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BREAST CANCER PREVENTION AMONG WOMEN RESIDING IN INFORMAL SETTLEMENTS

A QUALITATIVE STUDY IN NAIROBI, KENYA

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Beckmann, C & Wersäll, C. Breast cancer prevention among women residing in informal settlements. A qualitative study in Nairobi, Kenya. *Degree project in nursing 15 credit points,* Malmö University: Faculty of health and society, Department of Care Science, 2016.

Background: In Kenya breast cancer is the most common cancer in females. In comparison to countries in the western world, Kenyan women generally present when the breast cancer has advanced and chances of survival are low. This late breast cancer diagnosis becomes a considerably larger burden to a country with already limited resources to treat it and results in higher mortality rate.
Aim: The aim of the study was to illuminate Kenyan nurses working experience with breast cancer prevention among women residing in informal settlements of Nairobi.
Method: A qualitative study with eight semi-structured and open-ended interviews were held with nurses in four health care clinics. The data was analysed by a qualitative content analysis.
Results: The result of this study showed that the nurses working in clinics situated in the informal settlements had knowledge of breast cancer. They were capable in their preventative work and gave appropriate information to their patients. The main concern was being able to reach all the women in the community and create more awareness. Another concern was also to make the women prioritise their own health in spite of their financial situation.
Conclusion: The nurses in the informal settlements have knowledge of how to take care of their patients. However, there is a great need for awareness in the community so that women seek treatment early. In order to provide sufficient and a more meaningful care for patients, there is need of regular updates for the medical staff, especially nurses, as well as need of better equipment in the clinics.

Keywords: Breast cancer, experience, Kenya, nurses, prevention, qualitative study.

PREVENTION AV BRÖSTCANCER BLAND KVINNOR BOSATTA I SLUMOMRÅDEN

EN KVALITATIV STUDIE I NAIROBI, KENYA

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Beckmann, C & Wersäll, C. Prevention av bröstcancer bland kvinnor bosatta i slumområden. En kvalitativ studie i Naironi, Kenya. *Examenarbete I omvårdnad 15 högskolepoäng,* Malmö högskola: Fakulteten för Hälsa och Samhälle, Instutitionen för vårdvetenskap, 2016.

Bakgrund: I Kenya är bröstcancer den vanligaste formen av cancer bland kvinnor. Till skillnad från länder i väst söker inte kenyanska kvinnor vård förrän cancern har utvecklats till de sena stadierna då chansen för överlevnad är låg. Den sent diagnostiserade bröstcancern belastar ett land som redan har begränsade resurser att behandla sjukdomen vilket resulterar i högre dödlighet.
Syfte: Syftet med studien var att belysa hur sjuksköterskor arbetar preventivt med bröstcancer bland kvinnor bosatta i slumområden i Nairobi, Kenya.
Metod: En kvalitativ studie med åtta semistrukturerade och öppna intervjuer utfördes med sjuksköterskor på fyra vårdcentraler. Materialet var analyserat med hjälp av en kvalitativ innehållsanalys.
Resultat: Resultatet av denna studie visade att sjuksköterskorna i de informella bosättningarna hade kunskap om bröstcancer. De var kunniga i sitt förebyggande arbete och gav information till sina patienter. Det viktigaste för dem var att kunna nå alla kvinnor i samhället och skapa mer medvetenhet. Det var dock ett bekymmer att få kvinnor till att prioritera sin egen hälsa på grund av deras ekonomiska situation.
Konklusion: Sjuksköterskorna i de informella bosättningarna är kapabla att ta hand om sina patienter. Det finns dock ett stort behov av medvetenhet i samhället så att kvinnorna söker behandling tidigt. För att kunna tillgodose fullgod vård av patienterna krävs också regelbundna uppdateringar för den medicinska personalen, speciellt sjuksköterskorna, samt ett behov av bättre utrustning i klinikerna.

Nyckelord: Bröstcancer, erfarenhet, Kenya, kvalitativ studie, prevention, sjuksköterskor.

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INTRODUCTION

In many parts of the world breast cancer is the most common form of cancer among women. Kenya, on the eastern coast of Africa, is one of those affected nations. The majority of Kenyan women diagnosed with breast cancer have a poor chance of survival since they normally present themselves at clinics in the late stages of breast cancer (k4health, 2012). According to the World Health Organisation (WHO) a lot of effort is spent in managing preventable infectious diseases which are still today the biggest cause of death among Kenyan citizens (WHO, 2014). The second cause of death is cardiovascular diseases and the third cause of death being cancers (ibid). The burden of communicable diseases and limited resources are some of the reasons which have resulted in cancers receiving a low public health priority (WHO, 2011).

This is a Minor field study (MFS) which has been conducted in Nairobi, Kenya. The study was made possible through Malmö University and the sponsorship of the Swedish government agency SIDA. The prospect of doing a MFS has been intriguing since the start of our nursing education. The study was arranged to be carried out at a hospital, Ruaraka Uhai Neema (RUN), which is situated in the north eastern part of Nairobi. The suggested purpose was recommended by the initial gatekeeper and the fact that it was not an infectious disease was both surprising and intriguing. Also the fact that it was a topic suggested by the hospital provided a sense of relevance which stimulated further investigation.

BACKGROUND

The Republic of Kenya

Kenya is a country on the eastern coast of Africa. Kenya was a British colony which got its independence in 1963. The first president after the liberation was Jomo Kenyatta and his party KANU (Kenyan African National Union*)* then remained in power until 2003. It was not until 1992 that there was a free election, albeit disputed. This caused friction in many areas and stirred up violent behaviour (Nations Online, 2016). Kenyan elections still cause violence and in 2007 there was a major incident following the elections held that year which lead to the death of over a thousand people. The newly elected president at the time, Uhuru Kenyatta who is the son of the first Kenyan president, and his Vice President, William Ruto were accused of abuse against Kenyans. The accusations have since been dropped but it has most likely affected international relations (Landguiden, 2016). The country has also suffered from acts of terrorism with the recent major incidents in the Kenyan capital Nairobi. As well as a smaller city in the north eastern part of the country, Garissa, which experienced university killings where almost 200 people died and 150 people were injured. This is due to the involvement Kenya has in the conflict in Somalia, sending troops to support the Somali government against groups like the Al-Shabaab (ibid).

Economy and future

Kenya is one of the most developed countries on the African continent and can be seen as the major trade centre in eastern Africa. The capital is a central point for many businesses. Nairobi has a developing financial and IT technology sector which is more extensive than in neighbouring countries. A large portion of the

country's income comes from tourism which provides up to 50% of the Gross National Product, (GNP). However due to corruption economic growth is not as it could be. Kenya depends on its natural resources and exports as well as on the assistance and aid from other countries to strengthen the economy. The country is a large exporter to neighbouring countries as well as to the European Union (EU) producing and exporting large amounts of tea, coffee, horticultural products and fish (Kenya Embassy Berlin, 2015*).* Even with all the export from Kenya the imports are even higher. The country's demand on oil is increasing and it is imported which makes for a constant deficit in trade (Landguiden, 2016). Kenya has launched long-term goals of the country's development within a few areas. The goals include improving the quality of life of its citizens and therefore the Kenyan government is investing in its infrastructure and in its people (Kenya Vision, 2015).

Informal settlements

The UN Habitat defines an informal settlement, also known as slum, as an area with; 1.) Inadequate access to safe water; 2.) Inadequate access to sanitation and infrastructure; 3.) Poor structural quality of housing; 4.) Overcrowding; and 5.) Insecure residential status (Corburn & Karanja, 2014).

In Nairobi, 65% of its almost 3.2 million inhabitants are scattered around in different informal settlements in the capital (Corburn & Karanja, 2014). People from rural parts of Kenya often move to Nairobi in hope for a better life for themselves and their families. But with little and poor infrastructure as well as few opportunities people are pushed deeper into poverty (Child Fund, 2015). The reduced access to safe food and water as well as the poor sanitation, high unemployment and high crime in these areas has affected the dwellers health. Living in these highly concentrated populated slums resulted in the high risk of the spread of infectious diseases like tuberculosis and cholera. There is also an increasing problem with non-communicable diseases as well as injuries and violence. These informal areas are in great need of health care but these services are generally difficult to access (WHO, 2010).

RUN Hospital

The non-governmental Ruaraka Uhai Neema Hospital, is an institution supported by World Friends, an Italian non-governmental organisation, who run it in partnership with the Archdiocese of Nairobi and the CISP, the International Committee for the Development of People (RUN, 2015). Their idea was to create a referral medical centre that responds to the need for training of social and health workers, as well as guaranteeing the access to health services to the poor population of some of the most marginalized areas of Nairobi. In 2003 the Neema project was started and developed in three different phases. The first phase focused on providing out-patient services and in the second phase the focus was on the in-patient services. The third phase focused on development and training and the project turned into the Ruaraka Uhai Neema Hospital which became fully operational in March of 2009. The purpose of the RUN hospital is partly to ensure access to basic health care and prevention in the slums and also to enforce suburban basic health structures. It is funded by donors and one important donor was the European Union who supported a three-year project at the hospital starting in 2008. The hospital has a close partnership with a number of clinics in the different slum areas of Nairobi. It acts often as the referral hospital when more advanced treatments are needed for clients from the clinics in the slums (ibid).

Most of the clinics in the slums have huge catchment areas. For instance in Mathare, which is one of the larger informal settlements where the RUN hospital has a number of partner clinics, is one of the most populated areas in Nairobi. The official number of inhabitants is around 600 000 people in just five square kilometres (Mathare Valley, 2014).

Healthcare in Kenya

In terms of public health care in Kenya it is still very basic and poor. With almost half of the country's population living below the poverty line on less than one dollar a day, there is a struggle to provide basic health care services and medical treatment to the citizens (Child Fund, 2015). Health care is especially hard to get for those living in the rural communities as well as for the people living in populated informal settlements (ibid). The cost factor is what prevents 44% of Kenyans not to seek medical care despite their illnesses (Allianz Worldwide Care, 2016). Almost one million Kenyans fall below the poverty line every year because of costs related to health care (World Bank, 2014). The Kenyan government spends USD6.2 per capita on health care, which is considerably less than WHO´s recommended USD34 per capita. This has an effect on the ability of the health sector to provide an adequate level of health care to the inhabitants (ibid).

Many donors contribute to the Kenyan healthcare with up to almost 15% of the nation's health budget (Smart Global Health, 2016). The government recently launched new plans and strategies to provide the middle-class and lower income groups with the possibility of accessing health care. The aim of the new policies is to promote health so that people can avoid getting ill, reduce the time-period being ill as well as making it more affordable to receive health care (ibid). In Kenya most of the health care is provided by the state (WHO, 2009). There are also both profit and non-profit private providers that serve a great number of the population. Many organizations support the health care in the country within the non-profit public health care such as Italian co-operations and SIDA for example. This helps to provide better opportunities for health care and better resources for the people (ibid).

Breast cancer

Breast cancer refers to a malignant tumour in the breast tissue (Ericson & Ericson, 2012). It is most common to develop breast cancer from the milk ducts of the mammary glands but it may also develop from the lobules that supply the ducts with milk. The cancer can be locally restricted within the area of the duct or grow and take over surrounding tissue which can turn into metastases (ibid). Once the cancer cells metastasize it commonly spreads via the ducts of the lymph to the lymphatic nodes in the armpit and neck or spread via the blood to other tissues and parts of the body which causes abnormalities and results in death (k4health, 2012).

Though the specific cause of why breast cancer develops is unknown most of the risk factors, circa 90%, are thought to be related to life style and environment with 5-10% due to heredities (k4health, 2012). Some of the risk factors in developing breast cancer are as follows: woman, age, cancer in the family, exposure of oestrogens, high-fat diet, little physical exercise, BMI>30 and consumption of alcohol (ibid).

Breast cancer in Kenya

According to National guidelines for cancer management in Kenya cancer is the nation's third most common cause of death (kehpca, 2013). Breast cancer is the most frequent type of cancer in women. With the high prevalence of 51,7 cases per 100 000 females, which accounts for 23% of all cancer cases, this is the highest incidence rate ever recorded in a cancer registry in Africa (Korir et al, 2015). However in Kenya, like the majority of Africa, it is hard to get an accurate incidence and mortality rate of breast cancer since the data is based on limited population-based cancer registries (ibid).

In comparison to countries in Europe and North America where the incidences of breast cancer are higher. The difference being in Kenya it is generally detected at an advanced stage as well as being presented in much younger ages (k4health, 2012). In cases when breast cancer is detected before it has advanced, the chances of survival are much higher (Muthoni & Miller, 2010). But since Kenyan women do not seek health care until they experience pain or notice discharge from their breast the cancer mortality rates are much higher. This leads to a considerably larger burden to a country with already limited resources to treat the breast cancer once it is diagnosed (ibid). This is why the prevention of breast cancer is so vital.

Prevention

Cancer prevention aims to reduce threats to health. Its measures are intended to lower the number of people who develop the disease, the number of people who die from it and to help improve the quality of life for those who are diagnosed. It is recognised that cancer cannot be wiped out entirely from communities, but through prevention its effects can be reduced (ipcrc, 2011). Prevention of cancer is categorised into two parts: primary and secondary. Primary prevention involves what one can do to decrease the risk of developing the disease. This includes the promotion of health, as in maintaining a healthy lifestyle and avoiding risk factors. Risk factors such as eating a high-fat diet, being overweight or obese, low physical activity and the excessive use of alcohol. Secondary prevention refers to what one can do early on in the course of the disease. This is when breast cancer can be identified early and treated as soon as possible, and includes different methods of screening for timely detection to halt its progress. (k4health, 2012; kehpca, 2013).

Screening for breast cancer is an exam to identify asymptomatic individuals for any abnormalities in the breasts (kehpha, 2013). Screening for breast cancer involves breast self-examination, which is a simple examination done by the woman herself to identify any changes. Screening also involves a clinical breast examination which is performed by trained medical staff. Sometimes the use of ultrasound can be useful for women who have small breasts or women who are breast feeding. Another technique for screening is through the optimal specialised test of the breast, using low energy x-rays called a mammography test (ibid). Regular mammography tests are suggested for women in Kenya who are over 40 years of age, though screening programs have not yet been implemented for the general population (Kehpha, 2013; Korir et al 2015).

Nurses need to have adequate knowledge of breast cancer to teach the patients they treat about the risks and possible prevention of breast cancer as well as communicating on a level that the patients can understand (Mutoni & Miller, 2010). Simple checks like breast self-examinations every month can be

implemented in order to detect any changes and prevent the illness from progressing (ibid).

According to WHO the ratio for doctors in Kenya is 10 to 100,000 people whereas the nurse ratio is higher, 120 to 100,000. However the lack of doctors means an increased work load for nurses. The nurses also work in both rural and urban parts of the country at primary health centres which provide easier access for most people. This means they need to be well trained to perform clinical breast examination. Furthermore, they should have the knowledge to foresee the risk factors of breast cancer. Unfortunately, this is not the case and many nurses lack cognition (Mutebi et al, 2013).

In 2012 the Kenyan government introduced new guidelines to tackle the issue of breast cancer incidences (k4health, 2012). The government's idea is to stimulate awareness among women regarding breast cancer and to provide them with more information about the disease and how to prevent it. Since breast cancer can affect any woman and is usually detected at a late stage the information about prevention needs to reach all women regardless of social status. There are possibilities for advanced screening procedures such as mammography, fine needle aspiration and cytology but they are carried out in higher levels of health care and are not accessible for all, especially those out in the rural parts of the country or in the slums (ibid).

Area of concern

Breast cancer is the most common cancer among women in many parts of the world (k4health, 2012). In Kenya, much of the attention is in managing the preventable infectious diseases which are still today the biggest cause of death among its citizens (WHO, 2014). The second cause is cardiovascular diseases and the third cause is cancers and breast cancer is the most common cancer in females (ibid). The burden of communicable diseases and limited resources are some of the reasons that have resulted in cancers receiving a low public health priority (WHO, 2011). This has revealed that the majority of women are being diagnosed with breast cancer at an advanced stage. This is not only due to their lack of awareness or financial status but also from delays caused by their health care providers. These delays can be due to the medical staff's lack of experience regarding breast cancer, as well as the limited resources for treatment (Pace & Schulman, 2016). While there is not an especially high rate of breast cancer cases in Kenya, it is a silent killer due to low awareness and poor diagnosis. This shows the importance for further research of preventative measures when working with an exposed group of people.

AIM

The aim was to illuminate Kenyan nurses working experience with breast cancer prevention among women residing in the informal settlements of Nairobi.

Definitions

Prevention is a term that implicates to promote health and to prevent disease and its complications (Ehnfors et al 2000). In this study two categories of breast cancer prevention have been considered; primary and secondary. Primary prevention involves what can be done to decrease the risk of developing breast

cancer. While secondary prevention involves what can be done early on in the development of breast cancer (k4health, 2012).

Informal settlements are defined as an area with inadequate access to safe water, inadequate access to sanitation and infrastructure, poor quality of housing, overcrowding and insecure residential status (Corburn & Karanja, 2014).

METHOD

In trying to gain an understanding in how the nurses in the informal settlements work with breast cancer prevention, a qualitative research design was chosen. By using qualitative research to collect data, Basavanthappa (2007) explains ways of giving the researchers the tools in a systematic and interactive way to describe life experiences and give them meaning. The study was conducted with semi-structured and open-ended questions with nurses working in clinics in informal settlements.

Participants

To be included in the study the informants had to be English-speaking registered nurses of either sex working at the RUN hospital. Another inclusion criteria was that they needed to have a minimum of three years experience working in informal settlements.

A few weeks prior to departure it was brought to the authors attention that the nurses at the RUN hospital had limited experience working with outreach in the slums. With only a few nurses doing outreach once a month this meant an inevitable risk of limiting the final result of the study. It was then suggested by the Deputy Country Coordinator to arrange more suitable informants for the study via RUN's partner clinics which are based out in the informal settlements in the north-eastern part of Nairobi.

A Project Manager with connection at the RUN named Silvia acted as the gatekeeper. According to Polit & Beck, (2014) a researcher needs to negotiate with a gatekeeper to gain entry into their world. Silvia runs projects out in the slum together with the different clinics and so has gained their trust. Silvia introduced the authors to the four participating clinics. Information about the study (appendix 2) was given both orally and in writing to the head of the clinics as well as the head-nurses, who then passed on the information to potential participants. In two of the four clinics the head-nurses showed interest in taking part in the study.

The gatekeeper acted as a link between the authors and the clinics and helped to schedule the interviews. Out of the eight participant nurses, there were five females and three males, with between one and ten years experience working in the slums. Their ages varied between 25 and 49 years.

Half way through the interviewing process the researchers altered the latter inclusion criteria from three years to one year. The demographic questions had not been specified to years experience working in slum areas but to years working as a general nurse. As the information from the interviews of the concerned respondents essentially turned out to be valuable, it was decided to keep the

gathered data and instead change the criteria. However, one respondent was excluded from the study as this nurse had less than one year experience working in slums.

Data collection

In order to test the interview questions a pilot study was carried out with a nurse from the RUN hospital. Polit & Beck (2014) describes a pilot study as being a trial run before the real study is made. The pilot interview took place in a staff room and lasted for 29 minutes. The information provided by the nurse gave an indication as to if the questions used for the interview were relevant to the aim of the study and how much information could be gathered from one informant.

The four clinics included in the study had close relations to the RUN hospital and were situated in large informal settlement areas in the north-eastern part of Nairobi.

During the initial meetings with the four clinics, information about the study was handed out to the head-nurse for her to distribute among her staff. It was made clear by the authors that the information regarding the study would be passed on to suitable nurses who would show interest in participating. In Basavanthappa, (2007) this selection method is known as snowball sampling. It is a sampling procedure where the researcher identifies individual informants who they trust have the relevant information related to their study. These informants are then asked to nominate other potential informants (ibid).

After the introduction of the study the gatekeeper scheduled the interviews at a time that suited the clinic and the participants. The interviews with the nurses were all held in a secluded room at their workplace and lasted between 16 to 27 minutes. Before each interview a short description of the study and the aim was stated and the participant was asked to sign the letter of consent. In order for the researcher to inspire the respondent to permit the interview, Basavanthappa (2007) states it is good to highlight the worth of their cooperation. Sentences like "We are excited to learn about your experience and knowledge regarding preventative work with breast cancer" as well as "We appreciate you giving us your time for this interview" were made. Basavanthappa (2007) also states the respondents may feel incompetent or fear they would not be able to answer questions asked by the researcher. Such anxiety was limited by saying "we are not here to test your knowledge".

Polit & Beck (2014) describes semi-structured interviews ensures that all topics are covered according to a written interview-guide. Open-ended questions were also used to encourage informants to respond to a question in their own words (ibid). Both researchers were conducting the interviews together and all questions from the interview-guide (appendix 3) were asked. The opening question started with "Can you tell us about your experience working with prevention of breast cancer?" The rest were not asked in any particular order but chosen depending on the answer of the respondent. To enhance the answers given in depth questions like "how" and "what" were used. According to Kaminsky et al (2008), probing questions makes the participants focus on experiences instead of how they would like things to be or think they should be.

All conducted interviews were recorded with two mobile phones. It is important to record responses to keep relevant information from being lost (Basavanthappa, 2007). The responses were written verbatim and not paraphrased. The transcribing of the interviews was then written parallel with and in close adherence to the interviews. The transcribing was made separately but the first interview was transcribed together by both researchers to insure the finished transcribing was written in the same way. After all interviews were transcribed verbatim, the researchers swapped their work with each other to make sure that nothing was missed. The transcribed materials were typed into a word document of 24 pages.

A total of ten interviews were conducted from the 12th to the 22nd of April 2016. Eight interviews were included in the study. The two excluded was one pilot study and one interview which did not meet the criteria.

Data analysis

A content analysis inspired by Burnard (1991) was used to analyse the data which consisted of the eight transcribed interviews. It was a 14 stage process used to analysing semi-structured and open-ended interviews (ibid). All stages were performed except for stage eleven where selected respondents were to be asked to check the relevance in the results. This decision was made due to the lack of time.

After the daily interview sessions, the researchers discussed the outcome of the data. Throughout the data collection words and notes of the topics talked about in the interviews were written down to provide an overview of what was said. Once the interviews had been transcribed verbatim they were read through repeatedly. According to Burnard (1991) this should be done to get immersed in the data and to enable the author to get responsive of the world of the informant. The researchers then separately wrote notes on what was being said in the transcripts. These were discussed, compared and worked through. Categories emerged and notes that ended up in the same category were grouped together which developed two head categories, each with its own sub-categories. To improve the validity of the result and to watch out for researcher's bias, two fellow students were asked to make their own categories from the transcripts. These were compared and the final category system was written. To be able to identify which data that fit under which category the researchers went back to transcribed printed material. Each category was specified with its own colour code and the data that fit the category was highlighted with its matching colour. The writing of the result could then begin.

Ethical aspects

Before performing the study, ethical aspects came into play and the study was required to be reviewed by the faculty's Ethics Council. Basavanthappa (2007) describes the importance of considering ethical guidelines to protect human subjects when planning a research. Any research which could be harmful to study participants violates the ethical code of nursing and could be illegal (ibid). Central considerations on how to ensure the confidentiality of respondents, the handling and storing of the data and when the confidential data should be destroyed were discussed. In March 2016, ethical approval was given from the Ethical Council of Health and Society at Malmö University, HS2016/no 17.

According to Basavanthappa (2007) nurse researchers are required to obtain informed consent from their study participants, this enables them to make an informed and knowledgeable decision about participating. A researcher should also allow a participant a few days to digest the information written in the informed consent letter before giving their approval of participating in the study (ibid). Approximately one week prior to the interviews taking place, the head nurse and/or the head of the clinic was introduced to the researchers and informed of the study. Written information (appendix 1) about the study was also handed out together with a letter of consent (appendix 2). The given information contained the aim and the purpose of the study, that the data would be collected through interviews which would be audio recorded. Furthermore, it stated about how information would be handled to maintain anonymity and confidentiality. It was also indicated that the participation was voluntary and that they at any time during the study could withdraw without further explanation. After a few days, back at the clinics when the interviews were to be carried out, the participants were asked to sign the letter of consent (appendix 2). Through signing they confirmed they had taken part of the information and that they gave consent to the interview as well as having it recorded.

Before each interview the participants were given a random number or letter. These codes together with the audio recordings and the transcriptions were stored on two different flash drives, each protected with a password. The written study was kept on two different computers, both locked with its own password and kept in separate private rooms which only the researchers had access to. Once the study was examined and published, all data collected was erased.

RESULTS

The outcome of the collected data is hereby presented in this chapter. It has been categorized in order for it to be made easier to comprehend and also includes quotes from the actual interviews to create a deeper understanding for the readers. When conducting the interviews it became clear that certain topics were of concern for the participants. These topics were then formed into two major categories: Importance of early detection and Experience of awareness, each with its own sub-categories.

Table 1 Categories and sub-categories

Importance of early detection	**-Screening** **-Referral** **-Education**
Experience of awareness	**-Awareness in community** **-Nurses' wishes for improvement**

Importance of early detection

Early detection was the essence in working with prevention of breast cancer. This involved what the nurses were doing in order to receive response from the women out in society.

Screening

The analysis showed that there were not enough clinics and medical staff, as the catchment area was large, and did not make up for the growing need of health care. The women who attended the clinics came for antenatal check-ups, post-natal check-ups or family planning and this was when they got a full body examination. The nurses said that this system of reaching only the mothers or expecting mothers was not enough. They also mentioned that the medical camps, primarily offering cervical screening and family planning, were a good way of reaching the people. A lot of women attended the medical camps and could get an examination which included palpation of the breast. The mothers were also informed about the possibility of breast cancer and received information about breast cancer as well as other diseases.

”*/.../ we still have a very large group of the community who are not either pregnant who are coming for family planning the facility so which means we are missing out on this group /.../. (Interview 1)*

Sometimes the patient could be seeking treatment for something other than symptoms of breast cancer but would still receive a full body check-up in order to make sure and rule out any abnormal growth in their breasts. Unfortunately these thorough examinations did not happen often. A few of the clinics had more advanced equipment like ultra sound but for the most parts the examinations performed by the nurses were clinical breast examinations. When the patients first came to the clinic they were asked about their family history. All of the nurses knew that this was an important first step in order to establish the likelihood of the woman developing breast cancer. Since genetics is one of the risk factors getting breast cancer, it was vital for future care to have the patients as well as their families medical background.

“*/.../ maybe you have a family history of breast cancer so which means that you are more probe to have breast cancer than any other person who doesn’t have a history on that line.” (Interview 1)*

In order to detect breast cancer in its early stages, all of the interviewed nurses knew how to conduct appropriate breast screenings. The interviewed nurses were aware that breast cancer is on the increase in Kenya and mostly has a deadly outcome. They were further cognisant of the fact that if detected in its early stages and the cancer had not yet progressed and spread to other parts of the body, there was still a good chance of survival if the patient could receive timely and proper treatment.

”*/.../ screening is important because of early detection, those who have been detected early their prognosis is not that bad /.../.” (Interview 7)*

This particular nurse revealed the same information as all the other nurses. All interviewed nurses made comments regarding the importance of capturing the disease early before the cancer had advanced, meaning that when the cancer is only affecting the breast it is more treatable. According to what the nurses said and the result of this study revealed and confirmed, was that most patients were unfortunately only seeking help once cancer had already progressed into the late stages. This meant that the cancer was no longer only affecting their breasts but also other parts of their body. The ability for screening in these clinics was very

limited and so in the late stages of the disease they would refer their patients to facilities which were better equipped for further examinations and treatment.

Screening was not a priority among women living in informal settlements. It was the nurses experiences that women came to be seen often in the late stages of their illness and this was due mainly to the womens poor financial situation. The women were more concerned about being able to put food on the table than checking their own health.

”*/…/ in their mind their breast is not a priority, are you getting me, they will talk more of security.” (Interview 2)*

Since women do not prioritize their health, nurses went on to say that ill women would sometimes have to borrow money from their relatives in order to seek medical help and therefore might be considered a burden to the family. This could cause family members to leave one by one and she could face the risk of being left to die alone. Therefore, sick women often came to the clinics when they were in the late stages of cancer and even dying. All this made the preventative work with breast cancer screening even harder with this group of women. For further diagnose the sick women had to be referred to other clinics or hospitals where there could be and often was a long waiting period, which allowed the disease to progress.

Referral

Once suspicion of breast cancer was detected in a woman, through clinical breast examination or ultrasound, the patient was then referred to a better equipped facility, most likely a hospital. Since the nurses at the clinics lacked the necessary equipment to perform further examinations and in some cases also lacked deeper knowledge of the disease, they sent their patients to more specialized and better equipped centres in order for the patients to get the best care.

”*/…/ in most facilities here (The slum) we don’t have the breast cancer clinics, because we try to prevent that cure so we refer once the mothers come postnatal clinics to have that screening /…/.” (Interview 7)*

All the interviewed nurses said that they were not in the least shy of using the referral system and they were glad that such a system existed. The nurses felt this provided better services with the illness being detected early and what could not be done at the clinic would be attempted at the referred hospital, mostly Kenyatta National Hospital, Ruaraka Uhai Neema Hospital or St Marys, a well equipped missionary hospital.

“*I can say I give out the information I know about breast cancer, one about the examination, one in case there is any change in which they need ultrasound, I am able to send, and when it is beyond me and it is something which need further check up there is a referral system. So I can say, at my position without any favour./…/ if there is a referral system then why not?” (Interview 4)*

The nurses referred all patients that they suspected might have breast cancer. They expressed how this was a thoughtful process because they had to consider the fact that if the patient was referred to one hospital she might get good and adequate treatment quickly though most likely at a greater cost. Whereas in some situations

she could get nearly the same treatment cheaper at another hospital but then she would have to wait for it.

”*/.../ Saint Marys, yes it is a bit cheaper and they don't have a lot of patients like Kenyatta, to Kenyatta if we refer there it takes a longer time before they give you another return, there is a chance of delay of treatment.” (Interview 6)*

All nurses were aware of the long queues for treatment at the main public hospital, Kenyatta. They even pointed out that people could die while still waiting for treatment because there were so many people waiting in line. The nurses also mentioned that the treatment for cancer was very hard but the patients could at least get what was available in form of radiation and chemotherapy.

After the patients got referred they were followed up by the nurses in the clinics. It was also mentioned that to ensure that patients had got the treatment they needed, the nurses had help from community health workers and from Doctors Without Borders, in following up patients.

”*/.../ if this mother came here /.../ you have returned her home, she might not go to the hospital we have the community help workers, which are aside to follow this woman.” (Interview 2)*

Education

To be able to educate their patients the nurses needed to have sufficient knowledge themselves. All of the interviewed nurses said they had the knowledge to educate mothers regarding prevention on a basic level. Many nurses stated they had the ability to teach the women who came to the clinic to do the self-examination and tell them the reasons why it was needed to be done every month. The women were taught to do it the same time every month in order to detect a change. The women were also told that once there is something abnormal there is a need for immediate screening.

” */.../ cancer we try to educate them, there is something we call breast cancer and it presents this way, the signs which we can be able to see during the first first times and we tell them what they should do, what to do when they get something like a lump in the breast /.../” (Interview 8)*

The nurses mentioned that they had seminars and group talks about health in general and they included information about breast cancer. Although, it was the nurses experience that people would do whatever they wanted even though they had been given all the appropriate information.

”*/.../ we do have seminars, like mothers ok I am talking because I did in maternity, we do give them talks you know, so the earlier the better, so that they don't come at a late stage, the stage that we can not help /.../” (interview 2)*

All of the nurses were aware that they worked with women who for the most part had a low level of education. The nurses mentioned they found out what the patient already knew and picked up from there. The nurses also adapted their language so that the patient could better understand. Most of the nurses were mindful of the fact that they should not go into great depth when explaining but keep the information basic. All of the nurses were also physically showing the

patients how to do a self-breast examination. Since some of the women might not have had the ability to read, then at least they had been shown practically how to do the self-breast examination.

"*/…/ when you do practically and you tell her to do a demonstration it will stick in her mind/…/" (Interview 4)*

The nurses at the clinics knew the importance of education. They understood that by educating the patients, the women would be more aware of the symptoms and could also teach and pass information on to other women in their community. This formed a circle of information which helped women feel content as well as prevented them from being scared should they have noticed such symptoms.

"*/…/ we are making a great difference! Because if we teach the mothers about the examination of the breast.... we will empower them with knowledge and every mother will be aware/…/ (Interview 4)*

Experience of awareness

Under the second main category the nurses experience with awareness is explained as well as the outcome in the community. Also how the nurses expressed the need and interest for updates regarding the preventative work with breast cancer and the need to reach more people.

Awareness in the community

In case of disease nurses stated the importance of awareness to make sure women who noticed a change in their breast should seek medical attention in the early stage of the cancer. The majority of the nurses stated the fact there was an extensive awareness of breast cancer out in the community. Most women knew about breast cancer and that it was a serious disease.

The analysis showed that the majority of the nurses expressed the fact that women were very open with their feelings and that they were willing to talk about their symptoms both to nurses and among themselves. Especially when having health talks in groups the women shared their experiences and they had many questions. The nurses stated that breast cancer no longer was as stigmatizing as it used to be and that there was awareness, it was a disease like any other in need of attention. Women today saw the importance in seeking medical attention to improve their health.

"*/…/ they are always interested, they are very free, they always tell you what their problems are, the slum people are the best people so far, they don't get afraid to tell you their problem/…/" (Interview 3)*

The result showed the advantage of having affordable access to phones. Technological development had enabled more people to have mobile phones and even smart phones which in turn had increased awareness. Women today were more knowledgeable and interested. The nurses expressed how wonderful it was that more people were well-informed but that it also meant that nurses had to be the experts and be prepared to answer all forthcoming questions.

"*/…/ advantage is the ones who are going digital/…/ they are having smartphones and once you tell a mother something, you know they challenge you/…/ she is just*

like joking with her phone and in the next minute the next question she will give you her thing, yeah /…/" (Interview 5)

There were also women who had witnessed breast cancer in the family or seen it out in the community who came in to the clinic to seek information on how to check their breasts. Some women were concerned and would worry a lot thinking they would face a certain death because of breast cancer in the family. Nurses did the necessary examination and gave pertinent information assuring such women, albeit some women continued being wary of falling ill.

Though the analysis showed there was a high awareness among the women in the community, the result also stated the opposite. There were some challenges regarding the nurses preventative work with breast cancer as the nurses also experienced a low awareness and noticed ignorance as well as stigma.

"*/…/ somebody who wasn't aware, so they can have a normal lump and they are not even triggered that this is something abnormal and I should go and seek healthcare. /…/" (Interview 1)*

Some of the women were believed to be ignorant by the nurses. When falling pregnant these women were educated about breast self-examination and its importance but still these women would not practice it. This resulted in women not seeking help until they experienced late stage symptoms, for instance pain. Nurses had also noticed stigma, for instance one patient believed she was swollen because she had been sexually active at a young age.

Nurses wishes for improvement

The result revealed the participants had a broad knowledge about different procedures regarding prevention of breast cancer. However, many pointed out that in nursing college they were only taught the basics regarding breast cancer and said that with more training they could be even more equipped to inform patients. They stated that the additional training would empower them which in turn would bring quality service and benefit the people. The nurses said the organization assisting with updates were usually Neema Hospital. When they had a seminar scheduled they invited partner clinics to participate. But attending seminars was a challenge since going for training meant clinics were left understaffed.

"*/…/ facilitating needs quite a number of things involved, the staffs availability, the time of that person, there are so many things involved so in most cases I would say we have, it is not a constant thing but we need it./../" (Interview 2)*

The nurses talked about something they called Siamese trainings. These trainings were group talks between the medical staff themselves. Procedures and medicines keep on changing and as good practitioners they needed to support and update themselves as well as each other.

The analysis showed that the women whom the nurses caught for screenings were few. The ones who were screened for breast cancer by performing clinical breast examination were mainly the pregnant mothers during their routine checks, as well as a few from the medical camps and those who were seeking help for their symptoms.

”*/…/ the only people who we will capture the breast are those once whom are very sure, either the ANC or the postnatal, the other ones it is very hard. /…/” (Interview 2)*

The majority of the nurses expressed the wish to reach out more extensively and influence more women on prevention, on how to prevent getting breast cancer and how to detect early signs of breast cancer. They also mentioned how health talks in groups would benefit the women as they would then talk about it and that they would become aware of the importance of early detection. The nurses stated the possibility to enlighten more mothers with medical campaigns and posters. A few who dealt with many cases of cervical cancer screening, expressed that the implementation of routine screenings was seen to be a big benefit for the community.

”*/…/ me I would like to see the breast cancer also coming along, we make it like a routine to examine these mothers/…/ like the way with cervical cancer came just like that, /…/” (Interview 8)*

DISCUSSION

The discussion is divided into Discussion of method and Discussion of result. Discussion of method involves the discussion of the chosen method with its strength and weaknesses. Trustworthiness of the study is also explained. In Discussion of result the main findings are discussed together with previous studies.

Discussion of method

The study was aimed to illuminate Kenyan nurses working experience with breast cancer prevention among women residing in informal settlements. To enable the authors to investigate the aim a qualitative method with semi-structured and open-ended questions was chosen. Basavanthappa (2007) explains a qualitative method when collecting data is suitable for generating rich and descriptive information which helps to understand life experiences.

Initially the study was prepared to take place at the RUN hospital. However, it was brought to the authors’ attention that the hospital’s nurses had limited experience working in outreach clinics situated in informal settlements. Therefore, permission from four of the hospital’s partnering outreach clinics in informal settlements was sought to interview their nurses. Nurses working in clinics situated in informal settlements had more experience with the women residing in these areas and thus more likely to be able to provide more information, therefore this arrangement was seen as a strength.

Semi-structured interviews also allowed the participants to talk freely about their experiences and assured adequate coverage of all topics by the researchers. In gathering data, interviews are useful for collecting a wide range of information. Everything from factual to personal data involving people’s views, attitudes, values, beliefs, past experience and future goals can be collected through this method (Basavanthappa. 2007). The questions in the interviews were open-ended to enable participants to answer in their own words. Interviews were conducted according to Basavanthappa (2007)’s method, often superior to other methods

when gathering data as informants are usually more willing to talk than to write. The interviews also permitted to enhance some answers given by the participants by using probing questions.

The first interview was carried out as a pilot interview with a head-nurse to check the questions. The questions were considered sufficient but this particular interview was not included in the study as the researchers realised they had influenced some answers. Basavanthappa (2007) describes that people who do interviews are human beings therefore some biased factors are hard to overcome entirely. The responses can be influenced by inappropriate suggestions (ibid). When conducting the pilot study a few of the interview questions had to be rephrased as these would have directed the outcome of the conversations. It made the authors aware during the subsequent interviews to take time to rephrase questions in a way that would influence answers as little as possible which in turn strengthened the study.

To meet with the different staff members from the clinics situated in the slums, a project manager from the RUN hospital acted as a gatekeeper. The gatekeeper had gained their trust as she was running projects in the slums and had close contact with clinical staff working there. The researchers were introduced to the leading staff members who were then informed about the purpose of the study and the staff members were asked whether they would be willing to participate. By getting entrance to the clinics through RUN saved valuable time as the researchers were received and trusted straightaway by the leading staff. Another time saver was the choice of snowball sampling when selecting the study participants. Basavanthappa (2007) explains snow ball sampling where identified informants with relevant information who the researcher trusts, are then asked to nominate other potential informants. This choice of sampling could have affected the study outcome as only nurses who were thought to know much about the subject of the study could have been asked to participate, though this was not believed to be the case since the clinics had a small number of staff. Instead the ones asked to participate were the ones who were available at that time for an interview.

The interviews were all recorded onto two mobile phones. Basavanthappa (2007) states the importance to record responses to make sure no relevant information was lost. This way the researchers could concentrate on the interview instead of writing notes. At the introduction of the interviews, information on the aim and the purpose of the study was given once again. Further explanation was given to clarify the purpose of the recording and assurance was given about the confidentiality of the interview. At first recording with the phones were thought to make the respondents uneasy. But none of the participants were hesitant and gave their consent to be part of the study.

To enable participants to be comfortable talking and giving adequate answers the researchers needed to state their identities to get rid of any reservations or suspicion the informant may have about the researchers (Basavanthappa, 2007). The researchers also needed to create a friendly atmosphere of trust and confidence (ibid). This was created with an approachable and friendly manner when introducing themselves and sentences like “we are not here to test you” or “we appreciate you giving us of your valuable time” were believed to provide trust.

Kenya is a multilingual country with over 40 spoken languages and since English was inherited from colonial rule, the language was widely spoken (Landguiden, 2016). All interviews were carried out in English. This could have affected the outcome of the study since both the interviewers and the respondents did not speak English as their mother tongue.

Since the researchers were unfamiliar with the Kenyan English accent, there were a few instances when it was hard to make out what the respondents were saying. While the information was still fresh in the researchers minds and therefore to enhance the quality of understanding of each interview, each one was transcribed as soon as possible after every conversation. The interviews were transcribed verbatim separately by each researcher but the first interview was written together to make sure all subsequent interviews were written in the same manner. To strengthen the reliability and validity the researchers swapped their work to make sure nothing had been missed.

To answer the aim of the study the researchers planned to conduct around ten interviews. However, a saturation of the given information was met after six interviews with very little added information in the remaining two. According to Polit & Beck (2014) saturation could be reached with a small group of people if participants were able to talk effectively and reflect on their experiences.

There was a big variety among the interview subjects used in the study. Of the eight participants there were three males and five female nurses with a wide range of age as well as experience working with breast cancer. According to Graneheim & Lundman (2003) this variety of aspects generated answers which improved the credibility of a study.

Trustworthiness

To gain trustworthiness in the findings of a study, Graneheim & Lundman (2003) stated the importance of evaluating the procedure used to create these findings. Three concepts which were used to make this evaluation were credibility, dependability and transferability. Credibility refers to the focus of the study and how well the data and the analysis process worked together to answer the aim of the study (ibid). A high credibility had been reached since semi-structured interviews were made with nurses working in informal settlements. Furthermore, when analysing the data two fellow students made their own category system to enable a comparison before the final list was completed.

Dependability signifies the stability of data over time (Polit & Beck, 2014). If dependability is reached in a study, the generated findings would be the same if the study were to be replicated with similar participants in a similar context (ibid). The fact that both researchers conducted the interviews together within the short time period of ten days made the data collection consistent. Furthermore, the use of a topic guide making sure all questions were asked also made a strong dependability.

Transferability refers to the extent in which the results can be applied to other settings or groups (Granehemim & Lundman, 2003). To reach a level of transferability a thorough description needed to be made of culture and setting, the selection and characteristics of participants, collection of data and how it was analysed (ibid). A comprehensive report has been made of this study though it is

unlikely a reproduction would produce the same result. As the study was of a qualitative design, the result generated from participants' personal experiences will always be different. But with a similar environment context and health care system it could possibly generate comparable results.

Pre-understanding

Tuohy (2012) states it is important that the researchers acknowledge their pre-understandings to enable readers of their study to see possible factors that has influenced its outcome. None of the researchers had experience or much knowledge of how the nurses worked with breast cancer in the slums, though some research into the aim had been made prior to the actual interviews taking place. Articles and other research showed that the nurses did not work with breast cancer prevention as there were much focus the communicable diseases out in the informal settlements, while another one was that they did not know how to perform a clinical breast examination. The researchers were aware of these per-understandings and thus tried to put aside these not to affect the results of the study.

Discussion of result

This section presents the results of the study in comparison to sections of other previous studies.

Importance of early detection

The importance of early detection was one of the most essential issues in working with prevention of breast cancer. According to a study by Muthoni & Miller (2010) it was stated that when the cancer is detected at an early stage is it more treatable and can be cured (ibid) This was the main theme mentioned several times by all nurses at the clinics. According to WHO (2010) there are approximately 1 nurse to every 1000 patients in Kenya (ibid). Since the catchment for the clinics in the informal settlements was very large and there were few nurses to provide medical services the nurses concern was reaching out to the public and not only the patients who was seeking medical services in the clinics. In the study by Muthoni & Miller (2010) it was discussed about the possibility for women in the communities to have educational talks and to be provided with information regularly (ibid). The idea of group health talks was mentioned by several nurses from the different clinics as a way of distributing information about the disease. The informants said that there were some medical camps where the women came and received information and the nurses thought that this was a good way of catching the women and spreading knowledge. In the study of Muthoni & Miller (2010) it was stated that an effective way of reaching the low-income women were through women groups, churches and health facilities (ibid).

The nurses in the clinics were fully aware of the importance of screening, they implemented this as often as possible with their patients, normally palpation and sometimes ultra sound depending on the equipment at the facility. Muthoni & Miller (2010) mentioned that clinical breast examination and breast self-examination could be implemented without technical equipment and breast self-examination could be taught to the patients (ibid). This was something that was already being done by the nurses in this study since there was limited equipment available in the outreach clinics to do further examinations.

When the nurses suspected a lump in the breast of a patient they all knew where to refer since the availability for further examination and treatment was not possible in the clinics. Referring tended to be a challenge for the nurses as they looked at different aspects from the patients' point of view. The referral hospital was desired to be able to provide quick and cheap treatment. In a study by Pace & Schulman (2016) there was indication that the government did not prioritize breast cancer cases and that there was a lack of financial resources as well as limited human resources to handle such cases (ibid). This was something that the nurses in the clinics had to consider as they referred their patients. Since the financial situation was a main concern for the patients, the nurses tried to refer them to a hospital where the treatment was affordable but also the waiting period was not too long.

In order for the nurses to educate their patients they would need to have the knowledge themselves. Many nurses in the clinics stated that they did not have enough knowledge, in their own opinion, to provide good quality examinations for the women they treated. According to a study by Muthoni & Miller (2010) the working knowledge, of nurses, about the risk factors of breast cancer and the ability to perform clinical breast examination was inadequate (ibid). Most nurses in the clinics only did the basics, palpation and clinical breast examination, which was what they felt they had training for and most knowledge about, everything else was a referral. This was an important issue for the nurses in the clinics and they asked for more training in regards to examinations and more knowledge about breast cancer. This is mentioned by Pace & Schulman (2016) that better understanding, even among nurses, of breast cancer was needed in the low-income and middle-income countries (ibid). All of the nurses in the study knew that they had patients with low awareness and low educational status so when the nurses educated the patients they did it on very basic terms. They also showed the patients, practically, how to perform a breast self-examination and told the women when and why they must do it. The nurses were aware of the importance of education and that by educating the women they empowered them with knowledge on how to do the breast self-examination regularly and why. Muthoni & Miller (2010) pointed out that it was important to make sure the women were informed about the importance of regular health checks and that included breast cancer checks (ibid).

When it comes to detecting breast cancer it is better if one can detect it at an early stage. The nurses in this study knew that the earlier the detection the greater the likelihood of early treatment resulting in a good outcome. In the study by Mutoni & Miller (2010) there was a statement that early detection of breast cancer meant that there was a better prognosis and there was treatment that would be more successful and prolong the life of the patient (ibid). Although according to the study of Pace & Schulman (2016) there were no previous studies made to confirm that an early detection of breast cancer proved a significant difference in the mortality of women in the low-income and middle-income countries (ibid). This however was not a result due to early detection but rather to the fact that there was a long waiting list to get treatment and lack thereof. The working nurses knew of this issue and did their best to refer patients to places with good resources and shorter waiting time in order for the patients to be attended to as soon as possible since time was of the essence.

Experience of awareness

Many nurses in the study found that numerous women in the informal settlements were aware of breast cancer and its symptoms. A lot of the times such women had an acquaintance who had been ill and sometimes they had even experienced someone they knew who died from the disease. Mutebi et al (2013) mentioned in their study that many women have had experiences within their community of other women suffering from breast cancer so they were aware about the disease (ibid). Also the fact that the patients now had smart phones made a difference. People could now have easier access to information and were able to find out some facts for themselves. This factor also kept nurses on their toes as there was a need for them to be better informed than their patients.

Muthoni & Miller (2010) stated in their study that there was a need to implement strategies so women could receive regular health checks, get educational sessions so as not to be stigmatized by the community or even by their husbands (ibid). In this study a few of the nurses experienced that the awareness of the patients was high. They had access to smart phones and could receive information not only from the nurses but also from the community and other sources. Of course not all women could afford a smart phone but the nurses also stated that there was openness in the community to talk about breast cancer and the symptoms, the stigma was almost gone. Although the participants said this they also expressed the importance of maintaining confidentiality. They thought it could be an increase in women seeking medical attention if the women knew that nobody else would know why they were there at the clinic.

Most commonly breast cancer was detected in its late stages and this was due to a number of reasons. As the nurses have witnessed, women had other priorities and although they might have been informed and even aware of a change or a lump in their breast, they could not or would not seek help. This was almost always due to the lack of money. The women had other priorities and as long as they were not affected by the disease they would keep on working and taking care of their children before tending to themselves. Muthoni & Miller (2010) wrote in their article that women had no time for themselves and that they were meant to take care of children and put food on the table so even if they were sick they ignored it and went to find jobs to provide income (ibid). Even though the fees were subsidized, the cost for treatment was high and in the informal settlements the earnings were low. The nurses in this study also pointed out that the women sometimes borrowed money from relatives but as time went by the economically burdened relatives disappeard one by one and the women ended up dying alone. This may also have been a reason for them to ignore their symptoms and just keep going.

A major change is needed in the fight against cancer in the informal settlements of Nairobi as well as the rest of Kenya. The nurses were fully aware of this and had definite thoughts regarding what they would wish their future to be like. All the participants said they would like and were also in need of more education and regular updates on breast cancer. They also expressed their wishes for better screening facilities both within their own clinics as well as out in the hospitals where they refer their patients. They knew that time was of importance when it came to early detection so if they could do a simple but quick examination with the right equipment then it would save some time. Pace & Schulman (2016) wrote that in their findings it was revealed a great need for better understanding of breast

cancer by the medical staff as well as a big necessity to have accessible and affordable treatment that was effective for the women affected by the disease (ibid).

CONCLUSION

The nurses working in the informal settlements faced challenges in their work. The main issue in regards to their preventative work was the fact that most women came to the clinics to seek medical attention in the late stages of the disease when it had already spread to other parts of the body. This was mainly due to the women not prioritizing their own health or not being aware of the symptoms of breast cancer. The nurses also had concerns with the lack of finances, both in regards to the patients being able to pay for the treatment as well as the clinics not being equipped enough to provide sufficient service for the patients. All nurses knew that the cancer was more treatable if detected early. They had a desire to reach more people, mainly through medical camps. This would increase the awareness in the community and provide women with information about the disease. The women would then be aware of the symptoms and could get treatment early before the cancer had spread. In addition to the patients receiving information, the nurses wanted more regular updates and seminars in order for them to be able to provide better management of their patients' disease. Even though this was a small study, the general theme was consistent, that of the nurses wanted more knowledge for their patients as well as for themselves. However, it may not be adequate to draw major conclusions since the aim specified an outlined area with a limited number of nurses.

FUTURE VALUES

In this study it is implied that there is a need of more nurses to care for the patients. There is also a greater need for more knowledge both for the nurses and the community. To be able to get more knowledge there needs to be more availability for education for the medical staff so that they in turn can educate the women in the community. The topic of breast cancer prevention is something that needs more attention in order for the catchment among the women in the informal settlements to be greater. There is also an issue of funding, both for the female patients and the clinics. It would be of interest both for the government and the private organizations to invest in the clinics and hospitals and their medical staff, especially since breast cancer is a major killer in the community. As an example, to organize regular screening programs for women as well as campaigns to make awareness so the women can receive more information about the disease. This could be a first step on the way to making a difference and making a change in the community in regards to breast cancer prevention.

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APPENDIX 1

Information to participant

Project title:
Breast cancer prevention among women in slum areas. A qualitative study interviewing nurses in Nairobi, Kenya

Date: 4th April - 3rd June 2016

Study managers:
Caroline Beckmann - email: caroline@beckmann.se
Christina Wersäl- email: cremoire@gmail.com

Studying at Malmö University
Faculty of Health and Society
S-205 06 Malmö
Phone + 46 40 665 70 00

Education: Science in nursing
Level: Bachelor Degree

We, Caroline and Christina, are two nursing students from Sweden. Through our university, Malmö Högskola, and the agency SIDA (Swedish International Development cooperation Agency) we have been given the opportunity to go to Kenya to write our Bachelor Thesis. The RUN hospital has kindly invited us to come and do our thesis in your clinic. The purpose of our study is to explore how nurses work with breast cancer prevention among women residing in the slums of Nairobi. We would like to find out what local nurses are doing at a practical level, as well as what further measures they feel could be done to aid them in their challenges with breast cancer.

Breast cancer is a growing issue among women in Kenya; therefore we find it important to find out more about your preventative measures. To receive this information we would like to interview you, the nurses of the RUN hospital and its partners, on your thoughts and experiences regarding the preventative work with breast cancer in the slums. A single personal interview will be conducted by us with a duration of around 30 minutes and it will be held in a secluded area. With your permission we would also like to record our conversation. The information we receive from you will be handled confidentially, at the time of the interview your personal details and the information you provide will be coded to ensure your anonymity. By doing this nobody will be able to trace the information back to you. We will be the only ones listening to the recordings and the gathered information will be kept in safe storage. After the presentation of our thesis the information will also be destroyed. It is voluntary to participate in this study, which means you have the right to withdraw at any time without any further explanation. We would appreciate your participation in the study. Your local experience, input and ideas would be invaluable.

We would then ask you to sign the consent form (Appendix 2). The final thesis will be published at the university and a copy will be sent down to the RUN hospital.

APPENDIX 2

Letter of consent

Project title: Breast cancer prevention among women in slum areas. A qualitative study interviewing nurses in Nairobi, Kenya

Date: 4th April - 3rd June 2016

Study managers:
Caroline Beckmann - email: caroline@beckmann.se
Christina Wersäll - email: cremoire@gmail.com

Studying at Malmö University
Faculty of Health and Society
S-205 06 Malmö
Phone + 46 40 665 70 00

Education: Science in nursing
Level: Bachelor Degree

I have taken part of the given information regarding the study "Breast cancer prevention among women in slum areas". I have been informed that the participation is voluntary. I am also aware that I can withdraw from the study at any time and there will be no consequences for me if I choose to do so.
I hereby give my consent to the interview as well as have it recorded.

Name and signature:

Date and place:

APPENDIX 3

Questions

- Could you tell us about your experience of your preventative work regarding breast cancer in the slums.
- Can you tell us how you adapt your ways of giving preventative information in regards to the different backgrounds of the women?
- When you talk to the women in the slums would the recommendation of treatment that you give be any different considering their background and current situation?
- What importance do you think your preventative work regarding breast cancer has?
- When you suspect a woman having breast cancer, what do you do?
- What routines do you have regarding breast cancer screening?
- Do you feel you have enough knowledge when talking to women about breast cancer prevention?
- Do you think women feel free talking about their symptoms?
- Is there anything you would like to add regarding your preventative work with breast cancer?