of Nursing*

Research, 4(3). Retrieved from: www.snrs.org

Institute of Medicine (2001). *Health and Behavior: The Interplay of Biological, Behavioral, and Societal Influences* Committee on Health and Behavior:

Research, Practice and Policy, Board on Neuroscience and Behavioral Health. Washington, DC: National Academies Press. Retrieved from:

<http://www.nap.edu/catalog/9838.html>

Lazarus, R. S. (1993). Coping Theory and Research: Past, Present and Future.

Psychosomatic Medicine, 55, 234-247.

Leedy, P. D. & Ormrod, J. E. (2010). *Practical Research: Planning and Design*, (9th ed.).

Pearson Education International, New Jersey: Pearson-Prentice Hall.

Levin, E. G., Aviv, C., Yoo, G., Ewing, C., & Au, A. (2009). The benefits of prayer on mood and well-being of breast cancer survivors. *Support Care Cancer*.

17:295-306. DOI 10.1007/s00520-008-0482-5.

Mubuuke, A. G. (2013). Listening to the voices: an exploratory study of the experiences of women diagnosed and living with breast cancer in Uganda. *The Pan African*

Medical Journal, 16-60. Doi:10.11604/pamj.2013.1660.2431

Mukwato, K. P., Mweemba, P., Makukula, M. K., & Makoleka, M. M. (2010) Stress and Coping Mechanisms Among Breast Cancer Patients and family caregivers: A

Review of Literature. *Medical Journal of Zambia*, 37(1), 40-45.

Namuwaya, E. (News Times, October, 22 2012) Breast Cancer is on the Increase.

Retrieved from <http://www.newtimes.co.rw/news/index.php?i=15153&a=59821>

Namuwaya, E. (News Times, October, 29 2012). Breast Cancer Awareness is Still low.

Retrieved from: <http://www.newtimes.co.rw/news/index.php?i=15160&a=60075>

Okorie, N. (2012). Mass Media Strategies for Creating Awareness of Breast Cancer.

Public Knowledge Journal. Retrieved from: http://pkjournal.org/?page_id=1520

Park, K. (2007). Park's Textbook of Preventive and Social Medicine. (19th ed). Jabalpur, India.

Robson, C. (2002). *Real World Research* (2nd ed.). Oxford: Blackwell Publishing.

Wells, B. L., & Horn, J. W. (1992). Stage at Diagnosis in Breast Cancer: Race and Socioeconomic Factors. *American Journal of Public Health*. October. 82(10) , 1383-1385.

