KNOWLEDGE AND ATTITUDE TOWARDS THE PRACTICE OF BREAST SELF EXAMINATION AMONG WOMEN IN NAMUWONGO ZONES A AND B

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NOVEMBER, 2017
DECLARATION

I hereby confirm that this research report on, **Knowledge and attitude towards the practice of Breast Self Examination among women in Namuwongo Zones A and B** is my original work and to the best of my knowledge it has neither been printed nor submitted to any University/institution for the award or any academic awards or any other qualification.

Signature...............................................................

SAFIYA MAMMAN:

Date........................................................................
APPROVAL

This research report titled, “Knowledge and attitude towards the practice of Breast Self Examination among women in Namuwongo Zones A and B”, was under my supervision as the University supervisor. It is now ready for submission.

Signature ..............................................................

MRS. SITUMA ELIZABETH
SUPERVISOR

Date..............................................................
DEDICATION

I dedicate this work to my father, Alhaji Mamman Abubakar Dan Musa and my mother Hajiya Halima Mamman Dan Musa, my brothers Jamilu Mamman Dan Musa, Idris Mamman Dan Musa.
ACKNOWLEDGEMENT

I appreciate the Almighty ALLAH for the courage, competence and protection to carry out this research project successfully.

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OPERATIONAL DEFINITIONS

**Breast self-examination (BSE):** This is an exam done by a woman on her own breasts to check for abnormal breast tissues such as lumps or other changes.

**Knowledge about BSE:** These were respondents who had information about BSE. This is gained from various sources.

**Attitude towards BSE:** This is the perception respondents had towards breast self examination.

**Practice to BSE:** Or it was the use of hands by women to inspect and palpate their breasts and the surrounding breast areas for any abnormality.
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<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>BC</td>
<td>Breast Cancer</td>
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<tr>
<td>BSE</td>
<td>Breast Self-Examination</td>
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<tr>
<td>CBE</td>
<td>Clinical Breast Examination</td>
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<td>GLOBOCAN</td>
<td>Global Organization on Cancer</td>
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<td>IARC</td>
<td>International Alliance Related to cancer</td>
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<td>MOH</td>
<td>Ministry of Health Uganda</td>
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<td>NGO</td>
<td>Non Governmental Organization</td>
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<td>UCI</td>
<td>Uganda Cancer Institute</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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ABSTRACT

Background: The study assessed the level of knowledge, attitude and practice about breast self-examination among women in Namuwongo Zones A and B in February 2017 with an aim of preventing breast cancer among women.

Methodology: The study was carried out using a descriptive cross sectional design where 143 respondents were used. These were selected by simple random sampling. Data was collected through self administered interviews and data was analysed by Microsoft excel and Chi-Square Tests.

Results: Majority 81 (56.3%) of the respondents were between 18 and 30 years, 84 (58.7%) were married, 65 (45.7%) had secondary education, 50 (34.8%) were housewives, 118 (82.4%) were Christians and 131 (91.4%) had never had family members who suffered from breast cancer. Respondents had good knowledge about breast self examination because; all of them had ever heard of it where 77 (54.2%) heard from the media. Many rightly knew the signs of breast cancer 106 (73.8%). 112 (78.4%) knew that breast cancer could be detected early enough through physical identification of the signs and symptoms. 110 (77.2%) knew the right age BSE should be carried (above 19 years) and 123(85.8%) knew that it could be done by palpating with the palm and a minimum of three fingers. However, they did not know that it was only for females 82 (57%) and did not know it should be carried out weekly.

Majority had negative attitudes towards breast self-examination because; 106 (74.1%) perceived BSE as a sex abuse action and obscene, 89 (62.2%) believed could never know whether they had breast cancer through BSE and 75 (52.4%) didn’t know BSE helps in prevention of breast carcinoma.

Respondents’ practices towards breast self-examination were generally poor. In the first instance few had ever performed BSE. The few; 55 (38.3%) who had ever done it, never did it regularly where 32 (58.6%) of them examined their breasts monthly, 31 (38.9%) had last examined their breasts six months ago and mainly did it in the evening 24 (46.2%).

Conclusion: Despite having good knowledge about BSE, they had negative attitude towards it where they did not believe that could detect breast cancer themselves which deterred their will to perform BSE. The researcher therefore suggests enhancing health education and sensitization to all females about the prevalence of breast cancer and the importance of BSE.

Recommendation: Extensive health education campaigns should be provided to the community. Nurses should play role in developing a collaborative care model to provide education to the public.
CHAPTER ONE
INTRODUCTION

1.1 Background

Breast self-examination (BSE) is a screening method which involves the woman herself looking at and feeling each breast for possible lumps, distortions or swelling to detect early breast cancer. Breast self-examination is a simple, inexpensive, non-invasive procedure which helps a woman to know her breast and allows her to detect changes in the breast; such as breast masses or lumps (Burke et al., 2007).

Breast cancer is among the leading causes of cancer mortality in women worldwide. The incidence of breast cancer is rising more rapidly in population groups that enjoyed a low incidence of the disease (WHO, 2015).

The number of new cases of female breast cancer was 125.0 per 100,000 women per year. The number of deaths was 21.5 per 100,000 women per year. These rates are age-adjusted and based on 2009-2013 cases and deaths. Approximately 12.4% of women will be diagnosed with female breast cancer at some point during their lifetime, based on 2011-2013 data. In 2013, there were an estimated 3,053,450 women living with female breast cancer in the United States. In 2015, an estimated 231,840 new cases of invasive breast cancer will be diagnosed among women, as well as an estimated 60,290 additional cases of in situ breast cancer.

Breast cancer causes 376,000 deaths a year worldwide and about 900,000 women are diagnosed every year with the disease (WHO, 2016). In comparison of China and Europe, China exhibited lower breast cancer mortality rates of 6.6 per 100,000 (Zeng, 2010), while the respective mortality rate in Europe was equal to 16.1 (Ferlay, 2013) in accordance with incidence rates.

Globally, cancer is the top leading causes of death. It was estimated that 8.2 million people died of cancer in 2012 and Prevalence estimates for 2012 show that there were 32.6 million people alive who had had a cancer diagnosed in the previous five years. More than half of all cancers (56.8%) and cancer deaths (64.9%) in 2012 occurred in less developed regions of the world (IARC WHO, 2013).

Breast cancer accounts for 45% of all cancer in females aged 25–49 years and 34% of all cancer in the 50–74 year age group in the United Kingdom. The incidence in the age group between 15 and 24 is 3.1 per million of population in the UK (WHO, 2016). In the United States, the probability of developing breast cancer remains at 0.5% for women aged less than 39 years and 3.8% for women aged 40–59 years (WHO, 2016).
According to GLOBOCAN-2012 estimations, there were 14.1 million new cancer cases, 8.2 million cancer deaths and 32.6 million people living with cancer (within 5 years of diagnosis) worldwide, but 57% (8 million) of new cancer cases, 65% (5.3 million) of the cancer deaths and 48% (15.6 million) of the 5-year prevalent cancer cases occurred in the less developed regions (WHO, 2015). With regard to breast cancer (BC), about 1.3 million women are annually diagnosed with the affection worldwide and over 508 000 women died in 2011 from the disease, making it the top women cancer. Although BC is thought to be a disease of the developed world, almost 50% of breast cancer cases and 58% of deaths occur in less developed countries (WHO, 2015). The GLOBOCAN, (2012) reported the incidence of BC in East Africa close to 11.7%, second to cervix cancer with 27.1% estimated 5-year prevalence (IARC, 2015).

In Europe, an average of 20% of breast cancer cases occur in women younger than 50 years; 37% occur at age 50–64 and the remaining cases in women above this age (Europa, 2013)

In Turkey, a study (Karayurt, Ozmen and Cetinkaya, 2008) found low knowledge among adolescent females as to time for BSE (13.2%), frequency of BSE (21.8%) and BSE procedure (26.6%). In Europe a study reported that only 14.8% among students aged 17 to 30 years knew how to perform BSE. Close findings also were found in Malaysia (Zavare et. al., 2011), Yemen and Kuwaiti (Alharbi, Alshammari and Almutairi, 2012)

Another study in Jeddah Saudi Arabia indicated that 39.6% reported ever hearing of BSE, but only 14.4% and 7.1% respectively knew the correct frequency and timing. A study High School and College Students in Mid Western USA (Mafuvadze, Manguvo, He, Whitney and Hyder, 2013) concluded that annual efforts to disseminate breast cancer awareness and the availability of information about the disease, both college and high school students have a poor understanding of BC.

In 2015, approximately 40,290 women are expected to die from breast cancer. Only lung cancer accounts for more cancer deaths in women. In 2015, about 2,350 men will be diagnosed with breast cancer and 440 men will die from the disease. Excluding cancers of the skin, breast cancer is the most common cancer among US women, accounting for 29% of newly diagnosed cancers.

Globally, breast cancer is the most common malignant neoplasm among women (WHO, 2016). Breast cancer causes 376,000 deaths a year worldwide; about 900,000 women are diagnosed every year with the disease (WHO, 2016). Indeed, the incidence of breast cancer is rising more rapidly in population groups that enjoyed a low incidence of the disease (NK et al., 2009).
Although the incidence of breast cancer in developing countries is relatively low (Ko et al., 2013), about 50% of all cases of breast cancer are diagnosed in these countries (Haji-Mahmoodi et al., 2012; Sadler et al., 2011).

In 2012, 1.7 million women were diagnosed with breast cancer and there were 6.3 million women alive who had been diagnosed with breast cancer in the previous five years in the world. Breast cancer is the most common cause of death and the most frequently diagnosed cancer among women in 140 of 184 countries worldwide. Incidence rate remains highest in more developed regions, but mortality is relatively much higher in less developed countries due to lack of early detection and access to treatment facilities ((IARC WHO, 2013).

Among women, breast cancer (BC) is the most common cause of mortality accounting for 16% of cancer deaths in adult women (WHO, 2016). Data from South Africa’s National Cancer Registry (NCR) shows breast cancer as the leading cancer among women. In Ugandan women, breast cancer is third most common cancer following Kaposi’s sarcoma and cervical cancer with incidence rate of 22 per 100,000 women (WHO, 2015). In Nigeria, the incidence of breast cancer has been reported to be 33.6/100,000 (WHO, 2015; Alkhasawneh, Akhu-Zaheya and Suleiman, 2009).

In the year, 2016, an estimated 246,660 new cases of invasive breast cancer are expected to be diagnosed in women in the U.S and at the same time, 61,000 new cases of non-invasive (in situ) breast cancer are also expected. (Breastcancer.org, 2016) But in Asia, Australia had an ASR for breast cancer, at 86.0 per 100,000, in 2012 while China was with 2012 ASRs for incidence and mortality of breast cancer at 22.1 and 5.4 per 100,000 respectively. India’s 2012 ASR was 25.8 per 100,000 while Japan had a markedly lower ASR for breast cancer in 2012 of 51.5 per 100,000 and Singapore had an incidence ASR — 65.7 per 100,000 in 2012. (The Economist, 2016)

Among women in Iran, breast cancer is the commonest cancer comprising 21.4% of all cancers among females (Noroozi et al., 2010) and accounted for approximately one third of the registered female malignancies (Iraqi Cancer Board, 2010).

Although the incidence of breast cancer in developing countries is relatively low (Ko et al., 2013), about 50% of all cases of breast cancer are diagnosed in these countries (Haji-Mahmoodi et al., 2012; Sadler et al., 2011). In the developing countries, the literature indicates that breast cancer presents about one decade earlier than in developed countries (Noroozi et al., 2010).
In Nigeria, et al (2009) reported that 97.3% of women had heard of breast cancer and breast self-examination. Indeed, most of the respondents, (85.8%) knew how to perform breast self-examination correctly. 65.4% had a good attitude towards breast self-examination. This indicated a high level of awareness of breast cancer and breast self-examination among the respondents. Their attitude towards breast cancer and breast self-examination was fair though the practice was poor (Nk et al., 2009). The prevalence of BSE was 21%.

Among female university students, the percentage of adolescents performing BSE is also low all over the world. The findings among female university nursing students in Angola revealed that only 57.8% were knowledgeable about BC and its screening (Sambanje and Mafuvadze, 2012).

The third most common cause of death after infectious and cardiovascular diseases is cancer with breast cancer contributing to 23.3% of cancer deaths in Kenya. Among the annual deaths in Kenya, Cancer is estimated to be responsible for 7% of the total annual deaths. (Health in Kenya, 2014). Meanwhile, the early discovery of breast lumps through breast self-examination (BSE) is important for the prevention and early detection of this disease.

In a study carried out in Rwanda, almost 95% of respondents had heard about BC, but less than 25% had sufficient knowledge about BC diagnostic methods, BC risk factors and BSE. More than 74% of interviewed girls never had BSE for breast cancer purpose, and of those who agreed doing BSE, only 4% knew the real timeframe of doing it, consistent with the studies by other researchers worldwide (Ndikubwimana et al., 2016).

In Uganda, the incidence of breast cancer is unknown, although reports show that breast cancer is the third most common cancer among women with an estimate of 56% five-year survival rate. (Gakwaya et al., 2008) This is attributed to breast cancer being an invasive and aggressive disease and is associated with a poorer prognosis in older women. Early detection rates through breast self-examination (BSE) plays an important role in decreasing the morbidity and mortality rates. (Gakwaya et al, 2008)

More so, evidence showed that knowledge and appropriate use of screening methods significantly reduced the mortality rates associated with breast cancer in the United States and the United Kingdom (Jemal, 2009) and little has been done regarding the assessment of knowledge and attitudes towards practice of breast-self-examination among women attending Uganda Cancer Institute which inspired the researcher to do this research study.
Despite the benefits associated with BSE, most of the women (71%) have no idea about mammography or self breast examination (Kiguli-Mulwadde, et al., 2010). More than 80% of women irregularly perform it and many do not even know how to perform it. There is also evidence that women are more likely to perform BSE effectively when taught by physicians or a nurse. The purpose of this study is to assess the knowledge, attitudes and practices of Breast self-examination among women attending Uganda Cancer institute.

1.2 Problem statement

Breast cancer is the third commonest cancer in women in Uganda after Kaposi’s sarcoma and cervical cancer (MOH, 2015). Breast cancer incidence in Uganda is 22: 100,000 and five year survival rate is 56% (MOH, 2015). Breast cancer can be identified by an individual by simply carrying out regular breast self-examinations. Globally, over one million breast cancer cases are diagnosed annually (Ferlay et al., 2015). This amount to a total 411,000 deaths from breast cancer accounting for 14% of female cancer deaths worldwide. It is estimated that about half (60%) of breast cancer deaths occur in economically developing countries (Akpo, Akpo and Akhator, 2010).

Breast self-examination is a simple method of primary prevention of advanced stage presentation of breast cancer. It is a simple method which women can perform by themselves. Women who perform breast self-examination become more familiar with their breasts which make it potentially easy to identify abnormal breast growths and seek early medical attention. Although breast self-examination is not the ultimate confirmation of breast abnormalities, when performed accurately and regularly, it provides women with the opportunity to notice differences in breast tissues and detect breast cancer at an early stage (Wheeler et al., 2009).

Despite the benefits associated with breast self-examination (BSE), many women do not know how to perform it and few women perform it. Here less than 20% do self breast examination and more than 80% do not do it (Kiguli-Mulwadde, et al., 2010). Neither the teaching of breast self-examination (BSE) nor the performance of clinical breast examination (CBE) has been demonstrated in a screening setting to independently reduce breast cancer mortality.

In Uganda, women commonly seek for medical attention with visually obvious breast masses or ulcerated tumours that have been present for many months or years where greater than 77% of women are given a diagnosis of advanced-stage disease, including 26% with metastatic stage IV cancer at initial presentation. In a recent analysis of patients with breast cancer treated at UCI, 187 presented with stage III or IV disease (Galukande et al, 2015).
The awareness that has been created by nongovernmental organizations like Uganda Women's Cancer Support Organization (UWOCASO) on the benefits of BSE for early detection of breast cancer, late presentation of cases at advanced stages when little or no treatment can be done from any form of therapy has remained the same on breast cancer among Ugandan women. Since the assessment of knowledge and attitudes towards practices of BSE can serve as alternative measures for essential factors that contribute to breast cancer down-staging, the researcher was inspired to do so. Inadequate knowledge and wrong attitude towards BSE leads to poor practice. Therefore, it is worth investigating whether women have knowledge, good attitude and practice breast self-examination.

1.3 General Objectives
The study assessed the level of knowledge, attitude and practice about breast self-examination among women over 18 years in Namuwongo Zones A and B in March and April 2017 with an aim of preventing breast cancer among women.

1.4 Specific Objectives
• To assess the level of knowledge about breast self-examination among women over 18 years in Namuwongo Zones A and B.
• To examine the attitudes towards breast self-examination among women over 18 years in Namuwongo Zones A and B.
• To assess the practice of breast self-examination among women over 18 years in Namuwongo Zones A and B.

1.5 Research questions
• What is the level of knowledge about breast self-examination among women over 18 years in Namuwongo Zones A and B?
• What are the attitudes towards breast self-examination among women over 18 years in Namuwongo Zones A and B?
• To assess the practice of breast self-examination among women over 18 years in Namuwongo Zones A and B?

1.6 Significance of the study
Information on knowledge and attitudes towards practices of BSE among women aged 20 to 25 years attending Uganda Cancer Institute will be presented from the study.
Findings will create awareness to the health professionals about the level of knowledge and the women’s attitudes towards practicing BSE thereby improving the quality of patient care through educating the patients and the community about BSE.

The results of this study will also provide the data that will be used by U.C.I, Ministry of health and NGOs to identify he educational needs of women as far as BSE is concerned and prevention of late presentation of breast cancer.

Findings will also provide the future scholars and researches with information regarding data on Knowledge, attitude towards practice of self-breast examination among women.

The study is a partial fulfilment for the award of a Bachelor’s degree in Nursing Sciences of International Health Sciences University to the Researcher.
### 1.7 Conceptual framework

**Independent variable**
- Ever heard of breast self examination
- Knew the prevalence of breast cancer in the area
- Awareness that breast cancer can be detected early
- BSE can increases chances of survival from breast cancer
- Source of information about BSE
- Awareness of how to perform breast self examination
- Knowledge about the age to perform BSE
- Familiarity with number of time to do BSE

**Dependent variable**

**Breast Self Examination**

**Practices**
- Performance of BSE
- Reason for performance of BSE
- Frequency of BSE performance
- Plan of performing BSE
- Posture of performance of BSE
- Ever performed breast self examination
- Number of times one performs BSE
- Age at which one starts BSE
- Last time one performed BSE
- Time one performs BSE
- Usually perform BSE

**Attitude towards BSE**
- BSE can easily be done
- Anyone can get breast cancer
- BSE is not a sex abuse action
- BSE can enable me know about breast cancer
- BSE causes no harm
- BSE helps in prevention of breast carcinoma
- Touching my breasts is obscene
- BSE will not necessarily lead to a positive test
- Carcinoma of the breast cannot be transmitted
- It is good to seek medical help immediately after identifying a lump
- Breast cancer occur more commonly in old women
- Am at a high risk for developing breast cancer thus need BSE

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**Figure 1: Conceptual framework about knowledge, attitude and practices towards BSE**

The conceptual framework above describes the relation between knowledge; attitude and practices towards breast self examination among women in Namuwongo A and B.
CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction

This chapter presents literature reviewed from relevant previous studies and books in relation to the specific objectives of the study which include knowledge and attitudes towards practicing Breast Self-Examination.

2.2 Overview of Breast Self-Exam (BSE)

A breast self-examination (BSE) is a technique which allows an individual to examine his/her breast tissue for any physical or visual changes. It is often used as an early detection method for breast cancer. Women should perform a BSE at least once each month beginning at age 18 years.

The best time to do a monthly self-breast exam is about 3 to 5 days after your period starts when breasts are not tender or lumpy at this time of monthly cycle. It’s done at the same time every month (Gakwaya et al., 2016).

If one is pregnant, no longer have periods or their periods are irregular, one chooses a specific day each month. BSE should not be performed in the shower or with lotion on your skin or fingers. (Maurer Foundation, 2016)

**Breast Self-Exam procedure**

The first step is looking at the breasts in the mirror with shoulders straight and arms on the hips. Here the most important things to be observed are; breasts are in their usual size, shape, and colour. Secondly breasts that are evenly shaped without visible distortion or swelling. If any change is seen a doctor should be consulted for better advice.

Thirdly nipples should be observed to know whether they are still in their right position or are inverted. The dimpling, puckering, or bulging of the skin of the breast should be observed. Lastly the redness, soreness, rash, or swelling should also be taken note of.

The second step is raising the arms and look for the same changes in step 1.

The third step is; while still at the mirror any signs of fluid coming out of one or both nipples should be noted. The fluid could be a watery, milky, or yellow fluid or blood.
Step four is to feel the breasts while lying down, using the right hand to feel. The left breast should be felt by the right hand and the left hand to feel the right breast. A firm, smooth touch with the first few finger pads of the hand, keeping the fingers flat and together should be used. A circular motion, about the size of a quarter should be observed.

The entire breast should be covered from top to bottom, side to side — from the collarbone to the top of the abdomen, and from armpit to cleavage.

The pattern should be followed to make sure that the whole breast is covered. It can begin at the nipple, moving in larger and larger circles until the outer edge of the breast. The fingers can be moved up and down vertically, in rows, as if mowing a lawn. This up-and-down approach seems to work best for most women. All the tissues should be felt from the front to the back of the breasts: for the skin and tissue just beneath, light pressure should be used; use medium pressure for tissue in the middle of the breasts; use firm pressure for the deep tissue in the back. When the deep tissue is reached one should be able to feel down to the ribcage.

The fifth step is to feel the breasts while standing or sitting. The entire breast should be covered, using the same hand movements described in step 4. Normal findings are soft and non-tender breasts while abnormal findings are: Smooth, firm, round, movable, non-tender lump of 1-5cm size indicating fibro adenoma. Irregular shape, poorly defined borders, non-tender, immovable, increase in size as disease progresses—breast cancer.

2.3 Knowledge of women about breast self-examination

Atanga et al., (2012) noted that, nearly three quarters (74.17%) of participants had previously heard about BSE. Approximately 6 in every 10 women (59.17%) claimed to know how to perform BSE with 35% reporting performing BSE monthly and 12.5% performing it 6-monthly. As many as 40% of participants had never done a BSE, Atanga et al., (2012) noted that, Overall 25.6% of respondents were not aware of BSE (they had never heard of BSE, had absolutely no idea on how to perform a BSE and never practiced it) while 39.17% were partially aware (had heard of BSE, had a slight idea on how to perform it but did not practice it often) and 35% were substantially aware of BSE (had heard of BSE, knew how to perform it and practiced it often). Despite a substantial proportion of women not being aware of BSE nearly all of them (95%) recognized the importance of BSE for their health.

In Angola, a study of 595 university students indicated that a majority of them where not knowledgeable about breast cancer (Sambanje and Mafuvadze, 2012). In Senegal a survey of 300 women indicated only 42.7% having knowledge about BSE and only 29% practicing it
The situation appeared worse in women of African descent in South Africa in whom a survey indicated that close to one-fifth of women had not heard of breast cancer and half were not aware of BSE (Atanga et al., 2012).

Atanga et al., (2012) overall 51.77% of participants were partially aware of the causes of breast cancer (recognized at least two accepted causes of breast cancer) while 48.33% were substantially aware (recognized five or more commonly accepted causes of breast cancer). On the other hand 5% of respondents were not aware of risk factors of breast cancer (did not know any breast cancer risk factor), while 50% were partially aware (recognized at least two accepted breast cancer risk factors) and 45% were substantially aware (recognized five or more accepted breast cancer risk factors).

Specifically, in Nigeria, a study of female secondary students in Abuja indicated that while a high proportion knew about BSE being used to prevent breast cancer very few (10.1%) practiced it (Isara and Ojedokun, 2011). Similarly, close to three quarters of female undergraduate students in Nigeria had heard about BSE, although only about one in five had ever practiced it (Gwarzo, Sabitu and Idris, 2009). Still in Nigeria, a study of rural women revealed poor knowledge similarly perceptions about a mystical origin of breast cancer such as it being due an “attack from the enemy” (Oluwatosin, 2006).

In a study on Nursing Students of Arab American University/Jenin, Palestine, majority of students aged above 20 years (19.6%) had fair knowledge about BSE. One fifth of the students with poor knowledge were living in urban and rural areas (21.6%). (Ayed, 2015) whereas a study in Ghana, on female university students at Presbyterian University College 95% respondents had ever heard of breast cancer and BSE. (Sarfo et al, 2013).

In Karachi, Pakistan, a survey of 373 participants showed that 49% of the sample had heard about BSE, 38% knew how to do one but only 26% had ever done it. A survey of young college students in UK showed that greater perception of hindrances to BSE and also having a higher severity perception of breast cancer were characteristics of women who were not doing BSE despite being knowledgeable about it (Umeh and Jones, 2011). However, studies have also shown that improved literacy rates in general positively influences positive health behaviour towards breast cancer (Harirchi et al., 2012).

While it is accepted that the standards of teaching with regard to breast cancer should improve, there are doubts as to who are the best teachers to teach the students. Class teachers may not be the best option in this regard for two reasons; a) unfamiliarity with the subject and b) cultural
sensitivity (especially teaching the topic in non-gender segregated schools) which might leave them uncomfortable to discuss the topic.

The way out is to employ public health midwives and public health nurses who are the grass root level healthcare workers in the community. However they may also need proper training before undertaking this task as the experience in some countries is that level of knowledge on breast cancer and BSE is rather unsatisfactory among healthcare workers as well.

Adolescent females are an important target group for promotion of proper health habits, in particular with regards to breast health. To our knowledge there are no published data on knowledge, attitudes and practices among adolescent females on breast cancer in Sri Lanka, and few published studies worldwide (Karayurt, Ozmen and Cetinkaya, 2008).

The knowledge regarding risk factors for breast cancer in this sample was poor. The majority of respondents were not aware of early warning signs such as nipple changes and a lump in the armpit. The knowledge on screening methods was also unsatisfactory with a majority being unaware of either mammogram or BSE.

In a study on School Teachers in Mosul City, Iraq revealed that the main source of Self breast-examination knowledge was T.V. program (72.9%), while health professional form (34.4%) The study also depicted that 84.4% of participant had knowledge about technique about BSE, but knowledge regarding general information was low (Maarab et al, 2012).

Still in the same study in Mosul City, the ideal age to start practicing BSE was \( \geq 20 \) years old that was presented in 42.0% of the respondents and the right time to practice BSE was presented in 36.0%, of the study sample. Only half of the study sample showed the frequency for practicing BSE as monthly (Maarab et al, 2012).

In Ghana, a study on female university students at Presbyterian University College majority of respondents cited the media and formal education as their source of information on breast cancer and BSE. Even though the majority of respondents claimed they had heard of SBE, only 80% knew how to perform it. The study showed that majority of respondents were aware of breast cancer as a disease and self-breast examination as a screening method, but their knowledge and understanding of the method of BSE was very low (Sarfo et al., 2013).

Furthermore, respondents were asked on the methods of performing breast self-examination and 38% indicated standing and looking for discharges in front of the mirror, 9% indicated feeling
for changes in their breast while showering, 49% indicated feeling for changes in the breast while lying down, and 4% stated all the above (Sarfo et al., 2013).

Being health 100 (44.8%) and lack of knowledge 60 (26.9%) were the most reason mentioned for not practicing BSE. In a study done in Iraq, lack of confidence in their own examination (27%), fear from detecting a lump in the breast (25%) and that they had not been instructed to perform BSE (20%) were reason for no practicing BSE (Nada, et al, 2012). A study done among Jordanian nurses’ and Ghana, from the participants who did not performing BSE, I don't believe that it is beneficial, not having time “(too busy)” where reasons mostly reported (Amasha, 2013). This study contradicts with our result, the reason may be the Jordanian nurses and Ghanaian may have a better access for other means of early detection of breast cancer, like mammography.

A study in Uganda revealed a high awareness of breast cancer (98.0%) and BSE practices (76.5%) among university female students. Over half the students (61.3%) had an intermediate level of knowledge about risk factors related to breast cancer and the signs and symptoms of the disease. The majority (56.9%) of students received information about breast cancer via mass media (Godfrey, 2013).

Most participants stated that they did not know the signs and symptoms of breast cancer and few others mentioned a lump, swollen breasts, and discharge of pus from the nipples, and / or a bump / lump under the armpit. According to one other participant you could only tell you had breast cancer after testing at the hospital and the only time you could be able to tell before then, is when the breast develops a sore and becomes untreatable. Furthermore there was a consensus among the young women that any sign of a lump was a cue to go the hospital. “With BC, if I find the lump I can go to the hospital and get the lump checked and if its cancer I am able to remove the lump” Bomi 29years “You get swollen breasts, and you get pus from your nipples” Amanda 18yrs.

Nearly two fifth of the respondents reported that BSE should be performed a week after menses while 111 (30.2%) of the respondents didn’t know when to be performed. Similar findings of Saudi Arabia less than half (46.8%) of the respondents aware that should be performed A week after menses BSE (Dalal et al, 2014) and a study in Ghana, 62% stated some days after menstruation (Sarfo, et al, 2013)

In a study at College of Medicine of the University of Lagos, Nigeria, Only 53.6% knew that both male and female are required to perform breast self-examination, with 54.5% of the
respondents having the view that breast self-examination should start at less than 19 years while 45.5% were of the opinion that it should start at over 19 years of age. Most of the respondents, 85.8% knew how to perform breast self-examination correctly (Ink et al, 2012).

Tieng’O, Pengpid, Skaal and Peltzer, (2011) in an interviewer administered questionnaire administered to 375 women attending a health facility in Gaborone, Botswana, results indicate low knowledge of breast cancer examination, e.g. only 34.1% knew about the commonest presentation of breast cancer (painless breast lump).

Obaji, et al., (2013) in a study on the awareness and Practice of Breast Self-Examination among Market Women in Abakaliki, South East Nigeria The age range of participants was between 20 and 65 years, with a mean age of 34.3 (10.8) years. The age range between 20 and 29 years constituted the highest age group 35.3% (84/238). Majority 54.2% (129/238) had a maximum of secondary education. Of the 238 participants, 77.7% have heard of breast cancer, of which 73.9% thought that early detection would aid treatment. Only 38.9% (6/195), 13% and 13.4% have heard of BSE, clinical breast examination and mammography, respectively. Just 23.9% have been taught how to perform BSE, while 21.8% had done it in the past. One person 0.4% knew the correct frequency of BSE, and also did it regularly. There was a statistically significant difference between the level of education and awareness of BSE. However, there was no statistical significant difference between participant’s age and awareness of BSE.

A total of 340 (78.2%) out of the 435 did not agree that breast cancer patients should be isolated or stigmatized and 308 (70.8%) did not believe that the disease was a punishment from God. The majority agreed that breast cancer patients should live in the community (95.6%) and be supported (97.9%). Nevertheless, 292 (67.1%) of the respondents were afraid of patients with the disease.

Tieng’O et al., (2011) noted that with regards to BSE, only 152 (34.9%) of those aware of breast cancer knew of BSE as a method for the early detection of breast cancer, and only 93 (61.1%) had ever undergone screening or performed BSE themselves. Of those 93, 23 (24.7%) did so on the advice of health workers, and 28 (30.2%) did so as part of a routine medical examination. As for those respondents who were aware of breast cancer, 198 (45.5%) would undergo screening or perform BSE if it was of benefit to them, 111 (25.5%) if their family agreed, and 84 (19.3%) only if there was a known cure for breast cancer.

Tieng’O et al., (2011) reveal although participants had a positive attitude towards breast cancer examination, only few (23.5%) of those who practiced breast self examination (63.5%) (BSE),
practiced monthly as required. Similarly, only 22.7% had visited a doctor for clinical breast examination (CBE) in the past year, and 1.6% of the respondents had done mammogram in the past 2 years.

Brito et al., (2010) in a prospective and cross-sectional study, with conglomerate sampling, in which 552 women from 14 census sections about knowledge, practice and attitude about breast self-exam from women of a São Luís in North eastern municipality, Brazil, although 1/3 of the studied population did not know about BSE, the group of women who were informed about it showed adequate knowledge (60.9%), practice (59.5%) and attitude (90%). The family history of breast cancer (8.9%) was not associated with better knowledge and practice. The media (63.6%) was found to be important in disseminating information about BSE. After multivariate analysis, women with a partner (OR=1.9) presented more adequate knowledge; women older than 50 years (OR=11.7) had a better attitude towards BSE; women with more than five years of schooling (OR=2) and with a partner (OR=1.7) were associated with a more correct practice of BSE.

2.4 Attitudes of women towards breast self-examination

In a study on Nursing Students of Arab American University/Jenin, Palestine majority of the participants believed that all women should do BSE (63.9%). However, 4.2% of them stated that BSE causes embarrassment and 29.9% feared to think about breast cancer. About 21.6% wasn't interested in doing BSE (Ayed, 2015).

Whereas a study on School Teachers in Mosul City, Iraq revealed that more than half of the study sample believed that BSE is neither difficult and time consuming nor embarrassment. However regarding checking, 40% of the study samples believed that if they do not have any problem in their breasts, so there was no reason to examine their breasts since it would be wastage of time and triggering other complications that they did not have (Maarab et al., 2012).

In Ghana, a study on female university students at Presbyterian University College Respondents were asked if BSE is necessary and 65% of respondents strongly agreed that it is necessary, while 35% of respondents agreed that is not necessary (Sarfo et al., 2013).

In a study on School Teachers in Mosul City, Iraq One handed forty eight (74%) of the responders stated that they had never done BSE. The commonest reason given for not doing it, did not hear about did not hear about BSE (39.0%). Other reasons included: do not want (16.0%), had no knowledge of procedure (9.5%), Afraid (5.5%), and not useful (4.0%) (Maarab et al., 2012).
In Ghana, a study on female university students at Presbyterian University College had 76% respondents responded yes and 24% responded no when respondents were asked if they performed BSE. The minority of respondents (24%) who did not perform BSE, were further asked on their reasons for not performing BSE and 30% said they do not have time, 11% said they didn’t feel it was necessary, while 59% did not have a specific reason for not performing BSE (Sarfo et al., 2013).

Furthermore, respondents were asked about the factors that hindered their performance of BSE and 23% stated time as a factor, 15% indicated procrastination, 25% indicated forgetfulness, 6% attributed it to laziness, 13% stated the fear of discovering a lump in their breast, 6% indicated that they do not trust in their ability to perform the procedure correctly, 6% stated they have no available specific training program to guide them to perform the procedure correctly, and 6% stated they were anxious (Sarfo et al., 2013).

In a study at College of Medicine of the University of Lagos, Nigeria, 65.4% of the respondents thought that breast self-examination was necessary while 83.1% of the respondents have carried out breast self-examination. Of those that have carried out breast self-examination before, 87.4% did it to examine their breasts regularly while 6.8% did it because they have a family history of breast cancer (Ink et al., 2012).

In the same study in Nigeria, the respondents who had never performed breast self-examination, 46.7% did not because they do not have any symptom, 26.7% felt it was not important, 22.6% did not know how to do it, 20% felt they can never have cancer, 10% of the respondents felt they were violating themselves by touching their breast and did not believe in the efficacy of the test and 3.3% of the respondents were scared of being diagnosed with breast cancer. The respondents also felt that breast self-examination should be performed daily (23.8%), some weekly (22.5%), some monthly (50.8%) and some yearly (2.9%) (Ink et al., 2012).

In this study, about 60% of the respondents had a positive attitude toward BSE. A study done in Saudi Arabia more than two third of the respondents had positive attitude toward BSE because they regarded it a normal health care practice and not a sexual abuse (Dala, et al, 2014) While a study conducted in, Iraq 89.7% of the female had positive attitude toward learning the correct procedure of BSE with an intention to instruct others on the technique (Nada et al, 2012) and Nigeria in 2008 showed that from 100 health workers, [92%] positive attitude (Oluwole, 2008). This difference may be due to the level of knowledge between Nigerian health workers and
health students in our case and in other way the sample size taken Nigeria was small compared to our study.

2.5 Practices of women towards breast self-examination

The knowledge awareness of BSE was over 80% similar to figures cited in other studies such as by Demirkiran in 2007 performed among Turkey nurses. It is important that the awareness of BSE translates into adequate or appropriate practice early detection of breast lumps. Most cancerous breast lumps are self-discovered, but it is important that these lumps are discovered in the early stages when they are still small. Tumors detected at 2cm in diameter allow women more treatment choices and a greater chance of long-term survival (Gakwaya et al., 2008). In this study, lump sizes ranged from 2.4cm to 3.4 cm on average. They were smaller (2.4cm) for those who had lumps but were not aware of them and had not practiced BSE, and they averaged 3.4cm for those that were aware, they had the lumps.

Breast Self Examination should be practiced correctly and this involves a number of aspects; frequency, timing, a correct technique consistent application of it as well as acting on any positive findings without much delay. In published work, women who practice BSE tend to be younger, pre menopausal and of a higher socio economic status (O'Mahony and Hegarty, 2009). Possibly this has to do with access and exposure to health talk information through the media, peers and health workers. This description agrees with the demographics of this study even though, selection of this study population was self fulfilling.

In this study only 39.4% of the respondents have practiced BSE. Similarly in a study done in different part of developing countries in Asia and Africa including Ethiopia in different times the practice toward BSE is low (Legesse and Gedif, 2014). But in a study in Nigeria and Ghana the practice of BSE is higher than this finding 80% and 76% respectively (Oluwole, 20140. Concerning the frequency of BSE only 5.5% of the respondents did BSE monthly. This finding is lower than the studies done in other parts of the world and in our country, in Saudi study 17% (Dalal, et al, 2014), Nigeria 50% (Oluwole, 2008), Ghana 31% (Sarfo, et al, 2013) in Mekelle 29.5% (Legesse and Gedif, 2014), West Gojjam Zone 14.4% (Azage, Abeje and Mekonnen, 2013) practiced monthly basis. The variation is attributable due to the study setting, study participants in our case majority of the respondents were young ages and may have no concern about breast cancer, in other way, the study participants were health professionals, there may have adequate knowledge about breast cancer through experience. In addition due low sample size in case of study in Nigeria where sample size was 100.
Program enrolment and Attitude score remain significantly associated with practice of BSE. Women who enrolled in extension program were nearly 3 times more likely to practice BSE (AOR=2.91, 95%CI=1.75, 4.86). The reason could women enrolled in extension program mostly the married ones, no fear of touching their breast probably due to an experience in life. In addition this group of women might be aware about the risk of breast cancer in their previous exposure while engaging in diploma program or while in job through different means.

In a study carried out in Lagos Nigeria out of the 435 respondents who were aware of breast cancer, 51.8% obtained their information on breast cancer and breast self examination from friends and health workers. This was in contrast to the results of a study conducted in South Eastern Nigeria by Ibrahim and Odusanya (2009) which showed that health workers were the main source of information about breast cancer. Friends and family also seem to play a major role in terms of breast cancer awareness in Middle Eastern communities, as exemplified by the finding that 25.5% of the respondents who were aware of breast cancer would only undergo breast cancer screening if their family agreed. In the Middle East, breast cancer comes with a heavy cultural stigma, as exemplified by the study in which Laura Bush stated that, “Women in [the] Middle East are sometimes abandoned by their family when the disease is diagnosed, [and] such stories are discouraging” (Jaradeen, 2010).

Jaradeen (2010) in a study carried out in Jordan, the practice of BSE was low amongst the sample tested. Only 152 (34.9%) of those aware of breast cancer knew of BSE as a method for detecting breast cancer, and only 93 of those respondents (61.1%) had ever performed it. This is in line with the findings of Abdel Hadi,[23] who found that 37.3% of his study population practiced BSE.

In studies of other populations, the percentage of BSE awareness was 52% among Jordanian nurses (Abu Salem and Hassan, 2007), 37% among Australian students, and 31% among Pennsylvanian women. Other studies that showed low rates of BSE practice suggested that the practice is globally low among women, regardless of their age and occupation (Ahmed, Mahmud, Hatcher and Khan, 2006). However, the rates reported in this current study were higher than those described by previous Egyptian and Iranian studies, in which only 6% and 2.65% of the general study populations practiced BSE monthly, respectively (Ahmed et al., 2006).
Jordanian female students did not partake in breast cancer screening practices. More than a third of students who were aware of breast cancer did not feel that screening was necessary, and 28.8% of women reported being too busy. The provision of systematic health education (e.g. at college) may help to encourage breast cancer screening and change perceptions regarding screening. It is important to raise women's awareness regarding the potentially life-saving benefits of BSE practice. In addition, the accessibility of screening practices should be expanded with government support.

The evaluation of public awareness, attitudes and practice of BSE is of fundamental importance for the successful implementation of breast cancer control activities (Jaradeen, 2010). There are no known proven means to prevent breast cancer, which increases our reliance on the methods for early detection in order to improve patient outcomes.
CHAPTER THREE
METHODOLOGY

3.0 Introduction
This chapter presents description of the methods that were used in the study it presented the description of the study area, study participants, study design, selection criteria, data analysis plan and ethical considerations.

3.1 Study design
Descriptive cross sectional study design was used for conducting the study. This was chosen because it allowed the researcher to gather information needed to fulfil the study objectives at one point in a time. Quantitative research approach was used because there was need to enable the researcher to get much information from a big number of respondents.

3.2 Sources of data
The study was based on both primary and secondary data.

Primary data; this was information that was got directly from the respondents in the study area. Self administered structured interviews were used to collect data from the respondents in a period of two weeks.

Secondary data; This was information that was reviewed from published studies done from direct parts of the world about breast self examination and breast cancer. These mainly include; on-line journals, electronic books, library books, research dissertations, learning websites, etc.

3.3 Study Area
The study was carried out in Namuwongo Zones (A and B) located in Namuwongo village, Namuwongo Parish, in Makindye Division. Namuwongo village has a slum called "Soweto"; that is divided into seven zones namely: Industrial Area View, Go-Down, Kasanvu, Namuwongo A, Namuwongo B, Kanyogoga/Masengere and Yoweri Kaguta (YOKA). These zones had over 20,000 people living in very confined spaces, averaging 2 rooms for a family of at least 4 members (Tenywa, 2013).

The area is bordered by Lugogo to the north, Nakawa to the northeast, Kiswa and Bugoloobi to the east, Muyenga to the southeast, Kisugu and Kabalagala to the south, Kibuli to the west and Kololo to the northwest (Kamukama, 2012). The neighborhood is located approximately 6 kilometres (3.7 mi), by road, southeast of the Kampala City. The coordinates of Namuwongo are: 0°18'29.0"N 32°36'44.0"E (Latitude: 0.308050; Longitude: 32.612223) (Nasasira, 2014).
**Study period:** The study was conducted in March 2017.

### 3.4 Study population:
The study population included females aged 18 and above.

### 3.4.1 Selection criteria
**Inclusion criteria**
- Females aged 18 years and above from Namuwango zone A and B,
- Females who consented to participate in the study.

**Exclusion Criteria**
- All females below 18 years who decline to consented for the study and ill patients were eliminated from the study.

### 3.5 Sample size determination
A total of 143 respondents who were females from an accessible population of 223 adult females of Namuwongo Zones A and B were considered. The researcher selected the 143 respondents from 223 households in the area.

### 3.6 Sample size calculation.
Sample size was determined by the Slovenes formula because it helped to derive samples from a relatively small accessible population that was below 1000 people.

\[
n = \frac{N}{1 + N \cdot (e)^2}.
\]

Where;  
- \( n = \) Sample size  
- \( N = \) Population size  
- \( e = \) Standard margin of error (5% or 0.05)

\[
n = \frac{223}{1 + 223(0.05 \times 0.05)}
\]

\[
n = \frac{223}{1 + 223(0.0025)}
\]

\[
n = \frac{223}{1 + 0.5575}
\]

\[
n = \frac{223}{1.5575}
\]

\[
n = 143 \text{ respondents}
\]
3.7 Sampling technique
Simple random sampling technique was used to select participants for the study as long as they were above 18. This was used because it minimised selection bias among the desired population.

3.8 Sampling procedure
All females in Namuwongo zones A and B were eligible to participate in the study provided they full filled the selection criteria. These were selected by simple random sampling. Therefore every second person stood an equal chance to be selected as a respondent to participate in the study. The researcher made home to home visits where a total of at least 24 women were selected in six days until a sample size of 143 respondents was obtained.

3.9 Study variables
3.9.1 Dependent variable
Breast self-examination was the dependent variable in this study.

3.9.2 Independent variables
The independent variables in this study were Knowledge and attitude associated with breast self-examination.

3.10 Data collection tools
Tool of the study: A self-administered interviews prepared by the researcher were used. Questions were partly drawn using information on breast self-examination from the literature. Additional questions were adapted, after modification, from questionnaires used in similar studies.

The questionnaire had three sections. The first section was to elicit socio-demographic data on age, ethnicity, and marital status of each participant.

Questions relating to knowledge of breast self-examination were asked in the second part. Participants’ awareness of BSE and early detection methods were also assessed in this section. The third section assessed the attitude towards BSE while the fourth part of the questionnaire assessed practice of BSE among participants.

Scoring system of participants' knowledge was measured by relating the attributes within this variable.

The attitude was based on a likert scales measure on a five point schedule. Part will consist of 13 items, each item will have a group of answer points, 5 points for strongly agree, 4 points for
agree, 3 points for uncertain, 2 points for disagree, and one point for strongly disagree. The practice part will consist of 7 items; each item had a group of answer points, 5 points for always, 4 points for usually, 3 points for often, 2 points for sometimes, and one point for never.

3.11 Plan for data analysis
The quantitative data was entered and analysed using the Microsoft excel and Chi-square test version and the level of significance (α) set at 0.05. Descriptive and inferential statistical tests were presented. Demographic and baseline variables were presented using frequency, percentage, and bar chart.

3.12 Plan for quality control measures
Validity and reliability of the study
The questionnaire was revised and validated by panel of 5 experts in academic and health field; they agreed and no comments. Research assistants were well trained. Data quality was ensured by giving identification number and code to help entry and checking. Internal consistency among the questionnaire items was 0.90 Cronbach's alpha (α) and it was considered within the acceptable range.

A pilot study was used to test the instrument (Polit & Beck, 2012) defines pilot study as a smaller version of a proposed study conducted to define the methodology. It was developed much like the proposed study, using similar subjects, the same settings, the same treatment, the same data collection and analysis techniques.

A pilot study was conducted in Kisugu Village which is in the neighbourhood of Namuwongo with community leaders to determine the clarity of questions, effectiveness of instructions, completeness of response sets, time required to complete the questionnaire and success of data collection technique.

Pilot subjects were asked to comment on the applicability and appropriateness (validity) of the interview questions. All questions that were not clear to the respondents were clarified by the researcher so that appropriate answers were given by the respondent. The researcher took ten (10) minutes to interview every respondent.

3.13 Plan for dissemination
Five copies of the report were produced after compiling the study findings. One was submitted to International Health Sciences University School of Nursing, the second copy was submitted to IHSU Library, and the third and fourth copies was submitted to local administrators of
Namuwongo Zones (A and B) respectively while the fifth copy was retained by the researcher for personal reference.

3.14 Ethical considerations
The researcher got an introductory letter to be taken to the study area (local administrators of Namuwongo Zones (A and B) from the school of nursing. These granted the researcher permission to carry out the study in the area. Administrators then introduced the researcher to the local residents through home to home visit. Confidentiality was assured to all respondents before they were interviewed. The respondents were only included in the study after explaining them the purpose of the study and consent to participate. The study was voluntary and respondents had the freedom to withdraw at any time of their wish if they found it inevitable. However they were informed about this and those who were not very sure to complete the study were excluded.

3.15 Limitation of the study
A small sample size was used in this study limited generalizing the study findings to the entire population of women in the country since all women in Uganda did not have the same characteristics as those in Namuwongo Parish.
4.0 Introduction

This chapter presents the findings of the study based on the specific objectives that included; knowledge and attitude towards the practice of self breast examination among women in Namuwongo Zones A and B.

4.1 Socio-demographic characteristics of the respondents

4.1 Univariate analysis of socio-demographic characteristics of the respondents

The univariate analysis of socio-demographic characteristics of the respondents considered; respondents; age, marital status, occupation, levels of education and having a family member who suffered from breast cancer.

4.1.1.1 Description of respondents by socio-demographic characteristics

Table 1: Description of respondents by socio-demographic characteristics (N=143)

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Category</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>18-30 years</td>
<td>81</td>
<td>56.6</td>
</tr>
<tr>
<td></td>
<td>31-40 years</td>
<td>36</td>
<td>25.2</td>
</tr>
<tr>
<td></td>
<td>41-50 years</td>
<td>26</td>
<td>18.2</td>
</tr>
<tr>
<td>Marital status</td>
<td>Married</td>
<td>84</td>
<td>58.7</td>
</tr>
<tr>
<td></td>
<td>Singles</td>
<td>45</td>
<td>31.6</td>
</tr>
<tr>
<td></td>
<td>Divorced</td>
<td>11</td>
<td>7.6</td>
</tr>
<tr>
<td></td>
<td>Widows</td>
<td>03</td>
<td>2.1</td>
</tr>
<tr>
<td>Occupation</td>
<td>Housewives</td>
<td>50</td>
<td>34.8</td>
</tr>
<tr>
<td></td>
<td>Casual workers</td>
<td>44</td>
<td>30.5</td>
</tr>
<tr>
<td></td>
<td>Civil servants</td>
<td>30</td>
<td>21.2</td>
</tr>
<tr>
<td></td>
<td>Self employed</td>
<td>11</td>
<td>7.6</td>
</tr>
<tr>
<td></td>
<td>Students</td>
<td>08</td>
<td>5.9</td>
</tr>
<tr>
<td>Levels of education</td>
<td>No formal education</td>
<td>13</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Primary education</td>
<td>85</td>
<td>60</td>
</tr>
<tr>
<td></td>
<td>Secondary education</td>
<td>39</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>Tertiary education</td>
<td>06</td>
<td>4</td>
</tr>
<tr>
<td>Ever had a family member who</td>
<td>Yes</td>
<td>12</td>
<td>8.6</td>
</tr>
<tr>
<td>suffered breast cancer</td>
<td>No</td>
<td>131</td>
<td>91.4</td>
</tr>
<tr>
<td>Relationship with one who</td>
<td>Clan member</td>
<td>08</td>
<td>65.3</td>
</tr>
<tr>
<td>suffered from breast cancer</td>
<td>In-laws</td>
<td>04</td>
<td>34.7</td>
</tr>
</tbody>
</table>

From tables 1 above, majority 81 (56.6%) of the respondents were between 18 and 30 years and 84 (58.7%) were married. Being a housewife was the main form of occupation to majority 50 (34.8%) of the respondents and 131 (91.4%) had never had family members who suffered from breast cancer.
breast cancer. The highest level of education attained by majority 85 (60%) of the respondents was primary education as shown in figure 2 below.

![Figure 2: Description of the respondents by levels of education (N=143)]

Regarding religion most 118 (82.4%) of the respondents were Christians, 20 (40%) were Muslims and 5(3.6%) were from other faiths as shown in figure 3 below.

![Figure 3: Description of the respondents by religion](image_url)

### 4.2.1 Bivariate analysis of the social demographic characteristics of the respondents

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Category</th>
<th>Frequency</th>
<th>Total freq</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EPBSE</td>
<td>NPBSE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>Up to 30 yrs</td>
<td>21</td>
<td>60</td>
<td>12.2</td>
</tr>
<tr>
<td></td>
<td>Above 30 yrs</td>
<td>34</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>Marital status</td>
<td>Married</td>
<td>39</td>
<td>45</td>
<td>5.5</td>
</tr>
<tr>
<td></td>
<td>Singles</td>
<td>16</td>
<td>43</td>
<td></td>
</tr>
<tr>
<td>Level of education</td>
<td>Low levels</td>
<td>16</td>
<td>82</td>
<td>64.5</td>
</tr>
<tr>
<td></td>
<td>High levels</td>
<td>39</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Family member</td>
<td>Yes</td>
<td>10</td>
<td>02</td>
<td>11.1</td>
</tr>
<tr>
<td>Family member</td>
<td>No</td>
<td>45</td>
<td>86</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>55</td>
<td>88</td>
<td></td>
</tr>
</tbody>
</table>

From table 2 above, regarding age respondents who were 30 years and above were twelve times more likely to practice BSE than respondents who were below 30 years ($\chi^2=12.2; P=0.0004$), married respondents were almost six times more likely to practice BSE compared to respondents
who were singles \((X^2=5.5; P=0.0193)\), respondents who had higher levels of education were almost sixty five times more likely to carry out BSE compared to respondents who had low levels of education \((X^2=64.5; P=0.0000)\) and respondents who had ever had a family member who suffered from breast cancer were eleven times more likely to practice BSE compared to respondents who had never had a family member who suffered from breast cancer \((X^2=11.1; P=0.0008)\).

### 4.1.2 Findings on the Knowledge on Breast Self Examination

**Table 3: Findings on the knowledge on breast self examination \(n=143\)**

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Category</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ever heard of breast self examination</td>
<td>Yes</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Breast cancer was common in the area</td>
<td>Yes</td>
<td>08</td>
<td>5.6</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>135</td>
<td>94.4</td>
</tr>
<tr>
<td>Knew the common signs of breast cancer</td>
<td>Yes</td>
<td>106</td>
<td>73.8</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>37</td>
<td>26.2</td>
</tr>
<tr>
<td>Common signs of breast cancer</td>
<td>Dimpling, puckering, or bulging of the skin</td>
<td>56</td>
<td>52.8</td>
</tr>
<tr>
<td></td>
<td>Redness, soreness, rash, or swelling</td>
<td>33</td>
<td>31.1</td>
</tr>
<tr>
<td></td>
<td>Fluid coming out of the nipple</td>
<td>17</td>
<td>16.1</td>
</tr>
<tr>
<td>Breast cancer can be detected early</td>
<td>Yes</td>
<td>31</td>
<td>21.7</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>112</td>
<td>78.3</td>
</tr>
<tr>
<td>Carrying out BSE can improve one’s chances of survival</td>
<td>Yes</td>
<td>88</td>
<td>61.7</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>55</td>
<td>38.3</td>
</tr>
<tr>
<td>Reasons why carrying out breast self examination can improve one’s chances of survival</td>
<td>Cancer can be detected early</td>
<td>37</td>
<td>42.1</td>
</tr>
<tr>
<td></td>
<td>Treatment may be known</td>
<td>28</td>
<td>32.3</td>
</tr>
<tr>
<td></td>
<td>Knowledge about prevention may easily be acquired</td>
<td>23</td>
<td>25.6</td>
</tr>
<tr>
<td>Age breast self examination should begin</td>
<td>Less than 19 years</td>
<td>33</td>
<td>22.8</td>
</tr>
<tr>
<td></td>
<td>More than 19 years</td>
<td>110</td>
<td>77.2</td>
</tr>
<tr>
<td>Frequency of carrying out breast self examination</td>
<td>Monthly</td>
<td>62</td>
<td>43.2</td>
</tr>
<tr>
<td></td>
<td>Weekly</td>
<td>44</td>
<td>31.1</td>
</tr>
<tr>
<td></td>
<td>Daily</td>
<td>22</td>
<td>15.3</td>
</tr>
<tr>
<td></td>
<td>Annually</td>
<td>15</td>
<td>10.4</td>
</tr>
<tr>
<td>How breast self examination is performed</td>
<td>Palpate with palm and minimum of three fingers</td>
<td>123</td>
<td>85.8</td>
</tr>
<tr>
<td></td>
<td>Palpate with one finger</td>
<td>20</td>
<td>14.2</td>
</tr>
</tbody>
</table>

Results from table 3 above showed that, all the respondents had ever heard of breast self examination where 77 (54.2%) got the information from the media as shown in figure 4 below. Breast cancer was not common in the area as evidenced from 135 (94.3%). There was good awareness of the signs of breast cancer as reported by 106 (73.8%) of the respondents where; dimpling, puckering, or bulging of the skin was the most familiar as said by 56 (53.2%) of the
participants. There were 112 (78.4%) respondents who did not know that breast cancer could be detected early enough where 89 (79.3%) indicated that they could physically identify the signs and symptoms.

Eighty eight (61.7%) reported that carrying out breast self examination would improve one’s chances of surviving cancer since cancer would be detected early as reported by 37 (42.1%) of the respondents. Unknowingly, 70 (48.7%) thought that both males and females carry out breast self examination as shown in figure 4 below.

![Figure 4: Proportion of respondents who thought that both males and females carry out BSE](image)

One hundred and ten 77.2% knew that breast self examination should be carried out by people above 19 years. Majority 62 (43.2%) thought the breast self examination should be carried out monthly and 123 (85.8%) knew that it could be done by palpating with the palm and a minimum of three fingers.

![Figure 5: Source of information about breast self examination (n=143)](image)
Results showed that, 70 (48.7%) thought that breast self examination is done by both males and females, 61 (42.9%) thought females only and 12(8.4%) thought men only.

4.2.1 Bivariate analysis of knowledge towards self breast examination

Table 4: Bivariate analysis of knowledge towards self breast examination

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Category</th>
<th>Frequency</th>
<th>EPBSE</th>
<th>NPBSE</th>
<th>P-values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knew the procedure of performing BSE</td>
<td>Yes</td>
<td>32</td>
<td>35</td>
<td>123</td>
<td>10.1</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>23</td>
<td>53</td>
<td>20</td>
<td>1</td>
</tr>
<tr>
<td>Knew the age at which to perform BSE</td>
<td>Less the 19 yrs</td>
<td>14</td>
<td>39</td>
<td>53</td>
<td>10.8</td>
</tr>
<tr>
<td></td>
<td>More than 19 yrs</td>
<td>41</td>
<td>49</td>
<td>90</td>
<td>0.0227</td>
</tr>
<tr>
<td>Knew the signs of breast cancer</td>
<td>Yes</td>
<td>46</td>
<td>60</td>
<td>106</td>
<td>4.2</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>09</td>
<td>28</td>
<td>37</td>
<td>0.0412</td>
</tr>
<tr>
<td>Knew that breast cancer can be detected early</td>
<td>Yes</td>
<td>20</td>
<td>11</td>
<td>31</td>
<td>11.4</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>35</td>
<td>77</td>
<td>112</td>
<td>0.0007</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>55</td>
<td>88</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source primary data

Key
EPBSE: Ever Performed Breast Self-Examination
NPBSE: Never Performed Breast Self-Examination

From the table 4 above; knowledge about the procedure of performing BSE was significantly associated to breast self examination (P<0.05).

Findings showed that, respondents who knew the procedures of performing BSE were ten times more likely to practice BSE ($\chi^2=10.1; P=0.0327$), respondents who were more than 19 years were almost eleven times more likely to perform BSE compared to respondents who were 19 years and below ($\chi^2=10.8; P=0.0227$), respondents who were awareness of the signs of breast cancer were four times more likely to carry out BSE compared to respondents who never knew the signs ($\chi^2=4.2; P=0.0412$) and respondents who never knew that breast cancer can be detected early were eleven times more likely to practice BSE than those who knew ($\chi^2=11.4; P=0.0007$).
4.1.3 Findings on the attitudes towards breast self-examination

The results from respondents’ attitudes were measured using a Likert scale of 1-5. This was presented as SD=Strongly Disagree, D= Disagree, NT= Not Sure, A= Agree and SA= Strongly Agree.

<table>
<thead>
<tr>
<th>No</th>
<th>Attitudes towards breast self-examination</th>
<th>SD</th>
<th>D</th>
<th>NS</th>
<th>A</th>
<th>SA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Breast self examination could easily be done</td>
<td>8 (5.6%)</td>
<td>14 (9.8%)</td>
<td>5 (3.5%)</td>
<td>66 (46.2%)</td>
<td>50 (35.0%)</td>
</tr>
<tr>
<td>2</td>
<td>Could get breast cancer which made breast self examination necessary</td>
<td>5 (3.7%)</td>
<td>23 (16.4%)</td>
<td>3 (2.4%)</td>
<td>73 (51.2%)</td>
<td>39 (26.3%)</td>
</tr>
<tr>
<td>3</td>
<td>Breast self examination is not a sex abuse action</td>
<td>46 (32.1%)</td>
<td>60 (42.3%)</td>
<td>2 (1.3%)</td>
<td>31 (21.5%)</td>
<td>4 (2.8%)</td>
</tr>
<tr>
<td>4</td>
<td>With BSE one could know has the risk indicators for breast cancer</td>
<td>34 (24.2%)</td>
<td>55 (38.3%)</td>
<td>5 (3.6%)</td>
<td>22 (15.3%)</td>
<td>27 (18.6%)</td>
</tr>
<tr>
<td>5</td>
<td>Self-breast examination causes no physical harm</td>
<td>15 (10.8%)</td>
<td>25 (17.7%)</td>
<td>6 (4.2%)</td>
<td>62 (43.2%)</td>
<td>34 (24.1%)</td>
</tr>
<tr>
<td>6</td>
<td>Screening/self-breast examination helps in prevention of breast cancer</td>
<td>32 (22.3%)</td>
<td>43 (30.4%)</td>
<td>11 (7.8%)</td>
<td>31 (21.6%)</td>
<td>26 (17.9%)</td>
</tr>
<tr>
<td>7</td>
<td>Thought that touching their breasts is not obscene</td>
<td>26 (18.3%)</td>
<td>50 (34.9%)</td>
<td>5 (3.2%)</td>
<td>41 (28.8%)</td>
<td>21 (14.8%)</td>
</tr>
<tr>
<td>8</td>
<td>Breast self examination may not necessarily lead to a positive cancer test</td>
<td>20 (14.2%)</td>
<td>23 (16.2%)</td>
<td>4 (2.9%)</td>
<td>38 (26.8%)</td>
<td>57 (39.9%)</td>
</tr>
</tbody>
</table>

From table 5 above, majority 116 (81.1%) believed that breast self examination can easily be done, 11 (77%) believed could get breast cancer which makes breast self examination necessary, 106 (74.1%) perceived breast self examination as a sex abuse action, 89 (62.2%) believed they could never know the risk indicators of breast cancer through breast self examination, 96 (67.1%) Self-breast examination causes no physical harm, 75 (52.4%) screening/self-breast examination helps in prevention of breast carcinoma, 76 (53.1%) thought that touching their breasts was obscene and 95 (66.4%) believed that breast self examination may not necessarily lead to a positive cancer test.
4.1.4 Bivariate analysis of respondents’ attitudes towards breast self-examination

Table 6: Bivariate analysis of respondents’ attitudes towards breast self-examination

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Category</th>
<th>Frequency</th>
<th>Total freq</th>
<th>X²</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attitude</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anyone can get breast cancer</td>
<td>Agree</td>
<td>16</td>
<td>11</td>
<td>27</td>
<td>6.1</td>
</tr>
<tr>
<td></td>
<td>Disagree</td>
<td>39</td>
<td>77</td>
<td>116</td>
<td></td>
</tr>
<tr>
<td>BSE is not sex abuse</td>
<td>Agree</td>
<td>33</td>
<td>4</td>
<td>37</td>
<td>54.3</td>
</tr>
<tr>
<td></td>
<td>Disagree</td>
<td>22</td>
<td>84</td>
<td>106</td>
<td></td>
</tr>
<tr>
<td>Could know they have risk indicators for breast cancer through BSE</td>
<td>Agree</td>
<td>28</td>
<td>16</td>
<td>54</td>
<td>10.5</td>
</tr>
<tr>
<td></td>
<td>Disagree</td>
<td>27</td>
<td>62</td>
<td>89</td>
<td></td>
</tr>
<tr>
<td>BSE may not necessarily lead to a positive test</td>
<td>Agree</td>
<td>43</td>
<td>52</td>
<td>95</td>
<td>5.5</td>
</tr>
<tr>
<td></td>
<td>Disagree</td>
<td>12</td>
<td>36</td>
<td>48</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>55</td>
<td>88</td>
<td>143</td>
<td></td>
</tr>
</tbody>
</table>

Source primary data

Key

EPBSE: Ever Performed Breast Self-Examination
NPBSE: Never Performed Breast Self-Examination

Results from table 6 above indicated that, all the attributes of respondents attitudes towards BSE had a statistical significance towards BSE (P<0.05). Findings showed that respondents who believed anyone can be at risk of breast cancer were six times more likely to carry out BSE ($X^2=6.1; P=0.0195$), respondents who believed that BSE is not a sex abuse were fifty four time more likely to practice BSE ($X^2=54.3; P=0.0000$), respondents who thought could know that they had risk indicators for breast cancer through BSE were almost eleven times more likely to practice BSE ($X^2=10.5; P=0.0107$) and respondents who agreed that BSE may not necessarily lead to a positive test were almost six times more likely to practice BSE ($X^2=5.5; P=0.0180$).

4.2 Findings on the practices of Breast self-examination

Out of 143 respondents that participated in the study, only 88 (61.7%) had never practiced self breast examination as shown in figure 7 below.
Table 7: Findings on the practices of Breast self-examination  (n=143)

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Category</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reasons for not performing breast self examination</td>
<td>Am healthy</td>
<td>38</td>
<td>42.7</td>
</tr>
<tr>
<td></td>
<td>I’m afraid that it may reveal breast cancer</td>
<td>28</td>
<td>31.7</td>
</tr>
<tr>
<td></td>
<td>I haven’t just decided</td>
<td>13</td>
<td>15.2</td>
</tr>
<tr>
<td></td>
<td>It may be painful</td>
<td>5</td>
<td>5.7</td>
</tr>
<tr>
<td></td>
<td>I feel shy</td>
<td>4</td>
<td>4.7</td>
</tr>
<tr>
<td>Age at which respondents performed breast self examination</td>
<td>Less than 19 years</td>
<td>12</td>
<td>22.5</td>
</tr>
<tr>
<td></td>
<td>Above 19 years</td>
<td>43</td>
<td>77.5</td>
</tr>
<tr>
<td>Number of times respondent performed breast self examination</td>
<td>Once monthly</td>
<td>32</td>
<td>58.6</td>
</tr>
<tr>
<td></td>
<td>Annually</td>
<td>16</td>
<td>28.6</td>
</tr>
<tr>
<td></td>
<td>Once weekly</td>
<td>7</td>
<td>12.8</td>
</tr>
<tr>
<td>Last time they performed breast self examination</td>
<td>Last six months ago</td>
<td>31</td>
<td>56.7</td>
</tr>
<tr>
<td></td>
<td>Last 3 months ago</td>
<td>20</td>
<td>36.8</td>
</tr>
<tr>
<td></td>
<td>Less than a month</td>
<td>3</td>
<td>6.5</td>
</tr>
<tr>
<td>Time they normally performed breast self examination</td>
<td>In the evening</td>
<td>24</td>
<td>46.2</td>
</tr>
<tr>
<td></td>
<td>In the morning</td>
<td>21</td>
<td>38.9</td>
</tr>
<tr>
<td></td>
<td>At time of convenience</td>
<td>8</td>
<td>14.9</td>
</tr>
<tr>
<td>Places where respondents performed breast self examination from</td>
<td>Infront of a mirror</td>
<td>36</td>
<td>64.8</td>
</tr>
<tr>
<td></td>
<td>In the bathroom</td>
<td>13</td>
<td>23.8</td>
</tr>
<tr>
<td></td>
<td>When lying on the bed</td>
<td>6</td>
<td>11.4</td>
</tr>
</tbody>
</table>

Results from table 7 show that, majorly of the respondents basing on the fact that they 38 (42.7%) looked healthy without any pain in their breast. Most 43 (77.5%) started examining their breast when they were more than 19 years where 32 (58.6%) of them examined their breasts monthly. Thirty one (38.9%) had last examined their breasts six months ago and mainly did it in the evening as reported by 24 (46.2%) of the respondents. The largest number 36 (64.8%) of respondents examined their breasts infront of a mirror as shown in figure 6 below.

![Figure 4: Places where respondents performed breast self examination from (n=55)](image-url)
CHAPTER FIVE
DISCUSSION OF RESULTS

5.0 Introduction
This chapter presents the discussions of results. They are based on study findings in relation to the study specific objectives that included; knowledge and attitude towards the practice of self breast examination among women in Namuwongo Zones A and B.

5.1. Discussion of findings
5.1.1 Discussion of findings on the social demographic characteristics of the respondents
From the findings; age was a significant factor to breast self examination because its probability value was below 0.05 (P=0.0005), marital status was (P=0.0146), respondents levels of education were (P=0.0000) and ever had a family member who suffered breast cancer was significant at (P=0.0008).

Regarding age respondents who were 30 years and above were twelve times more likely to practice BSE than respondents who were below 30 years ($X^2=12.2; P=0.0004$) where majority 56.3% were between 18 and 30 years. Most of the respondents who had ever practiced breast self examination were above 30 years. This implied that most of the respondents who had ever practiced breast examination were above 30 years. This implied that most of the respondents were young females which resulted in low BSE. BSE was low among young females because they could have lacked adequate knowledge about reproductive health and the importance of breast examination in particular. Similarly, findings from a study carried out in Nursing Students of Arab American University/Jenin, Palestine, majority of students aged above 20 years (19.6%) had fair knowledge about BSE. In line with this study, Nyanungo et al., (2012) in a study carried out in Angola showed that majority of the respondents who were students were aged between 21 and 25 (51% of Medical students and 57% of non-medical students. It is a general belief among most young females being reluctant about their health status. Few of them endeavour to carry out medical check-ups unless they feel any discomfort.

The clinical implication is that, respondents who are young tend to have less attention to seeking health care services. This could be due to the fact that, they have inadequate exposure to health care services.

The public health care implication is that, majority of young people tend to think that they are safe from some health complications which makes them reluctant to seek health care services in time.
Married respondents were almost six times more likely to practice BSE compared to respondents who were singles ($X^2=5.5; P=0.0193$). This implies that BSE was more among married respondents as compared to single respondents. Most 58.7% of the respondents were married while the widows constituted the smallest portion marital status. This was because the study was carried out during the day when most of the people at home were married. It could be that married respondents were more attracted to BSE because they knew that cancer is very hard to treat and could have feared to die and leave their children helpless. Also most people who were single did not believe that they could be infected with breast cancer thus did not realize them but those who breast feed”.

The clinical implication is that, married respondents could have had more knowledge about BSE probably acquired during antenatal care, during delivery or during postnatal care unlike singles respondents who could have had less chances of having reproductive health education sessions.

The public health care implication is that, married respondents in most cases think that they should seek

Respondents who had higher levels of education were almost sixty five times more likely to carry out BSE compared to respondents who had low levels of education ($X^2=64.5; P=0.0000$). The highest level of education attained by majority 65 (45.7%) of the respondents was secondary education while the smallest number 5 (3.2%) never had formal education was significantly related to BSE at ($P=0.0000$). Secondary is relatively good level of education that can guarantee knowledge about different aspects regarding reproductive health. This is because this is taught at secondary school level.

Being a housewife was the main form of occupation to majority 50 (34.8%) of the respondents. Given the fact that most of the respondents were married; it was most probable for them to be housewives.

Religiously most 118 (82.4%) were Christians. This could be due to the fact that the area is predominately occupied with Christians. Given the religious doctrines advocate for secrecy and privacy, this could have kept most of the members less aware of BSE. Also given the fact that some respondents regarded it as an obscene practice, this could have limited their practice of BSE. There are also many churches which could have converted many people from other faith. Relatedly, one respondent asserted that,
“All my issues were solved by Jesus Christ’s blood... I am a born again Christian who cannot be threatened by breast cancer......it is not necessary for me to squeeze my breast checking for lumps... Jesus already looked for them and I am free”.

As a nurse, I would urge all people to desist from such attitudes towards diseases, because it is not a guarantee that whoever trusts God is free from any problem including diseases. Therefore there should be a strong policy by the government to regulate the way religious people address their congregations regarding diseases. This has misled many people from attending health care facilities because they are assured by their clerics that they are free from diseases.

The public health care implication is that, most of the respondents were Christian were some were born again who believed that with prayer every disease can be healed. This could have made them reluctant to carry out BSE, thus low BSE practice in the area.

Regarding prevalence of breast cancer, respondents who had ever had a family member who suffered from breast cancer were eleven times more likely to practice BSE compared to respondents who had never had a family member who suffered from breast cancer ($X^2=11.1; P=0.0008$). There were 131 (91.4%) respondents who had never had family members who suffered from breast cancer while 12 (8.6%) had never had family member who suffered from breast cancer. Out of 12 respondents who had breast cancer victims 8 (65.3%) were clan members to them. Not having any family member who had ever suffered from breast cancer could have led to their reluctance to perform BSE because they thought that were safe from cancer. One respondent said that,

“There is no need why I do self breast examination because in my family no one has ever suffered from breast cancer.

Similar findings were given in a study by Tieng’O, et al., (2011) in an interviewer administered questionnaire administered to 375 women attending a health facility who said that they were not at risk of breast cancer thus were not in need for breast self examination. In most cases, not only females who are reluctant to practice breast self examination, but most of the people are lazy to have medical checkups if they are not actually feeling any pain. This is a negative attitude which is one of the major factors responsible for high spread of diseases. The government should recruit more health care workers at the health facilities so that every person who needs their services gets them even if he or she is not sick.

The clinical implication is that majority of the respondents were not very familiar with breast cancer diseases since most of them had never had any family member who suffered from it.
The public health care implication is that, breast cancer is a feared disease in the community that even if someone suffered from it may not easily reveal due to fear of stigma. This could have kept community members unaware of those who suffered from it due to low disclosure.

5.2 Findings on the knowledge on breast self examination
Findings showed that, respondents who knew the procedures of performing BSE were ten times more likely to practice BSE ($X^2=10.1; P=0.0327$). All the respondents had ever heard of breast self examination where majority 54.2% got the information from the media. Breast cancer was not common in the area as evidenced from majority 94.3% of the respondents. Respondents got the information from a right source, because most of the information broadcasted over the media is first proven which implied that they had good knowledge. This enabled them to know more about breast care in the area and the country at large. This is in line with a study carried out in Ghana by Ayed, (2015) among female university students at Presbyterian University College, showed that, 95% respondents had ever heard of breast cancer and BSE. On the contrary, in a study carried out in Nursing Students of Arab American University/Jenin, Palestine, majority of students aged above 20 years (19.6%) had fair knowledge about BSE which implied low level of knowledge about BSE. In another study carried out in Rwanda, almost 95% of respondents had heard about BC, but less than 25% had sufficient knowledge about BC diagnostic methods, BC risk factors and BSE (Ndikubwimana et al., 2016).

Respondents who were more than 19 years were almost eleven times more likely to perform BSE compared to respondents who were 19 years and below ($X^2=10.8; P=0.0227$). More than 74% of interviewed respondents never performed BSE for breast cancer purpose, and of those who agreed doing BSE only 4% knew the real timeframe of doing it. This implied that, respondents had low knowledge about BSE. This could have resulted from the fact that, they were not familiar with BSE. The findings of the study are consistent with the studies by other researchers’ worldwide (Ndikubwimana et al., 2016).

The clinical implication, older respondents were more familiar with reproductive health care practices compared to respondents who were below 19 years.

The public health care implication is that, young people in most cases feel shy to reveal that they have complex health complications such as breast cancer. This inferiority perception even further keeps them less resilient to seek health practices that would save them from them due to ignorance about their facts.
Respondent who were awareness of the signs of breast cancer were four times more likely to carry out BSE compared to respondents who never knew the signs ($X^2=4.2; P=0.0412$). There was good awareness of the signs of breast cancer as reported by 73.8% of the respondents where; dimpling, puckering, or bulging of the skin was the most familiar 56 (53.2%) reported dimpling, puckering, or bulging of the skin. This implied that they knew the commonest and most prominent signs of breast cancer and could possibly have got this information from the media. This was good knowledge about BSE. On the contrary, Gueye et al., (2009) in a study carried out in Senegal among 300 women indicated only 42.7% had good knowledge about BSE.

The clinical implication is that, most community members who are aware of the signs and symptoms of the diseases are more likely to seek health care services compared to ones with low or without knowledge about them.

The public health care implication is that, community members who are knowledgeable about disease are more likely to practice appropriate health care services compared to ones who are not aware. This is associated with good knowledge about such a disease.

Respondents who never knew that breast cancer can be detected early were eleven times more likely to practice BSE than those who knew ($X^2=11.4; P=0.0007$). There were 112 (78.4%) of the respondents who knew that breast cancer could be detected early enough where 89 (79.3%) indicated that they could physically identify the signs and symptoms. This was a good knowledge, which could have been acquired during health education from the media. Similarly, findings from a study carried among school teachers in Mosul City, Iraq revealed that the main source of Self breast-examination knowledge was T.V. program (72.9%), while health professional form (34.4%) (Maarab et al., 2012). Out of the 55 respondents that performed BSE, 52.7% knew that breast cancer can be detected early enough and this was significant at ($P=0.0000$). This is why they used cheap and readily available means of checking for breast cancer through BSE. This is also time saving. Similarly in a study carried out in Cameroon, Atanga et al., (2012) noted that, nearly three quarters of participants had previously heard about BSE. Approximately 6 in every 10 women claimed to know how to perform BSE with 35% reporting performing BSE monthly and few performing it 6-monthly.

About respondents’ knowledge towards BSE; majority of the respondents who performed BSE knew the right procedures of doing BSE. This was not significantly associated with BSE ($P=0.1809$). It could be that, the way women performed BSE examination was not the issue, but
identifying the risk signs was the issue most of them considered. Most mothers revealed that, they did not mind which fingers they used to check their breasts but they minded about the problem that bothered them. Similarly, in Nigeria, a study of female secondary students in Abuja indicated that while a high proportion knew about BSE being used to prevent breast cancer very few (10.1%) practiced it (Isara and Ojedokun, 2011). Similarly, close to three quarters of female undergraduate students in Nigeria had heard about BSE, although only about one in five had ever practiced it (Gwarzo, et al., 2009).

The clinical implication is that, respondents who are in most cases aware of the health care procedure are more prone to utilizing such service or procedure which is not the case with other individuals without knowledge about the procedure

The public health care implication is that, majority of the community members are unaware of the health care seeking procedures which could be the reason for low practices of vital health care practices such as BSE.

Eighty eight (61.7%) reported that carrying out breast self examination would improve one’s chances of surviving cancer since cancer would be detected early. Given the fact that respondents knew that breast cancer could be detected early was an assurance that breast cancer could be treated if detected early.

Respondents 70 (48.7%) thought that both males and females carry out breast self examination. This was good knowledge because breast cancer affects both females and males. However, majority of the respondents that participated in the study did not know that both males and females can get breast cancer. Similarly, Ginsberg et al (2012) in a study carried out in Sub Saharan Africa found out that, most respondents never knew that both males and females can get breast cancer.

One hundred and ten 77.2% respondents knew that breast self examination should be carried out by people above 19 years. This was good knowledge because all females above 18 years develop breasts. Majority 62 (43.2%) thought the breast self examination should be carried out monthly and 123 (85.8%) knew that it could be done by palpating with the palm and a minimum of three fingers. This was good knowledge because a period of one month is good enough to realize any change in the body. Similarly, in a study carried out in Uganda indicated that the best time to do a monthly self-breast exam is about 3 to 5 days after the start of menstrual periods. This is because when breasts are not tender or lumpy at this time of monthly cycle. It’s done at the same time every month (Gakwaya et al., 2016).
The clinical health care implication respondents who are aware that one can carry out BSE at any age were more likely to carry out BSE.

5.3 Findings on the attitudes towards breast self-examination

Attributes to respondents attitudes towards BSE were; respondents who believed anyone can be at risk of breast cancer were six times more likely to carry out BSE ($X^2=6.1; P=0.0195$), respondents who believed that BSE is not a sex abuse were fifty four time more likely to practice BSE ($X^2=54.3; P=0.0000$), respondents who thought could know that they had risk indicators for breast cancer through BSE were almost eleven times more likely to practice BSE ($X^2=10.5; P=0.0107$) and respondents who agreed that BSE may not necessarily lead to a positive test were almost six times more likely to practice BSE ($X^2=5.5; P=0.0180$).

Majority 116 (81.1%) believed that breast self examination can easily be done. This is because some of them had been health educated about BSE, and thought could simply use their fingers to check for the lumps. Similarly, a study, by Dala et al., (2014) about 60% of the respondents had a positive attitude toward BSE. A study done in Saudi Arabia more than two third of the respondents had positive attitude toward BSE.

Respondents who believed anyone can be at risk of breast cancer were six times more likely to carry out BSE ($X^2=6.1; P=0.0195$). There were 110 (77%) respondents who believed could get breast cancer which made them think that breast self examination is necessary. This was a positive attitude because anybody may get breast cancer because there are many risk factors among the studied population that can lead to breast cancer. However findings in a study carried out in Nigeria by Sarfo et al., (2013) were in line with the present study carried out in Namuwongo. This was because 87% of the respondents did not fear of discovering a lump in their breast despite the fact that 6% indicated that they did not trust their ability to perform the procedure correctly. About respondents attitude towards BSE; majority 33(60%) of the respondents who performed BSE, disagreed that anyone can get breast cancer and this was significant at (P=0.0000). However regarding checking, 40% of the study samples believed that if they do not have any problem in their breasts, so there was no reason to examine their breasts since it would be wastage of time and triggering other complications that they did not have (Maarab et al, 2012).

Respondents who believed that BSE is not a sex abuse were fifty four time more likely to practice BSE ($X^2=54.3; P=0.0000$). Also 106 (74.1%) of the respondents perceived breast self examination as a sex abuse action which was a negative attitude. In medical practice, privacy
and due respect to an individual during health care seeking are some of the vital components of quality health care service delivery, however with BSE, privacy is a personal responsibility.

Respondents who thought could know that they had risk indicators for breast cancer through BSE were almost eleven times more likely to practice BSE \( (X^2=10.5; P=0.0107) \). There were 89 (62.2%) respondents who believed that they could never know whether they have breast cancer through breast self examination. To some extent they were right because some were not health educated about breast cancer and BSE. Even the practice itself is not meant for women to discover whether they have breast cancer, but it is just a lead to start medical diagnostic processes to find out whether the lumps they have on their breasts are cancerous. These findings were not in line with a study carried out in Iraq where majority of the female had positive attitude toward learning the correct procedure of BSE with an intention to instruct others on the technique (Nada et al., 2012). This difference may be due to the level of knowledge between Nigerian health workers and health students in our case and in other way the sample size taken Nigeria was small compared to our study.

Majority of the 67.1% respondents believed that self-breast examination has no physical harm to them. This is a positive attitude towards BSE The minority of respondents (24%) who did not perform BSE, were further asked on their reasons for not performing BSE and 30% said they do not have time, 11% said they didn’t feel it was necessary, while 59% did not have a specific reason for not performing BSE (Sarfo et al., 2013).

Findings further indicated the 52.4% of the respondents were aware that self-breast examination helps in prevention of breast carcinoma because the lumps in the breasts are easily identified. This helps to make a test necessary for every woman and this would be a vital step in seeking medical help. There were 78.2% agreed that they could know that they have risk indicators for breast cancer through BSE and performed BSE out of the 55 women and this was significant at \( (P=0.0000) \). This gave them confidence to carry the practice because they knew it would yield them positive results. Similarly, in a study carried out in Cameroon, Atanga et al., (2012) overall most of the participants were partially aware of the causes of breast cancer while few were substantially aware. On the other hand 5% of respondents were not aware of risk factors of breast cancer (did not know any breast cancer risk factor), while few were partially aware (recognized at least two accepted breast cancer risk factors) and few were substantially aware (recognized five or more accepted breast cancer risk factors).
The clinical implication is that, such respondents were aware of the importance of seeking health care knowledge. This could have resulted from the fact that the respondents were aware of what they were required to do.

There were 76 (53.1%) respondents who thought that touching their breasts was shameful. This is negative attitude in a nursing profession because there is no shame in control, prevention and treatment of diseases. There is need for health education about the importance of self care if preventable diseases are to be minimised in the country. Thirty three (60%) who performed BSE agreed that BSE is not a sex abuse and it was significant factor in performance of BSE ($P=0.000$). This was a positive attitude which could have resulted from the fact that mother were briefed about BSE by the health care workers mostly through the media. Similarly, Dala, et al., (2014) in a study carried out in Saudi Arabia, about 60% of the respondents had a positive attitude toward BSE because they regarded it a normal health care practice and not a sexual abuse.

The clinical implication is that, they could have had low knowledge about identification of health complications on the body, because health care diagnostics are not regarded obscene and shameful so long as they are intended to discover a life worrying complication.

The public health care implication is that,

Respondents who agreed that BSE may not necessarily lead to a positive test were almost six times more likely to practice BSE ($X^2=5.5; P=0.0180$). More so, 95 (66.4%) participants believed that breast self examination may not necessarily lead to a positive cancer test. This was positive attitude because a mere checking or medical diagnosis for the disease does not predispose one to sickness. Regarding the necessity of BSE, 43 (78.2%) agreed that BSE may not necessarily lead to a positive cancer test. This was because they had got information from the media and knew the importance of BSE. Similarly, in Uganda revealed a high awareness of breast cancer and BSE practices were more among university female students. Over half the students had an intermediate level of knowledge about risk factors related to breast cancer and the signs and symptoms of the disease. The majority of students received information about breast cancer via mass media (Godfrey, 2013).

The clinical implication is that, diagnosis is not met to confirm that one has a health complication but to check for the health status of a person. Health care seeker should be given adequate information about the necessity of diagnosing for a disease before the actual signs and symptoms are clearly seen.
The public health care implication is that, most community members have much fear to seek diagnosis about health care seeking because they do not want to know that they are suffering from a certain disease. This is a negative perception lead to increased disease infection.

5.4 Discussion of the findings on the practices towards breast self-examination
Out of 143 respondents that participated in the study, few of the respondents had ever self examined their breasts. This could be due to the fact that most of them looked healthy without any pain in their breast which made them reluctant to carry out breast self examination. This was similar to findings in a study by Demirkiran (2007) performed among Turkey nurses. However, in a study carried out in Ethiopia indicated that, few of the respondents practiced BSE. These findings were similar with those from different part of developing countries in Asia and Africa including Djibouti where BSE was low (Legesse and Gedif, 2014).

The clinical implication is that, most of the respondents had a poor health care seeking behaviour which could have resulted in low BSE.

The public health care implication is that, most people feel shy to check their breast while others who are highly affiliated to their religious doctrines think that BSE is obscene to carry out BSE because the process appear as an obsessed process.

Most and 43 (77.5%) of the respondents started examining their breast when they were more than 19 years where most of them examined their breasts monthly. It was a good practice to start BSE at 18 years and above because by this period a woman experiences regular menstrual cycles and other changes in body. Some of them could have given birth by this period which could e same of the factors that could predispose them to breast cancer. In relation, in a study carried out in Nigeria and Ghana the practice of BSE is higher than this finding 80% and 76% respectively (Oluwole, 2014).

The clinical health care implication is that respondents could have thought the breast cancer can not be acquired by younger women which implies a wrong perception this could have resulted from inadequate information about health complications and their advances.

The public health care implication is that, BSE was not a well known and important health care practice in the study community. This could have led to their low practice especially among young women.

Thirty one (38.9%) had last examined their breasts six months ago and mainly did it in the evening as reported by few of the respondents. This was a long period they had taken which
implied a poor practice. Ideally BSE should be carried out monthly or twice after the on-set of the menstruation period. It should also be done in the morning when the body is still fresh. During this period there is high level of sensitivity which helps the woman to know what happens to the body. However in a study carried out in Ireland, findings showed that, BSE should be practiced correctly and this involves a number of aspects; frequency, timing, a correct technique consistent application of it as well as acting on any positive findings without much delay (O'Mahony and Hegarty, 2009). Other findings presented inadequate frequency of BSE only 5.5% of the respondents did BSE monthly in East Africa. This finding is lower than the studies done in other parts of the world such as; Saudi study (Dalal, et al., 2014), Nigeria (Oluwole, 2008), Ghana (Sarfo, et al., 2013) in Mekelle (Legesse and Gedif, 2014), West Gojjam Zone (Azage et al., 2013) practiced monthly basis.

The clinical health care implication is that, respondents never regularly checking adverse developments on their body which could have implied a poor health care seeking behaviour.

The public health care implication is that, it was not a common practice for the community members to practice BSE for breast cancer because they could have thought that it is only done by trained health care providers.

The largest number 36 (64.8%) of respondents examined their breasts infront of a mirror. This is a right practice because it enables the woman to have good view of all the parts of her breasts and identify any adverse changes. These may basically include visual changes that cannot be felt by touching or feeling through pain and tenderness.

The clinical implication is that majority of the respondents were aware of the right way to practice BSE. This is because before a mirror a woman can clearly see any changes on her breasts.
CHAPTER SIX
CONCLUSIONS AND RECOMMENDATIONS

6.0 Introduction
This chapter includes; the major findings of the study and the suggested solutions to the problems found in the study.

6.1.1 Conclusion
Majority of the respondents were between 18 and 30 years, married, had secondary education, were housewives, were Christians, had never had family members who suffered from breast cancer.

6.1.2 Findings on the knowledge on breast self examination
All the respondents had ever heard of breast self examination where they got the information from the media. Breast cancer was not common in the area. There was good awareness of the signs of breast cancer where; dimpling, puckering, or bulging of the skin were the commonest known signs. They knew that breast cancer could be detected early enough through physical identification of the signs and symptoms were aware that carrying out BSE would improve one’s chances of surviving cancer since cancer would be detected early. They knew that BSE should be carried out by people above 19 years when palpating with the palm and a minimum of three fingers.

6.1.3 Findings on the attitudes towards breast self-examination
There was negative attitudes towards breast self-examination because they perceived BSE as a sex abuse action and obscene, could never know whether they had breast cancer through BSE and didn’t believe that BSE helps in prevention of breast carcinoma. However, some believed that BSE can easily be done, couldn’t get breast cancer which makes BSE unnecessary, causes no physical harm and BSE may not necessarily lead to a positive cancer test.

6.1.4 Practices towards breast self-examination
Respondents’ practices towards breast self-examination were generally poor. In the first instance few had ever performed BSE. The few, who had ever done it, never did it regularly and by the time of the study they had taken long without examining them. They never did it at a right time as majority did it in the evening. However, they did not examine their breasts regularly and had taken long and never did not at a right time despite examining their breasts infront of a mirror.
6.2 Recommendations

6.2.1 Findings on the knowledge on breast self examination

- Breast cancer being uncommon in the area does mean its non existence. Therefore the government should enhance health education and sensitization about self examination its occurrence so that more people are made aware of it with not costs incurred.

- The health care providers should thoroughly educate females on how to perform breast self examination. This would help them to achieve reliable results when they perform it.

- The public should know that breast self examination is only for females with breasts and should self breast examination is for everyone even if healthy at the moment.

- Breast self examination should at least be done weekly or anytime one may feel or notice any unusual chance on the breasts.

6.2.2 Findings on the attitudes towards breast self-examination

- Women should refrain from the belief that breast self examination is obscene. It is part of a medical process that if done by an individual herself in privacy would not lead to embarrassment.

- Women and community member should know that if breast self examination is done through the right procedures, can help one to know whether they have breast cancer.

- All community members should seek the right knowledge about breast self examination. This would help them to know when they should start the practice, the right time when it should be done, places where to do it from and how to do it.

- All females should know that, breast self examination does not necessarily lead to a positive cancer test. It just helps one to identify any abnormalities that could be lead to cancer.

- Proper breast self examination is not harmful to the individual

6.2.3 Practices towards breast self-examination

- All women should carry out breast self examination most especially when they feel any unusual occurrence among them breasts.

- All females should regularly self examine their breasts even if they feel healthy. This should be done at least once every week.

- Breast self examination should be done in the morning when one is lying on the bed.

- They should also self examine their breasts infront of a mirror so that they view all its parts.
REFERENCES


Nkala, V.X. (2014) Young women’s perceptions of Breast Cancer, A qualitative study exploring perceptions of breast cancer among first- degree relatives of breast cancer patients in Bulawayo Zimbabwe, Thesis submitted as part of the Master of Philosophy Degree in International Community Health, Community Medicine University of Oslo; Norway.


World Health Organization (WHO). (2015) Fact sheet No. 297: Available at:


APPENDICES

APPENDIX I: CONSENT FORM

Title of the study..................................................................................................................................................

Name of Investigator...........................................................................................................................................

I understand that I am agreeing to participate in a research project that the purpose of the study is to identify...............................................................................................................................................................

I will be asked a series of interview questions and the investigator will record my answers. My name will not be used and the confidentiality of my responses will be protected. The entire produce will take 10 minutes. My participation will take place in a private area with only the researcher present. I can decline to answer any question.

Risks
The interview is entirely voluntary and does not entail any foreseeable risks. I understand that I may quit at any time. All data will be maintained in a locked file by investigator for one year and then shredded. Benefits of participation may include a contribution to scholarly research that identifies issues of................................................................. There will be no direct benefits to the subjects.

Participation
I understand that my participation in this study is voluntary and that I may withdraw from the study at any time. My refusal to participate will involve no penalty or loss of benefits to which I am otherwise entitled. I will understand that I will not be compensated for my participation. An offer has been to answer all of my questions and concerns about the study. I will be given a copy of the dated and signed consent form to keep.

Signed.............................................................. Date............................................................

Investigator .......................................................... Date.............................................................
APPENDIX II:

QUESTIONNAIRE

Dear participant am Mamman Dan Musa Safiya, a student of International Health Sciences University pursuing a bachelor’s degree in Nursing Sciences. As requirement a research study has to be carried to fulfil the course hence a study on the knowledge and attitude towards the practice of self breast examination among in Namuwongo Zones A and B is carried out. I dearly appeal for your participation to make it a success. The information provided will be treated with privacy and will strictly be used for academic research purposes by the researcher. Your time and cooperation will highly be appreciated.

Serial number…………………….....................      Date………………………………….

Section one: Socio-demographic data of the participant

1. What is your age?
   a) 18 - 30 years  □□□□      b) 31-40 years  □□□□
   c) 41-50 years

2. What is your marital status?
   a) Married  □□□□      b) Single  □□□□
   c) Divorced  □□□□      d) No  □□□□

3. What was the highest level of education you attained?
   a) No formal education □□□□      b) Primary □□□□
   c) Secondary education □□□□      d) Tertiary education □□□□

4. What is your occupation?
   a) Housewives □□□□      b) Casual workers □□□□
   c) Civil servants □□□□      d) Self employed □□□□
   e) Student □□□□      f) Others (specify)………………………………

5. What is your religion?
   a) Christianity □□□□      b) Islam □□□□
   c) Others □□□□

6. i) Do you have any one in your family who has suffered breast cancer
   a) Yes □□□□      b) No □□□□
ii) If yes what is the relationship with that person
   a) Cousin
   b) Aunt
   c) Mother
   d) Grandmother
   e) Others

Section B:
Knowledge on Breast self examination

1. Have you ever heard of Breast self examination
   a) Yes
   b) No

2. Is it common in your environment?
   a) Yes
   b) No

3. Can it be detected early?
   a) Yes
   b) No

4. Can you improve chances of survival from breast cancer by carrying out breast self examination?
   a) Yes
   b) No

5. Have you ever heard of breast self examination
   a) Yes
   b) No

6. How did you hear about it
   a) Home
   b) Peer group
   c) Television/ radio
   d) Newspaper
   e) Others (specify)

7. Who should perform breast self examination?
   a) Males only
   b) Females only
   c) Both males and females

8. At what age should breast self examination begin?
   a) Less than 19 years
   b) More than 19 years

9. How often should breast self examination be carried out?
   a) Daily
   b) Weekly
   c) Monthly
   c) Annually

10. How is breast self examination performed?
    a) Palpate with one finger
    b) Palpate with palm and minimum of 3 fingers
c) Any how

11. Would you want to know more about breast self-examination?
   a) Yes                  b) No

12. If yes, why perform a breast self examination?
   a) To know whether my breasts are healthy
   b) Performed without a reason

Section Three:
Attitudes towards breast self-examination

<table>
<thead>
<tr>
<th>No.</th>
<th>Attitudes towards breast self-examination</th>
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<tbody>
<tr>
<td>1</td>
<td>Breast self examination could easily be done</td>
</tr>
<tr>
<td>2</td>
<td>I can get breast cancer which makes Breast self examination necessary</td>
</tr>
<tr>
<td>3</td>
<td>Breast self examination is not a sex abuse action</td>
</tr>
<tr>
<td>4</td>
<td>I can never know that I have breast cancer through breast self examination</td>
</tr>
<tr>
<td>5</td>
<td>Self-breast examination causes no harm</td>
</tr>
<tr>
<td>6</td>
<td>Screening/self-breast examination helps in prevention of breast carcinoma</td>
</tr>
<tr>
<td>7</td>
<td>I think touching my breasts is obscene</td>
</tr>
<tr>
<td>8</td>
<td>Breast self examination will not necessarily lead to a positive cancer test</td>
</tr>
<tr>
<td>9</td>
<td>Carcinoma of the breast cannot be transmitted</td>
</tr>
<tr>
<td>10</td>
<td>If you develop breast lump, would you hurriedly go to see a doctor</td>
</tr>
<tr>
<td>11</td>
<td>Do you believe that breast cancer occur more commonly in old women</td>
</tr>
<tr>
<td>12</td>
<td>Am at a high risk for developing breast cancer thus should do breast self examination</td>
</tr>
</tbody>
</table>

Section Four:
Practices of Breast self-examination

1. i) Have you ever performed breast self examination?
   a) Yes                  b) No

   ii) Reasons for not performing breast self examination
       a) Am healthy
       b) I’m afraid that it may reveal breast cancer
       c) I haven’t just decided
       d) It may be painful
e) I feel shy
f) Others (specify)………………………………………………..

iii) If yes, how often do you perform BSE in a year?
a) Once in a month ........................................

b) Once in 3 month ........................................

c) More than once in quarter of a year .......................

d) Not very often...........................................

e) Never in a year ............................................

2. At what age did you start practicing BSE (Breast Self Examination)
a) <25 of age  b) 25-30  c) 30-35  d) >35 of age

3. If you don’t practice SBE regularly then what are the reasons (Skip those who practice regularly, once in a month) one can answer more than one.
   a) I don’t have breast problem. ..........................
   b) I don’t think I should ..............................
   c) I don’t feel comfortable doing this ..............
   d) I do not know how to do that ....................
   e) Carelessness ........................................
   f) Too frequent to practice. .........................
   g) I don’t think it is necessary. .................
   h) Unsure about its benefit .........................
   i) Or, specify other reason..............................

4. When was the last time you performed a breast self examination?
a) Less than a week ago .................................

b) Less than three to six months ago .................

c) More than one year ago ..............................

5. What time do you normally perform breast self examination>?
a) Morning ........................................

b) Afternoon ........................................

c) Evening ........................................

6. Where do you usually perform breast self examination?
a) In front of a mirror ..............................

b) Lying on the bed ..............................

c) In the bathroom ..............................

End
APPENDIX III:
INTRODUCTORY LETTER

THE L.C.T. CHAIRMAN,
ZONE A., NAMUWONGO
MAKINDYE DIVISION

Dear Sir/Madam,
RE: ASSISTANCE FOR RESEARCH

Greetings from International Health Sciences University.

This is to introduce to you Mamman DanMusa Safiya, Reg. No. 2014-BNS-FT-032 who is a student of our University. As part of the requirements for the award of a Bachelors degree in Nursing of our University, the student is required to carry out research in partial fulfillment of her award.

Her topic of research is: Knowledge and attitude towards the practice of self breast examination among women in Namuwongo Zones A & B

This therefore is to kindly request you to render the student assistance as may be necessary for her research.

I, and indeed the entire University are grateful in advance for all assistance that will be accorded to our student.

Sincerely Yours,

Ms. Agwone Avenes
Dean

The International Health Sciences University
P.O. Box 7782 Kampala – Uganda
(039) 284-3840  FAX: 284-3873

Office of the Dean, School of Nursing
Kampala, 30th May 2017
NAMUWONGO ‘B’ VILLAGE LC I
BUKASA WARD, MAKINDYE DIVISION URBAN COUNCIL KCCA
P.O BOX C/O 2540, K’LA [U]
TEL:0782-478793/ 0702-882304

Our ref: 01/16/03/2017

Your Ref: ____________________________ Date: 16-03-2017

TO

THE

DEAN SCHOOL

OF NURSING.

RE: NAMMAN DAIMUSA SAFIYA.

The above named student successfully carried out her data collection in our village from 1st – 15th of March 2017.

It entailed knowledge attitude towards the practice of self breast examination among women in Namuwongo ‘A’ and ‘B’.

We have seen her report and our village committee on health acknowledge the results.

I hereby seek your acknowledgment and approval of her data.

Yours in solidarity

[Signature]

[Stamp]
NAMUWONGO ‘A’ LCI
BUKASA PARISH, MAKINDYE DIVISION
P.O BOX 5265, KAMPALA (U) TEL: 0776-920297/0701-920297

Our Ref: NLC.L.C.1/207
Your Ref: ........................................
Date: 16th March 2007

To

DEAN OF SCHOOL
NURSING

DE: MAMMON NATMUBO SAFITA

This letter serve to confirm your notice that the student MAMMON JOHN MUST SAFITA came in my area of jurisdiction and gathered information pertaining knowledge attitude towards the primary breast examination and exam respectively from 10th-15th 2007.

I received her in my office.

Therefore the purpose of this letter is to request your support to render her medical service.

Yours faithfully,

[Signature]

NAMUWONGO ‘A’ LCI
BUKASA PARISH, MAKINDYE DIVISION
P.O BOX 5265, KAMPALA (U) TEL: 0776-920297/0701-920297

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APPENDIX V: MAP SHOWING KAMPALA DISTRICT

[Map of Kampala District showing divisions]

KEY

*NAMUWONGO ZONES A & B*
APPENDIX VI: MAP SHOWING STUDY AREA