

A study to assess the knowledge, attitude and practice of Breast Self-Examination among the women of a selected urban community

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Abstract: Breast cancer is a global health problem and is significantly rising all over India. It ranks first among all types of cancers pushing cervical cancer to number two. It leads to considerable rate of mortality, morbidity, over-burden to health system and added direct medical expenditure in India. Trend analysis shows that there has been a rise of 50 to 100% increase in the incidence of breast cancer in the last 20 years all over the world. In a study done in India, five-year survival rate was 56% among patients diagnosed with breast cancer at a later stage in comparison to 85% for cases diagnosed early. One of the reasons for poor diagnosis has been identified as late diagnosis of the breast cancer leading to advanced staging and poor prognosis. Globally clinical breast examination, Breast- Self examination & mammography are the recommended screening test for the detection of breast cancer. However BSE being a cost effective method and a test that can be done by self in privacy, it's been advocated as one of the best screening methods by many of the cancer institutes and oncologists for detection of any change in the breast.

Key words: Assess, Attitude, Breast Self-Examination, Knowledge, Practice, Urban community, Women

Introduction

Breast cancer refers to the erratic growth and proliferation of cells that originate in the breast tissue. Malignant tumors penetrate and destroy healthy body tissues. Signs of breast cancer may include a lump in the breast, a change in breast shape, dimpling of the skin, fluid coming from the nipple, or a red scaly patch of skin. The good news is that breast cancer is easy to treat if it is detected early on. In nine out of ten cases of early breast cancer, women will live another five years at the minimum. This delay in presentation could be due to poor awareness of detecting the symptoms. Breast self-examination (BSE) is a simple, private and a quick way of taking control over your own breast health. The concept of breast self-examination (BSE) was promoted in the 1950s by Cushman Haagensen, a Breast Surgeon from the United States of America (USA), at a time when mammography was yet to be developed, and many women were diagnosed when the tumour that had become large and inoperable. Haagensen hoped that encouraging breast self-examination would help catch tumours earlier when they were still treatable, and when amenable to surgical excision without the need for the more disfiguring operation of mastectomy.

Objectives

- To determine the knowledge on breast self-examination among the women from a selected urban community.
- To assess the attitude towards Breast Self-Examination among the women of urban community
- To assess the practice towards Breast Self-Examination among the women of urban community
- To find out the association between knowledge, attitude and practice of breast self-examination.
- To determine the association between knowledge, attitude and practice of breast self-examination with that of the socio demographic variables.

Methodology

A descriptive cross sectional design and a survey approach was used for the study.

Sample size & sampling technique

A sample size of 165 was taken for the study, samples were selected using systematic random sampling and the data was collected using a structured questionnaire and a structured interview technique.

Duration of study

The study was conducted over a period of 6 weeks and the subjects were women aged between 20-70 years, fulfilling the inclusion criteria and belonging to a selected urban community.

Data collection

The self-developed structured questionnaire consisted of four parts, of which the part I consisted of five questions pertaining to the socio demographic profile, part II consisting of 10 questions to elicit data related to knowledge on BSE, part III comprising of 10 questions for collecting information on attitude towards BSE and part IV had 10 questions regarding practice of BSE.

Results

Table 1: Socio-demographic data
 Section I: Distribution of women according to socio demographic variables

n=165

Category		Numbers
Age (Yrs)	20 – 30	44 (26.7)
	31 – 40	43 (26.1)
	41 – 50	31 (18.8)
	51 – 60	21 (12.7)
	>60	25 (15.8)
Marital status	Married	143 (86.7)
	Unmarried	8 (4.8)
	Widow	14 (8.5)
Education	Illiterate	66 (40)
	Primary	45 (27.3)
	Middle school	24 (14.5)
	High school/Diploma	20 (12.1)
	Graduate/ PG	10 (6.1)
Occupation	Clerk	3 (1.8)
	Profess	4 (2.4)
	Shop owner	6 (3.6)
	Teacher	2 (1.2)
	Unemployed	75 (45.5)
	Unskilled	75 (45.5)
BSE information	Yes	69 (41.82)
	No	96 (58.18)
Sources of BSE information (n=69)	Health worker	31 (44.93)
	Media	14 (20.29)
	Friend	16 (23.19)
	Relative	8 (11.59)

n=165

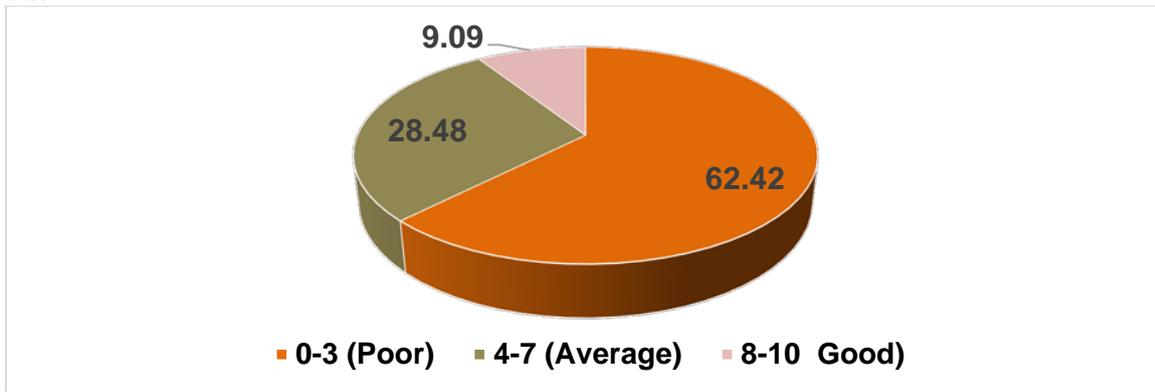


Fig 1: Knowledge wise distribution on BSE in the study group

In the present study, majority of the population (63 %) had poor knowledge about BSE, 28% had average knowledge and 9% had good knowledge scores.

Table 2: Attitude wise distribution towards BSE in the study group

n=165

Attitude score	Numbers
>20 (Positive attitude)	155 (93.94)
≤ 20 (Negative attitude)	10(6.06)
Total	165 (100)

The study showed that majority of the subjects (93.94%) had a positive attitude towards BSE and 6.06% had a negative attitude towards BSE. The present study further revealed that majority of the subjects (96%) had poor practice scores, 4% had average scores and none had good practice scores on BSE.

n=165

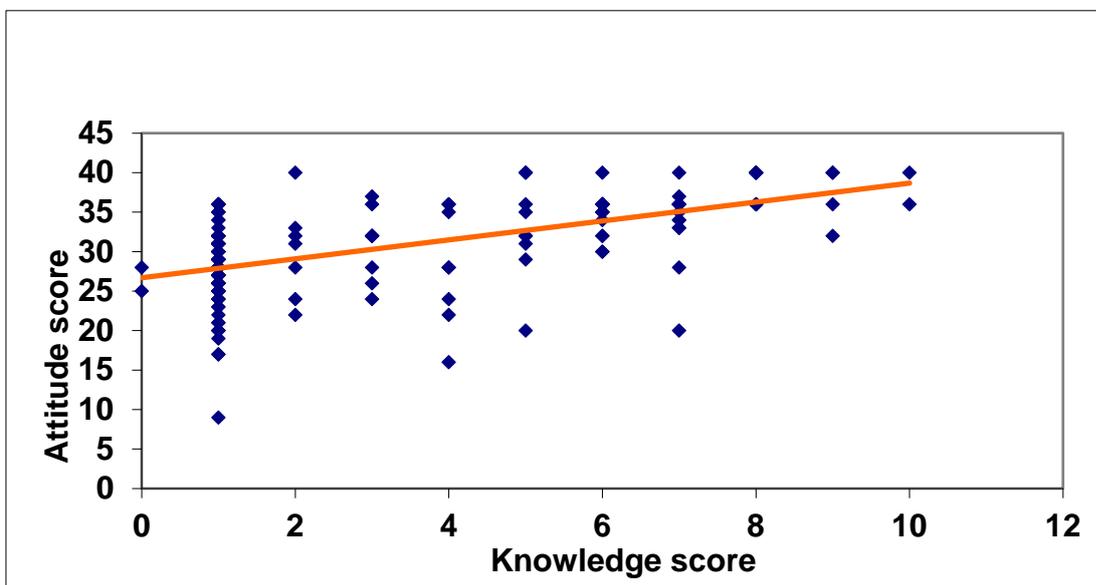


Fig 2: Correlation between knowledge and attitude score in the study group

As per the data on Fig 2 the study revealed that there is a significant positive correlation between the knowledge and attitude scores at the p value < 0.0001 which was estimated using Karl Pearson’s correlation coefficient.

Table 3: Correlation between knowledge and practice score in study group

n=165

Correlation between	r Value	P Value
Knowledge & Practice score	0.45<0.0001	

The data on Table 3 shows that there is a significant positive correlation between knowledge and practice scores in the study group at a p value > 0.0001 which was estimated using the Karl Pearson's correlation coefficient.

Table 4: Correlation between attitude and practice score in study group

n=165

Correlation between	r Value	P Value
Attitude & Practice score	0.314	<0.0001

The data on Table 4 depicts that there is a significant positive correlation between attitude and practice scores in the study group at a p value < 0.0001.

n=165

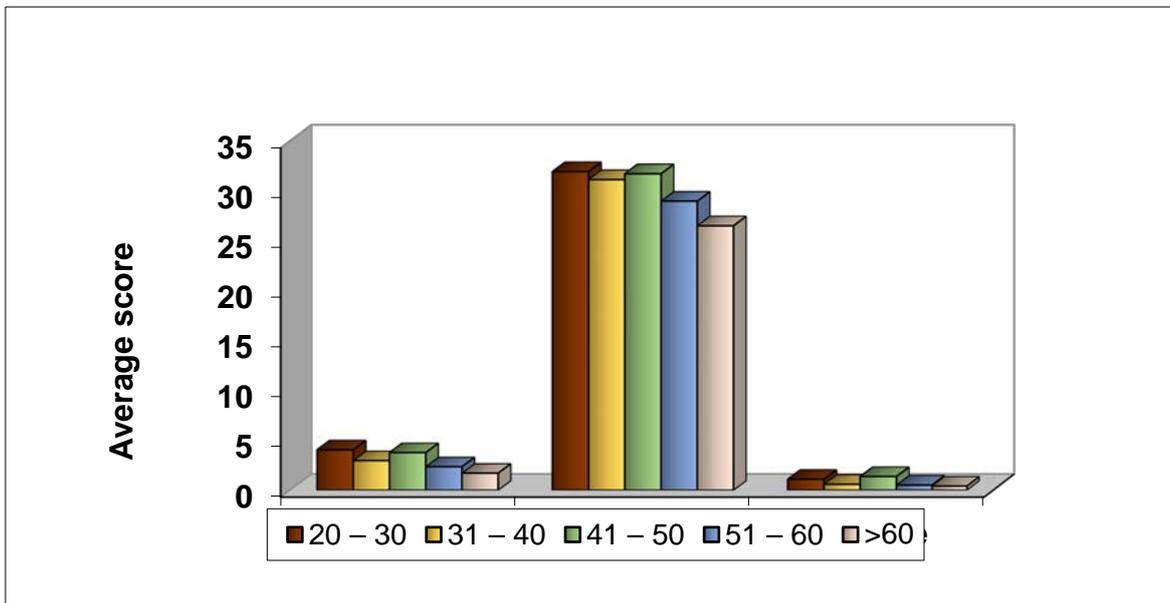


Fig 3: Comparison of knowledge, attitude and practice score in relation to the age of the study group

n=165

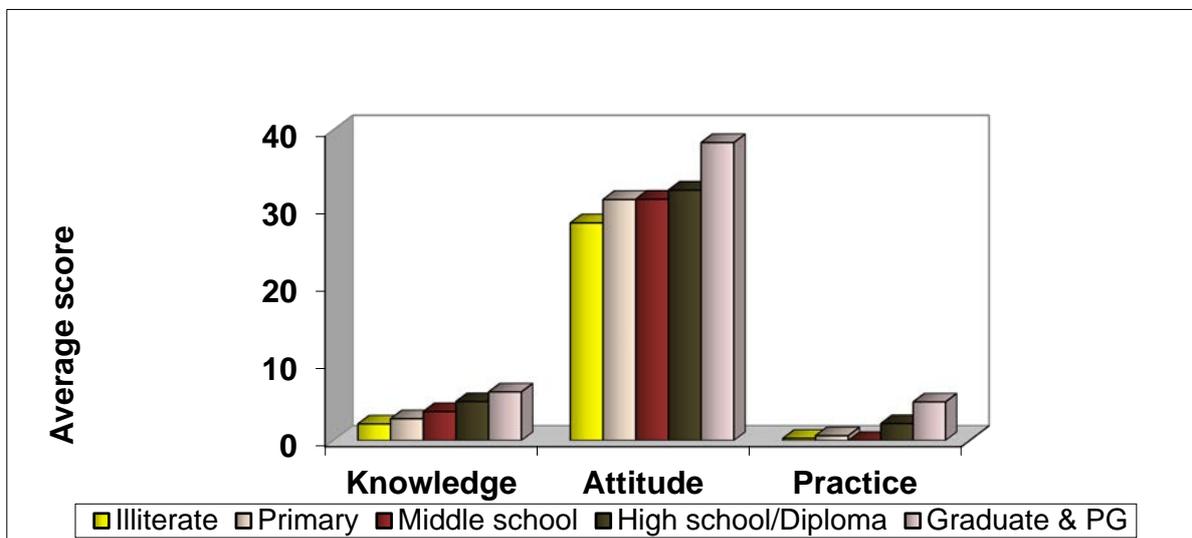


Fig 4: Comparison of knowledge, attitude and practice score in relation to the educational status of the study group

Table 5: Comparison of Knowledge, Attitude, Practice score according to BSE information in study group

n=165

Score	BSE: Yes (n=69)		BSE: No (n=96)		MW test	P Value
	Mean	SD	Mean	SD	Z Value	
Knowledge	5.91	1.99	1.19	0.86	11.46	<0.0001
Attitude	33.81	4.99	28.08	5.06	6.74	<0.0001
Practice	2.03	4.78	0	0	4.23	<0.0001

Conclusion

The study found that the majority of the subjects under study had an above average knowledge scores about BSE and an excellent attitude scores whereas they exhibited very poor practice scores. The study also found that the Knowledge, Attitude and Practice scores were poor with the advancing age and the fact being that the incidence of breast cancer, associated with poor staging is prevalent among the elderly women. There is also a significant correlation of knowledge, attitude and practice scores with that of the occupational status as the KAP scores on BSE are found to be the lowest among the unskilled and the unemployed. There is also a significant positive correlation between the knowledge and attitude, knowledge and practice, and attitude and practice. The knowledge, attitude and practice scores were high among those subjects who had an access to health care information about BSE than those who did not have any access to health care information.

Recommendation

1. A similar study may be conducted on a larger scale.
2. A comparative study can be conducted between the urban and rural population on the knowledge, attitude and practice towards BSE.
3. An extensive study may be conducted to evaluate the effectiveness of a structured teaching program or a self-instruction manual in improving the knowledge, attitude and practice towards BSE.
4. The findings of this study may be used to develop a self-instruction manual or organize a health camp or a health campaign on Breast cancer awareness.
5. A comprehensive study may be conducted for the identification of barriers as perceived by the population towards the practice of BSE.
6. Exclusive studies can be conducted on women diagnosed with breast cancer about the diagnostic methods adopted by these women in detecting them so as to increase the importance of BSE in early detection of breast cancer.
7. An experimental study can be conducted to evaluate the effectiveness of a Self-Instruction manual or other forms of AV Aids in improving the knowledge about breast cancer and BSE

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