

Family support to women with breast cancer in Mexico: The male role

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Abstract

We explored the role of men in supporting women with breast cancer (BC). We used a set of qualitative, exploratory studies conducted between August 2008 and March 2013 in six states in Mexico with women diagnosed with BC, their male partners, directors of civil society organizations engaged in BC and health service providers. Information was collected through interviews recorded and transcribed after receiving informed consent. Two main elements summarize the role of men in supporting a female partner with BC: changes in their daily routine that reflect performance of activities at home to physically and emotionally support his partner; and, accompanying her in seeking and obtaining medical care. An emergent finding was the indication by interviewed men of the demand and need for information and emotional support. The male support of partners during the different stages of the disease is crucial and should be supported and encouraged by health services

Background

The ageing of the population and the increase in chronic noncommunicable diseases (CNCs) are pressing global challenges that extend well beyond health care to include social and economic systems [1]. Cancer is a leading NCDs and its impact reaches beyond the physical health of individuals and has serious social and economic consequences [2-4].

Breast cancer (BC) is one of the most common cancers and a leading cause of death of women having globally 1.67 million new cancer cases diagnosed in 2012 (25% of all cancers) (International Agency for Research on Cancer (IARC), 2016). In low and middle-income countries (LMICs), BC has become one of the most common causes of death, especially of young women.

Mexico, an upper middle-income country with an advanced yet protracted and polarized epidemiological transition, has undergone a large increase in BC mortality, moving from 1,206 deaths in 1980 to 4,966 in 2010 [5-8]. BC is the second leading cause of death of young women aged 30 to 54 and the most frequent cause of cancer deaths overall [9-11]. The health system has been struggling to meet this challenge and has included BC treatment coverage in national insurance plans in an effort to increase survivorship [12].

The case of Mexico epitomizes what will be a challenge for other middle-income countries and the region of Latin America and the Caribbean. The increase in the number of women with BC and the foreseeable increases in survival will result in the need for greater support and care by the family, as well as the health system and the community. Improving support systems for women with BC will

improve survivorship experience and contribute to reducing costs and suffering to all – the woman, her family and the community, the health system and the economy. Reducing abandonment, family disintegration and loss of employment are some of the key outcomes of a stronger support system and these rely heavily on the role of the male partner in societies in Latin America.

Several studies have demonstrated the crucial role of social networks and the family in the morbidity and mortality of patients with serious illness [13,14]. In the case of women with BC, support from their partners during all stages of the disease is particularly important [15-18].

In spite of the enormous structural changes occurred in developing societies, the family continues to be an important productive unit and provider of services. Population aging and the epidemiological transition with the accompanying increase in CNCs places a series of additional demands on the family taking care of those with long-term illness and supporting older adults [19].

The vast majority of this burden - the care and support in the home of persons who are ill, disabled and elderly - has fallen on women with a direct family relationship (mother, child, wife) and who live with

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the person for whom they care [20-23]. When an adult woman suffers a long-term, debilitating illness – as is the case with a BC diagnosis – family caregiving systems are severely challenged. While women continue to carry the majority of the burden of caring for the family, there is global evidence that in some settings, men are beginning to assume more of the caregiving and family support role. Recent studies show an increase in the number of men caring for the health of individuals in the household and the amount of time they spend on this activity. However, evidence for developing regions and in response to an illness of a prime age woman, is still very limited [24-26].

Cancer deeply affects the family system for long periods of time, and the family's response to this challenge in turn profoundly affects the development and quality of life of the person who is ill, in many cases, the structure and dynamics of the family nucleus [27,28]. A breast cancer diagnosis imposes severe and immediate demands on all members of the family, especially if the disease is diagnosed at an advanced stage, as is the case for the vast majority of BC patients in low and middle-income countries [29]. The nature of these demands varies according to several factors, including: the severity of the illness, degree and type of disability it produces, internal or external perception of deformation (for example, mastectomy), life prognosis, course of the illness (relapses or progression), treatment and resulting side effects, pain and symptoms of helplessness and inability experienced by the ill [30]. The family and the patient are affected by cancer in a variety of ways: emotionally, economic security, in everyday life including care of children and income earning ability, plans for the future, what it means for oneself and others and even the meaning of life. For the patient, the disease is aggressive and traumatic and can affect the woman in all areas of her life, leading to both short and longer-term changes in her ability to continue with her activities of daily life both inside and outside of the home and in the perception of herself and her body image [31,32]. Family support for women with BC goes substantially beyond income support, cleaning the home and caring for the children. The implications for women and their partners extend to the intimate, emotional and sexual realms.

A common belief is that men emotionally detach from the painful experience of cancer, isolate themselves, and in the most extreme cases abandon the relationship [33]. Nevertheless, available publications on the topic-almost exclusively from high-income countries and primarily the United States - show that this stereotypical behavior is a myth in many societies. No evidence has been found of a greater propensity for separations and/or divorce between partners dealing with BC, and when a marriage does end, it is generally a result of preexisting couples problems [34-36]. The published literature suggests that male partners of women with BC experience distress, anxiety and depression as a result of the diagnosis and show concern about the wellbeing of their partner, about whether or not medical treatments will be successful and how to help her. They have fears about their future and that of their children, as well as about the progression or remission of the disease. Other issues concerning men are the cost of treatments and how to pay for them if they do not have medical insurance, as well as changes in the woman's body due to the treatments (i.e. mastectomy), in their relationship as a couple and sexuality [37-39].

Despite the growing burden of BC in LMICs, there is almost no published evidence on the behavior and role of male partners. The purpose of this article is to explore the role of men in providing family support to women with BC using qualitative data from Mexico. This document primarily focuses on identifying role changes in the family's everyday life and on support and help for the woman diagnosed with

BC (domestic activities, caring for children, seeking medical care and emotional support). The findings and recommendations can be extrapolated and of use in generating policies and programs in LMICs to support healthier BC survivorship for women, families and communities and reduce the costs of the disease for patients and the health system.

Methods

Three research projects were conducted within the same methodological design. Two were carried out by the National Institute of Public Health, Mexico (INSP, Spanish acronym) and one by the Universidad Autónoma del Estado de Morelos (UAEM, Spanish acronym). The first was conducted between August 2008 and January 2009, the second between September and November 2010 and the third between July 2012 and March 2013. The first two projects, were financially supported by the Instituto Carlos Slim de la Salud and the Comisión Nacional de Protección Social en Salud (CNPSS, Spanish acronym), and the third by the Consejo Nacional de Ciencia y Tecnología (CONACyT, Spanish acronym), respectively. In addition, technical support was provided by the Harvard Global Equity Initiative, "Tómalo a Pecho" and the Fundación Mexicana para la Salud (these last two are Mexico-based, registered, civil society organizations).

The studies were based on the use of techniques to collect, process and analyze qualitative information. Diverse topics related to the experience of women with BC were explored: the pathways to detecting the cancer, the process of seeking and obtaining health care, family (particularly by partners) and social support during different stages of the disease, the perception of the woman's own image and her relationship with her partner after diagnosis and treatment.

The sample selection for the studies was performed using two successive stages. The study locations were selected during the first stage: Mexico City, Queretaro, Oaxaca and Jalisco for the first study; Morelos, Nuevo Leon and Jalisco again (to incorporate innovations in care for BC) for the second study; and three rural municipalities in the state of Morelos for the third. The main criteria used were: a) BC mortality and incidence rates as reported in the 2007-2012 National Health Program; b) level of human development in an effort to study states with differing social, economic, educational and health conditions, and c) the ability to access informants (women with BC) through civil society organizations (CSO). The key informants were selected during the second stage and included: a) women diagnosed with BC, b) male partners of women with BC, c) CSO directors, and d) health personnel in contact with the BC patients. The inclusion criteria and procedures to recruit informants are provided in Table 1.

The sample was determined using a deliberate sampling strategy according to the predetermined inclusion and exclusion criteria. This was characterized by seeking cases for which it was possible to obtain information with the greatest richness and variability. The information was collected using semi-structured interviews with the use of a previously designed guide. The interviews were recorded with digital audio after obtaining informed consent from participants. A total of 141 interviews were performed (54 with women diagnosed with BC, 27 with male partners of the women with the disease, 13 with CSO directors and 47 with health personnel from public institutions). The majority of male partners were legally married to the patient while the rest had a long-standing relationship and lived together. In the sample we did not find female partners of women with BC. The topics explored included: prior and subsequent information and knowledge about BC; feelings about the illness; emotional and other

Table 1. Inclusion Criteria and Procedures to Recruit Informants

Type of Informant	Inclusion Criteria	Recruitment
Women diagnosed with breast cancer	<p>Women diagnosed at least one year before the moment the study began, with the following characteristics:</p> <ul style="list-style-type: none"> • Diagnosis stage to determine if it was early or late, since this represents different courses in terms of type of and adherence to treatment and survival conditions and family and couples' relationships. • Age: range between 25 and 70 years which represents different life cycles- reproductive, menopause, older adult-and, therefore, different perceptions of the problem. • Educational level: the literature indicates that education, and literacy of women in particular, contributes greatly to the health of the woman and her family. • Health insurance: whether covered by a social security institution or public insurance (Seguro Popular). This variable is directly related to accessibility to diagnosis, treatment (including medications), control and follow-up of the pathology. • Belonging to special population groups, such as the indigenous population which presents cultural particularities that are normally not seen in other population groups. 	<p>Participants were recruited through self-help groups provided by civil society organizations (Grupo RETO in Guadalajara, Morelos, Queretaro, Mexico City and San Juan del Rio-Querétaro; Fundación CIMA*^b Mexico City and Nuevo Leon; VIVE in Guadalajara; DAR in Guadalajara; and KUXTAL in Yauatepec-Morelos). The purpose of these groups was to provide spaces for women to be psychologically treated in case of a crisis arising from the interviews; expressed in psychological terms, so they would have <i>containment</i>.</p> <p>The procedure consisted of contacting the directors of the CSO, requesting them to invite different women and identify those who would be willing to be interviewed (taking into account the selection criteria). With this information the research team directly contacted the possible interviewees to determine the date, hour and place of the interview.</p>
Males partners of women with breast cancer	Men 25 years of age or older, partners of women diagnosed with breast cancer	<p>Participants were recruited in two manners:</p> <ol style="list-style-type: none"> a) Asking the women interviewed if their partner would be willing to be interviewed and extending the invitation through her. b) Direct invitation from those in charge of the CSO self-help groups.
Directors of civil society organization	Those in charge of a Civil Society Organization dedicated to advocacy and support of women diagnosed with the disease.	CSO dedicated to BC were sought in each of the states selected. Once identified, a personalized invitation (through a letter) was sent to the directors to conduct an interview at the place, day and time convenient for them.
Health personnel having contact with patients	<ul style="list-style-type: none"> • Physicians having contact with patients in primary care health centers in the public service provider network. • Physician having contact with users of the <i>Oportunidades</i> human development program. • Promoters in public health centers providing primary care. • Specialist physicians having contact with women diagnosed with breast cancer in secondary and tertiary levels of care in health institutions. 	Access to and selection of health personnel was performed using the "snowball" technique.

Source: elaborated by authors

support received from the partner, the family and others in everyday life activities including women's health care; who was accompanying her in the search for and transportation to health services; financial aspects; and men's experience of their partners' illness.

The research project received approval from the Ethics and Research Commission of the National Institute of Public Health, Mexico according to the ethical principles established by the Helsinki Declaration.

The information was coded with specialized Atlas Ti software for the analysis of qualitative data. A phenomenological approach was used as a basis for the data analysis. To guide the analysis, codes and families of codes were identified according topics and sub-topics derived from the interview guides and other available information. These were organized into a coding guide that was reformulated throughout the analysis process based on the information provided by the informants. Theoretical saturation was sought for the objectives proposed for each of the topics explored and those arising from the informants themselves. This way of ordering enabled us to cross information about topics and types of informants. The analysis was performed through the triangulation of data as well as using distinct sources of information, in addition to comparing the information provided by different informants on one or several topics.

In the results section and for the purpose of systematization, the testimonies quoted are accompanied by the codes established by the investigators for each interview. The codes guarantee anonymity of informants and confidentiality of the information that they provided.

As in most qualitative studies, the sample selected does not intend to represent a universe of population but to provide a rich amount of

information of a diverse group of individuals about their feelings and perception about illness and health, and about their participation in the social response to cancer care. It is also important to highlight that health experts and CSO representatives agree that male partners can represent elements that hurdle the seek for health care. Still in many cases they abandon the relationship once they are aware about the BC diagnosis. Since this study reports the experience of men who provide support to the partners, the sample does not include women without partners.

Results

Two overall topics related to family support provided by males to partners diagnosed with BC were identified: a) changes in their everyday routine reflecting assumption of activities in the household to physically and emotionally support the partner, and b) accompanying the partner in her search and obtainment of medical care. Another finding was the demand and need indicated by the male partners or information and emotional support.

The informants' profile is shown in Table 2.

Changes in men's daily life to physically and emotionally support his partner

Although the majority of interviewed males declared to have assumed the role of carers, differences were observed about the time dedicated to care, the type of support they offered (emotional, physical) and the activities and duties undertaken (domestic work, health care of partner, accompaniment to the hospital). It is common a readjustment of the use of time and social roles performed as provider. In these regards, they assume activities such as household administration

Table 2. Profile of the Informants

Informants/ characteristics	Women with BC	Male Partners of Women with BC	Representatives of CSO Dedicated to Breast Cancer	Health Personnel in Contact with Women Diagnosed with BC
Total Interviewed	54	27	13	82
Geographic location	Mexico City:6 Jalisco: 15 Morelos: 9 Nuevo Leon: 9 Oaxaca: 7 Queretaro: 8	Mexico City:6 Jalisco: 8 Morelos: 4 Nuevo Leon:3 Oaxaca: 3 Queretaro: 3	Mexico City:5 Jalisco: 3 Morelos: 1 Nuevo Leon:1 Oaxaca: 1 Queretaro: 2	General Physicians 19 Specialist Physicians 23 Nurses 21 Psychologists 6 Technicians 5 Social Workers 8
Age	The average age was 53 years with a range of 26 to 70. Five women were of reproductive ages.	The average age was 59.9 years with a range of 42 to 72.	Most of the women were middle aged (45 to 65 years old), who were volunteers who directed or coordinated support groups for women with BC. Three were physicians (one female) who directed a CSO that provided services to detect, diagnose and/or treat BC ("Fucam" and "Mexfam") and perform reconstructive surgery ("DAR" group).	The average age was 49 years old with a range of 26 to 68. The youngest, resident physicians performing their social service internships.
Number of children	Average of 3 children per woman, ages 6 to 41 years. Six women indicated not having children.	Average of 3 children per male, ages 12 to 41 years.	Not applicable	Not applicable
Educational Level	17 women had a Bachelors or technical level education, 19 completed high school, 5 had attended middle school, 8 elementary school and 5 indicated not having had a formal education.	17 informants indicated having a technical or professional level education, 9 completed elementary and some secondary school and only 1 indicated not having had formal education.	3 CSO indicated being physician specialists, 6 had a Bachelor's degree, 1 had completed high school, 2 had middle school education and 1 indicated having only an elementary education.	23 had a postgraduate degree (specialist physicians in gynecology, surgery, oncology and radiooncology); 24 had a Bachelors level education (13 general physicians, 5 nurses and 6 psychologists); 29 had a technical level (5 radiologist technicians, 16 nurses and 8 social workers). The remaining 6 were resident physicians performing their social service internships.
Health Insurance Status	40 had some type of health insurance (13 with Seguro Popular and the remaining with IMSS, ISSSTE or private insurance). The remaining 14 indicated not having any type of insurance.	23 had some type of insurance (IMSS, ISSSTE, Seguro Popular, private insurance) and 4 indicated not having any type of health insurance.	Not applicable	Not applicable

Source: elaborated by authors

and care of children they were formerly responsibility of the woman. Women interviewed and their partners expressed that BC changed their lives in every sense, including their family and personal lives, work and social relationships. Diagnosis and beginning of treatment forced significant change in family dynamics. Housework that woman had usually performed- cooking, cleaning and caring for the children- was assumed primarily by the partner, as indicated in the testimony given by one of the male partners, an accountant from Guadalajara (51 years old):

"Many tasks that my wife normally used to do she can no longer do and that affects the family life very much". VarGua-1/2010

In consequence, males rearranged their use of time to spend part of it to support the partner in basic tasks such as showering and dressing, as well as cleaning wounds and changing bandages (after surgery) and taking her to the hospital to receive chemotherapy or radiotherapy treatment. In some cases, the men even reduced their paid work schedule to increase the time spent at home and to help with diverse activities.

An extremely important aspect of support for woman with BC is the emotional support the man provides to his partner. Men stated that the most common ways in which they expressed their support were: 1) show his affection and have intimate times together, 2) not show rejection of the physical change (mastectomy); 3) accompany her to medical appointments and treatments; 4) encourage reintegration into the family, social activities and work; 5) motivate her to spend time in different productive and/or recreational activities; and 6) encourage her

participation in talks and activities by CSO self-help groups dedicated to BC. One male informant (50 years old) from Oaxaca who worked in a shop stated:

"The woman thinks that things aren't the same anymore, that I am going to look for someone else (...) I would make her see that it was not going to affect us as a couple or as a family, I have shown her that. I keep treating her the same, I might not be very affectionate, but once in a while I buy her something, I hug her". VarOax-5/2008

Women, for their part, are conscious and show appreciation about the effort and help they receive from their family, partner and friends. One woman (58 years old) from Oaxaca who lives in a free union with her partner and three older children expressed this as follows:

"I saw how many friendships, friends and family were supportive of me (...) even with all the pain, it was something really wonderful" MDxTaOax-10/2008

Although the women value help and support from their family members (partners, children, parents, siblings), receiving care makes them experience mixed feelings of loneliness, rejection, being left out, and in some cases helpless. As a homemaker (45 years old), married with three adolescent children recalls:

"I felt bad. They didn't let me do anything, no cooking or cleaning. I stopped participating in my children's [school] events. My husband went in my place (...). It was more difficult for me than for them". MDxJal-3/2010

In summary, when a woman suffers from BC, the role of the male in the family dynamics generally changes. In our sample, the man tended to change from being a receiver of care to assuming the role of caregiver. When the man assumes this role, he organizes his priorities, time and activities to provide physical and emotional support throughout the course of the illness.

After diagnosis and the course of treatment had been completed, men in our sample began to return to their daily lives. Although they often continued their supportive habits, for example, domestic activities, they returned to work and do personal and social activities. For their part, women slowly returned to their roles of taking care of household duties and reinitiated their family and social activities. Some tried new activities such as taking capacity-building courses or becoming involved as volunteers in CSO self-help groups dedicated to BC. In these regards, a 59 years-old male with technical studies and owner of an auto repair shop, referred.

“My wife takes care of the baby [grandchild] in the mornings; she is free in the afternoons and goes to embroidery and baking classes. I send her off to class myself, so she isn’t cooped up here”. VarOax-5/2008

Seeking and Obtaining Medical Care for the Patient

Access to and seeking and obtaining medical care for women with BC involves several obstacles and barriers, as indicated by several of the interviewees: information (i.e. little knowledge about the disease and the warning signs), social (i.e. social role assigned to the woman influences her putting the care of her family, housework or paid work before her own health), cultural (i.e. myths, taboos, moral restrictions, lack of knowledge of her own body), economic (BC is a disease involving high diagnosis and treatment costs) and the organization of health services (lack of timely care, insufficient availability of services, long waiting periods, lack of training and sensitivity on the part of the first contact and specialist physicians).

Despite the information on changes in daily habits and supportive care obtained from the interviews described above, there is also evidence that partners are not always supportive and that male attitudes can negatively affect timely seeking of care by the woman. The men play two opposing roles in the process of diagnosing the disease and seeking care: as facilitators and barriers. As a facilitator, with the first signs of the disease in the woman, the man begins to search and collect information from a variety of sources. He may also be the one to recognize signs of abnormality in the breast (a lump or retraction) during intimacy and urges the woman to have a check up. After diagnosis, he accompanies his partner to her medical appointments and therapeutic procedures and supports her economically to defray the costs of care. As a physician from Guadalajara stated:

“Many women go to the doctor because their boyfriend or husband detected a lump in their breast.” PS1MedGua-7/2010

The man can also be a barrier to early diagnosis. They may discourage women from seeking medical care by refusing to allow other men to “see” and “touch” their partners, even if the other man is a physician and the partner know that the purpose of the checkup is to prevent disease and preserve the health of the woman. Several of the women diagnosed with BC who were interviewed and some of the CSO representatives and health personnel indicated that this attitude is an expression of “machismo” in Mexico, as can be seen in the following testimony from an oncologist:

“I have overheard a husband saying “nobody is going to touch my wife, so forget it doctor” PS3CxOncoMor-3/2012

Beyond “machist” manifestations of male behavior, it is worth to highlight the disposition shown by interviewed males to support their ill partners. Interviews revealed a broad variety of males hidden feelings regarding the disease through which they get sensitized, become emotional and suffer their partners’ condition. In practical terms they support their partners in the identification of symptoms, in the decision to seek care, to deal with pain and body changes as well as supporting them economically.

Partner’s need and demand for information and emotional support

Most of the men interviewed recognized that they had very little or only vague information about BC at the time their partners were diagnosed. A recurring theme in the interviews with these informants was lack of knowledge about the characteristics of the disease, treatment and its effects, consequences of the disease and how to communicate the news to children and family members. They also did not know at the time of diagnosis and treatment how to emotionally and psychologically support the partner in order to have a harmonious relationship and learn to deal with the disagreements and distancing associated with the consequences of the disease. A businessman in Guadalajara (49 years old) said:

“There is willingness, but you don’t know how to help (...) many husbands do not know how to help”. VarGua-10/2008

In addition to changing roles, relationship problems stemming from the feelings of the women associated with the disease add to the men’s burden. The majority of the men experiences this situation as rejection, and describes a physical and emotional distancing of the partner. One possible explanation for this phenomenon, according to what the informants themselves expressed, is the loss of the female image, particularly after surgery. This is described in the following testimony by a 47 year old male with a bachelor level education having to labor positions, one as taxi driver and a second one as concierge at a primary school.

“She didn’t want me to look at her (...). She got quieter (...) All of that was very difficult to overcome. (...) I still see her dealing with this problem”. VarDF-3/2008

Some partner informants expressed that during the process of the disease the woman attracts all of the attention. This adds to the burden the disease places on the partner. He faces mood changes in the woman and in the physical and emotional relationship, is over-worked (as caregiver and provider) and this produces high levels of stress, anxiety and feelings of loneliness. This was expressed by the following testimony of a 42 year-old male, married for 19 years with his wife and with two children.

“I started to feel very lonely because almost all the attention was on my wife (...). I was holding a lot in, trying to be very strong for her”. VarDF-1/2008

Psychological-emotional support for men is practically non-existent and some of the male partners recognized and expressed their need for this. For example a 49 year-old male, businessman, holding a bachelor degree in biology and with three children stated:

“I never received any professional care in the form of support (...). You also need support to be able to vent about the family problems”. VarGua-10/2008

It is required to offer professional support to male partners of women with BC in two ways. First to provide them with information

that enable them to support their partners in the evolution of the disease and treatments, and second, to offer them support to enable them to understand and process their own emotions (stress, anger, fear, isolation) so they can adapt to changing family, social and labor environments.

Discussion

The statistics and the literature about the participation of men in caring for the ill at home, shows that this phenomenon is increasing [40-42].

The evidence obtained from our study is consistent with that reported by the scientific literature from other countries with respect to the role of men in supporting, helping and caring for his partner after diagnosis with BC [43-45]. In our sample, the typical activities of the men are altered and they have to assume the roles and activities that are stereotypically considered "female". The dynamics of family, social and work relationships also changed.

In our sample, when the partner was ill the men helped to care for the home, the children and the health of the women, and expressed responsibility and solidarity. They indicated that they received very little support and guidance from health personnel in medical institutions or elsewhere to enable them to offer better emotional care and support to the partner and to themselves. Further, our male respondents indicate their lack of knowledge about the partner's disease.

Yet, the perception of the men about their participation in the activities of the nuclear family is one of "offering support" to the women to perform "tasks that corresponded to their gender (to women)," particularly after treatment begins. The men do not actually perceive those tasks as a shared responsibility of men and women. The beginning of treatment triggers a set of changes in the organization of the home, in which men assume roles and activities that they usually do not undertake. As the treatment becomes less intense and the women begin to show fewer symptoms, both the men and the women gradually return to their initial activities and pre-determined roles.

Another important aspect expressed by the male partners is emotional support and they perceived this as a commitment and solidarity with their partner. Although there is a return to "normality" in terms of the tasks involving in caring for the home and family, that same notion is not clear in the case of other areas of support. The disease is understood as having a severe affect, lasting for long periods and this always being the possibility of a relapse. The changes seem to have an effect on both affective as well as intimate-sexual aspects of the relationship, the emotional and physical distances increase and changes in communication are observed. The men in our sample demonstrate that they are emotionally affected by the disease in ways that are long-term. This is similar to that reported by the literature [46,47].

The results of the interviews with health professionals, on the other hand, indicate that many men act as barriers to both early detection and diagnosis of BC and effect care-seeking on the part of women. This is associated, according to the respondents with "machismo". These findings indicate that the responses from our sample of male partners may represent the "best case scenario" in Mexico – men who are willing to share their feelings, fears and challenges and women who were not abandoned by their partners at diagnosis or during treatment. Future research should focus on women who did not receive support from family and partners.

It is important to note that even the men in our sample – those who made an effort to be supportive – expressed the need for more

information and support. These findings indicate the need for a response from all several parts of the medical and care community. In addition to medical care for the woman, both the women and their families (particularly their partners) require information, capacity-building and emotional support in order to cope with the course of the disease.

First and foremost, women and their partners need clear, precise and timely information about the disease, its evolution, treatment, secondary and adverse effects of therapies, as well as the prognosis of the progression of the disease and resources available to cope with it. As indicated by other publications [48-51] the role of information is important not only to guide positive action towards seeking out medical care but also to reduce the burden on the women and the nuclear family caused by anxiety and stress.

In addition, because men are observed to participate in the direct care of the women at home (cleaning the wound, changing bandages, administering medication, managing some of the symptoms, among others), training to men by health personnel is needed (for example, nurses) to perform these activities, which clearly contribute to improving the wellbeing of the patient and reduce the need for institution-based care.

Finally, psychological support for the women, their partners and the nuclear family is essential. Similar to our findings, the international literature indicates the importance of emotional and psychological support of ill women to more easily cope with the disease, reduce levels of distress and anxiety and provide elements that contribute to a better quality of life [52,53]. Furthermore, not only do women need this type of support, as was demonstrated, but men also require emotional support to cope with the woman's illness and the changes in their relationship (both affection and sexuality) and, thereby, provide her and the family with the support needed. This aspect, in particular, deserves the attention of health personnel in medical care institutions and at the primary level of care.

Conclusions

The needs expressed by the male partners that require a response from the cancer care community are: more and better information to more effectively support their partners during the course of the disease and emotional support for themselves to help them cope with the process. The information and education should extend more generally to men (with or without a partner with BC) to guarantee that are supportive of all of the women in their lives (mothers, sisters, daughters, etc.) to invest in their own health by leading health lifestyles and accessing care that promotes early detection of diseases such as BC. Indeed, capacity building around early detection of BC is a tool for promoting the overall health of women and societies by reducing "machismo". Acting to meet the needs of men to meet the challenge of BC will help to convert them from barriers for women and the health system, into health promoters who facilitate change.

Finally the male support of partners during the different stages of the disease is crucial and should be supported and encouraged by health services and policies.

Declaration of competing interests

The authors declare that no financial, labor or other type of relationships exist that could be construed as a conflict of interest with respect to the present work. That is, we have not received "benefits in the form of money, goods, hospitality, or subsidies" from any source that has a particular interest in the results of this investigation.

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