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A Study with Bangladeshi Women: Seeking Care for Breast Health

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ABSTRACT

In many low- and middle-income countries breast cancer survival is low. Reasons for this are multifactorial, but delayed presentation for care is a common theme. In this survey study with 100 urban Bangladeshi women, we examined the role of socioeconomic and sociocultural factors on their likelihood to seek breast care from a family physician. In our multivariate model, a woman's age and education significantly predicted her likelihood to see a physician. Sociocultural aspects (e.g. concerns about time commitment of family members and personal household obligations) were significant at bivariate level. Findings are discussed in relation to practice, policy and research.

INTRODUCTION

Worldwide, breast cancer is the most frequently occurring cancer in women. Half of all new cases and two-thirds of breast cancer deaths occur in low- and middle-income countries (LMIC) where access to health care is limited due to poverty and prevalent cancer myths, stigma and taboo about the female body ([Ferlay et al., 2010](#); [Ginsburg , 2013](#); [Story et al.,2012](#)). According to the World Health Organization between 2008 and 2012 there was a 20% global increase in breast cancer incidence and a 14% increase in breast cancer mortality, much of which was accounted for by growing economies, where Westernization of diet and lifestyles predict for a so-called “cancer transition” – an increase in the cancer incidence with decrease in the Human Development Index ([Bray, Jemal, Grey, Ferlay, & Forman, 2012](#)). Due to limited access to health care system, and a lack of awareness and cancer advocacy, women living in developing countries are often diagnosed with cancer at the late stage of their disease, making cancer treatment more challenging ([Akinyemiju, 2012](#)). Additionally, several social, cultural, and health infrastructural factors play important roles in women’s decision making process to seek medical care on time ([Ginsburg, 2013](#); [Story et al., 2012](#); [Ahmad, Mahmood, Pietkiewicz, McDonald, & Ginsburg, 2011](#)). Understanding these factors, therefore, is of profound importance to design public health programs and campaigns so that women living in LMIC acknowledge the need for seeking medical care at an early stage of the disease, when effective treatment can greatly improve the odds of long term disease-free survival.

Bangladesh is one of the most densely populated countries in the world, where an estimated 160 million people are living in 147,570 square kilometres (Worldometers, 2016). The capital, Dhaka, ranks first worldwide in the urban population density (Demographia World Urban Areas,

2015). According to a 2011 census, 8.9 million people (55.4% males and 44.6% females) resided in 316 square kilometer area (Bangladesh Bureau of Statistics, 2014). The low-lying coastal geography of the country results in frequent flooding, cyclones and tidal bores, which impact people's livelihood as majority of the population works in the agricultural sector (The World Bank, 2014). Despite recent economic growth, nearly one third of the population lived below the poverty line in 2010, and the Gross National Income per capita was only \$1,090 in 2014 (The World Bank, 2016). The literacy rate for seven years and older was reported to be 51.8% in 2011 (Bangladesh Bureau of Statistics, 2014). Another major challenge is the lack of a national health insurance system, limiting access to health care for residents particularly living in rural areas. Although, more than 70% of the land area of the country is classified as rural, most public hospitals are located in urban areas (The World Bank, 2016). Such health infrastructural challenges are compounded by rapid urbanization and the adoption of a so-called "Westernized lifestyle" in terms of diet, physical activity, and tobacco consumption, contributing towards the increasing rates of chronic, non-communicable diseases such as cardiovascular disease, cancer and diabetes ([Bray et al., 2012](#)). At the same time, Bangladesh has made extraordinary progress in improving maternal and child health by recently meeting the Millennium Development Goals 4 and 5 for maternal mortality and childhood survival ([Chowdhury et al., 2013](#)). This structural shift has set the stage for Bangladeshi women's overall better health along with some reduction in risks for breast cancer by lowering the number of pregnancies ([Porter, 2008](#)).

Women's care-seeking for breast health is also likely to be influenced by social and cultural norms. This has been documented in several studies conducted in rural Bangladesh and South Asian immigrant communities in the United States (US), the United Kingdom (UK), and Canada.

Women migrated from South Asia tend to prioritize their family responsibilities neglecting self-care (Ahmad, 2012; [Crawford, Ahmad, Beaton, & Bierman, 2015](#)). Likewise, patriarchal family structures may serve to limit woman's decision-making and freedom to participate in activities outside home ([Feldman, 2001](#); [Ahmad et al. 2011](#)). In Bangladesh and neighbouring regions, the gender-based norms of *purdah* also lead to an expectation of modesty, which can manifest in a hesitation (or reluctance) to discuss reproductive health issues, especially with male healthcare providers ([Amin, 1997](#)). The beliefs of *karma or kismet* (i.e. destiny determines one's life quality and longevity) in South Asian communities may also reduce motivation to seek care, leading to fatalism ([Bottorff et al., 2001](#)). For example, Story et al investigated factors that hinder health care-seeking for a breast symptom in rural Bangladesh and found that women were hesitant in seeking care even when low-cost or free breast health services were available because of myths about causes of breast cancer (e.g., evil deeds), worries about the financial burden on family, fear of her husband divorcing her, or abandonment by family ([Story et al., 2012](#)). However, little is known about such sociocultural barriers for urban Bangladeshi women. To address this knowledge gap, we conducted an exploratory cross-sectional survey among urban women living in Dhaka, the capital city of Bangladesh. We hypothesized that socioeconomic and cultural factors would predict the likelihood of seeking care for breast health among women living in urban areas of Bangladesh.

METHODS

The study protocol was developed in collaboration with local experts and approved by the research ethics board of the [name to be added]. Adult women residing in Dhaka were eligible to participate if they could read, write and understand Bangla or English language. In order to

develop a sampling frame, we first identified major public places of gathering for women in Dhaka. The list included schools and hospitals. Given the public nature (i.e. courtyards and waiting rooms) of these gathering places, permission from specific institutions was not deemed necessary; the only exception was teacher-lounges in three participating schools.

Survey Instrument

The survey included sections on socio-demographics, general health, sociocultural decision-making, and a vignette on breast lump with questions on likelihood to see a family physician. The survey and consent form were translated and back translated from English to Bangla. The face validity of the questionnaire was assessed by consulting representatives from local research groups. This led to refinements, such as defining family physician (FP) as “*a doctor whom you always contact first for your health problem*”.

Socio-demographic variables included age; relationship status (married, common law, widow, separated, divorces or single); children (yes or no); highest level of education (less than grade 10, completed grade 10, college/university, or post-graduate); annual household income (below average, about average, or above average); employment status (part-time, full-time, not employed, retired, or on disability), and social support self-rated on a 5-point scale (poor to excellent). **Health related** variables were overall health self-rated on 5-point scale (poor to excellent); any major health problem (yes or no); access to FP (yes or no); gender of FP (male or female); and ever having had a routine physical checkup (yes or no). **Sociocultural decision-making** items, as predictors of seeking breast health care, were identified through literature review and our previous work ([Story 2012](#); [Ahmad et al., 2011](#); [Ahmad, 2012](#); [Crawford et al., 2015](#); [Fledman, 2001](#); [Amin, 1997](#); [Bottorff et al., 2001](#)). Through consultations with community

representatives, eleven items were included in the final survey where each item was rated on a 5-point Likert scale for level of importance in deciding to see a FP. The *main outcome* was likelihood to see a FP (not likely, unsure, somewhat likely, very likely, extremely likely) on finding a breast lump. The latter two sections were operationalized by first presenting a vignette asking to “*Imagine that you are taking shower and during washing yourself you suddenly discover a small, painless lump in your left breast*”. Next, participants rated their likelihood to visit a FP for breast health care (main outcome) followed by the sociocultural decision-making items.

Sample and Recruitment

Given the exploratory nature of the study, we aimed to recruit a convenience sample of 100 female participants. A research assistant fluent in English and Bangla [author initial to be added] approached the potential participants using key community contacts; those identified as eligible and expressed interest in the study were given further details. The research assistant ensured that there were no males present in the vicinity during recruitment and survey conduction. All of the invited eligible women agreed to participate, provided written consent and completed the paper-pencil survey. The response rate was 100%. Each participant received an honorarium of BDT700 equivalent to \$10 Canadian. Of note, 25 participants did not accept the honorarium. A majority of participants were recruited from waiting rooms and teachers’ lounges in schools.

Data Analysis

All data was entered into a statistical software program, SPSS Statistics TM version 20. Preliminary statistical procedures examined distributions of the individual items (e.g., means, standard deviations, skewness and kurtosis). The quality of data was evaluated by percentage of

missing responses, which were low. We executed direct logistic regression with the ‘likelihood to see a family physician’ as the outcome variable and six predictor variables: age, income, education, concerns about time-burden on family members, concerns about completing the household chores, and having a family physician for physical exam. We report here odds ratios and 95% confidence intervals; a p value of less than 0.05 was considered statistically significant. The importance of predictors was assessed by the Wald criterion. Due to our restricted sample size, variables that had a significant association with the outcome at the univariate level were entered in the logistic regression analysis.

RESULTS

The mean age of participants was 41 (18 to 67 years) and more than two-thirds were currently in a marital or intimate relationship (77%) while most had children (90%). Details are provided in Table 1. Almost half of the participants had post-graduate level education (52%) and nearly two-thirds were employed part- or full-time (66%); most reported their annual household income “around or above average” (74%). Participants rated their overall health as nearly “good” (mean score of 2.7) and social support as “good” (mean score of 2.9). The majority of participants had a regular FP (67%) but never had a routine physical checkup (68%). In response to the vignette, the majority of participants (79%) affirmed their likelihood to see a FP and a few (19%) selected ‘not likely/unsure’ responses.

Participants rated eleven decision-making items for importance in deciding to see a FP for breast lump (Table 2). Four items had a mean scores of >3 : ‘discuss the lump findings with my family and friends’ (item 1); ‘have a female family physician to examine me’ (item 11); ‘worry about

my short life once cancer is diagnosed' (item 10); and 'consider how would I complete my household work and take care of children' (item 7). On comparing the scores for women likely and not likely/unsure to see a FP for breast lump, statistically significant differences were found for item 7, item 11 and 'consider the burden it would put on the time of my family members' (item 5). These items had higher importance for women not likely/unsure to see a FP.

The main outcome of 'likelihood to see a FP' was entered in the regression model with six predictor variables, identified significant on univariate analyses: age, income, education, concerns about time-burden on family members, concerns about completing the household chores, and having a family physician. A test of the full-model against the constant-only model was statistically reliable, $X^2(6, n = 98) = 24.89, p < 0.001$, indicating that the predictors, as a set, reliably distinguished between women choosing 'likely' and 'not likely/unsure' to see a FP in response to the breast lump vignette. Although the overall success rate was 84.7% for accurate classification of women, the success rate was lower for the 'not likely/unsure' group (47.4%) than the 'likely' (93%) group. The model explained 37% *Nagelkerke R Square* variance in the likelihood to see a FP. The importance of predictors was assessed by the Wald criterion.

According to the Wald criterion the predictors of age and income remained significant over and above other predictor variables (Table 3). The odds of 'likelihood to see a FP' increased by 10% with a one unit increase in age. The odds of 'likelihood to see a FP' increased by 5 times with a one unit increase in income.

DISCUSSION

This study with urban Bangladeshi women focused on examining the role of sociocultural and socioeconomic factors on a woman's likelihood to seek breast health care from a family

physician. Participants were offered a vignette to first imagine that one incidentally identifies a breast lump while taking a shower, and then to rate their likelihood to see a family physician for clinical assessment. In univariate analysis, three sociocultural items along with age, income and education were significantly associated with the likelihood to seek care. However, only age and income remained significant in the multivariate analysis. These findings highlight the importance of socioeconomic inequality in determining the probability of breast care seeking in the studied sample. We discuss these findings in light of existing research and propose future directions for practice, policy and research.

Socioeconomic status plays an undeniable role in determining health. This recognition has gained momentum since WHO 2008 report *on Closing the Gap in a Generation* (Commission on Social Determinants of Health, 2016) and scholars have examined new and old datasets to understand such relationships. One such work by Akinyemiju focused on ten LMIC by analyzing World Health Study (WHS) 2000-2003. The authors found that the likelihood of having had a mammogram decreased with the use of public transport, long travel time, rural residence and low household income. The study did not report on country-specific determinants, however, Bangladesh ranked lowest on cancer screening rates. Findings of our study fill an important knowledge gap by generating localized knowledge and calls for action at the policy front for addressing the upstream determinants of income, education and accessible care. The time is ripe for health and social policy advancement in Bangladesh. The country is experiencing a consistent annual economic growth rate of 6% (Worldometers, 2016), generating resources to address upstream determinants of health. However, setting of the policy agenda is not easy due to the growing urbanization and privatization leading to political fragmentation. For example, on one

side, experts report that “The private sector is a major player in health service delivery in Bangladesh...[and] believed to offer higher quality of care than the public sector” (Bergeson-Lockwood, Madsen & Bernstein, 2010, pg.5). On the other, the burgeoning subsidized public health care system aims to reach a large number of people but faces substantial challenges in accessibility and quality of care. Combating these push-and-pull dynamics requires strong leadership to move the policy agenda towards upstream determinants of health (Bangladesh Bureau of Statistics, 2014).

Another pillar for improving population health is enhancing preventative health care. In our study a high number of women had post-secondary education and access to a regular family physician, but two-thirds never had a routine physical examination. As our sample came from the capital city of Dhaka, which has better health infrastructure than other regions of the country, this speaks to the overall scarcity of system level resources for preventative health care, especially when a high need for acute care still exists. Several of the national policy frameworks (e.g. Bangladesh Ministry of Health and Family Welfare, 2011, 2016a, 2016b) employ an indiscernible or at best limited gender-based lens towards preventive health and primary care. This begs the question: is women’s health falling through cracks due to multiple push-and-pull dynamics faced by the country? Given the evidence on increasing incidence of cancer and late stage diagnosis, urgent attention is needed at the policy and practice level to strengthen resources around women’s health and promote awareness and uptake of preventative care including cancer early diagnosis and screening ([Mitra, 2011](#)).

The findings of our study also advance understanding about sociocultural forces that may influence women’s uptake of efforts to improve breast cancer early diagnosis in Bangladesh. A

study participant's likelihood to seek breast care was associated with their perceptions of the time burden on family, obligations to complete household chores, and the need to have a female family physician. These findings are consistent with other studies conducted with South Asian women residing in the US, UK or Canada ([Ahmad et al. 2011](#); [Crawford et al., 2015](#); [Bottorff et al., 2001](#)) and with women in Bangladesh ([Ginsburg, 2013](#); [Story et al. 2012](#); [Feldman, 2001](#); [Amin, 1997](#)). Although sociocultural variables were not significant at the multivariate level in our study, we believe this was a function of small sample. Future studies with larger samples should examine the predictive relationship of sociocultural norms in determining the uptake of cancer screening.

Our study has some limitations. Due to the small sample size, our study may lack power to detect a small effect size. This was also evident in the large confidence intervals in our estimates.

Additionally, we employed convenience sampling to recruit study participants from few urban places of gathering, which may not be the representative sample of urban Bangladeshi women. Furthermore, a substantial number of participants had post-secondary education and were employed. This warrants caution when interpreting the findings for other regions of Bangladesh. Nevertheless, the community based approach of recruitment in our study led to 100% response rate. Other strength of the study was its culturally sensitive process of translation and back-translation. This led to high completion rate for all of the survey items, increasing confidence in the reported results.

In conclusion, our study finds support for the key role of socioeconomic forces in influencing the likelihood of urban Bangladeshi women to seek care for breast health. Indeed, an upstream approach is vital to enhance early detection and treatment of breast cancer in the studied

population. Our study also suggests that women's concerns about family members' time commitment and personal household obligations may influence their health seeking decision. Future research is needed to examine the role of sociocultural aspects so that public health programs can respond better to rapid urbanization and changing lifestyles in the low and middle income countries, including Bangladesh.

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Table 1: Socio-demographic Characteristics

Variable	Proportion or Mean		
	Overall (n = 100)	Breast Lump Vignette & Likelihood to See FP	
		Not likely/Not sure (n =19)	Likely (n = 79)
* ¹ Age, mean (n)	41.0 (100) (SD 8.7)	36.6 (SD 3.9)	42.0 (SD 9.3)
Relationship status,% (n)			
- Married/ common-law/ with partner	76.8 (76)	68.4 (13)	79.5 (62)
- Widowed / separated/divorced/single	23.2 (23)	31.6 (6)	20.5 (16)
Had children, % (n)	89.9 (89)	89.5 (17)	89.7 (70)
* ² Highest education % (n)			
- Less than grade 10	17.0 (17)	36.8 (7)	10.1 (8)
- Grade 10/ college or university	31.0 (31)	26.3 (5)	32.9 (26)
- Post-graduation	52.0 (52)	36.8 (7)	57.0 (45)
* ³ Annual household income, % (n)			
- Below the average	26 (26)	57.9 (11)	16.5 (13)
- Around/above average	74 (74)	42.1 (8)	83.5 (66)
Employment status, % (n)			

- Part-time/ full-time employed	66.0 (66)	73.7 (14)	63.3 (50)
- Not Employed/ retired/on disability	34.0 (34)	26.3 (5)	36.7 (29)
Social support, mean (n)	2.9 (100) (SD 1.1)	3.3 (SD 1.2)	2.9 (SD 1.1)
Self-perceived health, mean (n)	2.7 (100) (SD 1.0)	2.4 (SD 1.0)	2.7 (SD 1.0)
Had a major health problem, %(n)			
- Yes	24.0 (24)	15.8 (3)	84.2 (16)
- No	76.0 (76)	25.3 (20)	74.7 (59)
Had FP, % (n)			
- Yes	67.0 (67)	47.4 (9)	27.8 (22)
- No	33.0 (33)	52.6 (10)	72.2 (57)
Had a female FP, %(n)			
- Yes	44.4 (28)	30.0 (3)	47.2 (25)
- No	55.6 (35)	70.0 (7)	52.8 (28)
Had a routine physical checkup (ever), %(n)			
- Yes	31.3 (31)	15.8 (3)	35.4 (28)
- No	68.7 (68)	84.2 (16)	64.6 (51)

Note:

*Likelihood to See a Family Physician: statistically significant difference between two groups.

¹Student t-test $p = 0.00$;

² χ^2 test $p = 0.14$;

³ χ^2 test $p = 0.00$

Table 2: Breast Lump Vignette and Decision Making Items

<i>To visit my family doctor for the breast lump, it is important for me to...</i>	Mean		
	Overall	Breast Lump Vignette & Likelihood to See FP	
		Not likely /Not sure (n = 19)	Likely (n = 79)
1. Discuss the lump finding with my family and/or friends	4.21 (100) (SD 1.10)	4.05 (SD 1.13)	4.24 (SD 1.11)
2. First try traditional, homeopathic or herbal treatments	1.54 (100) (SD 1.1)	2.05 (SD 1.41)	1.51 (SD 0.94)
3. Seek permission from my husband and/or mother-in-law	2.75 (99) (SD 1.61)	3.11 (SD 1.69)	2.65 (SD 1.59)
4. Think about taking time off from paid work and its consequences	2.93 (100) (SD 1.7)	2.89 (SD 1.56)	2.91 (SD 1.74)
5. * ¹ Consider the burden it would put on the time of my family members	2.73 (100) (SD 1.29)	3.32 (SD 0.67)	2.59 (SD 1.37)
6. Check availability of a family member or friend to accompany me	2.53 (100) (SD 1.34)	2.47 (SD 1.12)	2.58 (SD 1.39)
7. * ² Consider how would I complete my household work and take care of children	3.08 (1000) (SD 1.43)	3.63 (SD 1.01)	2.95 (SD 1.49)
8. Look for assistance in commuting to the	2.55 (100)	2.47 (SD 1.22)	2.56 (SD

family physician's office	(SD 1.37)		1.39)
9. Think about mental stress of having a diagnosis of cancer	2.95 (100) (SD 1.38)	3.11 (SD 1.29)	2.94 (SD 1.41)
10. Worry about my short life once cancer is diagnosed	3.15 (100) (SD 1.51)	3.68 (SD 1.45)	2.97 (SD 1.49)
11. * ³ Have a female family physician to examine me	3.67 (100) (SD 1.62)	4.47 (SD 0.69)	3.46 (SD 1.73)

Note:

*For the Likelihood to See a Family Physician significant differences were found on employing

Student t-test

¹p = 0.00;

²p = 0.02;

³p = 0.00

Table 3. Logistic Regression

Variable	B^a	Wald Test	Sig	Odds Ratio	(95% CI) ^b Odds Ratio	
					Upper	Lower
Age	0.09	4.2	0.04	1.10	1.00	1.21
Income ^c	1.79	5.3	0.02	5.99	1.29	27.72
Education						
Education (1) ^d	1.03	1.3	0.26	2.79	0.46	16.98
Education (2) ^e	0.46	0.22	0.64	1.58	0.23	10.86
Consider burden...on time of family	-0.15	0.22	0.64	0.87	0.47	1.59
Consider how to complete...household chores	0.03	0.01	0.91	1.03	0.59	1.81
Have a female family physician to examine	-0.40	2.2	0.14	0.67	0.39	1.15
(Constant)	-2.1	0.53				

^a B : Coefficient estimated for the model

^bCI: Confidence Interval

^cAround/Above average=1 vs. Below average=2

^dGrade 10 /College/University=1 vs. Less than Grade 10 = 0

^ePost-graduate=1 vs. Grade 10 /College/University=0