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Clinicians' experiences and perspectives of breast cancer and possible integration of breast cancer prevention and early detection into palliative care

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ABSTRACT

Background: Late presentation of breast cancer (BC) is a public health concern due to its impact on survival and mortality, especially, in low-resourced countries. Prevention and early detection of breast cancer are required to improve breast cancer outcomes in developing countries.

Objective: This study explores clinicians' experiences and perspectives of breast cancer and possible the integration of breast cancer prevention and early detection into palliative care.

Method: A qualitative exploratory design was employed to understand the subject of interest. In-depth-interviews were conducted using a semi-structured interview guide to generate data from seven clinicians who provided symptomatic care to patients and families diagnosed with advanced breast cancer in a developing country. The data were collected at the palliative care clinic of the Komfo Anokye Teaching hospital. The data were analyzed concurrently with data collection using thematic analysis.

Results: Three main themes emerged from the data and these were: breast cancer presentation, barriers to achievement of early detection and lastly, the need for an intervention. The themes also had sub-themes.

Conclusions: The study recommend the development of a model to guide the integration of breast cancer prevention and early detection into palliative care.

1. Introduction

Breast cancer (BC) is the most frequent diagnosed malignancy among women in the world. Global estimates project that about 19.7 million cases of breast cancer will be recorded in the year 2024. (Anderson, 2014). Further projections indicate that by the year 2020, over 1 million women in Low-and-middle-income-countries (LMICs) will develop the disease annually (Anderson, 2014). Occurrence and death rates of breast cancer are rising in Sub-Saharan Africa (SSA) somewhat due to an epidemiological evolution caused by the adoption of a western life style, genetic and reproductive factors and improved life expectancy (Bray & Soerjomataram, 2015).

This is the case of most developing countries including Western Africa, where an estimated age standardize incidence rate of 37.3 per 100,000 and mortality rate of 17.8 per 100,000 of breast cancer have been reported (International Agency for Research on Cancer & World Health Organization, 2018). One of these countries is Ghana, a country with no national-level breast cancer registry (O'Brien et al., 2013), yet, Globocan ranked the disease as first among all malignancies with an estimated new cases of 4645 (22.1%) and mortality of 1871 (13.5%) in 2018 (Bray et al., 2018; International Agency for Research on Cancer & World Health Organization, 2018). This is a confirmatory report of an existing hospital-based data projecting an increasing trend in breast cancer incidence in Ghana ranging from 7.5% in 1972 to 24.1% in 2014 (Biritwum, Gulaid, & Amaning, 2000; Clegg-Lamptey, Aduful, et al., 2009; Dakubo & Naaeder, 2014; Edmund, Naaeder, Tettey, & Gyasi, 2013; Laryea et al., 2014). Further, over 70% of Ghanaian women wait for over 14 months before seeking healthcare for a breast cancer symptom, hence, their disease is commonly diagnosed at stage III and IV (Bonsu & Ncama, 2019b; Ohene-Yeboah & Adjei, 2012) when treatment is mainly palliation. Although active standardized cancer treatment is less expected to be successful at this stage (Ginsburg et al.,

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2017), these women still receive more intensive and expensive anti-cancer treatment such as chemotherapy. Yet, poor prognostic outcomes result. Hence, mortality rates of 31.2% and below 25% overall 5-years survival with poor quality of life have recently been noted as the hall mark of the disease in Ghana (Dakubo & Naaeder, 2014; Mensah, Yarney, Nokoe, Opoku, & Clegg-Lamptey, 2016).

Unfortunately, this serious problem has not been recognized in Ghana, hence, no country-wide program has been launched in Ghana to target breast cancer to address prevention and early detection of the disease. Consequently, no preventive services are available to Ghanaian women in the context of breast cancer (Mena et al., 2014; Obrist et al., 2014; Zelle et al., 2012), as recommended by global guidelines (El Saghir et al., 2011; World Health Organization, 2007b). The World Health Organization (WHO) describes early detection to include screening of asymptomatic women and timely diagnosis of those with breast cancer symptoms (World Health Organization, 2007a). However, due to context-specific challenges, mammographic screening seems prohibitive for most women in developing communities including Ghana. Therefore, breast health education and clinical breast examination (CBE) that are integrated into existing healthcare programs at all levels of prevention appears to be a resource-compatible prevention and early detection modality for breast cancer in this context.

Palliative care provides a symptomatic care to patients and families facing terminal illness such as advanced breast cancer. The concept of palliative care is evolving in Ghana and its services are now available to patients and families diagnosed with late stage breast cancer, mainly on an out-patient basis (Lynch, Connor, & Clark, 2013; Zelle et al., 2012). Hence, palliative care offers clinicians easy access to patients' families who most often may be experiencing fear, anxiety, uncertainties, and may be harboring several unanswered breast cancer-related questions. In this regard, palliative care may clearly be judged to be of potential benefit as it seems to be a golden opportunity to address families concerns and initiate breast health education, teach breast self-examination (BSE) and possibly offer CBE through clinician-family interactions.

The current study forms part of a large single case-study research that developed a model seeking to facilitate the integration of breast cancer prevention and early detection into cancer palliative care in Ghana and beyond (Bonsu & Ncama, 2019a). The broader context of the study explored and described the experiences of women diagnosed with advanced breast cancer on symptom recognition and appraisal as a reason for delayed presentation (Bonsu & Ncama, 2019b). The findings underscored that health professionals played a role that led to delayed presentation with a poor outcome (Bonsu & Ncama, 2019b). Under such premise, it became apparent to explore the experiences and perspectives of clinicians on breast cancer and its early detection measures.

Therefore, the current study focused on the clinicians experiences and perspectives on the phenomenon under study. The study's objective was to explore breast cancer in Ghana as reported by clinicians practicing in a cancer palliative care unit and to solicit for their perspectives on possible prevention and early detection strategies. The study was conducted in the palliative care clinic of the Komfo Anokye Teaching Hospital in Kumasi from January to June, 2018.

1.1. Study method

The study employed a qualitative exploratory design to explore breast cancer and possible integration of prevention and early detection strategies into palliative care. The design allowed a comprehensive understanding of what the clinicians assigned to a real life and a contemporary phenomenon (Creswell & Poth, 2017). Using an exploratory design, the study answered the research question: What are the experiences and perspectives of clinicians working in a palliative care clinic in a tertiary healthcare facility in Ghana on breast cancer and potential integration of breast cancer prevention and early detection into palliative care?

The study setting was the Komfo Anokye Teaching hospital. As described in previous study (Bonsu & Ncama, 2019a) the hospital is the only public health facility for cancer management in the Ashanti region of Ghana and beyond. An outpatient palliative care service is also available to advanced breast cancer patients and families in the hospital. Breast cancer is the most frequently diagnosed cancer among women at the Komfo Anokye Teaching hospital and in the Ashanti region at large (Laryea et al., 2014). Further, about 80% of women present with advanced breast cancer (Ohene-Yeboah & Adjei, 2012), making the facility a suitable site to explore clinicians' experiences and perspectives on breast cancer and possible integration of breast cancer prevention and early detection into palliative care .

Clinicians working at the Komfo Anokye Teaching hospital constituted the study population. The sampling frame was the list of all the palliative care multidisciplinary team members working at the Komfo Anokye Teaching hospital (KATH). A non-probability purposive sampling approach was employed to intentionally select participants with specific homogeneous features who are believed to possess the information necessary to answer the afore-stated research question This sampling approach ensured that participants were selected to specifically include those who were: (1) delivering palliative care services at the out-patient palliative care clinic, (2) providing care to advanced breast cancer patients and families, and (3) had more than one-year working experience in breast cancer care and palliative care. Based on the above criteria, participants were recruited to share their experiences and perspectives on the phenomenon of interest (Creswell & Poth, 2017). Clinicians who were not working at the palliative care clinic and those with ≥ 1 year working experience in breast cancer and palliative care were excluded from the study. The sample size for the study was seven (7) and this was determined by saturation (Creswell & Poth, 2017; Punch, 2013), as successive interviews generated similar responses and no new themes and sub-themes emerged. The sample included an oncology and palliative care specialist nurse (1), palliative care specialists (2), an oncology and palliative care specialist (1) and medical officers (3). Data were collected at the palliative care clinic of KATH. The clinician in-charge of the palliative care clinic linked the lead author (ABB) to all the palliative care team members who were eligible for the study. The seven (7) team members whom the researcher met were eligible and were selected. Details of the study were explained to them and were given the study's information sheet. Once they had made an informed choice, the interviews were scheduled based on their preference and availability. One clinician was part of the pilot study and the remaining six participated in the main study.

Face-to-face in-depth interviews were conducted using a semi-structured interview guide (***additional file***) at an office in the hospital. The interviews were audio tape-recorded, lasted between 60 and 90 min and had themes that focused on different aspects of breast cancer, prevention and early detection as well as integration into palliative care. In this study, the vital criteria of rigor in qualitative researches such as credibility (whether the findings of the study can be trusted or believed); confirmability (whether the results can be validated by others); dependability (whether the study can be repeated to obtain same or similar findings) and transferability (whether the findings can be compared to similar findings from similar settings) were employed to ensure the trustworthiness of this study (Guba & Lincoln, 1989). Methodological rigor was achieved through concurrent data analysis coupled with member checking with participants to ensure the full understanding and true presentation of participant's realities. This allowed confirmation of the data from participants before conclusions were drawn. Replication of the study and potential applicability of the findings in alike settings was achieved by detailed description of the study methodology, design, and setting, as well as the participants' background. Also, taking detailed field notes at each interview and discussion of study findings among authors ensured auditability of the study.

Ethical approval was sought and granted by the Committee on Human Research, Publication and Ethics, Kwame Nkrumah University of Science and Technology and KATH, Kumasi (Ref: CHRPE/AP/546/17 & CHRPE/AP/554/17) and Biomedical Research Ethics Committee, University of

KwaZulu-Natal, South Africa (Ref: BE549/17). Institutional permission was also sought and granted by KATH (REG. NO: RD/CR17 /251). The study was discussed with the participants and they were further briefed on their rights to voluntary participation and withdrawal from the study without consequences. All participants gave their consent by writing to both the interview and the audio-recording of the interview prior to collecting the data. Participants' confidentiality was ensured by conducting the interview in an enclosed office with no interruption. Information that could reveal the identities of the participants were excluded from the transcripts to ensure participants' anonymity.

1.2. Data analysis

All the interviews were transcribed verbatim and analyzed concurrently with data collection following the principles of thematic analysis (Miles, Huberman, & Saldana, 2013). Data were managed with NVivo (NVivo eleven (11), copyright © 1999–2015 QSR international); a qualitative software for the management and analysis of the qualitative data. All the transcribed data were exported into NVivo eleven (11) for storage and coding. The transcripts were read repeatedly to make sense of participants' emic. Data were analyzed following the processes of thematic analysis. Transcripts were read line by line to identify emerging themes from the data. This informed the open coding (Miles et al., 2013). Coding was grounded in the data and the themes were inductively generated from the data. Initial themes and patterns identified from the data were organized and grouped under primary themes to represent the main patterns. The organization of the emerged themes was done by their relationships and similarities. Themes emerged initially from the data were followed up in subsequent interviews and corroborated with field notes to fully develop themes. The coding was iterative; where necessary, some themes were merged, deleted or later added as the analysis progressed. To check the accuracy of the transcription, member check was done with participants before final conclusions were drawn from the data (Guba & Lincoln, 1989). Following the full development of the key themes and sub-themes, summary of participants' statements (quotes) were generated and this illustrated participants' perception about breast cancer, its prevention, early detection strategies and integration. The lead author (ABB) initially analyzed the data, and the second author (BPN) confirmed the findings to ensure that the respondents' realities were correctly and truly represented, with discourse discussed.

2. Results

Using a thematic analytical approach, three (3) main themes emerged from the data and these included: breast cancer presentation, barriers to early detection and lastly, the need for an intervention. These themes also had sub-themes as presented in Table 1. Demographical data of the participants were collected prior to the interviews. The ensuing sections of the result presents the demographical characteristics of the participants and the themes.

2.1. Demographics of participants

The age groups of the seven clinicians were: ≤39 years (5) and ≥40 years (2). Three were females and four males. Their clinical experiences in breast cancer and palliative care ranged from 3 to 15 years. Three were certified palliative care specialist (1 nurse and 2 doctors), one was a radiation oncology specialist and the rest were at the rank of senior medical officers. Table 2 presents the demographical features of the participants. Themes emerged from the data are described below.

2.2. Theme # 1: breast cancer presentation

All the seven clinicians shared their realities on breast cancer as clinically experienced in relation to: clinical incidence and stage at presentation, and lastly, poor outcomes of the disease and treatment.

2.3. Sub-theme # 1: clinical incidence and stage at presentation

All the seven clinicians agreed that breast cancer was the most occurring cancer among women and an average of 5 women diagnosed each week. This is evident in the quotes below:

*"So, it is a leading cancer in the country. Three (3) women are diagnosed a day, we usually clack for three days, hence, it would be nine (9) a week, four by nine is thirty-six (4*9 = 36) …. Averagely, 36 new breast cancer per month. It could be more, much more" (Kofi).*
"It is very common, and I see about 7 advanced breast cancer women at the palliative clinic on Fridays" (Pat).

The age range and stage at presentation was reported at young and late respectively, as illustrated below:

"We are around forty-five and sixty-two (45-62) but typically forties. Advanced or end-stage! That's why I say it is difficult" (Agyapong).
"You rarely see women with early stage breast cancer, most of our patients will be at advanced stage and metastasis as well at the time of presentation" (Akwasi).

2.4. Sub-theme # 2: poor outcomes of the disease and treatment

Outcomes of the disease and treatment were related to the stage at presentation and it was reported as poor across all the clinicians. A specialist had this to say:

"The aim of treatment is palliation. There are limited options for treatment at the stage the patients come, and the outcome is poor though expensive. They often present in a bad state so, they die few weeks to months after diagnosis" (Baba).

Adizah had this to share post 4 years practice in oncology and palliative care in the context of breast cancer:

"Because our women come at advanced stage, chance of survival is very slim" All my patients do not survive the disease.

2.5. Theme # 2: barriers to achievement of early detection of breast cancer

This theme describes factors believed to be impediment to the achievement of early detection of the disease within the developing context under study. All the clinicians cited overlapping factors, which were related to the patient and the healthcare system. Two sub-themes identified were: patient-centered barriers and mistrust in the contemporary healthcare structures.

Table 1
Themes and sub-themes.

Number	Theme	Sub-theme
Theme #1	Breast cancer presentation	• Clinical incidence and stage at presentation Poor disease and treatment outcomes
Theme #2	Barriers to achievement of early detection of breast cancer	• The patient-centered barriers Mistrust in the contemporary healthcare structures
Theme #3	The need for an intervention	• Integration of awareness and screening initiatives into palliative care services Develop a model of care Extension of early detection program into the community Advocacy among health professionals

Table 2
Participants profile.

Pseudonyms	Age group (Years)	Gender	Educational level	Profession	Specialty	Current grade	Palliative care team member	Directly involve in breast cancer care	Years of practice in palliative care & breast cancer	Current position in the hospital
Pat	≤ 39	Female	Ph.D.	MD	Palliative Surgery	Specialist	Yes	Yes	6	Palliative Surgeon
Kate	≥ 40	Female	MSc.	Nursing	Oncology and Palliative	Nurse specialist	Yes	Yes	15	Oncology and Palliative care nurse
Baba	≥ 40	Male	Ph.D.	MD	Radiation Oncology	Specialist	Yes	Yes	8	Radiation Oncologist
Agyapong	≤ 39	Male	Fellowship	MD	Palliative	Specialist	Yes	Yes	3	Palliative Care Specialist
Kofi	≤ 39	Male	Tertiary	MD	Palliative Oncology	Resident	Yes	Yes	6	Resident in Oncology and palliative Care
Adizah	≤ 39	Female	Tertiary	MD	General practitioner	Senior Medical Officer	Yes	Yes	4	Senior Medical Officer
Akwasi	≤ 39	Male	Tertiary	MD	General practitioner	Senior Medical Officer	Yes	Yes	5	Senior Medical Officer

2.6. Sub-theme # 1: patient-centered barriers

During the interviews, it emerged that early diagnosis of breast cancer begins with symptom discovery and appraisal, which is influenced by educational level of women, their awareness and level of knowledge of breast cancer, as well as their risk perception for breast cancer. Limited awareness and knowledge resulting in poor breast cancer symptom recognition were mentioned as barriers to early care seeking.

> *"A lot of the problem is partly from the women. Due to limited knowledge of the disease, sign and symptom of breast cancer are not seen as important. There is that thing of defining what needs to be sent to the hospital; if it doesn't incapacitate you, you shouldn't go to the hospital" (Pat).*
>
> *"Most of the patients do not know about the disease, they have no idea about the nature of breast cancer and have not seen it in their families as well. Hence, they do not see themselves at risk of breast cancer and symptoms of the disease is misinterpreted and ignored' (Kofi).*

Influence from the social networks of patients was another factor noted by the clinicians as limiting healthcare seeking. The clinicians echoed some of the stories shared with them by women during clacking that it is the submission to decisions of their families and friends that delayed them from presentation. To illustrate, Kate shared about how the actions of a sibling for one of her patients led to the delay of her sister's diagnosis:

> *"This young patient consulted her elder sister when she discovered the painless lump. Her sister felt the lump and said it was nothing serious. It was therefore ignored until it became painful and increased in size. The sister later took her to a church for prayers to relieve the pain. At the church, the symptom was interpreted as a spiritual occurrence which does not need medical attention"*

Health beliefs and disease representations also emerged from the data as barriers to the achievement of early detection. Fatalistic thinking, causal attributions of breast cancer, fear of surgery, beliefs that breast cancer cannot be treated and has no cure as well as preference for spiritual and traditional healing were commonly cited as contributing to delay presentation among patients. For instance, Pat had this to share:

> *"The patients have some maladaptive health beliefs and representations of breast cancer. For instance, they think that once you see a lump and you go the hospital, you will undergo surgery which will kill you. Hence, hospital is not an initial option for breast symptom"*
>
> *"Due to underlining cultural beliefs, most of the patients prefer herbal medicine and prayer camps as sources of healing. They spend so many months at these places and eventually present late for medical evaluation with advanced disease" (Kofi).*

All the clinicians acknowledged that inaccurate information on the disease disseminated through radio and television influences patients' decision on care seeking for breast symptoms. For instance, radio health talk shows often feature traditional healers who claim that they have medicines that melt breast lumps and cure breast cancer. This and other related adverts direct most women to herbalist with the hope for cure. To illustrate, Agyapong had this to share:

> *"Women are misled by what they hear on the radio by herbal medicine practitioners. Hence, they tend to believe that their lumps will dissolve and heal with herbal medicine. So, this is their first choice for care for their breast symptoms. More than 90% of the patients visit herbal centers for months before they come to us"*

2.7. Sub-theme # 2: mistrust of the contemporary healthcare structures

The clinicians acknowledged that lack of facilities for screening,

diagnosis and treatment of breast cancer within a meaningful reach of patients was a source of barrier to early detection of the disease. Geographical accessibility and cumbersome referral systems within a strange environment most often led woman to give up on modern medicine. This is illustrated in the quote below:

"There are no screening facilities to offer CBE for the women. Patients with lumps must travel long distance to the city seeking healthcare with no relative around to host them. They are often frustrated with the referral patterns, which they interpret as time and money waste, hence, they commonly give up and returns in months in very bad states dying (Pat).

High cost of treatment was unanimously mentioned by the clinicians as a significant challenge for the patients they see. Although the National Health Insurance Scheme was supposed to cover all women cancers, the scheme did not realistically cover treatment for breast cancer; hence, patients pay out of pocket for everything related to breast cancer. This pose financial stress which led patients who have no solid financial support to give up on modern medicine.

"Treatment for breast cancer is very expensive, and the patients have to pay out of pocket for everything because the NHIS is practically not working as claimed. Hence, the cost of medical care, travel cost and cost of living causes the patients to avoid hospital" (Akwasi).

Clinicians further noted that lack of confidence in the healthcare system led to delay in using it. Misdiagnosis and mismanagement of breast symptom by health practitioners at the first place of care, lack of meaningful diagnostic pathways, lack of skills amongst medical practitioners, a limited oncology workforce and negative attitude of some health professionals led patients to lose trust in the modern medicine option. This increases patients' preference for traditional and spiritual sources of treatment. To illustrate, Adizah shared an experience of one of her patients who presented with metastatic disease in a very bad state. She narrated:

"The patient and her family told me their reason for the delay. The woman reported to a district hospital within 2 days of symptom discovery, but she was told by a clinician that there was nothing wrong with the breast. She was not satisfied because she could feel the lump, hence, she moved to a regional hospital in the national capital city for further consultations, but she was again told that the breast was ok and she was managed on pain killers and antibiotics for 5 months. She then sought care at a private oncology center when additional symptoms of pain and lymphadenopathy occurred, yet, she was told that her breast was ok and managed on painkillers and antibiotics for close to one year. The breast ulcerated but she stopped the private consultation due to high cost of care and worsening symptoms. Then a family friend directed them to a herbalist where she spent an additional 3 months before reporting to our facility. Even, as a teaching hospital, she spent over 4 months during medical evaluation to get a confirmed pathology report. Most of her laboratory investigations such as mammography was done at a private facility because, our mammography machine broke down some years back and has not been fixed. Most of our patients go through similar situations"

2.8. Theme # 3: the need for an intervention

All the clinicians recognized an urgent need for an intervention to make women aware of breast cancer, promote prevention and early detection, and enhance the competencies of health professionals in breast cancer diagnosis and management. Further, a model of care for the intervention was proposed. Four sub-themes emerged: integration of awareness and screening initiatives into palliative care services, development of a model of care, extension of an early detection program into the community and lastly, advocacy among health professionals.

2.9. Sub-theme # 1: integration of awareness and screening initiatives into palliative care services

All the clinicians acknowledged the need to initiate awareness and screening services for asymptomatic women through palliative care to promote early detection of the disease. To the clinicians, every disease prevention program will work best if it is integrated into palliative care due to the opportunity of meeting families and the entire community through one patient. For instance, Pat viewed palliative care as a big tool for changing knowledge, attitude and cultural narratives around breast cancer. She shared:

"I believe every disease prevention can be integrated into palliative care. The time is now, to develop a framework for awareness and early detection among the family. It is a big tool for change and it will always be a good opportunity to do prevention amongst those asymptomatic women who are experiencing the physical and financial suffering associated with the disease in the family. It will change the knowledge base; the attitudes, and the perceptions. It is a way of changing the cultural narrative and notion around breast cancer in the society"

All the clinicians recognized that palliative care must include prevention and early detection amongst families of patients and not limit to end of life care and bereavement support only. Through their clinical practice, the clinicians had observed that an exposure of an individual to the sufferings and death of an advanced breast cancer patient instills a sense of fear and creates a fatalistic outlook about the disease. These individuals often wished to be addressed by clinicians regarding the disease, especially, the cause and prevention of subsequent occurrence in the family. Hence, addressing patients' and families' concerns about the disease, giving health education to the families on breast cancer, teaching BSE and offering CBE during clinical sessions were noted as a good step to provide breast health services to at-risk women.

"Palliative care is not all about care for the dying oohh…., this perception must change because it is an adjuvant therapy throughout the cancer continuum and includes prevention at the pre-diagnosis stage. Hence education on breast cancer, BSE teaching and offering CBE must be given to the families accessing supportive care services for the disease" (Kate).
"Yes, I've said we need to integrate three things into palliative care; education, BSE teaching and CBE. That is the way to go. Educate the women with any opportunity we get. When the women witness the disease in a family member or a friend, it instills a sense of fear and they identify the disease as a killer. We should use this as a golden means to educate and screen them and change their mindset about breast cancer. The hospital must go a step further to understand that this must be a policy for us and support us" (Agyapong).

2.10. Sub-theme # 3: develop a model of care

This theme refers to the perspectives of clinicians which suggest a development of a care model to aid the integration of preventive and early detection services into palliative care. All the clinicians judged the initiation of breast health and screening services for advanced breast cancer patients and families to be of benefit. However, they recognized that a framework would be needed to guide such practices in their clinical work. Hence, the clinicians proposed the development of a model. This is evident in the narratives below:

"Clearly, we need to promote prevention and early detection of breast cancer through palliative care……., but we will need a model to help us integrate such services into our clinical practice" (Kofi).
"There should be a protocol or a model that says that, do this…. and that…… in delivering care to the patients and families. This will guide any clinician who come to work in the palliative care clinic. Hence, developing a model of care is paramount"(Pat).

2.11. Sub-theme # 3: extension of an early detection program into the community

During the interviews, the clinicians discussed the need to extend the awareness and early detection services beyond the boundaries of palliative care to include the community of the patients so that women who do not visit the clinic could be covered. The patients and recipients of the breast health services at the palliative care clinic were commonly identified as appropriate agents for dissemination.

> *"We can start with the patients' families but then as time goes on, we can and must extend into the communities to increase the coverage. As I told you, last year, we saw two hundred and sixty (2 6 0) breast patients in this hospital alone. So, imagine, if we were to be meeting their relations though such a protocol. Each of them brought two relatives, that's about five hundred and twenty (5 2 0), which is not bad, but we can use these women to reach their communities. Encourage them to share the news and teach their fellow women about breast cancer and BSE. The women will eventually spread the whole idea in their communities" (Akwasi).*

2.12. Sub-theme # 4: advocacy among health professionals

All the clinicians acknowledged that provider and health system related factors contribute to delay presentation with breast cancer symptoms. Interesting stories were shared on this theme, however, the main concepts that emerged were lack of meaningful diagnosis facilities, knowledge deficit on breast cancer, its diagnostic pathways and management among health professionals as well as unprofessional attitudes of some health professionals. Therefore, advocacy among health professionals was noted as a key to build their competencies on breast cancer education, counseling, communication, breast examination techniques and referral paths and networks.

> *"Most often, the women tell us that they visited government health facilities with a small breast lump, but their time was much wasted. The reason is obvious; clinicians' knowledge deficiencies, unprofessional attitudes coupled with limited diagnostic facilities. We need education for the health professionals themselves because they do not know about the disease, examination techniques, evaluation measures and treatment. They just go in to remove the lump, no pathology evaluation, put women on analgesics and antibiotics and then discharge them with no appropriate referral for timely treatment. Frankly, I am a clinician, but we should acknowledge that the competencies of our colleague clinicians need to be built around breast cancer if early detection can be achieved" (Baba).*

3. Discussion

The study explored the experiences and perspectives of clinicians working in a palliative care setting in a tertiary healthcare institution on breast cancer and possible integration of its prevention and early detection of breast cancer in palliative care. Three main themes with sub-themes emerged as presented in the results section.

This study revealed an increasing clinical incidence of breast cancer among women in Ghana. For instance, an average of five (5) women diagnosed of breast cancer per week at the study setting was commonly reported by the study participants. This is a confirmatory findings of prior reports about the increasing incidence of breast cancer in most developing countries including Ghana (International Agency for Research on Cancer & World Health Organization, 2018; Laryea et al., 2014). In addition, the disease was noted by the study participants to occur in young women who commonly present with advanced stage disease due to delayed presentation, a common finding in a previous report (Ohene-Yeboah & Adjei, 2012). This is recognized as a public health concern in developing communities due to its impact on survival, and mortality. Hence, context-specific and cost effectives measures aimed at promoting early detection to improve survival in this setting is recommended (Zelle et al., 2012).

Patient-related and health system (provider)-related delays were identified as the key accrediting agents for the advanced stage diagnosis commonly observed in the developing context under study. As noted in prior studies (Clegg-Lamptey, Aduful, et al., 2009; Clegg-Lamptey, Dakubo, & Attobra, 2009; Ohene-Yeboah & Adjei, 2012), our findings affirmed the existence of barriers impeding on developing countries' ability to achieve early detection of breast cancer. Commonly cited barriers by the clinicians in this study were lack of early detection facilities, limited awareness and knowledge of breast cancer, health beliefs, societal influence, preference for traditional sources of treatment, and unprofessionalism of health providers leading to lack of trust in the modern healthcare structure. Given the absence of a national program for breast cancer prevention and control program in most developing countries including Ghana (Mena et al., 2014), the clinicians in our study recognized the need to address these burdens through integrative clinical initiatives at all levels of prevention. This, they believed, could possibly change the knowledge base, maladaptive attitude and beliefs and the cultural narrative of women around breast cancer and influence future health seeking behaviors of women for breast symptoms. This lend support to the recommendations made by the WHO (World Health Organization, 2007a).

Palliative care, a type of care which gives clinicians the golden opportunity to meet families and other social networks of advanced breast cancer patients was identified in this study as the most appropriate context to integrate breast cancer prevention and early detection services for women. For the clinicians, palliative care must be calibrated over time to meet the informational needs of women who are experiencing the suffering of advanced breast cancer in their families. The clinicians acknowledged that the initiation of services such as breast cancer health education and counselling, BSE teaching and CBE to families of advanced breast cancer patients while delivering palliative care services is feasible and achievable. Knowing the genetic predisposition of breast cancer (Antoniou et al., 2014; Pyeritz, 2012), the clinicians recognized family history and exposure to the realities of the disease as an important tool to initiate interventions that will modify women behaviors toward the disease. The usefulness of family history as a tool to initiate breast cancer education and screening as indicated in this study has been acknowledged in the literature over a decade ago (Guttmacher, Collins, & Carmona, 2004; Pyeritz, 2012). In this regard, a recommendation was made by all the seven clinicians who participated in the study to develop a contextualized intervention and model that will guide the integration of breast cancer prevention and early detection into palliative care.

To achieve early detection of breast cancer, the competencies of health professionals in health education and counselling, CBE skills, medical evaluations for breast symptoms, diagnosis, referral patterns and treatment of breast cancer were recognized as crucial by all the clinicians who participated in this study. These enablers have also been recognized by various cancer organizations such as the Union for International Cancer Control (UICC) (Neumann, 2017). Hence, advocacy among health professionals around these concepts were recommended, as the clinicians identified that some level of deficiencies among their own colleagues contributed to delay presentation of breast cancer symptoms. In addition, a recommendation was made by the clinicians to extend the prevention and early detection services to patients' communities using the patients and their families as agents for dissemination.

4. Conclusion

This study presents findings observed and experienced by participants in their clinical practice. The study revealed findings that confirmed the steady increase of breast cancer and its associated burdens within the context of a developing country. All the clinicians reported

that breast cancer was commonly diagnosed among young women and at an advanced stage with unfavorable treatment outcome. Several patients and health system-related factors were identified by clinicians as barriers to the achievement of early detection of the disease in this setting. For instance, lack of meaningful facilities for screening, diagnosis and treatment of breast cancer were acknowledged. Under such premise, a call was made by all the clinicians who participated in the study to develop an intervention that will potentially integrate breast cancer prevention and early detection into palliative care. This, they believe, will serve as a guide for palliative care clinicians to introduce prevention and early detection approach to suffering. Future study should explore the existing screening pathways in developing countries to gain more insight into the phenomenon. Also, a study to develop a model that will integrate breast cancer prevention and early detection into palliative care is required.

5. Limitation and strength

The recruitment outlet for the study was the palliative care clinic of a tertiary healthcare facility hence, only clinicians who were part of the palliative care team were included. Also, the study was conducted in one healthcare facility. This may have implications for generalization, hence, the use of the findings for generalization purpose should be done with caution. Despite these limitations, the study has highlighted varied factors acting as barriers to early detection of breast cancer, but all these centered-on patients' and providers' delays as well as deficiencies in breast cancer screening, diagnosis and treatment. These findings provide a good guide for clinicians and further researchers to identify areas to focus breast cancer prevention and early detection programs.

6. Implication

- A need to integrate breast cancer prevention and early detection into palliative care
- A model to guide the integration of breast cancer prevention and early detection into palliative care is paramount
- Advocacy among health professionals is required to influence breast cancer early detection, diagnosis and management

Declaration of Competing Interest

The authors declare no competing interests.

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