

Spousal desertion and coping strategies among women with cervical cancer in Nigeria: a schematic framework for wellbeing

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Abstract

Background: Women that are not in good health cannot contribute to sustainable development but effective coping during and after sickness could enhance their contributions to development.

Objective: The study examined the coping strategies among women with cervical cancer in different marital context in Nigeria

Methods: In-depth interview from eight women survivors and patients of cervical cancer in two distinct marital contexts characterised by the presence or absence of husband from two states of Nigeria. Data were analysed using content analytic procedures and premised upon relationship-focused coping strategy theory.

Results: The study identified basic coping strategies as seeking support from religious organisations and adjustment of sexual lifestyle.

Conclusion: The study concluded that women's coping strategies on cervical cancer varied according to marital context. The authors recommend counselling, increasing cervical cancer risk awareness and husband-wife support, especially during life-threatening sicknesses to engender quick recovery and improved well-being for sustaining women contributions to development.

Keywords: Cervical cancer, coping strategies, framework analysis, husband desertion, sexual partner, in-depth interview, SDGs, Nigeria

Introduction

Health is generally sacrosanct to the achievement of sustainable development. For obvious reason, women that are not in good health cannot contribute to sustainable development (Mitchell and Bates, 2011; Winkler et al., 2008) Mitchell and Bates, 2011; Winkler et al., 2008) (Wittet & Tsu, 2008; Mitchell & Bates, 2011). Among the various health challenges of women is cervical cancer that is considered as the world's deadliest but preventable disease (Boutayeb, 2006; Ebu and Ogah, 2018; Stewart and Wild, 2017). Cervical cancer is the second leading cause of cancer-related deaths among women in developing countries (Guan et al., 2012; WHO, 2010; A. A. Wright et al., 2014), and the commonest malignancy of the genital

tract in Nigeria (Kolawole, 2011), with annual increasing death tolls (Kolawole, 2008a; Omolara, 2011a) which have made the disease and its management a public health concern. While there are studies that have supported the availability of screening, early detection, and medical treatment, aided by good health-seeking behaviour for its effective management (DeSantis et al., 2011; Howlader et al., 2012a; Modibbo et al., 2016a; Youlden et al., 2012a), the importance of social and family supports have also been proven to be significant with the coping and recovery time among the patients (Cohen and Lemay, 2007a; Cohen and McKay, 1984a; Preston-Martin et al., 1990). Nowadays, families and marriages are becoming

more volatile, and disruption, divorce, separation, and lone-parent, are becoming more prominence (Cvrcek, 2011; Martin and Bumpass, 1989; Sayer and Bianchi, 2000; Vignoli and Ferro, 2009). These phenomena have potentials for decreasing availability of support and care during illnesses and diseases from the relatives. Studies have also indicated that the divorced, separated, lone-parents are more susceptible to deplorable conditions including sicknesses and diseases (Ross et al., 1990; Trivedi et al., 2009). In addition, they often face long recovery time and challenges with their post-sickness social and physical relationships (Cohen and McKay, 1984b; Evans et al., 2014; Sullivan et al., 1998; Yeji et al., 2014). However, effective coping strategies for sick women in challenged marriages are not prominent in the literature.

African culture encourages marriage and intact family while spousal desertion or separation is often frowning at. Specifically, intact marriage has been proven to be a strong predictor of health and well-being, that desertion engenders decline in both physical and mental health while married people live healthier than the unmarried (Hughes and Waite, 2009; Karraker and Latham, 2015; Lillard and Waite, 1995; Umberson, 1992; Williams and Umberson, 2004; Winking and Gurven, 2011). It was also confirmed that women who received emotional and social support within intact marriage enjoy an improvement in the quality of life (Ransom et al., 2005) than otherwise. Thus, studies that address the management of disease in separated marriages could be of great help in discouraging spousal separation and help the spouses concern to live healthier. The study also has the potential of alerting the practitioners on the possible patient perspectives on the disease and how their behaviour is affected.

In additional to the various world united fora, initiatives and agencies that have been addressing the issues of the spread, treatment and prevention of (general) cancers among women world-wide, the Federal Government inaugurated the National Commission on Cancer Control, National Policy on Reproductive Health and Strategic Framework in 2007 and established few public diagnostic centers for cancer (Adetifa and Ojikutu, 2009). There is also the Life Empowered Anchors Hope (LEAH) Charity Foundation with the programmes for interventions on both breast and cervical cancers. However, till date, there are no specific known initiatives on post-cancer coping or recuperation. Despite all these efforts, the deaths due to the cervical cancer are surpassing the magnitude of deaths from the same disease in many other countries (Jemal et al., 2012; Modibbo et al., 2016b; Ogundiran et al., 2010; Sylla and Wild, 2012). The IARC's projection of potential

increase rate of 70% in the next 20 years and doubling tendency by 2030s (Gill et al., 2015) is generally scary and has become issues of concern. Literature is saturated with the coping strategies with sicknesses or diseases, marital disruption including sexual dysfunctions among couples (Amoo et al., 2017a, 2017b; Cutrona et al., 1986; Lepore, 2001; Mitchell et al., 2011; Thoits, 1986), but studies on the options available for women without spouses/partners in the face of cervical cancer are rare, especially as it relates to qualitative study in Nigeria.

Literature review and theoretical framework

The study adopted the relationship-focused coping strategy that support the direction of strategies towards the management of stressor (from the patients or affected individuals) and emotional coping strategy that aims on the management of emotional consequences of the stressor (Coyne and Downey, 1991; Hinnen et al., 2008). The relationship theory is spousal/partner's dependent, hinges upon the support or withdrawal of the spouse/partner (Coyne and Downey, 1991; Hinnen et al., 2008). The supportive behaviour of the spouse is therefore crucial in both the search for treatment and continues survival of the patient. In the context of sickness and intimate relationship, partners are the primary source of support and are crucial in the adaptation processes involving women with cervical cancer (Coyne and DeLongis, 1986; Coyne and Downey, 1991; Hinnen et al., 2008). Specifically, in the relationship-focused coping strategy, spouses are expected to provide support (e.g. emotional), especially in terms of communication, knowing how the partner feels (showing empathy) and helps in avoiding further distress decisions, be actively involved in home chores which she might be unable to do and seek for her protection (Coyne and Downey, 1991; Hinnen et al., 2009). Notwithstanding the provision of medical treatment, marital context especially the presence of, and the support from spouses could affect the treatment, the healing time, and emotional wellbeing of the patient. Cervical cancer is a life-threatening and relationship threatening trauma. While studies have reported that support from the partner/spouse is paramount in the adjustment with life-event (cervical cancer in this case) (Hinnen et al., 2008; Kolawole, 2011), the questions on how to manage with the disease in the face of marital challenges especially where the husband (the supposedly closer partner) are not available are not conspicuous in the literature.

Data and methods

Research design

The study employed qualitative research approach using in-depth interview to explore coping strategies among cervical cancers survivors where spouses are available and where spouses are not available. The research is a part of 2015 larger study on Behavioural Risk Factors for Breast and Cervical Cancers in two states of Nigeria and funded by Covenant University Centre for Research, Innovation and Development (CUCRID). The main study covered both quantitative and qualitative studies and took place in two states (randomly selected from South West and North Central) out of the six geo-political zones in Nigeria. The report for this paper was exclusively based on extracted data from the 8-in-depth interviews among cervical cancer survivors.

Participants' recruitment

The respondents for this study were selected thorough a number of processes within the purview of the random techniques adopted in the main study: (1) self-reported (women who answered YES to the questions if they ever experienced cervical cancer were requested to participate in separate in-depth interview on specified day and as agreed by the participant; (2) leading informant approach in locating the survivors and, (3) out-patients of oncological specialised health facilities and traditional herbal homes who volunteered to share their experiences were also selected and interviewed. We purposively selected these health facilities for easy access to the patients who could participate in the interview. We sought the formal permission from the proprietor-authority of these health centres and also followed due community reconnaissance procedure such as seeking express permission from community leaders, especially where the participants were living or where the participant resides. Participants voluntarily consented to share their experiences. All respondents were assured of confidentiality of their responses and anonymous reporting of the research findings. We also encouraged them to participate but made to understand that they are free to or not to answer any question as deemed necessary and also liberty to withdraw at any stage of the interview. Overall, only 2 cervical cancer survivors were recruited through self-confirmation of ever experienced cervical cancer, 2 survivors through the informant and four from both health facilities and traditional herbal homes.

Data collection

The interview covered issues on the life style history especially in terms of occupation and sexual relationship, knowledge and how the disease was

detected, health seeking behaviour and coping strategies. Where necessary, questions were translated in local dialect for adequate understanding. The in-depth interview approach provided opportunity to ask series of open ended questions that were accompanied with probe for clarifications and more details. In addition to the recording of the responses, the note taker writes down the responses from each participant. This is to ensure that nothing is missed out should the recording instrument fails. Also, comments and report from other members of all members of team were always reviewed before the next interview and formed additional input in the analysis (Piercy, 2004; Piercy et al., 2013).

Data analysis

The analysis in this study covered only 8 cervical cancer survivors and patients. The analysis attempted to identify the behaviour or responsiveness of the patients that were conditioned by the exposure to the absence of spouse/sexual partner. Responses from the patients were transcribed and the textual data analysed using systematic content analytic procedure (Green and Thorogood, 2004). Specifically, after the transcription, the responses from all the interviewees were all assembled together and a number of pages on Microsoft Word were opened with each page detailing responses to each specific question. The transcripts were read and reviewed several times for content understanding (Piercy et al., 2013). This review exercises provided opportunity to understand and note down useful comments from the responses. Where necessary, long sentences were broken into simple short sentences, grouped by related comments or questions and emerging issues were categorised accordingly. Responses were coded as well. The coding system permitted thorough examination of clusters of comments made by respondents and those in the notes we took. Codes were re-checked to identify connections for possible development of patterns with reference to the research questions. Certain codes that were not necessary were removed, some were merged to another. These procedures were repeated for every interview. Where necessary, the responses were cross-tabulated by the presence or non-presence of spouse/partner and by age group for ease of comparison. Copies of notes extracted were also used as a guide in the interpretation of participants' summations.

Precisely, we identified, examined and interpret the patterns of responses and themes from the collected textual data both from women without husbands. Several themes identified were further organised into a more succinct themes and displayed

in figure 1. These common themes were specifically used to provide solutions to questions on coping strategies. The results were benchmarked with existing literature for support, contradiction or as an indication of new observations. The whole exercise was ensured to adhere to RATS guidelines for qualitative study (Clark, 2003; Green and Thorogood, 2004) and also the consolidated criteria for reporting qualitative research (COREQ) to present the important aspects of the research (Tong et al., 2007). The results of the analysis are therefore presented as excerpts having corrected for grammatical errors.

Validity and integrity of the data

To ensure the validity and integrity of the data, participants' reviews were used. The responses written down were read out at the end of each interview to ensure correctness and a seemingly agreement or re-confirmation on the responses. Also, the wide range of the samples, in terms of the presence or absence of spouses/partners, including the different age groups covered was considered as addition to the credibility to the data. However, in this study, the case of confounding and bias are relatively minimal or non-existence since the causes of desertion are not considered as factors in the analysis of how the patient are coping with the disease (Breslow et al., 1987; Wacholder et al., 1992). There was also problem of definition since no respondent could confirm any legal, customary separation or divorced with her husband, hence the use of desertion and separation intermittently.

Results

Demographics

The results revealed that all the women interviewed were in the age group 20-49 and had ever married. Larger proportions of them were however living alone (i.e. separated). There were no evidence of legal or customary separation or divorced with spouse as confirmed by all the respondents. Among the respondents, only two had no formal education but virtually all of them could communicate in pidgin. Six out of the eight were formerly working as teachers and traders before the disease while only two were engaged in teaching. The lifetime-cumulative-sexual-partners were ≥ 2 for most of the respondents. Two out of the eight women have not given birth (i.e. zero-parity).

Pre-cervical cancer infection awareness and support

Knowledge of cervical cancers' symptoms before the incidence was relatively low. Only two women had read about cervical cancer while no one has ever attended training/seminar on the subject matter.

Responses from the women revealed that self-examination was rare among the women and several reasons were adduced for it. Relatively, a third of respondents believed *there are no such times for close examination of the body*. A woman respondent expressed her concerns: *"where do I get the time to be checking every part of my body like that"* (woman age 37).

However, there are variances in institutional support in terms of location. Few respondents from one of the states (Kwara State) had received free-medical examination and subsidised treatment including surgery. Women from the second state (Ogun State) could not lay claim of any public support except the assistance they are receiving from relatives.

Coping strategies

The results of the assessment of coping strategies with cervical cancer revealed two distinct groups of responses: (1) responses from women with husband and, (2) women without husband/partner including living-alone women. The analysis appraised the missing link (conceptualised as what they are actually missing or not missing) between the presence and absence of the husband/partners, and the adopted management steps already taken (described as the coping strategies). Thus, the coping methods are those strategies, approaches or steps adopted towards the adaptation to their new experience or used to sustain themselves in the new status (with cervical cancer experience). Using the thematic framework approach, the data coding produced emerging concepts/terminologies that were mapped into themes. The responses revealed the basic things that they are currently missing due to the absence of their husbands/partners. These are in the form of loss of marital intimacy, stigmatisation, regrets and financial burden. These are depicted in figure 1.

Excerpt from those who are enjoying support from relatives are as follows:

"The marriage is 'for-better-and-for-worse'. It is my husband's responsibility though, the concerns are not as strong as before or when the thing was first discovered/confirmed" (Woman, aged, 46).

"We discussed issues relating to the sickness often. As I hear him greeting me every morning and asking me how I felt overnight, the pains of the night always quickly disappears" (Woman, aged, 37).

Coping strategies among the women without spouses

The mapped responses revealed four distinct coping strategies among the women without spouses. However, only few approaches could be directly linked to the specific challenges or what they are missing in the absence of spouses.

Continuous check up and medical consultations

Prominent among these is continuous check up in the health facilities continuous check up in the health

facilities and regular consultation to avoid re-occurrence of the infection. Many of the women that are currently receiving treatment indicated that they have learnt a lot of lessons from the various contacts they have with the medical personnel and would not cease from visiting medical centres for check up and advice. Basic coping approach is their constant visitation to the health facilities either orthodox or modern facilities).

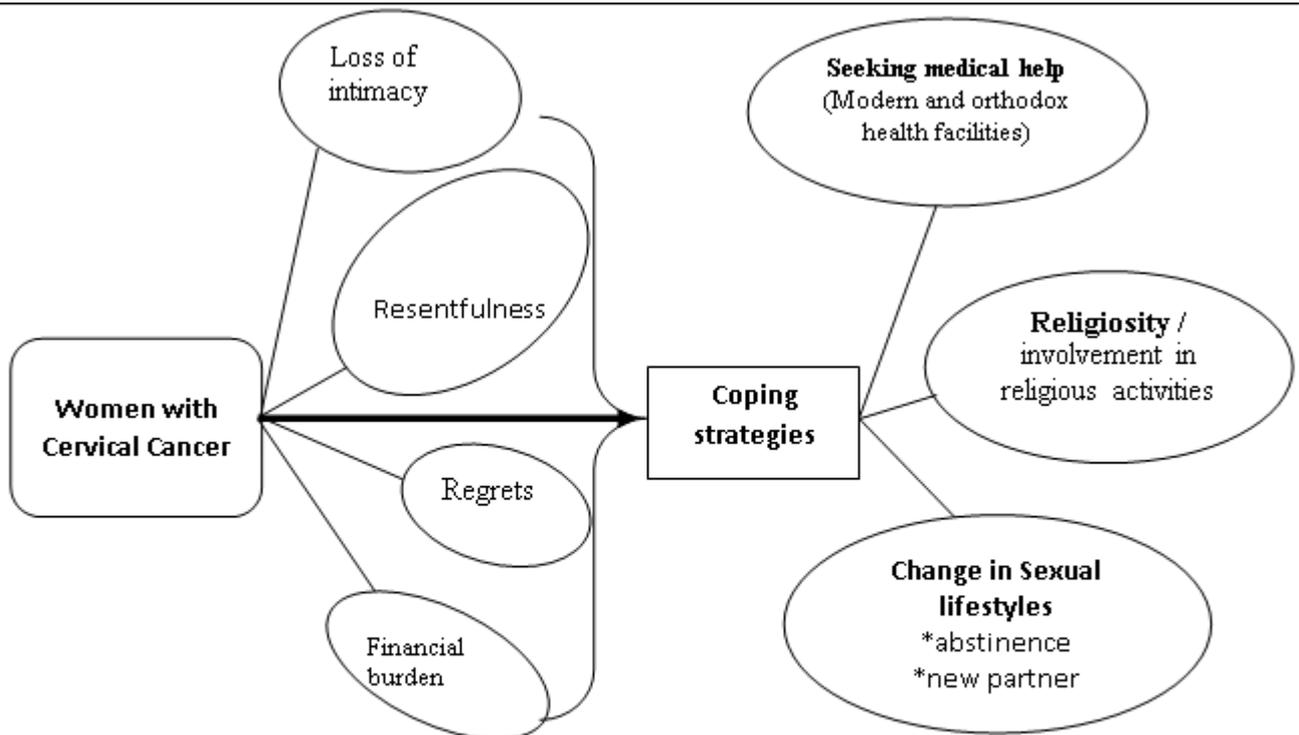


Figure 1: Diagrammatic illustration of perspectives and coping strategies among ever-married women cervical cancers survivors without husbands

Source: Authors' Mapping, 2018

Religiosity and seeking support from religious body

Another methods being adopted by majority of the survivors is to be involved in one religious activity or the other. This according to them, enables refocusing on the good things of life rather the disappointment of the past. Few excerpts from their responses are as follows:

"For me, my group (religious group) have encouraged me to love sharing my experience with other member. The concern now is how to assist others in avoiding cervical cancer by living a sexual healthy life"
(Woman, aged 43)

"I depend on my church for the remaining chemotherapy expenses and they have been helpful"
(woman, aged 38)

Adjustment of sexual lifestyles

Questions were posed on their current sexual desire and what the coping steps they have or currently taken. Generally, many of them considered sex as important in marital relationship and as the main concerning for men in marital relationship. Three women specifically believed men are incontinence and that they cannot withstand abstinence despite the frailty of their partners' health. Virtually, all the women that were living alone or with absent spouse believed sex as the primary reason why their husbands left (deserted) them and it was not necessarily because of the infection.

The analyses however revealed that there are those who are not interested in sex and those who have had sex and those who might have as the 'situation improves'. Most answers were from the survivors. Three women out of the women interviewed expressed they have lost the desire for sex considering what they passed through and those factors that were suspected to be the cause of the cancer. Included in this category were the women that were receiving treatment as at the time of the interview. Few of the excerpts are as follows:

"How can there be sex after all these 'chemos' (i.e. chemotherapies), painful operations and so on? No, that 'one' (i.e. sexual intercourse) is on hold or maybe stopped forever" (Woman, aged 40).

Notwithstanding that the majority initially indicated that sexual intercourse was not their major concern currently, two of the women are 'looking forward to start enjoying their sex life again'. A woman indicated that she had suppressed her sexual desires and would only have sex when it is absolutely necessary and after being completely healed. Another two indicated that they have recently engaged in sex. According to one of them *"when your husband runs away, what you expect? I just started 'it' (having sex)" (Woman, aged, 48).*

Discussion

The study provided insight into the women's perspectives on absence of husband/partner and the coping strategies during illnesses and diseases (and cervical cancer in this case). The study is important especially in the search for cross-cutting approaches to achieve women wellness that should require evaluating every aspect of their health challenges. The fact that the study touches on foremost killer disease positioned the study as fundamental to the achievement of developmental goal, especially in a country with high maternal morbidities and maternal deaths (De Sanjosé et al., 2012; Kolawole, 2008b; Omolara, 2011b; WHO/ICO Information Centre, 2010; K. Wright et al., 2014). The overall results also indicated some risk factors for cervical cancer screening in Nigeria which could inform new strategies to improve cervical screening in Nigeria. It is understood from this study that social and family support could play a fundamental to coping or quick recovery among the patients (Cohen and McKay, 1984b; Evans et al., 2014; Sullivan et al., 1998; Yeji et al., 2014), but the common yearning among the women is the presence of husband/partner. Two fundamental outcomes of the research are the evidences that cervical cancer can strain marital

relationship, and that lack of opportunity for sex within marriage could also aid separation between the couple. However, most ever-married women that are cervical cancer survivors and who are dissatisfied, are vengeful and would want their husbands to be held responsible for their ill health problems. While, few of the existing studies on cervical cancer in Nigeria have been quantitative (Kolawole, 2008b; Omolara, 2011b), those that are qualitative are mostly not theory based and have not considered coping strategies (Jedy-Agba et al., 2012; Modibbo et al., 2016b). The adoption of theory of relationship-focused coping strategy to authenticate the importance of support from close-relatives during illnesses (Coyne and DeLongis, 1986; Coyne and Downey, 1991; DeLongis and O'Brien, 1990; O'Brien and DeLongis, 1996), has made the study more scientifically relevant.

Another major contribution of this study is that it knitted the triangular disease management ideas raised in three distinct schools of thoughts. Whereas, the first class of studies indicated the importance of family and social support for effective management of illnesses (Cohen and Lemay, 2007b; Cohen and McKay, 1984b; Gamarra et al., 2009; George, 2016; Ross et al., 1990); another group of studies emphasised availability and access to screening and treatment facilities (Howlader et al., 2012b, 2011; Kohler et al., 2011; Modibbo et al., 2016b; Youlden et al., 2012b) while the third group highlighted that families and marriages are becoming more volatile (Becker, 1981; Cvrcek, 2011; Martin and Bumpass, 1989; Sayer and Bianchi, 2000; Vignoli and Ferro, 2009) and that the emerging lone-parent, divorced, separated are more susceptible to deplorable conditions including sicknesses and diseases (Ross et al., 1990; Trivedi et al., 2009). This study therefore submitted that notwithstanding the lack or limited access to health facility and care, and challenges with marital relationship, cervical cancer victims can still cope effectively using the coping strategies highlighted in this study. Women that are not in good health cannot contribute to sustainable development, but the adoption of coping system could have the potential to keep women in continuing participation in income generating economic activities and other developmental activities. The schematic technique adopted in this study renders the study important by providing a simple overview of the ever-married women's perspectives on absence husband and post-cervical cancer infection in the study location. The information and coping strategies identified could be replicated by other patients, not only with cancer sickness but for those that might be experiencing health challenges within and outside the study locations.

Specifically, the results revealed two categories of survivors and responses (1) responses from cervical cancer survivors that have husbands and; (2) responses among the cervical cancer survivors without husbands. Similarly, the responses varied along these two classes. The study thus, identified common perspectives such as loss of intimacy, resentfulness, financial challenges and basic coping strategies as medical checkup, resentfulness, involvement in religious activities (religiosity), seeking support from religious organisations and adjustment of sexual lifestyle. Notwithstanding, the stigmatisation experience by the survivors could be inimical to good health seeking behaviour among the victims and increasing the level of morbidity and eventual mortality among the victims.

Limitations of the study

The sensitivity surrounding the topic and the stigma over the cervical cancer posed serious challenge in the identification of the survivors. The in-depth interview approach adopted, the data analysis procedure was time consuming and the method did not permit interactions among the participants. This is because since only one respondent was interviewed at a time which is unlike focus group discussion. Although, only few in-depth interviews were conducted, the fewer number was manageable; the shared information seemed to be comprehensive enough considering the time frame and limited funding of the project.

Conclusion and recommendations

The study concluded that the women's perspectives and coping strategies on cervical cancer varied according to the marital context that is basically subjected to the presence or absence of the husband. It highlighted the absence of partner's support during sicknesses and disease, (especially in the case of cervical cancer), is fundamental to the achievement of the general wellbeing of women. The identified missing link created by the absence of the husband such as loss of intimacy, resentfulness, financial challenges could be attenuated or managed by basic coping strategies of medical checkup, religiosity or seeking support from religious organisations and adjustment of sexual lifestyle. The authors recommend counselling and increasing awareness about the risk factors of cervical cancer, including community sensitisation towards non-stigmatisation on women with cervical cancer. There is also the need for enabling policy that could demand husband's support for the wife, especially during life-threatening sicknesses and diseases, and vice-versa. This could reduce trauma experience by the victim, raise hope, engenders quick recovery and improve well-being

among women in Nigeria, and by extension, other sub-Saharan Africa countries.

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Conflict of interest

We declare no conflict of interest

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