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Ascertaining the Religious Coping Strategies among Women Living with Cervical Cancer in the Greater Accra Region: A Case of Korle Bu Teaching Hospital

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Abstract:

The purpose of this study was to ascertain the religious coping strategies among women living with cervical cancer in the Greater Accra region of Ghana. The study employed quantitative research approach specifically descriptive survey research design. The population included all women diagnosed with cervical cancer, 18 years and above and receiving treatment at the National Radiotherapy Centre and Nuclear Medicine of the Korle-Bu Teaching Hospital, Accra. A sample size of 113 was arrived at given a population of 160 using Krejcie and Morgan (1970) sampling formulae. Quota sampling was used to select participants for this study. The instruments used for the study was Brief Religious Cope (Brief RCOPE) by Pargament, Koenig and Perez (2000). Also, descriptive statistics thus mean and standard deviation was used in analyzing research question 1 and 2 whiles One-Way Multivariate Analysis of Variance (MANOVA) was used in examining the difference in religious coping practices. The mean of means obtained on the various research questions indicated an endorsement for positive religious coping among women living with cervical cancer. On the other hand, respondents did not reappraise God for things happening to them. Also, it was found that there is a statistically significant difference in the religious coping practices of women living with cervical cancer with respect to religious background. It is recommended that there should be an integration of positive religious coping techniques by nurses, physicians, pharmacists, clinical psychologists/counsellors and spiritual leaders into psychotherapy and counselling of women living with cervical cancer to enhance their skills in cancer management so as to ensure a holistic care of cervical cancer survivors.

Keywords: Health belief model, brief religious cope (Brief RCOPE)

1. Introduction

Cancer is a serious public health problem not only in Ghana but also worldwide, worsening in recent years as a result of growing population in developing countries such as Ghana (Nkyekyer, 2000). The World Health Organization (2017) defines cancer as a generic term for a large group of diseases characterized by the growth of abnormal cells beyond their usual boundaries that can invade adjoining parts of the body and/or spread to other organs. The cancer disease is different from other chronic diseases because its pathology usually leads to deformities, pain and mutilation which causes great psychological impact and negative feelings from the very time of diagnosis (Nakashima, Koifman, & Koifman, 2012). The key risk factor for infection is the exposure to the Human Papilloma Virus (HPV) types 16 and 18 shortly after becoming sexually active at an early age or having multiple sexual partners (ACS, 2015; Ago, Agan, & Ekanem, 2013; Anorlu, 2008; Eze, Emeka-Irem, & Edegbe, 2013). Other risk factors include: continued use of oral contraceptives, smoking, intrauterine device, immunosuppressant, poverty (Eze, Umeora, Obuna, Egwuatu, & Ejikeme, 2012; Denny, 2005). Cervical cancer continues to pose a threat in developing countries, especially in Africa where an estimated 53,000 women each year die of the disease. A study by Ferlay et al. (2010a) reported that approximately 85% of all cervical cancer related problems occur in developing countries such as Africa. To buttress this assertion, Anorlu (2008) posits that in Sub-Saharan Africa, cervical cancer is one of the most common cancer in women, and second to breast cancer in northern Africa. From the afore mentioned reports, cervical cancer remains a major cause of morbidity and mortality among women in Africa (Sankaranarayanan, Budukh, & Rajkumar, 2006).

In Ghana, the case is no different as cervical cancer happens to be the leading cause of cancer-related deaths among women (Parkin & Bray, 2006). Additionally, a report by the International Agency for Research on Cancer (IARC) revealed that in 2008, about 3,038 Ghanaian women developed cervical cancer of which 2,006 died (Adjei-Mensah, 2013). A study conducted in Accra by Duda, Chen & Hill (2005) reported that among the gynaecological cancers diagnosed at any hospital in Ghana, 60% to 70% of the cases are cervical cancer cases and are mostly diagnosed at the advanced stages. Thus, the occurrence and mortality rates of cervical cancer in Ghana are among the highest worldwide (WHO/ICO, 2007).

Indicators from the National Centre for Radiotherapy and Nuclear Medicine at the Korle-Bu Teaching Hospital reported that from 2013 to 2014, 183 and 162 cases of cervical cancer were recorded respectively (Radiotherapy Centre, Korle-Bu, 2015).

Religious coping has been found to be one of the major forms of coping strategies for low self-esteem and psychological distress adopted by people battling terminal illness like cervical cancer (Ayele, Mulligan, Gheorghiu, & Reyes-Ortiz, 1999). Religious coping strategies includes seeking meaning in life, gaining control of stressful situations, seeking comfort, intimacy and closeness with God. Pargament, Koenig, and Perez (2000) identified positive religious coping strategies to include seeking spiritual support from God, engaging in rituals to facilitate life transition, seeking spiritual forgiveness, seeking support from a religious body or clergy and seeing a stressful situation in a larger meaning (spiritual aspect of religious coping). Negative religious coping (e.g., reappraisals of God's powers, feeling abandoned or punished by God, etc.) reflects a tenuous relationship with God and is associated with worse well-being in people with cancer (Pargament, Smith, Koenig & Perez, 1998).

According to Pobee (1992), Ghana is reported to be a religious country owing to 97.3 percent of the population belonging to a particular religious orientation with Christianity being the dominant religion comprising 80.2 percent, followed by Islam 15.2 percent and 2.0 percent representing Traditionist/spiritualist (Ghana Statistical Service, 2015). The WIN-Gallup International, 2012 reported Ghana to be the most religious population in the world with 96 percent of the population reporting the importance of God and religion in their daily lives. It is clear that women living with cervical cancer in a religious population would draw strength from their religious beliefs and practices in the face of life-threatening situations and terminal conditions. Hence, religious coping would be a preferred choice for most women living with cervical cancer to handle daily life hustles and boost their self-esteem as well.

Notwithstanding numerous researches conducted in exploring the role of religion in health outcomes in other parts of the world, little is known about how women living in Accra with cervical cancer explore their religious beliefs as a coping mechanism. This justifies the need to examine how women living with cervical cancer in a religious country like Ghana draw strength and meaning from their religious.

1.1. Purpose of the Study

The main purpose of this study is to ascertain the religious coping strategies of women living with cervical cancer in Greater Accra Region using Korle-Bu Teaching Hospital as a study area. Specifically, the study seeks to:

- Examine the patterns of religious coping practices adopted by women living with cervical cancer in Accra.
- Determine the difference in the religious coping practices of women with cervical cancer with respect to their religious background.

1.2. Research Questions

- What are the positive religious coping practices used by women living with cervical cancer in Accra?
- What are the negative religious coping practices used by women living with cervical cancer in Accra?

1.3. Research Hypotheses

- H_0 : There is no statistically significant difference in the religious coping practices of women with cervical cancer with respect to religious background.
- H_1 : There is a statistically significant difference in the religious coping practices of women with cervical cancer with respect to religious background.

1.4. Significance of the Study

The results of this study will inform clinical health psychologists, cervical cancer treatment and prevention groups or associations, as well as health professionals about the impact of religious coping on women living with cervical cancer since interventions. This would go a long way to help health professionals to inculcate assessment of religious coping during therapy sessions for women living with cervical cancer and also integrate religious coping as part of psychotherapy for women living with cervical cancer. The outcome of the study will be of relevance to researchers who would be interested in exploring the impact of religious coping among women living with cervical cancer in a Sub-Saharan African cultural context. Also, religious community leaders who provide counselling for their members in time of distress especially those with cervical cancer will be able to understand and effectively employ the appropriate religious coping strategies for the good of their members diagnosed with cervical cancer.

1.5. Delimitation of the Study

The study was delimited to women living with cervical cancer accessing medical care at the Korle-Bu Teaching Hospital (KBTH), 18 years and above and willing to participate in the study with no sign of any mental disorder. Even though women living with cervical cancer sometimes experiences other psychological conditions such as discrimination, stigmatization, shame, guilt, stress, anxiety and depression, this study was delimited to only ascertaining the religious coping strategies among women living with cervical cancer in the Greater Accra Region using Korle-Bu Teaching Hospital as a study area.

1.6. Limitations of the Study

The first limitation to the study was the adaptation of the religious coping instrument (Brief RCOPE) developed by a non-African Psychologist which may not be culturally friendly within the Ghanaian setting. Also, the sample size for the study was a major limitation to the study because women living with cervical cancer who were attending the Korle-Bu Teaching Hospital were not willing to participate in the research due to the sensitive nature of their condition as well as fatigue syndrome leaving only a few women living with the condition to take part in the study.

2. Literature Review

The chapter presents a summary of the related empirical literature reviewed, theoretical and conceptual underpinning to the current study.

2.1. Concept of Cervical Cancer

Cancer is a disease in which cells in the body grow out of control. Cancer is always named for the part of the body where it starts, even if it spreads to other body parts later. When cancer starts in the cervix, it is called cervical cancer. The cervix is the lower, narrow end of the uterus. The cervix connects the vagina (the birth canal) to the upper part of the uterus. The uterus (or womb) is where a baby grows when a woman is pregnant. Cervical cancer is the easiest gynaecologic cancer to prevent with regular screening tests and follow-up. It is also highly curable when found and treated early (Centre for Disease Control and Prevention, 2016). Cervical cancer develops in the tissues of the cervix, which is a part of the uterus. Uterus is an organ belonging to female reproductive system. The cervix connects the upper part of uterus. It is divided in two portions- endocervix (the upper part of cervix which is close to the body of uterus and is covered by glandular columnar cells), and exocervix or ectocervix (the lower part of cervix which is in close proximity to the vagina and is covered by squamous cells) (American Cancer Society, 2009).

According to the Centre for Disease Control and Prevention (2016), all women are at risk of contracting cervical cancer. It occurs most often in women over age 30. The Human Papilloma Virus (HPV) is the main cause of cervical cancer. According to the National Cancer Registry Programme (2009), there are few causes and risk factors for cervical cancer. Among some of these are:

2.1.1. Multiple Sexual Partners and Early Sexual Activity

Cervical cancer-causing HPV types are nearly always transmitted as a result of sexual contact with an infected individual. Women who have had many sexual partners generally have a higher risk of becoming infected with HPV, which raises their risk of developing cervical cancer. There is also a link between becoming sexually active at a young age and a higher risk of cervical cancer. However, if a woman develops cervical cancer it does not mean she had several sexual partners or became sexually active earlier than most other females. It is just a risk factor.

2.1.2. Immunosuppression

People with weak immune systems, such as those with HIV/AIDS, or transplant recipients taking immunosuppressive medications are at a higher risk of developing cervical cancer.

2.1.3. Genetic mutations

Scientists at Albert Einstein College of Medicine of Yeshiva University found that women with certain gene variations appear to be protected against cervical cancer.

2.1.4. Mental Stress

A woman who experiences high levels of stress over a sustained period may be undermining her ability to fight off HPV and be at increased risk of developing cervical cancer.

2.1.5. Giving Birth at A Very Young Age

Women who gave birth before the age of 17 are significantly more likely to develop cervical cancer compared to women who had their first baby when they were aged 25 or over.

2.1.6. Multiple Pregnancies

Women who have had at least three children in separate pregnancies are more likely to develop cervical cancer compared to women who never had children.

2.1.7. Oral Contraceptive Pills

Long-term use of the oral contraceptive pills slightly increases a woman's risk. There is some evidence that long-term use of oral contraceptives may increase the risk of cancer of the cervix (the narrow, lower portion of the uterus). The results of a study conducted by scientists at National Cancer Institute (NCI) and other cancer centres support a relationship between extended use of the pill (5 or more years) and a slightly increased risk of cervical cancer (Brinton, Daling, & Liff, 1995).

2.1.8. Other Sexually Transmitted Diseases (STD)

Women infected with Chlamydia, Gonorrhoea or Syphilis have a higher risk of developing cervical cancer. According to the Southern Africa Litigation Centre (2012), cervical cancer is the most common cancer in women in sub-Saharan Africa and is a leading cause of death in women in Southern Africa. The disease is a prime example of global inequality in health. Mortality from cervical cancer in developed countries is substantially lower than in developing nations because of the availability of prevention, early detection, and treatment. Cervical cancer is the third most common cancer in women, and the seventh overall, with an estimated 530 000 new cases in 2008.

2.2. Religious Coping

Religious coping is different from normal coping, because it includes activities that apply only to religious people. Pargament, Smith, Koenig, and Perez (1998) identified several religious coping mechanisms, both positive and negative. Seeking spiritual support, forgiveness, religious purification and benevolent religious appraisal were all related to less psychological distress. Negative coping mechanisms such as spiritual discontent, demonic or punishing God reappraisal and interpersonal religious discontent, were connected with depression, lower quality of life and psychological symptoms. Spirituality and religiosity can be broadly defined as any feelings, thoughts, experiences, and behaviours that arise from a search for the divine or the sacred (Hill & Pargament, 2003). Psychologically, religious and spiritual beliefs can be conceptualized as part of a person's cognitive schema and world view. Thus, as part of an individual's general orienting system, religiousness and spirituality may exert influence on how individuals appraise situations, participate in activities, and develop personal goals (Carone & Barone, 2001). If people are pushed beyond their limits by situations outside their control, they may want to choose their coping strategies based upon a pre-existing orienting system, including their religious faith (Harrison, Koenig, Hays, Eme-Akwari, & Pargament, 2001). Religion and coping are thought to converge when an individual who has a religious orientation to life in general is faced with adverse circumstances that exceed the limits of one's internal and external resources. Therefore, religious coping can be understood as "the use of religious beliefs or behaviours to facilitate problem-solving to prevent or alleviate the negative emotional consequences of stressful life circumstances".

Research identifies three basic styles of religious coping: self-directed, deferring, and collaborative (Pargament, Kennell, Hathaway, Grevengoed, Newman, & Jones, 1988). A self-directing style reflects the belief that God has little direct influence in the lives of individuals; therefore, it is the individual's responsibility to solve problems for themselves. Conversely, the deferring style emphasizes the choice to wait for God to directly intervene in human affairs to provide a solution to the presenting problem. The collaborative coping style involves a decision to share responsibility with God for solving the problem. Pargament (1997) posits that these religious coping strategies can be categorized into general positive and negative constructs, based on typical outcomes (Pargament, Smith, Koenig, & Perez, 1998). The Collaborative coping strategy is the only approach to religious coping which consistently displays a positive relationship with emotional adjustment measures. The self-directive and deferring styles are generally negatively correlated with emotional adjustment measures, except in certain situations where events may be entirely beyond the control of an individual.

2.3. Religious Coping Practices

A diagnosis of cancer may trigger several religious concerns for the individual along with feelings of anxiety, hostility, discomfort, and social isolation (McIllmurray, Francis, Harman, Morris, Soothill, & Thomas, 2003). In the same way, religious coping may assist the individual in coping with a diagnosis of cancer (Jenkins & Pargament, 1995). According to Sears and Greene (1994), religious coping seems to have important implications for the level of anxiety experienced by individuals awaiting cardiac transplant. In a study of cardiac patients, 67.5% described private prayer to be the most frequently used practice out of a list of 21 non-medical help-seeking or coping behaviours (Ai, Dunkle, Peterson, & Bolling, 1998). Other means of religious coping included having faith in God (73%), participation in church activities (52%), and religious service attendance (54%).

Individuals with different types of cancer often spontaneously reported religious faith to be important in dealing with cancer (Flannelly, Flannelly, & Weaver, 2002). For many people with cancer, religious coping may help them deal with increased spiritual needs, and it may help them make sense of their illness (Mickley, Soeken, & Belcher, 1992). Religious coping and involvement with religious activities may help individuals maintain a sense of control, hope, and purpose.

McIllmurray et al., (2003) examined the religious needs and beliefs of individuals with cancer and realized that participants for this study were at least 18-years-old and had one of four types of cancer (breast, colorectal, lymphoma, or lung). Of the 354 participants, 83% of the respondents reported having religious faith. A greater number of older individuals reported religious faith compared to younger individuals. After conducting a logistical regression, researchers found that those who reported having religious faith and who used religious coping, needed less help for dealing with feelings of guilt and sexuality, compared to those who said they had no religious faith and did not rely on religion for coping. They also had fewer unmet needs overall (32% v. 52%). The researchers concluded by highlighting the importance of the individual's religious and spiritual beliefs in the experience of cancer. They proposed that having knowledge about the individual's spirituality and religiosity should help service providers predict the psychosocial needs and respond appropriately.

Using qualitative methodology, Dein, Stygall, and Martin, (2006) examined the ways women with breast cancer used prayer as a coping mechanism in dealing with their condition. The researchers conducted semi-structured interviews with 30 women regarding their use of prayer for six months to five years following a diagnosis of breast cancer. Of the 30

participants, 23 reported using prayer as a way to help them cope with cancer. Researchers also found themes to the prayers. These themes included issues related to God's nature and moral accountability, healing as a collaboration between God and the individual, God as a form of social support, praying to cope rather than be cured, and perceptions and beliefs about the efficacy of prayer. These findings suggest that participants utilized prayer as a way to elicit support and comfort from God and to help them cope with the diagnosis of cancer (Dein, Stygall, & Martin., 2006).

2.4. Religious Background and Religious Coping

According to Siegel, Anderman and Schrimshaw (2001), religion serves as a resource for coping with various types of pain and suffering by providing people with hope, comfort, acceptance and strength. Moreover, religion plays an important role in dealing with stressors and helps individuals in their pursuit of meaning of life. One of the benefits of religion is that it gives people significant relationships and social support from religious groups.

Religious background and religious coping are important parts of recovery. Studies show that there is a significant association between religious coping and various types of stressors, such as cancer (Yi et al., 2006), and chronic pain (Dunn, & Horgas, 2004). In a review of literature on spirituality, Sigmund (2003) established that women with a high level of spirituality displayed fewer unpleasant thoughts and anger, and spiritual interventions and activities helped many female survivors of sexual abuse overcome negative thoughts about self and God through their religious faith and activities. Findings suggest that positive religious coping is significantly associated with better functioning, adjustment and coping with the stressful situations (Harrison et al., 2001).

3. Research Methodology

The study employed the quantitative research approach using specifically the descriptive survey research design. Target population included all women diagnosed with cervical cancer, 18 years and above and receiving treatment at the National Radiotherapy Centre and Nuclear Medicine of the Korle-Bu Teaching Hospital, Accra. A sample size of 113 was arrived at given a population of 160 using Krejcie and Morgan (1970) sampling formulae. Quota sampling was used to select participants for this study. The quota sampling was used in categorizing the participants into five distinct groups as early adolescence (15-24 years), early adulthood (25-34), middle adulthood (35-44 years), late adulthood (45-54) and the old or aging adulthood (55 years and above). Quota sampling was considered as the most appropriate sampling techniques for this study because of the participant characteristics in the study.

The instruments used for the study was Brief Religious Cope (Brief RCOPE) by Pargament, Koenig and Perez (2000). The Brief RCOPE (Pargament, Koenig, & Perez, 2000) is a 14-item measure of religious coping with major life stressors. According to Pargament, Koenig and Perez (2000), the Brief RCOPE has a good inter-item reliability with a Cronbach's alpha of $\alpha = 0.65 - 0.80$ as reported in their original study. The scale has a high Cronbach's alpha of $\alpha = 0.92$ and $\alpha = 0.82$ for positive and negative religious coping respectively. It can, therefore, be concluded that the Brief RCOPE has demonstrated its utility as an instrument for research and practice in the psychology of religion and spirituality. Parametric tests were used to test the study hypotheses thus One-Way Multivariate Analysis of Variance (MANOVA) was used in examining the difference in religious coping practices.

4. Results and Discussion

The demographic information of respondents covered in this study are age, marital status and religious affiliation.

Variable	Frequency	Percentage (%)
Age group		
15 – 24 years	6	5.4
25 – 34 years	13	11.7
35 – 44 years	18	16.2
45 – 54 years	40	36.0
55 years & above	34	30.6
Marital status		
Married	50	45.0
Single	15	13.5
Divorced/separated	2	19.8
Widow	24	21.6
Religious affiliation		
Orthodox	54	48.6
Pentecostal/Charismatic	39	35.1
Islam	18	16.3

Tables 1: Demographic Characteristics of Respondents

Source: Field Work (2018); N = 111

From Table 1, majority of the respondents 40 (36%) were within 45 – 54 years, 34 (30.6%) were 55 years and above, while 6 (5.4%) were between 15 – 24 years. There were more married women 50 (45%), followed by widows 24 (21.6%), single 15 (13.5%), and divorced/separated 2 (19.8%). The study was dominated by respondents with Orthodox

background 54 (48.6%), followed by Pentecostal/Charismatic 39 (35.1%), and Islam 18 (16.3%). Nearly half of the respondents 55 (49.5%) were traders, whereas few 7 (6.3%) were teachers and health workers each.

4.1. What Are the Positive Religious Coping Practices Used by Women Living with Cervical Cancer in Accra?

This research question sought to determine the positive religious coping practices used by cervical cancer patients. Respondents were asked to respond to 14-item on religious coping practices. A cut-off mean of 2.5, which is the midpoint was used as a criterion measure of the responses. Mean scores above 2.5 depict endorsement of 'a great deal' whereas mean scores below 2.5 depicted endorsement of 'somewhat' for the items. The responses of respondents are shown in Table 2.

Statements	M	SD
Positive Religious Coping		
I looked for a stronger connection with God	3.76	.53
I asked forgiveness for my sins.	3.74	.50
I tried to see how God might be trying to strengthen me in this situation.	3.67	.59
I tried to put my plans into action together with God	3.66	.58
I sought Gods love and care	3.63	.60
I sought help from God in letting go of my anger.	3.34	.79
I focused on religion to stop worrying about my problems.	2.77	1.11
Mean of means	3.51	.67

Table 2: Positive Religious Coping Practices

Source: Field Work (2018); M – Mean; SD – Standard Deviation

As presented in Table 2, the mean of means score showed an endorsement for positive religious coping was 3.51 out of 4.0. This suggests that respondents were high on the use of positive religious coping. This was evident as respondents among other things looked for a stronger connection with God ($M = 3.76$, $SD = .53$), they asked for forgiveness of sins ($M = 3.74$, $SD = .50$), they tried to see how God might be trying to strengthen them in their situation ($M = 3.67$, $SD = .59$). Harrison et al., (2001) and Ano and Vasconcelles (2005) confirms that positive religious coping is significantly associated with better functioning, adjustment and coping with the stressful situations.

4.2. What Are The Negative Religious Coping Practices Used By Women Living With Cervical Cancer In Accra?

This research question sought to determine the negative religious coping practices used by cervical cancer patients. The responses of respondents are shown in Table 3.

Statements	M	SD
Negative Religious Coping		
I questioned Gods love for me.	2.41	1.08
I wondered whether God had abandoned me.	2.13	1.10
I decided the devil made this happened.	2.12	1.17
I wondered what I did for God to punish me.	1.98	1.18
I questioned the power of God.	1.96	1.13
I felt punished by God for my lack of devotion.	1.89	1.22
I wondered whether my church had abandoned me.	1.33	.81
Mean of means	1.97	1.10

Table 3: Negative Religious Coping Practices

Source: Field work (2018); M – Mean; SD – Standard deviation

On the contrary, respondents were low on the use of negative religious coping, with the mean of mean score of 1.97 out of 4.0. This suggests that respondents did not reappraise nor did they endorse God for things happening to them. Specifically, respondents did not question God's love towards them ($M = 2.41$, $SD = 1.08$), they did not wonder whether God had abandoned them ($M = 2.13$, $SD = 1.10$), and they did not feel punished by God for lack of devotion ($M = 1.89$, $SD = 1.22$).

The findings from research question 1 and 2 showed that respondents were high on the use of positive religious coping. Positive religious coping has been found to be used by patients suffering from chronic conditions such as cervical cancer as seeking spiritual support, forgiveness, religious purification and benevolent religious appraisal in reducing psychological distress associated with the condition (Pargament et al., 1998). The use of positive religious coping by majority of the respondents can be attributed to the way religious coping was measured by the Brief RCOPE. This study revealed that most women living with cervical cancer use positive religious coping as measured by the Brief RCOPE not necessarily because of their condition but because already they are culturally-religious. Being diagnosed with cervical cancer makes newly infected women to engage in religious practices such as praying, going to church, fasting, engaging in church activities, seeking God's guidance as a means of drawing closer to God for healing

4.3. Research Hypothesis

- H_0 : There is no statistically significant difference in the religious coping practices of women with cervical cancer with respect to religious background.
- H_1 : There is a statistically significant difference in the religious coping practices of women with cervical cancer with respect to religious background.

This hypothesis sought to determine differences in the level of religious coping among cervical cancer patients with respect their religious background. To test this hypothesis, one-way MANOVA was performed to compare the mean scores of religious coping among respondents with regard to their religious background. The predictor variable was religious background, which has three levels: Orthodox, Pentecostal/Charismatic, and Islam. The criterion variables were positive religious coping and negative religious coping. Prior to the conduct of one-way MANOVA, Shapiro-Wilk test was performed to test the normality of the data. Table 3 presents the results.

Shapiro-Wilks				
Religious coping	Religion	Stjyuatistic	Df	Sig.
Positive	Orthodox	.924	54	.002*
	Pentecostal/Charismatic	.949	39	.074
	Islam	.926	18	.163
Negative	Orthodox	.960	54	.070
	Pentecostal/Charismatic	.946	39	.062
	Islam	.942	18	.315

Table 3: Test of Normality in Terms of Religion
*Significant at the 0.05 Level

From Table 3, Shapiro-Wilks test was not statistically significant for all the religious groups ($p > .05$) apart from that of Orthodox group on positive coping ($p = .002$). Visual examination of the normal Q-Q plot for the Orthodox group suggests that the data was normally distributed. Based on this result, it can be concluded that the data on positive religious coping and negative religious coping were normally distributed. In addition to the normality assumption, homogeneity of variance and homogeneity of variance-covariance matrices were also tested. Table 4 presents the means and standard deviations for the groups.

	Religion	N	Mean	Std. Deviation
Positive coping	Orthodox	54	24.93	2.26
	Pentecostal/Charismatic	39	24.26	2.69
	Islam	18	24.17	1.95
	Total	111	24.57	2.38
Negative coping	Orthodox	54	13.99	3.45
	Pentecostal/Charismatic	39	14.77	5.33
	Islam	18	11.33	2.77
	Total	111	13.83	4.25

Table 4: Descriptive Statistics
Source: Field work (2018)

From Table 4, the mean and standard deviation of patients from Pentecostal/Charismatic in terms of negative religious coping was; $M = 14.77$, $SD = 5.33$, that of Islam was; $M = 11.33$, $SD = 2.77$, and that of Orthodox was; $M = 13.99$, $SD = 3.45$. in terms of positive religious coping, Orthodox patients had the highest mean; $M = 24.93$, $SD = 2.26$. The result of Box's M test of equality of covariance violated the variance-covariance matrices assumption, $F = 3.04$, $df_1 = 6$, $df_2 = 26342.17$, $p = .006$, $M = 43.702$. The data on positive religious coping did not violate the homogeneity of variance assumption ($p = .237$). However, data on negative religious coping violated the homogeneity of variance assumption ($p < .001$) because some assumptions were violated as a result Pillai's Trace multivariate test was performed and the results are presented in Table 5.

Effect	Value	F	Hypothesis df	Error df	Sig.	Partial Eta Squared
Intercept	.99	6176.47	2	107	.000	.991
Religious Background	.10	2.96	2	216	.021*	.052

Table 5: Pillai's Trace Multivariate Tests for Difference in Religious Coping in Terms of Religious Background
*Significant at .05 Level

The results in Table 5 shows a statistically significant difference in the combined religious coping among cervical cancer patients with respect to their religious background, $F(2, 216) = 2.96, p = .021$; partial eta squared = .052; Pillai's Trace $V = .10$. The result implies that 5.2% of the variance in the combined criterion variables (positive and negative religious coping) was explained by religious background. Separate univariate ANOVAs were performed on the combined criterion variables using Bonferroni adjusted alpha level of .025 and the results are presented in Table 6.

Source	Dependent Variable	Df	Mean Square	F	Sig.	Partial Eta Squared
Intercept	Positive-coping	1	53954.45	9558.24	.000	.989
	Negative- coping	1	16113.21	944.80	.000	.897
Religion	Positive-coping	2	6.80	1.21	.304	.022
	Negative- coping	2	73.92	4.33	.015*	.074
Error	Positive-coping	108	5.65			
	Negative- coping	108	17.06			

Table 6: Test of between-Subject Effects in Terms of Religious Background
*Significant at .025 Level

As presented in Table 6, the univariate test showed a statistically significant difference in negative religious coping among cervical patients in terms of religious background, $F(2, 108) = 4.33, p = .015$, partial eta squared = .074. This result implies that religious background explained 7.4% of the variance in negative religious coping. The results however revealed no statistically significant difference in positive religious coping among cervical cancer patients based on religious background, $F(2, 108) = 1.21, p = .304$, partial eta squared = .022. The result implies that religious background explained 2.2% of the variance in positive religious coping. A post hoc analysis was performed to determine differences in negative religious coping among cervical cancer patients. Table 7 presents the results.

(I) Religion	(J) Religion	Mean Difference (I-J)	Std. Error	Sig.
	Islam	2.65*	.80	.006
Pentecostal/Charismatic	Orthodox	.79	.97	.699
	Islam	3.44*	1.07	.006
Islam	Orthodox	-2.65*	.80	.006
	Pentecostal/Charismatic	-3.44*	1.07	.006

Table 7: Multiple Comparison on Negative Coping (Game-Howell)
*Significant At .025 Level

From the post hoc analysis, there is a statistically significant difference between the mean scores of negative religious coping for cervical patients from Orthodox and those from Islam, $p = .006$. Similarly, there is a significant difference between the mean scores of negative religious coping patients for patients from Pentecostal/Charismatic and those from Islam, $p = .006$. However, there is no statistically significant difference between the mean scores of negative religious coping for patients from Pentecostal/Charismatic and Orthodox, $p = .699$. Based on the results, it can be concluded that patients from Pentecostal/Charismatic used negative religious coping more than patients from Islam. Similarly, patients from Orthodox used negative religious coping more than patients from Islam. However, there was no difference between the use of negative religious coping between patients with Pentecostal/Charismatic and those with Orthodox backgrounds.

Based on the results, $F(2, 216) = 2.96, p = .021$, the p-value is less than .05 therefore, we fail to reject the null hypothesis which states that "there is no statistically significant difference in the religious coping practices of women with cervical cancer with respect to religious background." From this hypothesis, it was found that there is a statistically significant difference in the religious coping practices of women living with cervical cancer with respect to religious background. Though, the findings of this study revealed a statistically significant difference in religious coping practices of cervical cancer patients with respect to their religious background, the difference exist only in negative religious coping and not positive religious coping. The results from this study further revealed that patients from Pentecostal/Charismatic and Orthodox used negative religious coping more than patients from Islam but however, there was no difference between the use of negative religious coping between patients with Pentecostal/Charismatic and those with Orthodox backgrounds. With reference to this finding, McIlmurray et al. (2003) and Jenkins et al. (1995) highlights how a cancer diagnosis may trigger several religious concerns/practices along with feelings of anxiety, hostility, discomfort, low self-esteem and social isolation and the importance of religious coping practices in assisting the individual cope with the distress associated with the diagnosis of cancer. It can therefore be inferred that cervical cancer patients attending Korle-Bu Teaching Hospital with various religious background resort to either negative or positive religious coping in dealing with their cervical cancer diagnosis.

5. Conclusion

Although, there are limited published works on religious coping practices of women living with cervical cancer with respect to their religious background, it can be asserted that women living with cervical cancer irrespective of their

religious orientation attending Korle-Bu Teaching Hospital (Accra) spontaneously reports the importance of religious faith in dealing with their condition.

6. Recommendation

Base on the findings of this study, recommendation is strongly made for the integration of positive religious coping techniques into psychotherapy and counselling of women living with cervical cancer. This is because positive religious coping techniques has vast benefit for women living with cervical cancer and also effective in reducing low self-esteem symptoms in women living in cervical cancer. Hence, it is imperative for Ghana Psychological Association and the Mental Health Council (Ghana) under the Ministry of Health to develop some standard guidelines for integrating and teaching positive religious coping to women living with cervical cancer experiencing any form of psychological distress. Also, this study recommends to the Ministry of Health and Ghana Health Service to train and retain nurses as well as physicians on the early signs of cervical cancer. It should also be of key interest to the Ministry of Health and Ghana Health Service in organizing regular in-service training for nurses, physicians, pharmacists, clinical psychologists/counsellors and spiritual leaders in enhancing their skills in cancer management so as to ensure a holistic care of cervical cancer survivors.

7. Suggestion for Further Study

This study has contributed to the understanding of the religious coping strategies among women living with cervical cancer in the greater Accra region but further research needs to be conducted on understanding the relationship between religious coping and self-esteem in women living with cervical cancer in Ghana.

8. References

- i. ACS. (2015). *American Cancer Society: Facts and Figures*. American Cancer Society.
- ii. Adjei-Mensah, E. (2013). Ministry of Health begins vaccination against cervical cancer. *Daily Graphic* NO 19073, p. 11. Accra.
- iii. Ago, B. U., Agan, T. U., & Ekanem, E. (2013). Cancer of the Uterine Cervix of University of Calabar Teaching Hospital, Calabar, Nigeria. *Cancer Research Journal*, 1(4), 37–40. <http://doi.org/10.11648/j.crj.2013.0104.12>.
- iv. Ai, A. L., Dunkle, R. E., Peterson, C., & Bolling, S. F. (1998). The role of private prayer in psychological recovery among midlife and aged patients following cardiac surgery. *Gerontologist*, 38, 591-601.
- v. Anorlu, R. I. (2008). Cervical Cancer: The Sub-Saharan African Perspective. *Reproductive Health Matters*, 16(32), 41–49.
- vi. Ayele, H., Mulligan, T., Gheorghiu, S., & Reyes-Ortiz, C. (1999). Religious activity improves life satisfaction for some physicians and older patients. *Journal of the American Geriatrics Society*, 47, 453–455.
- vii. Carone, D. A. & Barone, D. F. (2001) A Social Cognitive Perspective on Religious Beliefs: Their functions and impact on coping and psychotherapy. *Clinical Psychological Review* 21(7), 989-1003.
- viii. Centers for Disease Control and Prevention. (2004). *Programme operations guidelines for STD prevention: Community and individual behaviour change interventions*. Retrieved from <http://www.cdc.gov/std/program/community/9-PGcommunity.htm>.
- ix. Dein, S., Stygall, J., & Martin, P. (2006). The use and expectations of prayer among women with breast cancer. *Healing Ministry*, 13, 23-31.
- x. Denny, L. (2005). The prevention of cervical cancer in the developing world. *BJOG*, 112, 1204–12.
- xi. Eze, N., Emeka-Irem, E., & Edegbe, F. O. (2013). A six- Year Study of the Clinical Presentation of Cervical Cancer and the Management Challenges Encountered at a State Teaching Hospital in Southeast Nigeria. *Clinical Medicine Insight: Oncology*, 151–158.
- xiii. Eze, J. N., Umeora, O. U., Obuna, J. A., Egwuatu, V. E., & Ejikeme, B. N. (2012). Cervical Cancer awareness and cervical screening uptake at the Mater Misericordiae Hospital, Afikpo, Southeast Nigeria. *Annals of African Medicine*, 11(4), 238–243. <http://doi.org/10.4103/1596-3519.102856>.
- xiv. Ferlay, J., Shin, H., Bray, F., Forman, D., Mathers, C., & Parkin, D. M. (2010a). Estimates of worldwide burden of cancer in 2008: GLOBOCAN 2008. *International Journal of Cancer*, 127(27), 2893–2917.
- xv. Ghana Statistical Service. (2015). *Ghana Demographic and Health Survey 2014. Key Indicators*. Retrieved from http://www.statsghana.gov.gh/docfiles/DHS_Report/Ghana_DHS_2014
- xvi. Harrison, M. O., Koenig, H. G., Hays, J. C., Eme-Akwari, A. G., & Pargament, K. I. (2001). The epidemiology of religious coping: A review of recent literature. *International Review of Psychiatry*, 13, 86–93.
- xvii. Hill, P. C., & Pargament, K. I. (2003). Advances in the conceptualization and measurement of religion and spirituality: Implications for physical and mental health research. *American Psychologist*, 58, 64–74.
- xviii. McIlmurray, M. B., Francis, B., Harman, J. C., Morris, S. M., Soothill, K., & Thomas, C. (2003). Psychosocial needs in cancer patients related to religious belief. *Palliative Medicine*, 17, 49-54.
- xix. Mickley, R., Soeken, K., & Belcher, A. (1992). Spiritual well-being, religiousness and hope among women with breast cancer. *Image*, 24, 267-272.
- xx. Nakashima, J. D. P., Koifman, R. J., & Koifman, S. (2012). Cancer incidence in the Western
- xxi. Amazon: population-based estimates in Rio Branco, Acre State, Brazil, 2007-2009. *Cadernos de saude publica*, 28(11), 2125-2132.

- xxii. Nkyekyer, K. (2000). Pattern of gynaecological cancers in Ghana. *East African medical journal*, 77(10). Retrieved from <http://www.ajol.info/index.php/eamj/article/view/46708>.
- xxiii. Pargament, K. I., Koenig, H. G., & Perez, L. M. (2000). The many methods of religious coping: Development and initial validation of the RCOPE. *Journal of clinical psychology*, 56(4), 519-543
- xxiv. Pargament, K. I., Sith, B. W., Koenig, H. G., & Perez, L. (1998). Patterns of positive and negative religious coping with major life stressors. *Journal for the Scientific Study of Religion*, 37,710-724.
- xxv. Pobe, J. S. (1992). *Religion and politics in Ghana: A case study of the Acheampong Era*. Accra, Ghana: Ghana Universities Press.
- xxvi. Radiotherapy Centre, Korle-Bu. (2015). *National Centre for Radiotherapy and Nuclear Medicine, Korle-Bu Teaching Hospital: Cancer Statistics (Annual Report)*. Accra-Korle-Bu: Radiotherapy Centre.
- xxvii. Sankaranarayanan, R., Budukh, A. M., & Rajkumar, R. (2001). Effective screening programmes for cervical cancer in low-and middle-income developing countries. *Bulletin of the World Health Organization*, 79, 954-962.
- xxix. Sears, S. F., & Greene, A. F. (1994). Religious coping and the threat of heart transplantation. *Journal of Religion and Health*, 33, 221-229.
- xxx. Southern Africa Litigation Centre. (2012). The right to cervical cancer services in southern Africa. *The Lancet*, 380, 54-62.
- xxxi. WHO. (2015). *Human papillomavirus (HPV) and cervical cancer (No. N 380)*. RetrievedFrom<http://www.who.int/mediacentre/factsheets/fs380/em/>
- xxxii. WHO/ICO. (2007). *Summary report on HPV and cervical cancer statistics in Ghana*. Information Centre on HPV and Cervical Cancer (HPV Information Centre).
- xxxiii. Yi, M. S., Mrus, J. M., Wade, T. J., Ho, M. L., Cotton, S., Peterman, A. H. ... Tsevat, J. (2006). Religion, Spirituality, and Depressive symptoms in patients with HIV/AIDS. *Journal of General Internal Medicine*, 5, S21-27.