

ORIGINAL ARTICLE

Trajectories to a cancer diagnosis: Why and when women seek help for breast symptoms in Vietnam

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Abstract

Women in low- and middle-income countries where the prevalence and mortality of breast cancer are growing rapidly are more likely to be diagnosed at advanced stages, which negatively affects their treatment outcomes and chance of survival. The current literature in those settings tends to focus largely on explaining patient delay in seeking medical attention for breast symptoms. Meanwhile, little is known as to what prompts women to attend screening and diagnostic services after discovering symptomatic breasts. Drawn upon the data from in-depth interviews with 33 breast cancer patients in Central Vietnam conducted in 2019, this paper examines the context of women's decisions about breast screening and how the practice of seeking cancer diagnosis occurred. Our findings reveal an absence of a national screening program and that seeking medical advice was conducted on an ad hoc basis after self-detection of breast symptoms. Women's interpretations of symptomatic breasts as suspicious signs of cancer, the co-occurrence of important life events, or encouragement by people in their social network motivated women to seek medical attention at different public and private health facilities. Their encounters with the health sector often involved multiple visits across time and space in which they experienced various forms of diagnosis delay produced by the health system. Our study carries implications for interventions to encourage women's awareness of early cancer symptoms and prompt medical presentation after self-discovery of symptomatic breasts.

KEYWORDS

breast cancer, cancer, cancer screening, diagnosis, early detection, help-seeking, Vietnam

1 | INTRODUCTION

During the 2000s, the incidence of breast cancer declined or stabilised in North America or Europe, but increased rapidly in African and Asian countries with historically low incidence (Bray et al., 2004; Joko-Fru et al., 2020). However, screening programs and breast cancer control strategies in low- and middle-income countries (LMIC)

generally remain lacking (Dey, 2014; Samarasekera & Horton, 2017), resulting in late-stage presentation and lower breast cancer survival rates than in high-income countries (Anderson et al., 2011; Sankaranarayanan et al., 2010). The breast cancer mortality rate is considerably higher at 15.0 deaths per 100,000 persons in countries with a low or medium Human Development Index (HDI) as compared to 12.8 deaths per 100,000 persons in higher HDI countries

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even though the latter record 88% higher rates of incidence (Sung et al., 2021).

The current literature in resource-constrained contexts concentrates largely on explaining patient delay in seeking medical attention for breast symptoms. There is evidence suggesting that cultural beliefs surrounding women's bodies and illness (Banning et al., 2010; Dey, 2014; Hwang et al., 2017; Steiness et al., 2018); misinterpretations of abnormal symptoms (Moodley et al., 2016; Pruitt et al., 2015); perception of cancer incurability, notably the concept of fatalism (Drew & Schoenberg, 2011; Kaiser et al., 2013; Kassam et al., 2017); as well as the stigma of cancer (Azaiza & Cohen, 2008; Hwang et al., 2017) are deterrents to women's participation in screening and diagnosis-searching practices. Recent research has also acknowledged systemic factors that explain women's unwillingness to seek breast cancer screening and diagnosis after discovering symptomatic breasts, including the absence of screening and diagnostic services; culturally and linguistically inappropriate screening-promoting materials; high costs; a lack of or untimely medical referrals; gender insensitivity of the health systems; or the discriminatory attitudes of healthcare providers (Manderson, 2011; Pasick & Burke, 2008; Pruitt et al., 2015; Salman et al., 2018; Woof et al., 2019).

Meanwhile, regarding facilitating factors, previous studies have noted that women's appraisal of breast or other bodily symptoms as potential signs of cancer, for instance, breast pain, is held as an important factor that precipitates their help-seeking practices (Bonsu & Ncama, 2019; Marlow et al., 2014). Being encouraged by people in their social network is also found to influence women's decisions to get examined after they notice abnormal symptoms (Crawford et al., 2016; Kohler et al., 2017; Unger-Saldaña & Infante-Castañeda, 2011). Considering health-system factors, existing studies have highlighted the importance of having sympathetic, trusted healthcare providers (Marlow et al., 2014; Thorburn et al., 2012) or having health insurance that covers breast cancer care services (Hanson et al., 2009) as motivators to cancer diagnosis-seeking.

However, less is known about how the interplay of personal, relational and contextual factors is involved in diagnosis-seeking by women in low-resource countries. Informed by the concept of an "illness trajectory" proposed by Strauss and colleagues (Strauss et al., 2017), we aim to analyse the help-seeking process from the early stage of identifying breast symptoms. An "illness trajectory" refers "not only to the physiological unfolding of a patient's disease but to the total organization of work done over that course" (Strauss et al., 2017). We extend our analysis beyond personal factors to consider the women's interaction with different actors involved throughout the process as well as the broader context of the health and social care systems in which the trajectory occurs (Allen et al., 2004).

Like many lower-middle-income countries, breast cancer morbidity and mortality have been growing rapidly in Vietnam. It has now become the most common cancer among Vietnamese women, comprising 25.8% of all newly detected cancer cases and claiming 9345 deaths nationwide in 2020 (GLOBOCAN, 2020). As a national breast

What is known about this topic

- Low- and middle-income countries where the incidence of breast cancer is rapidly increasing often record late-stage presentation and lower breast cancer survival rates than high-income countries.
- The current literature in resource-constrained contexts concentrates largely on explaining patient delay in seeking medical attention for breast symptoms while factors that encourage women to attend screening and diagnostic services are less researched.
- Understanding the trajectories of a breast cancer diagnosis since one's self-identification of symptomatic breasts may enable the development of interventions to enhance women's awareness of early cancer symptoms and reduce diagnosis delay.

What this paper adds

- This study considers the influence of both informal social networks and the formal health sector in women's pathways to a diagnosis of breast cancer.
- We highlight the importance of women's interaction with people in their informal networks, notably cancer survivors, as catalysts to their help-seeking decisions.
- The urgency to seek help when a symptom or bodily change arises does not lead to prompt detection due to various forms of diagnosis delay produced by the health system.

screening program is nonexistent in Vietnam, patients are often detected at later stages than those in Western countries (Jenkins et al., 2018). As such, understanding the trajectories to a breast cancer diagnosis once a woman discovers symptomatic breasts is vital to the development of public health interventions that encourage women's early cancer symptom awareness and reduce diagnosis delay.

2 | METHODS

2.1 | Study design

The analysis in this paper is based upon data from in-depth interviews with 33 breast cancer patients conducted within a larger study exploring the lived experiences of breast cancer in Thua Thien Hue, a province in the Central region of Vietnam, from April to December 2019. The fieldwork combined multiple data collection techniques (observation, interviews and focus groups) and involved breast cancer patients and their families, medical professionals and other stakeholders as we describe elsewhere (Do & Whittaker, 2020).

2.2 | Procedure

Women participating in our interviews were recruited via a breast cancer peer support network, through encounters during observation at the oncology ward of a public tertiary hospital, or using the snowball technique through the participants' referrals. Informants must be breast cancer patients who resided in the Central region and are aged 18 and above. Neither of the two authors had established a relationship with any of the research participants prior to the fieldwork.

We developed opened-ended questions to guide our in-depth interviews and asked women how they found out about their cancer, their treatment and the changes they had experienced in their life since the diagnosis of breast cancer. All interviews were conducted in Vietnamese by the first author who is a native speaker and each lasted from 45 to 120 minutes. We also conducted follow-up interviews with 16 patients to validate the information obtained in the first interview and explore new issues emerging from other informants' interviews. The interviews took place in a private room that the hospital assigned to this study, in a hospital's cafeteria, or at the informants' home.

2.3 | Ethical considerations

This study obtained ethics approval from the university where the authors are working and a local research institute in Vietnam. A written explanatory statement was provided to potential participants which detailed the information about our research and participation, including confidentiality issues. Before seeking consent from all participants, TD verbally described that the interviewer herself and the second author AW – who was the Principal Investigator of this research, are social scientists, not medical doctors and were unable to provide any medical advice throughout the research process. We also clarified that the participation (or refusal to participate) in the research would have no consequence on the treatment of the patients. Interviews only took place after written or verbal consent was obtained. All names quoted in this paper are pseudonyms.

2.4 | Data analysis

We digitally recorded most interviews or took extensive notes during and after the interviews when the women indicated their preference for not using a recorder. All recordings were then transcribed verbatim in Vietnamese. We eliminated all identifiable information from the transcripts as well as observation and interview notes before loading them into NVivo software for analysis.

Using the grounded theory approach (Charmaz, 2014), we began analysing data simultaneously during the data collection phase to identify patterns and themes that we needed to further validate. Data collection took place until saturation was reached, that was

when no new issues were discovered. The rigour of our analysis was achieved through triangulation by employing various data collection methods across different sites (medical and community settings), but also drawing on multiple sources of information.

The coding process started with TD applying open coding to analyse a subset of ten interview transcripts which ensure variability in the patient's age, rurality and cancer stage. While on fieldwork, TD maintained a memo in English to describe her first impressions of the data, noting recurrent and emergent themes and concepts, and regularly updated and shared with the second author. AW then used these documents and a full transcript which was translated from Vietnamese into English to independently code and identify potential themes. From this stage, we identified emergent codes which were later refined through constant comparison within and between transcripts and collapsed into broader codes. After translating all the broader codes with samples of respective quotations into English, TD met with AW and worked together to compare how we had interpreted the data. Upon reaching a consistent code structure, we conducted focused coding on the entire dataset by synthesising larger data segments under the codes established earlier and identified the final categories and the relationships between them. For this paper, we present the categories and their associated quotations related to the informants' responses to the questions surrounding the initial identification of breast symptoms that led to their search for a cancer diagnosis.

3 | FINDINGS

These 33 patients came from ten Central provinces and 19 resided in rural areas. Our sample was quite diverse in terms of informants' educational attainment, marital status (Table 1), and the duration of living with breast cancer, ranging from a couple of months to over 8 years by the time of our fieldwork.

Figure 1 illustrates the sequential stages of the pathway to a cancer diagnosis, starting with the identification of abnormal breast symptoms until the women's entry into the health sector. We describe the notable themes related to the discovery of breast lumps that led to a cancer diagnosis and the diagnosis-seeking trajectories below.

3.1 | Initial discovery of breast symptoms

Our informants often focused on the initial sudden, self-detected nature of their discovery of breast symptoms as the result of self-examination rather than the role of any structured screening program. Such practices were described as part of their everyday routine, such as while taking a bath, getting dressed or lying down at bedtime which were more instinctive than methodical:

It was very accidental. At night, I remembered around ten o'clock, I was about to go to sleep. As a routine I

TABLE 1 Characteristics of the 33 patient informants

	N (%)
Age group	
Below 30	2 (6.1)
30–39	7 (21.2)
40–49	12 (36.4)
50–59	7 (21.2)
60 and above	5 (15.1)
Marital status	
Single (never married)	5 (15.2)
Married	24 (72.7)
Divorced/separate/widowed	4 (12.1)
Education	
No schooling or not completing primary degree	3 (9.1)
Primary	9 (27.3)
Lower secondary	7 (21.2)
Upper secondary	3 (9.1)
Vocational training	1 (3.0)
College/University or Higher	10 (30.3)
Cancer stage when first diagnosed	
I	7 (21.2)
II	15 (45.5)
III	3 (9.1)
IV	1 (3.0)
Unknown	7 (21.2)

moved my hands around the breasts, you know, do an examination for myself. Then suddenly I found a small, very small lump, the same size as a black bean. I felt a bit abnormal. (...). The next morning I still felt bothered. So I went to a private clinic where they sent me out for an ultrasound. The result was not very positive. They only did a physical examination and could not conclude anything. So I arranged my work and went to Hue City right away. It was only 10 days since I first discovered the lump to the day when I had the first surgery.

(Tuyen, aged 36)

While a clinical breast examination and mammogram are recommended as a component of annual routine care (American Cancer Society, 2020), such a practice is missing from our informants' accounts. Women who worked in the formal sector often reported their participation in regular health check-ups, usually on an annual basis, which were provided to them as part of their employment benefits. However, the examination package seemed homogenous for women of all age groups and rarely included breast screening. Hay (aged 47) was at first not sceptical about abnormal breast symptoms she unintentionally found because the results from previous health screening did not detect any signs of cancer:

Every year we were sent to have a medical check-up. However, during such examination, it was done perfunctorily, mainly focused on ear-nose-throat. They did not check your breasts, no test, nor ultrasound, not even a breast physical examination even though most of the staff at the childcare are female.

(Hay, aged 47).

While a small handful of women reported their presentation for a clinical breast examination including an ultrasound as part of their routine health examinations, none of the informants we interviewed had ever had a mammogram prior to their cancer diagnosis. Khiem was a deviant case whose cancer was detected during annual mammographic screening arranged by the hospital she was working. However, her cancer was diagnosed at an already advanced stage (stage IIIB):

You know, it was the first time I was sent out for a real test that the hospital paid for. Previously, there was nothing like that (...) When I had the surgery [mastectomy], the lump was still small, only 1 cm [in diameter]. It was right on the top of the breast, exactly at the same location as the node I discovered some time ago. It was not big, that's why I could not identify it myself.

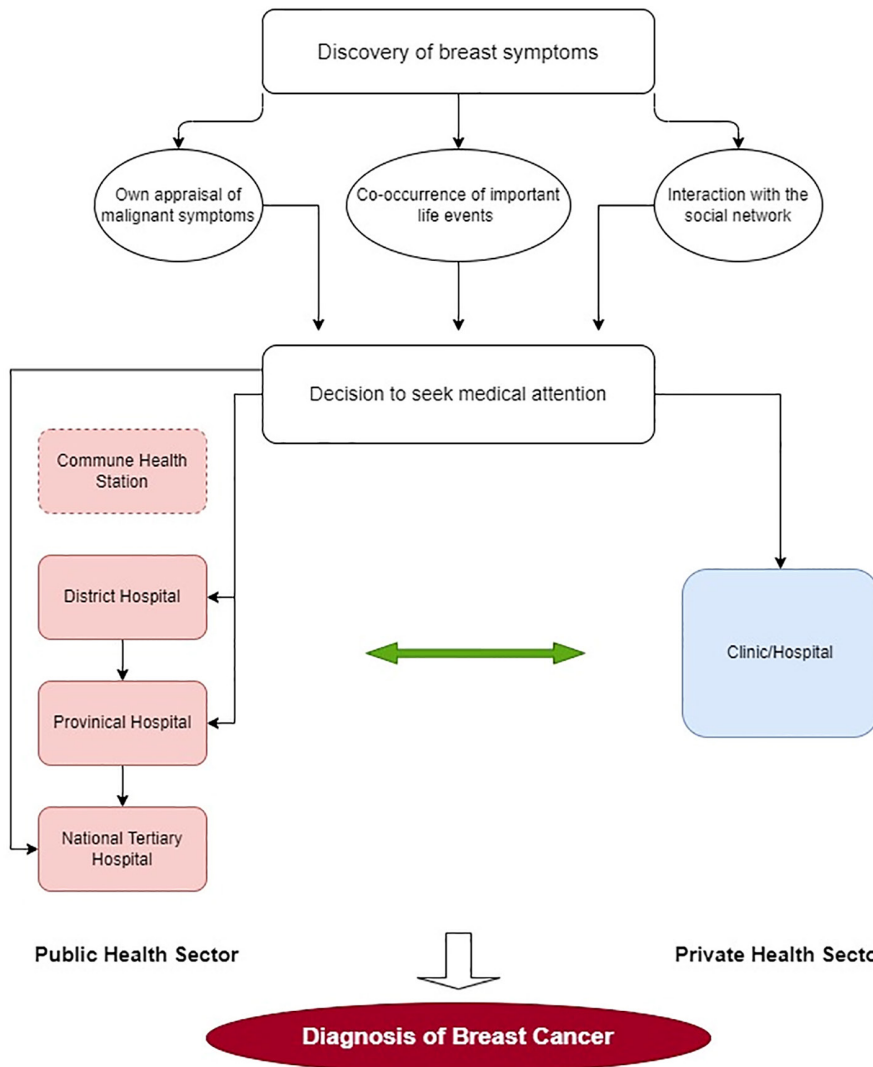
(Khiem, aged 45)

3.2 | Urgent care-seeking: Facilitators

At the discovery of symptomatic breasts, a woman's appraisal or intuition was often mentioned as the most important factor that triggered her care-seeking behaviour. If she perceived a symptom's development as normal, she was likely to leave it unattended or resort to self-medication, usually using medicinal herbs. However, when a change in the body was appraised as severe or suspicious which matched their knowledge of breast cancer, most participants emphasised the urgency of seeking biomedical advice, as summarised by 54-year-old Thi: "The lump often grows very fast, getting bigger instantly because it has legs. So we need to treat it at the hospital. We need to remove it immediately. If you use the Southern medicine [herbs], it cannot be treated quickly."

A woman's own interpretation of the acuteness of a breast symptom was based on a variety of factors in relation to the lay knowledge of cancer as a condition that rapidly develops, thereby undermining a patient's physical state. In this regard, women distinguished a malignant symptom on the basis of the timing of its discovery, its location, the persistence of the symptom, or the shape of the found lump. For example, the following were considered suspicious signs: a sore breast; an inverted nipple; a solid lump that clings onto the breast; unusual discharge from the nipples; a fast-growing breast lump; a lump found close to the chest; a movable breast lump; an inflamed breast; or reddish inflammation in the breast.

FIGURE 1 Diagnosis-seeking trajectories



In many cases, women could not describe in detail the characteristics of the lump at their first discovery. Rather, they used general terms, such as a “lump” or a “node” to describe a breast symptom. However, when such symptoms arose with other bodily changes that made them “feel tired”, “not right,” or coincided with the advent of important life events that disrupted “vital energy,” it often triggered greater fear, prompting them to urgently seek medical attention:

My story I know is similar to many others', that was a lump discovery after a funeral (...) In 2015, my brother-in-law passed away. On the day when we held the funeral, I went to help organise it. After everything was finished, I went back home on my motor-bike. When I crossed the bridge, I suddenly felt very cold even though it was in the mid-summer when the weather was extremely hot. Not long after that, I found a lump in my chest [which was later diagnosed as breast cancer].

(Chi, aged 62)

Chi's account overlapped with those of other informants who often drew on the *yin-yang* principles (Hsu et al., 2009) to explain the impact of funeral attendance on expediting a cancer diagnosis. In viewing death as having a *yin* nature, they believed that funeral sites are filled with *yin* or cold element, therefore, attending one would lead to an imbalance in the attendees' vital energy. As a patient with cancer is considered to have an excess of *yin*, exposure to more of this principle would exacerbate their disorder, rendering symptoms worse and in such cases, making them more easily detected.

Women's help-seeking behaviours were notably influenced by their interaction with their social network. In this regard, knowing another woman who had breast cancer prompted women to present for a medical examination after they discovered some symptoms. Many patients often mentioned that communication with an existing patient was vital to their appraisal of a symptom or bodily change because they were able to compare their own symptoms and find the similarities, and encouraged to seek medical advice. Tra, for instance, recalled that when she first identified a breast lump, she thought it was associated with her fever and fatigue due to her hard work and lack of rest. She did not intend to visit a

clinic until a neighbour who had been recently treated for breast cancer urged her to get examined and reassured her about cancer manageability:

That woman, she asked me: "Why did you dare not to go? There was a woman here named Lan, she died because of a similar lump. Now you have a lump, why not go for a check-up? If necessary, they will remove it, why do you leave it like that?" She offered to help me guard the motorbikes [Tra's income-making source] so that I could go for a check-up. Then I followed her advice.

(Tra, aged 56)

Our interviews also revealed the influence of a person with a medical background who was mentioned as a critical driving force to the women's early presentation at a hospital, such as the case of Tuyen (aged 36) mentioned earlier. Her decision to visit a clinic immediately after discovering an abnormal symptom resulted from her own appraisal, but also due to the insistence of her husband who was a doctor at a provincial hospital. Meanwhile for Duong, her friend encouraged her to continue searching for a second opinion after the first examination:

By that time I watched many programs on television warning about breast cancer and asking women to check their breasts regularly. So every day I did my own examination, then one day I found a lump. Right after that I visited a private clinic where they told me it was benign but then I talked to an acquaintance working at the Medical College Hospital. She told me to get there and have another check-up. There they found out it was cancerous.

(Duong, aged 47)

The role of one's social network in encouraging women to seek medical attention did not only come in the form of advice or information but also in the provision of practical support during their visit to a hospital for examination. For patients who lived in remote locations, having a relative living close to major public hospitals facilitated their access to specialised oncology services or provided them with logistical assistance such as temporary shelter during their hospital visit. Mong, a resident in a rural district which is approximately five-hour bus ride from a public hospital with an oncology ward, first ignored the node in her left armpit. She stressed that she could obtain a timely diagnosis because of her sister who lived in the city:

I was so foolish that time. I thought that it was just a benign symptom and did not need to be examined. Until I talked to my youngest sister. She said: "My dear, you must do it [go for an examination]. (...). Then we came here [the Central Hospital] for the first time

in my life. She took me to have an examination, then a biopsy.

(Mong, aged 53)

3.3 | Encounter with the health sector

The women's subsequent help-seeking trajectories from the initial medical contact until the confirmation of breast cancer often involved visits to different healthcare providers at multiple levels and sectors of the health system. In many cases, they often started with a visit to a private clinic which was noted in the earlier narratives of Duong and Tuyen. Our informants often explained their decisions of choosing a private clinic visit as the first point to seek medical attention for multiple reasons, such as closer proximity to their home, shorter waiting time, and easier registration procedure. In other cases, it was suggested by their providers:

First, he [a doctor at a public provincial hospital] told me to visit a private clinic so that they could do the operation [a lumpectomy] for me and I could get home early. If I stayed at the hospital for the operation, it would take me longer because I had to wait until they had a vacant bed. Outside they did not provide a lot of care, so it was shorter.

(Tra, aged 56)

The private-public segregation is not always clear because many doctors at public hospitals are also employed by private clinics on a part-time basis or operate their own clinic where they work after official business hours. Given such characteristics, in seeking examination for symptomatic breasts, patients often moved back and forth between the two sectors:

I was recommended to see a doctor here. I called him and he told me he could see me and did an examination for me first at his home-based clinic. (...). I had to acknowledge his expertise because he could know it was cancer without a biopsy. He only needed to do a physical examination and an ultrasound. He got an ultrasound machine at home. And after that, he told me to visit a larger private clinic for a mammogram before he helped admit me to the public hospital [where the doctor worked full-time].

(Hom, aged 36)

While our informants' accounts highlighted the common practice of visiting a private clinic to have their first examination, it was also at this sector that patients were more likely to report the incidence of medical errors:

First, I went for a breast examination [an ultrasound]. They told me that I had a cyst, like a fibroid and

prescribed some medication for me. Well, around 4 months later, I returned to that clinic, it is not a public hospital but a private clinic, they call it a high-quality clinic. They told me the fibroid had already gone. So I no longer paid more attention to it. Then a few months later [in 2016] I had to run some errands in Hue City and took that chance to have a health check-up at Hue College Hospital where they found out about my cancer.

(Ninh, aged 51)

When the patients reported experiencing diagnostic errors, their accounts mainly pointed to a healthcare provider's misinterpretation of clinical or ultrasound results. A few mentioned that a misdiagnosis came after a biopsy; meanwhile, we interviewed no patient with an account of a diagnostic error that involved the use of a mammogram. This might suggest the limited capacity of healthcare providers as well as the shortage of breast screening facilities at lower-level medical facilities:

In early 2012 I found many cysts in my left breast, so I went to the provincial hospital in Dong Hoi to have them examined. The doctors there only removed the cysts after an ultrasound but did not give me a biopsy because they said that all the cysts were benign. I went back home and after a while, the cysts re-appeared and I felt body aches. Because I had two brothers residing in the South, they asked me to go to Saigon to be re-examined. [Later that year] There at Saigon Oncology Hospital they concluded I had cancer.

(Tho, aged 43)

Given the constraints regarding laboratory and imaging capacity at lower-level hospitals, it is not surprising that our informants often expressed their strong preference for accessing tertiary national-level public hospitals to obtain cancer-diagnostic services. None of the interviewed women sought an examination at a commune health station (illustrated with a dashed rectangle in [Figure 1](#))—the primary care of point within Vietnam's public health system. A few visited a district or provincial-level hospital to get screened while many women bypassed local-level facilities and went straight to public hospitals in major urban cities without any referral like 53-year-old Mong mentioned earlier. Meanwhile, others did so only after their negative experiences at the initial encounters, mainly misdiagnosis or the lack of trust in the providers:

First a lump appeared on the top of my breast, the same size as the tip of my finger. After that I had a fever, so I went for an examination at the district [public] clinic in Ba Don. There they concluded that it was just a fibroid. But they only [physically] examined it, did not send me out for any tests. So I packed my

stuff and went to Hue City because I did not really trust that result. Here they sent me out for a biopsy and after that they suspected it was cancer. They operated to remove the lump first.

(Nhan, aged 39)

Travelling to an urban hospital for care was inevitable for those who initially sought care at a public hospital in their place of residence but received a referral due to the shortage of oncology expertise and resources at local healthcare facilities:

I went for an examination in Dong Hoi [a capital city of a province with 1 million people]. There the doctor came to the conclusion that it was breast cancer. Only by physical examination he told me, without sending me out for any tests. And he said because it was malignant, I had to be treated at another higher-level hospital. He asked me whether I would like to go to Hanoi or Hue.

(Phan, aged 46)

Because of the common practice of skipping lower-level hospitals, but also the exclusion of several diagnostic cancer services from the public health insurance, including screening mammography, most women reported having to pay for their tests entirely out-of-pocket, irrespective of their public insurance status. Additionally, they had to bear substantial costs associated with transportation and accommodation, let alone the opportunity cost of their medical visits. For many patients, the additional tests required to confirm a diagnosis at tertiary hospitals included the same tests they had previously undertaken. Tra (aged 56) for instance, was admitted as an inpatient for more than 20 days and went through various diagnostic tests, including another ultrasound which a district public hospital had previously performed on her earlier that month: "I paid the hospital fees, so they admitted me. I was staying in the inpatient room waiting for the test results. I did many tests again and again."

4 | DISCUSSION

In this paper, we have illustrated the nuances of the process from women's first detection of breast symptoms until their entry into the health sector to seek a cancer diagnosis. Consistent with previous studies on breast cancer screening in Vietnam (Jenkins et al., 2020) and other contexts where healthcare resources are limited (Bonsu & Ncama, 2019; Khakbazan et al., 2014), our interviews reveal the absent role of a national screening program and women's limited access to routine breast care. This finding also corroborates what we found in other components of our study with the lay public and healthcare providers, whereby we only identified the presence of some sporadic cancer screening events. Held as part of the collaboration between some tertiary hospitals and local health facilities, most events were operated at a small scale, reliant on external non-governmental

funding, and could hardly reach the population in rural or remote areas. For the majority of women in our research, seeking medical advice for symptomatic breasts was conducted on an ad hoc basis after self-detection of breast symptoms rather than participating in any routine program. Even though some had access to annual health screening as part of their employment benefits, such practice did not involve breast examination with the use of mammography and was often performed in a perfunctory manner. This situation may leave asymptomatic breast cancer or painless cancerous lumps undetected, leading to late-stage diagnosis and increased mortality and the burden of treatment (Dey, 2014).

As prior research in other LMICs has similarly noted (Kohler et al., 2017; Unger-Saldaña & Infante-Castañeda, 2011), our study demonstrates the importance of women's interaction with people in their informal networks, notably cancer survivors, as catalysts to their help-seeking decisions. Knowing someone previously diagnosed with breast cancer could trigger women's presentation to a doctor because such contact allows them to reappraise their symptoms to be pathological, but also educates them about cancer management with biomedical interventions, circumventing any fear of death. Our findings recommend health promotion programs engage with potential facilitating forces, such as cancer patient peer networks, to raise early symptom awareness and encourage women's prompt medical presentation in response to suspicious signs of cancer.

Our research confirms the complex, non-linear nature of the diagnosis-searching process (cf. Courcy & Rivière-Pigeon, 2021; Leung et al., 2011) by illustrating the circuitous trajectories that involved multiple social interactions and episodes across time and space. In many cases, the urgency to seek help when a symptom or bodily change emerged did not lead to prompt detection due to various forms of diagnosis delay produced by the health system that was beyond the patients' control. Those factors are recognised among the main barriers to timely treatment, causing a significant financial burden to the patients and their families as treating breast cancer is substantially more costly when diagnosed at later stages (Khakbazan et al., 2014; Moodley et al., 2016). For many women in our study, the first medical presentation often started with a private provider; however, it was also in this sector where medical errors were more likely to be reported. Diagnosis delay was also caused by the imminent requirements to bypass standard referral procedures and navigate through different medical providers in distant locations since laboratory and imaging services are not available or of sub-standard quality in lower-level health facilities. Recent studies examining the help-seeking practices of other non-communicable diseases in Vietnam have suggested a similar pattern regarding the low utilisation of health services at commune health stations as found among our informants, which is primarily due to the unpreparedness of the primary care system in attending to those related needs (Duong et al., 2019; Gammeltoft et al., 2022). Therefore, strengthening primary healthcare and establishing a mammographic screening program nationwide could significantly improve the access to and quality of diagnostic services. As identified throughout our research, the widespread perception of the efficacy

of biomedicine in detecting and treating cancer holds the promise for women's high uptake of screening mammography when it is made widely available and accessible.

Limitations of this study should be noted. Firstly, our analysis here does not reflect the situation of patients excluded from our recruitment who had just received their cancer diagnosis or were seriously ill and receiving end-of-life care due to our concerns over their psychological distress. Secondly, as some women had been diagnosed a long time prior to our interviews, they might have had difficulty recollecting the initial discovery of symptomatic breasts. However, a major contribution of our research is that it is among the first accounts in Vietnam exploring factors that motivate women to seek help for symptomatic breasts and unfolding health-system barriers accountable for the delay in cancer diagnosis.

5 | CONCLUSION

In this paper, we have considered the influence of both informal social networks and the formal health sector in women's pathways to a diagnosis of breast cancer. Our study carries implications for interventions to prompt medical presentation after self-discovery of breast symptoms in a context where a national screening program is absent. Given the diversity in our participants' backgrounds and cancer stages, our findings might also inform strategies aimed at providing early access to effective diagnostic services in different regions of Vietnam and other LMICs.

AUTHOR CONTRIBUTIONS

TD: Conceptualization, Methodology, Fieldwork, Data Analysis, Writing - Original Draft Preparation, Review, Editing and Finalisation; AW: Supervision, Conceptualization, Methodology, Data Analysis, Writing - Original Draft, Review and Editing and Final Approval.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

Due to ethical concerns related to the collection of personal information, including participants' medical profiles, the data analysed in this study cannot be made publicly available.

ETHICS APPROVAL

This study was approved by Monash University Human Research Ethics Committee (Project 14130) and the Internal Review Board in Human Subject Research of the Institute for Social Development Studies (Vietnam).

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