EAS Journal of Nursing and Midwifery
Abbreviated Key Title: EAS J Nurs Midwifery
ISSN: 2663-0966 (Print) & ISSN: 2663-6735 (Online)
Published By East African Scholars Publisher, Kenya

OPEN ACCESS

Volume-8 | Issue-6 | Nov-Dec -2026 | DOI: https://doi.org/10.36349/easjnm.2026.v08i06.001

Original Research Article

Determinants of Self-Breast Examination Practice among Women Attending Family Planning Clinic at Chuka Level 5 Hospital, Kenya

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Article History
Received: 07.09.2026
Accepted: 31.10.2026
Published: 05.11.2026

Journal homepage:
https://www.easpublisher.com

Quick Response Code

Abstract: ***Background*:** Breast cancer is the leading cancer among women in Kenya, with late-stage presentation contributing significantly to high morbidity and mortality. Self-breast examination (SBE) is a cost-effective screening method for early detection, yet its uptake remains low, particularly in rural and sub-county healthcare settings. This study investigated the determinants of SBE practice among women attending the family planning clinic at Chuka Level 5 Hospital, Tharaka Nithi County, Kenya. ***Methods*:** An analytical cross-sectional design utilizing a mixed-methods approach was conducted. A total of 129 women were selected through systematic random sampling, while six healthcare providers (nurses, clinical officers, and gynecologists) were purposively sampled for key informant interviews. Data were gathered using researcher-administered questionnaires and structured interview schedules. Quantitative data were analyzed using SPSS v29 using descriptive statistics, Chi-square tests, and logistic regression analysis. Qualitative data underwent thematic analysis. ***Results*:** The mean age of participants was 26.03 ± 7.46 years (range 18–54), with 54.3% residing in rural areas and 55.9% having attained tertiary education. The prevalence of SBE practice was 66.1%; however, only 52.4% performed it on a monthly basis, and 47.6% performed it at the recommended time after menstruation. Primary reasons for non-performance included lack of awareness of correct steps (30.0%) and forgetfulness (27.9%). Women with primary education were significantly more likely to perform SBE compared to those with tertiary education (AOR = 0.247, 95% CI: 0.101–0.608, p = 0.002). Farmers were 4.48 times more likely to perform SBE than women in formal employment (AOR = 4.48, 95% CI: 1.31–15.29, p = 0.017). Overall knowledge of SBE was moderate (mean 69.88%), with 38.6% demonstrating good overall knowledge. Family encouragement significantly promoted SBE uptake (AOR = 0.345, 95% CI: 0.148–0.806, p = 0.014). Qualitative findings highlighted knowledge gaps regarding proper technique and the need for regular reminders. ***Conclusion*:** Although general awareness and reported practice of SBE are moderate, regular monthly compliance and knowledge of correct technique remain suboptimal. Targeted educational strategies focusing on formally employed and highly educated women, as well as family-centered health education, are urgently needed to improve screening practices.

Keywords: Self-Breast Examination, Breast Cancer, Early Detection, Family Planning, Chuka Level 5 Hospital, Nursing, Midwifery, Kenya.

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1. INTRODUCTION & BACKGROUND

Breast cancer remains a major global public health concern. Globally, cancer incidence continues to climb, with female breast cancer ranking second overall and contributing approximately 2.3 million new cases (11.6%) and 6.9% of total cancer deaths annually. In Sub-Saharan Africa, breast cancer is the leading cause of cancer-related morbidity and the second leading cause of cancer mortality among women.

In Kenya, breast cancer is the most frequently diagnosed malignancy among women, accounting for nearly 25% of all female cancer cases and 16.1% of all

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cancer deaths. Unfortunately, a significant proportion of women present with late-stage disease due to delayed diagnosis, lack of awareness, financial constraints, and restricted access to diagnostic facilities. Early detection through screening methods such as Clinical Breast Examination (CBE), mammography, and Self-Breast Examination (SBE) is critical to reducing mortality. SBE offers a non-invasive, cost-effective, and empowering tool that enables women to become familiar with their breast tissue and detect subtle changes early.

2. STATEMENT OF THE PROBLEM & OBJECTIVES

2.1 Statement of the Problem

Despite national policies such as the Kenya National Cancer Control Strategy promoting early screening, SBE practice remains low and inconsistent across various counties. While general awareness campaigns exist, localized data regarding the exact prevalence, knowledge levels, sociodemographic factors, and cultural influences on SBE in Tharaka Nithi County—and specifically at Chuka Level 5 Hospital—have remained undocumented. Understanding these factors is essential for designing targeted, context-specific interventions.

2.2 Objectives of the Study

1. To determine the prevalence and practice patterns of SBE among women attending the Family Planning Clinic at Chuka Level 5 Hospital.
2. To assess the level of knowledge regarding SBE among women attending the clinic.
3. To evaluate the sociodemographic determinants influencing SBE practice.
4. To examine the cultural and psychosocial factors associated with SBE uptake.
5. To analyze the relationship between knowledge levels and the actual practice of SBE.

3. METHODOLOGY

3.1 Study Site & Design

The study was conducted at the Maternal and Child Health (MCH) / Family Planning (FP) Clinic at Chuka Level 5 Hospital, Tharaka Nithi County, Kenya. An analytical cross-sectional study design employing mixed quantitative and qualitative approaches was utilized.

3.2 Target Population & Sampling

The target population comprised women seeking family planning services and healthcare providers (HCPs) working at the clinic. Systematic random sampling was used to select 129 women. Purposive sampling was used to select 6 key informant healthcare providers (nurses, clinical officers, and gynecologists).

3.3 Data Collection & Analysis

Quantitative data were gathered using researcher-administered questionnaires, while qualitative data were obtained via key informant interview schedules. Quantitative data were analyzed using SPSS Version 29. Descriptive statistics (frequencies, percentages, means, standard deviations) and inferential statistics (Chi-square tests and binary logistic regression reporting Adjusted Odds Ratios [AOR] with 95% Confidence Intervals) were performed. Qualitative data were analyzed contextually using thematic analysis. Ethical approval and permits were obtained from relevant ethics review committees (CUIERC, NACOSTI, and county authorities).

4. RESULTS

4.1 Sociodemographic Characteristics

The mean age of the 129 participants was 26.03 ± 7.46 years (range 18–54). The majority were aged 18–28 years (54.3%), unmarried/single (45.7%), had tertiary education (55.9%), resided in rural areas (54.3%), and were Catholic (47.2%). Regarding occupation, 27.6% were formally employed, 24.4% were students, and others were engaged in farming or informal work.

4.2 SBE Practice & Prevalence

A total of 66.1% (n=85) of respondents reported ever having performed SBE. However, regular monthly practice was reported by only 52.4% of those who practiced. Only 47.6% performed SBE at the recommended timing (a few days after menstruation). The main reasons for non-practice included belief that their breasts were normal (30.0%), forgetfulness (27.9%), and fear of detecting a lump (18.6%).

4.3 Knowledge on SBE

While 92.2% had heard of SBE and 90.6% agreed that SBE aids in early detection, only 38.6% possessed a "good" overall knowledge score. The overall mean knowledge score was 69.88%. Healthcare providers were the primary source of information (75.0%). Women with poor knowledge were significantly less likely to perform SBE than those with good knowledge (COR = 0.204, 95% CI: 0.079–0.526, p = 0.001).

4.4 Sociodemographic & Cultural Determinants

- **Education:** Women with tertiary education were significantly less likely to perform SBE compared to those with primary education (AOR = 0.247, 95% CI: 0.101–0.608, p = 0.002).
- **Occupation:** Farmers were 4.48 times more likely to perform SBE compared to formally employed women (AOR = 4.48, 95% CI: 1.31–15.29, p = 0.017).
- **Family Support:** Women who reported receiving family encouragement were significantly more likely to practice SBE (AOR = 0.345, 95% CI: 0.148–0.806, p = 0.014).

5. DISCUSSION

The overall prevalence of SBE practice in this study (66.1%) is higher than in several previous rural studies in Kenya, indicating positive reach from health education at family planning clinics. However, the gap between "ever performing" SBE and performing it monthly at the correct post-menstrual timing demonstrates a persistent need for reinforcement.

An unexpected finding was that women with tertiary education and formal employment showed lower odds of regular SBE practice. Qualitative insights suggest that busy working schedules and perceived low vulnerability contribute to this trend. Furthermore, strong family support served as a crucial catalyst for consistent SBE uptake, emphasizing the role of social and home environments in health behavior change.

6. CONCLUSION & RECOMMENDATIONS

6.1 Conclusion

Although general awareness of SBE is high, consistent monthly practice adhering to proper techniques remains moderate. Educational attainment and employment type significantly influence practice patterns, with family support playing a protective, encouraging role.

6.2 Recommendations

1. **Policy (Ministry of Health):** Develop visual, user-friendly, and culturally tailored health materials targeting educated and formally employed women who may miss clinic health talks.
2. **Clinical Practice:** Healthcare providers at MCH/FP clinics should incorporate brief practical demonstrations using anatomical models during routine visits.
3. **Community & Family:** Involve family members and partners in health promotion programs to build supportive domestic environments.

7. DECLARATIONS

Ethics Approval & Consent: Ethical approval was granted by CUIERC and NACOSTI. Written informed consent was obtained from all participants.

Conflicts of Interest: The authors declare no competing interests.

Funding: Self-funded / Master's research program.

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Cite This Article: Ireri, J., Gitonga, L., & Mukhwana, S. E. (2026). Determinants of Self-Breast Examination Practice among Women Attending Family Planning Clinic at Chuka Level 5 Hospital, Kenya. *EAS J Nurs Midwifery, 8*(6), 176-178. https://doi.org/10.36349/easjnm.2026.v08i06.001