BMC Women's Health

RESEARCH

Open Access

Psychosocial and cultural determinants of resilience among clinically stable breast cancer survivors post-chemotherapy in a tertiary care setting in Ghana

Sulleh Gbande[1], Lillian Akorfa Ohene[2*] and Lydia Aziato[3]

Abstract

Background Breast cancer remains a leading cause of mortality among women in Africa. Many patients present at advanced stages because of limited awareness and restricted access to timely healthcare, contributing to elevated mortality rates and considerable psychosocial distress.

Aim This study investigated the psychosocial and cultural determinants of resilience among women who survived breast cancer following chemotherapy in a tertiary care setting in Ghana. It addresses a research gap concerning the influence of cultural and psychosocial factors on survival.

Methods This study employed a qualitative descriptive design. Fourteen breast cancer survivors were purposively sampled between January and March 2018. In-depth data were collected through semi-structured interviews in English. Selection bias related to language was purposively minimized. Data collection and analysis occurred concurrently, and content analysis was used to interpret the results.

Results The data analysis identified four themes and eight subthemes. The themes included psychosocial support systems, cultural beliefs and practices, personal coping strategies and meaning-making, and socioeconomic and environmental factors.

Conclusion This study highlighted the multifaceted and highly individualized experiences of women who received chemotherapy for breast cancer in resource-limited settings in Ghana. The findings indicated that psychosocial support from families, peers, and compassionate healthcare providers substantially strengthens emotional resilience. Furthermore, cultural and spiritual beliefs are essential for coping, as they provide meaning and emotional stability during physical distress. Personal growth, optimism, and adaptive coping strategies also enabled the women to reinterpret their illness experiences in a more positive light.

Keywords Breast Cancer, Cultural Determinants, Psychosocial, Resilience, Survivors, Post-Chemotherapy Women

*Correspondence:
Lillian Akorfa Ohene
lohene@ug.edu.gh
[1]Department of Nursing, School of Nursing and Midwifery, University of Health of Health and Allied Sciences, Ho-PMB, 31, Volta Region, Ho, Ghana
[2]Department of Public Health Nursing, School of Nursing and Midwifery, University of Ghana, Accra, Ghana
[3]School of Nursing and Midwifery, University of Health of Health and Allied Sciences, Ho-PMB, 31. Volta Region, Ho, Ghana

Background to study

Breast cancer is one of the most prevalent malignancies among women globally and remains a leading cause of cancer-related mortality [1]. In Africa, incidence rates are rising, with many women presenting at advanced stages due to limited awareness and insufficient access to timely health care. These challenges contribute to elevated mortality rates and considerable psychosocial distress [2]. In Ghana, this pattern persists, with late-stage diagnoses often resulting from delayed health-seeking behavior and limited access to diagnostic and treatment services [3]. The high prevalence rate of the advanced stage of the disease, significant treatment-related side effects, and psychosocial burden associated with breast cancer in Ghana highlight the need to understand not only clinical outcomes but also the ways in which women adapt and maintain their well-being during and after treatment [4]. This epidemiological context underscores the relevance of resilience, defined as a multidimensional construct encompassing psychological, social, and cultural adaptation, for women navigating the challenges of chemotherapy [5, 6].

Chemotherapy is a fundamental component of breast cancer management, leading to improved survival rates and prolonged disease-free intervals [7]. Its curative and palliative effects have been well established in both early stage and metastatic diseases [8]. However, these therapeutic benefits are frequently accompanied by a range of adverse effects that extend beyond physical symptoms [9]. Women receiving chemotherapy commonly experience fatigue, nausea, alopecia, neuropathy, and immunosuppression [10]. These symptoms can persist or evolve into long-term complications, including cognitive impairment and chronic pain [10, 11]. Despite these challenges, a growing body of literature documents the resilience exhibited by women undergoing breast cancer treatment. Resilience is a dynamic, multidimensional process involving positive adaptation to adversity, trauma, or significant stress [12]. It includes psychological flexibility, emotional regulation, a sense of purpose, and mobilization of social support [12]. In the context of breast cancer, resilience may be enhanced through individual coping strategies, culturally relevant spiritual beliefs, and professional psychosocial interventions that promote self-efficacy and hope [13].

Resilience is not solely an individual trait but is shaped by the complex interplay of psychosocial and cultural influences. In Ghana, where communal ties, cultural beliefs, and spiritual values are deeply rooted, these factors significantly influence women's perceptions of illness, coping mechanisms during adversity, and transition into survivorship [14]. Family and community support, religious faith, and cultural interpretations of illness and healing play pivotal roles in shaping coping responses [8]. Psychosocial factors, including emotional well-being, self-esteem, body image, and coping mechanisms, are well-established contributors to resilience in cancer survivors [15]. Chemotherapy frequently results in visible bodily changes, such as hair loss, weight fluctuations, and mastectomy-related scarring, which can adversely affect self-image and identity, particularly among younger women [16]. These changes may exacerbate emotional distress and diminish the quality of life. Nevertheless, social support from families, peers, and healthcare providers can mitigate psychological distress and strengthen resilience [17]. In collectivist societies such as Ghana, where interpersonal connections are central to identity and well-being, this support is especially vital during the post-treatment phase [18].

Cultural beliefs also significantly shape resilience [19]. In many African contexts, illness is frequently interpreted through spiritual or supernatural frameworks, and healing is regarded as holistic, encompassing the mind, body, and spirit [20]. Therefore, religious faith and traditional healing practices serve as essential coping resources [21, 22]. Faith-based resilience, characterized by prayer, trust in divine intervention, and spiritual hope, is associated with improved psychological adjustment and reduced cancer-related fear [21]. In Ghana, many women seek prayer camps, spiritual consultations, and religious rituals for physical healing, emotional reassurance, and social reintegration [23, 24]. These cultural dimensions, often overlooked in biomedical models, highlight the importance of culturally competent post-cancer care [25].

Despite increasing global interest in resilience in cancer care, limited research has examined the intersection of psychosocial and cultural factors in sub-Saharan Africa, particularly among women transitioning into survivorship following chemotherapy [26]. Much of the existing literature remains focused on biomedical outcomes, providing limited insight into survivors lived experiences and identity reconstruction in culturally diverse contexts [27]. In Ghana's Accra Metropolis, where traditional and urban lifestyles coexist, survivors may utilize both modern healthcare and indigenous resources to build resilience. Understanding these unique experiences is essential for developing effective and culturally relevant interventions. In this context, the present study explored the psychosocial and cultural determinants of resilience among clinically stable breast cancer survivors' post-chemotherapy in a tertiary care setting in Ghana.

Methods

Research design

A qualitative descriptive design was adopted to explore the psychosocial and cultural determinants of resilience among clinically stable breast cancer survivors

post-chemotherapy in a tertiary care setting in Ghana between January and March 2018. In this study, survivorship included ongoing psychosocial and economic challenges, as well as disease-free status. This design allows researchers to examine how people understand and describe a particular phenomenon or lived experience [28]. This study adhered to the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist to ensure transparency, rigor, and completeness in reporting all aspects of the research process [29].

Participants and setting

The research took place in Accra and focused on interviewing women aged 18 years and older who had been diagnosed with breast cancer and were living in urban areas of the city. The eligibility criteria required participants to have a confirmed diagnosis of breast cancer, previous exposure to chemotherapy, and the ability to speak and understand English. Individuals who were newly diagnosed, mentally impaired, critically ill, hospitalized, or suffering from persistent pain were excluded. Purposive sampling was used to select 14 participants. The study was conducted at the largest tertiary teaching hospital in Accra, located in the Greater Accra Region, the most urbanized area and capital city of Ghana. It is one of the major tertiary referral hospitals in Ghana, with a bed capacity of 2,000. It comprises 21 clinical and diagnostic departments and houses three national centers of excellence, including the National Radiotherapy and Oncology Center. This center provides state-of-the-art radiotherapy and medical oncology services and serves as a key provider of cancer care, particularly for patients in southern Ghana. On average, the hospital attends 1,500 outpatients daily and admits approximately 250 inpatients. Although Ghana's National Health Insurance Scheme (NHIS) covers some aspects of breast cancer treatment, patients and their families often bear out-of-pocket costs for specific therapies and supportive services. For this study, women who had completed chemotherapy at least three months prior to data collection were recruited from the oncology and radiotherapy units.

Data collection method

Individual qualitative interviews were conducted with 14 participants. Ethical approval was obtained from the Teaching Hospital where the research was conducted. Participants who had received chemotherapy for breast cancer at the hospital were identified as eligible and provided with detailed information sheets outlining the study protocol. Interviews were conducted via telephone at times convenient for each participant. A semi-structured interview guide (Supplementary document) was employed to guide the discussion and ensure alignment with the study objectives. With informed consent, the interviews were conducted in English and audio recorded. Each interview lasted for 45–60 min. Data saturation was achieved after the twelfth interview, with two additional interviews conducted to validate the consistency of the emerging themes. Demographic information was collected at the start of each interview, followed by questions regarding breast cancer diagnosis, types of diagnostic tests, treatment modalities, and treatment duration. Probing questions were used to explore the key themes from the interview guide. Data collection and analysis occurred simultaneously, and member checking was performed with the participants when clarification was needed to validate the findings.

Data analysis

An inductive content analysis approach was utilized to interpret the data, enabling the generation of codes, subthemes, and overarching themes directly from the participants' narratives rather than from pre-existing theories [30]. This method has proven effective in uncovering novel insights, particularly in contexts where existing research is limited. Data analysis was conducted alongside data collection to promote a deep and ongoing understanding of the findings [30, 31]. The first author transcribed the interviews verbatim and engaged in repeated readings to identify key meanings. Concepts with similarities were grouped and categorized into subthemes, which were later synthesized into broader themes. To ensure the rigor and trustworthiness of the findings, the second and third authors independently examined the analytical process to mitigate any bias.

Trustworthiness

To enhance the trustworthiness of this study, several strategies were employed to ensure credibility, transferability, dependability, and confirmability of the findings [32, 33]. The first author, who is a trained interviewer, conducted all the interviews using a standardized interview guide to maintain consistency in data collection. Verbatim transcription was achieved through detailed field notes and audio recordings, ensuring the accurate capture of participants' narratives. Simultaneous data collection and analysis facilitated member checking with the selected participants, allowing for the validation of emerging interpretations and ensuring that the participants' perspectives were accurately represented. To improve dependability, the research process was documented meticulously, including methodological decisions and analytical steps, which allowed for potential audit trails. All authors independently coded the data. Intercoder agreement was assessed through regular research meetings, where coding discrepancies were discussed and resolved collaboratively, strengthening the study's confirmability. Rich, thick descriptions of the context and

Table 1 Participants demographic characteristics ($P=14$)

Demographics	Frequency (*P*-Total Participants)
Date of Diagnosis	$P=14$
2013	4
2014	3
2015	3
2016	4
Age of Participants	$P=14$
30–39	3
40–49	5
50–59	3
60–69	1
70–79	2
Educational levels	$P=14$
High School Certificate	4
College Diploma	2
Bachelors	8
Occupation	$P=14$
Health Workers	1
Teachers	4
Account officer	1
Self-employed (Trade)	2
Pensioner	2
Fashion Designer	4
Tribe	$P=14$
Ga	5
Akan	4
Ewe	2
Hausa	3
Marital status	$P=14$
Married	11
Single	1
Widow	2
No. of Children	$P=14$
One	1
Two	6
Three	3
Four	2
Five	2

participant responses were provided to support transferability, enabling readers to determine the applicability of the findings to other settings or populations to support transferability.

Results

Demographic characteristics of participants

The study sample comprised 14 women aged 38–78 years. Among them, three were in their late 30s, five in their early 40s, three in their early 50s, one in her early 60s, and two in their late 70s. The average age was approximately 49.5 years, with a standard deviation of 13.6 years. Most of the women (79%) were married, with marriage durations spanning 1–38 years. One participant was single, and two were widowed. For more information, refer to Table 1.

Table 2 Themes and sub-themes

Themes	Sub-themes
1. Psychosocial Support Systems	i. Family ii. Peer support iii. Healthcare provider communication and empathy
2. Cultural Beliefs and Practices	i. Impact/Influence of traditional beliefs and healing practices on coping ii. Role of religion and spirituality in emotional recovery
3. Personal Coping Strategies and Meaning-Making	i. Personal narratives and transformation through illness ii. Self-efficacy, optimism, and adaptive coping mechanisms
4. Socioeconomic and Environmental Factors	i. Economic challenges and access to supportive resources ii. Community stigma and its effect on self-image and recovery

Themes and sub-themes

To answer the research question, What are the psychosocial and cultural determinants of resilience among women survivors of breast cancer post-chemotherapy, four (4) themes and eight subthemes emerged from the data. The themes were psychosocial support systems, cultural beliefs and practices, personal coping strategies and meaning-making, and socioeconomic and environmental factors. See Table 2 for details.

Theme one: psychosocial support systems

Three subthemes emerged: family, peer support, and healthcare provider communication and empathy.

Subtheme i: family support The analysis of the participants' accounts revealed that family, in both immediate and extended forms, constitutes a fundamental pillar of support for individuals undergoing chemotherapy. Immediate family members provide daily motivation and a strong sense of purpose, while extended family networks contribute through spiritual and emotional solidarity. Together, these support systems help patients navigate the challenges of treatment, reduce psychological distress, and foster a sense of hope and perseverance.

> *"My husband and children were my biggest motivation. Even when I felt like giving up during chemo, they reminded me why I needed to keep fighting" (P3).*
>
> *"My extended family held regular prayer meetings and checked in on me almost every day. Their presence made me feel less alone." (P5).*

The excerpts from data exemplify the crucial role of immediate and extended family in patient coping during chemotherapy. The presence, encouragement, and spiritual support offered by these networks not only motivate patients to endure treatment but also mitigate feelings of isolation and despair. These findings underscore the importance of fostering strong familial and community bonds as part of comprehensive patient care.

Subtheme ii: peer support The narratives of the participants demonstrated that peer and group support are critical components of coping with breast cancer. Interacting with others who have similar experiences fosters empathy, practical advice-sharing, and psychological comfort. Formal support groups, in particular, provide ongoing, structured support that can become central to a patient's social world during treatment.

> *"Talking to other women who had gone through breast cancer helped me cope." (P7).*
> *"I joined a support group at the hospital, and it became like a second family." (P1).*

The data also highlights the role of community in the healing process. The "second family" metaphor used by P1 illustrates the creation of strong, familial-like bonds within the group. This sense of community is vital for individuals who may feel misunderstood or isolated in their broader social circles. Peer groups create safe spaces for open expression, vulnerability, and mutual aid, which are essential for holistic healing.

Subtheme iii: healthcare provider communication and empathy The professional support provided by nurses and doctors complements familial, peer, and group support, creating a comprehensive network of care. For many patients, healthcare professionals serve as a critical resource for both information and emotional comfort. The attentive, compassionate care described by P4 and P9 is essential in helping patients navigate the uncertainties and stresses of cancer treatment.

For example, the data highlighted the nurse's commitment to taking time to listen and thoroughly explain each phase of treatment. This behavior exemplifies patient-centered care, where healthcare professionals prioritize clear communication, education, and emotional support. The act of listening validates the patient's concerns and builds trust, while detailed explanations empower patients by reducing uncertainty and anxiety related to complex medical procedures.

> *"My nurse always took time to listen and explain every step of my treatment." (P4).*
> *"When the doctor looked me in the eyes and said, 'You are not alone in this,' it gave me courage." (P9).*

Theme two: cultural beliefs and practices

Two sub-themes emerged: the influence of traditional beliefs and healing practices on coping, and the role of religion and spirituality in emotional coping.

Subtheme i: influence of traditional beliefs and healing practices on coping The experiences of study participants revealed the multidimensional value of cultural and traditional practices in coping with cancer. These practices not only offer physical or symbolic comfort but also play a vital role in emotional support, personal empowerment, and social connection. The blending of traditional and biomedical approaches exemplifies how patients and families negotiate between cultural heritage and contemporary treatment, aiming to maximize both healing and meaning.

> *"I felt emotionally supported by those traditional rituals. It gave me a sense of control and connection to my roots." (P8).*
> *"My mother insisted I use herbal medicine alongside chemotherapy… believing in our traditional ways helped me feel like I wasn't alone." (P11).*

The data above emphasized that cultural practices do more than address individual needs. They also reinforce ties to family, community, and heritage. Engaging in rituals or traditional medicine creates shared experiences, strengthens family bonds, and situates the individual within a broader cultural narrative. This collective aspect is essential for psychological well-being and for maintaining continuity with one's identity and background during illness.

Subtheme ii: role of religion and spirituality in emotional coping According to the data, personal faith practices and church community involvement were critical resources for cancer patients navigating the emotional and existential challenges of illness. Prayer, spiritual music, and collective religious activities provide comfort, hope, and a strong sense of belonging. These elements were indispensable components of holistic support systems during times of vulnerability. For example, the accounts of P14 and P6 illustrated the profound impact of faith and church communities on coping with illness. Spirituality and religious participation addressed both the emotional and existential dimensions of suffering, while communal support from faith groups reinforced a sense of social connection and shared purpose.

"Praying every day and listening to gospel music helped me through the darkest days." (P14).
Church communities also provide collective emotional support.
"My church community visited, prayed with me, and encouraged me." (P6).

These findings give hope and directive that collaborating with faith leaders and integrating spiritual support into holistic care plans can further enhance emotional well-being, resilience, and overall patient outcomes.

Theme three: personal coping strategies and meaning-making

Two sub-themes emerged: personal narratives and transformation through illness, and self-efficacy, optimism, and adaptive coping mechanisms.

Subtheme i: personal narratives and transformation through illness Shared experiences revealed the dual reality of cancer treatment: while it is often accompanied by pain and uncertainty, it also holds the potential for deep personal growth. The process of enduring and overcoming chemotherapy can prompt individuals to re-evaluate their lives and discover inner resources they may not have previously recognized. For example, the accounts from P2 and P12 demonstrated it as follows….

"Going through chemotherapy changed how I see life." (P2).

P12's account focused on the discovery of personal resilience and strength, and she simply puts it as:

"It made me realize my inner strength." (P12).

These accounts demonstrated that, in addition to its hardships, the cancer journey can lead to profound personal transformation. These changes may manifest as newfound perspectives on life and the affirmation of inner strength. Such psychological shifts are essential in fostering hope, resilience, and a positive re-engagement with life after illness.

Subtheme ii: self-efficacy, optimism, and adaptive coping mechanisms The women also demonstrated the effectiveness of intentional, psychological coping strategies in managing the emotional complexities of cancer treatment. These approaches described the adaptive capacity of individuals to respond to adversity with agency and positive mindset, influencing both immediate emotional health and long-term recovery trajectories.

"I looked in the mirror and said positive affirmations." (P7).
"I focused on what I could control." (P10).

Both data above showed the value of empowerment in the coping process. Employing affirmations (P7) and focusing on control (P10) are proactive strategies that enabled the women to participate actively in their own emotional care. These methods foster a sense of autonomy, helping patients to navigate the emotional upheaval that often accompanies serious illness.

Theme four: socioeconomic and environmental factors

Participants described financial hardship, limited access to supportive resources, and community stigma as challenges they experienced during treatment.

Subtheme i: economic challenges and access to supportive resources All the study participants reported extreme financial burden that accompanied cancer treatment. The stark choice between purchasing essential medication and providing basic needs such as food illustrated the acute trade-offs many families faced. This situation highlighted the intersection of health and socioeconomic status, where basic needs such as nutrition and medical care become mutually exclusive due to resource limitations. Such stressors can profoundly affect treatment adherence, physical health, and psychological well-being.

"Sometimes I had to choose between buying medication and feeding my children." (P3).
"I couldn't afford the time or money to join support groups regularly." (P1).

The participants' reflections revealed more than just material deprivation. They also hinted at the significant emotional burden borne by patients. For participants 3 above, the need to make impossible choices likely generates guilt, anxiety, and a sense of helplessness. For participant 1, the inability to participate in support activities may lead to frustration, sadness, and increased vulnerability to depression or loneliness.

The experiences of P3 and P1 described the profound impact of financial hardship on cancer patients' ability to access both medical treatment and psychosocial support. These challenges not only threaten physical health but also exacerbate psychological distress and social isolation. Addressing these barriers requires both systemic change and targeted interventions at the community and institutional levels.

Subtheme ii: community stigma and its effect on self-image The data also pointed to the presence of negative social attitudes and misconceptions about illness. Being

perceived as "cursed or weak" reflected cultural beliefs that associated cancer with supernatural causes or personal failure, rather than recognizing it as a medical condition. Such stigma can lead to social exclusion, discrimination, and judgment, compounding the emotional burden of the illness itself. For example, P9 in a statement said….

"They thought I was cursed or weak." (P9).

P4's narrative illustrated the direct psychological toll of stigma and negative perceptions. "It took a toll on my confidence" signals a decline in self-worth, possibly stemming from internalizing others' judgments or feeling devalued by one's community. This diminished confidence can affect multiple areas of life, including relationships, employment, willingness to seek help, and engagement with treatment.

"people labeling the cause of the condition took a toll on my confidence." (P4).

Social stigma remains a significant, often invisible, barrier to the holistic well-being of cancer patients. The narratives of P9 and P4 demonstrated that negative community attitudes can erode self-confidence, trigger emotional distress, and contribute to social isolation.

Discussion

This study presents a multidimensional understanding of the support systems and challenges experienced by women undergoing chemotherapy for breast cancer. Four major themes emerged: psychosocial support systems, cultural beliefs and practices, personal coping strategies and meaning-making, and socioeconomic and environmental factors, each with significant implications for supportive cancer care in resource-limited settings.

The study showed that family support, especially from spouses and extended family, was a primary motivator for participants. Peer support groups also offer a "second family," alleviating emotional isolation and enhancing resilience. This aligns strongly with the findings from a psychological intervention program among breast cancer patients in the United States, where social support from family and peers was a significant protective factor against psychological distress [34] among breast cancer patients receiving treatment. Similarly, Kiemen et al. emphasized that peer support among patients with breast cancer fosters shared understanding, validation, and emotional solidarity [35]. The relevance of extended family and community support, especially in collectivist cultures such as Ghana, is echoed by Adam and Koranteng [36], who emphasized that family- and church-based support networks play a pivotal role in cancer care across sub-Saharan Africa. In a recent qualitative study exploring psychosocial factors in breast cancer survivors, social resources including family, community, and cultural support were identified as foundational in promoting resilience and fostering adaptive well-being after diagnosis and treatment, highlighting the value of psychosocial support systems in long-term adjustment and quality of life among women facing breast cancer [10].

Another notable finding was that empathetic communication from nurses and physicians, characterized by eye contact, active listening, and reassurance, significantly improved participants' adherence and emotional well-being. This finding is consistent with a report by DeAngelis [37], who emphasized that therapeutic relationships, when marked by compassion and clear communication, enhance patients' coping capacity. Additionally, Azarabadi et al. noted that emotionally attuned provider communication reduces anxiety, and fosters trust in oncology settings [38]. Empathy was described not just as emotional support, but as a tangible therapeutic tool, reinforcing the WHO's recommendation that palliative care should integrate psychosocial and communication elements [39].

The role of spirituality and religious practice was deeply influential in the participants' ability to endure treatment. Gospel music, prayer, and faith in a divine purpose were common coping strategies. These findings are consistent with Moudatsou et al. findings in a longitudinal study involving 596 persons aged 55 or over who were hospitalized on the medical inpatient services of a southeastern university medical center and Veterans Affairs Medical Center between January 1996 and March 1997, where they reported a positive outcome in patients who used prayer and faith as a coping mechanism [40–42]. Pargament et al. argued that spirituality provides a framework for meaning making, particularly in life-threatening illness [43]. Further evidence suggest that religious coping was associated with lower distress and greater peace among women with breast cancer [44, 45]. In the Ghanaian context, Daniels et al. similarly noted that spiritual beliefs often influence how illness is perceived and managed, reinforcing the importance of integrating spiritual care into cancer services in Ghana [46].

Participants reported being unable to afford transportation or treatment and experienced community stigma. This finding echoes the work of [47], who found that financial constraints and stigma were the leading factors in delayed breast cancer care in sub-Saharan Africa. Magwesela et al. also highlighted that stigma and poverty intersect to worsen treatment outcomes in low-resource settings [48]. Notably, community stigma where women were seen as "cursed" if they contracted cancer compounded psychological distress and negatively impacted self-image. Such cultural narratives align with the findings of Maree and Wright in South Africa, where breast

cancer was often viewed through supernatural or moralistic lenses, intensifying emotional suffering [49].

A notable divergence arises in the use of traditional healing. In this study, participants largely viewed traditional healers and rituals as complementary, emotionally supportive practices that affirmed their cultural identity and enhanced their sense of control during illness. However, Sakafu et al. reported that reliance on traditional healers in Tanzania delayed hospital treatment and contributed to advanced-stage cancer diagnoses, with traditional beliefs functioning as barriers rather than complements to biomedical care [50]. This discrepancy likely reflects the differences in the positioning of traditional healing within the care trajectory. In the current study, traditional practices were used alongside biomedical treatment rather than as a substitute, aligning with a form of medical pluralism that enabled patients to meet their cultural and spiritual needs while maintaining access to hospital-based care. It is important to note that these differences reflect distinct national, cultural, and health system contexts, and findings related to traditional healing practices in Tanzania should not be assumed to directly mirror experiences in Ghana, where patterns of integration, health-seeking behavior, and oncology service availability may differ. In contrast, Sakafu et al. reported exclusive reliance on traditional healing delayed access to effective medical intervention, leading to poorer outcomes [50].

Limitation

This study had several limitations that should be acknowledged. First, its qualitative design and small, context-specific sample limit the generalizability of the findings beyond women receiving chemotherapy in tertiary care settings. Second, restricting interviews to English may have introduced a language-based selection bias, favoring participants with higher education, urban residence, and greater familiarity with the health system. Third, the exclusion of women who were newly diagnosed, critically ill, hospitalized, experiencing persistent pain, or mentally impaired introduces survivorship and clinical stability bias, potentially underrepresenting the experiences of vulnerable patients. Finally, social desirability bias may have influenced the participants' responses. Collectively, these factors should be considered when interpreting the findings and their applicability to broader populations in future studies.

Conclusion and implication

This study highlights the complex and deeply personal experiences of women undergoing chemotherapy for breast cancer in a resource-limited context in Ghana. The participants' narratives suggest that psychosocial support from family, peers, and empathetic healthcare providers may enhance emotional resilience, whereas cultural and spiritual beliefs appear to provide meaning and emotional grounding amid physical suffering. Personal growth, optimism, and adaptive coping strategies were also observed as potential factors that helped women positively reframe their illness experiences. Therefore, healthcare providers should consider integrating culturally sensitive, patient-centered approaches that address the emotional, spiritual, and socioeconomic dimensions of care. Attention to socioeconomic hardship, limited access to support services, and community stigma can further inform tailored support strategies. Overall, these findings provide a foundation for hypothesis-driven inquiries into supportive interventions that may enhance resilience among women undergoing chemotherapy for breast cancer in similar contexts.

Abbreviations

COREQ	Consolidated Criteria for Reporting Qualitative Research
CPN	Certificate Protocol Number
IRB	Institutional Review Board
NHIS	National Health Insurance Scheme
NMIMR	Noguchi Memorial Institute for Medical Research
P	Participants
USA	United States of America
WHO	World Health Organization

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12905-026-04407-0.

Supplementary Material 1.

Acknowledgements

The authors express their gratitude to all the women who participated in this study.

Authors' contributions

The study was conceptualized by all authors, SG, LAO and LA. SG collected all the data. SG, LAO and LA contributed to its analysis. SG prepared the initial draft of the manuscript. LAO and LA took turns to review the draft. All authors, SG, LAO and LA reviewed and approved the final version of the manuscript.

Funding

This study did not receive any specific funding or grants from commercial or public institutions.

Data availability

The datasets used and analyzed during this study are available from the corresponding author upon reasonable request.

Declarations

Ethics approval and consent to participate

Ethical approval for this study was granted by the Noguchi Memorial Institute for Medical Research Institutional Review Board of the University of Ghana (NMIMR-IRB CPN017/17–18). Informed consent was obtained from all participants, and the study adhered to the applicable guidelines and regulations.

Consent for publication

Not applicable.

Competing interests
The authors declare no competing interests.

Received: 25 May 2025 / Accepted: 13 March 2026
Published online: 17 March 2026

References

1. Bray F, Laversanne M, Sung H, Ferlay J, Siegel RL, Soerjomataram I, et al. Global cancer statistics 2022: GLOBOCAN estimates of incidence and mortality worldwide for 36 cancers in 185 countries. Cancer J Clin. 2024;74(3):229–63. https://doi.org/10.3322/caac.21834.
2. Azubuike SO, Muirhead C, Hayes L, McNally R. Rising global burden of breast cancer: the case of sub-Saharan Africa (with emphasis on Nigeria) and implications for regional development: a review. World J Surg Oncol. 2018;16(1):63. https://doi.org/10.1186/s12957-018-1372-x.
3. Brinton L, Figueroa J, Adjei E, Ansong D, Biritwum R, Edusei L, et al. Factors contributing to delays in diagnosis of breast cancers in Ghana, West Africa. Breast Cancer Res Treat. 2017;162(1):105–14. https://doi.org/10.1007/s10549-016-4074-y.
4. Ortmann O, Blohmer JU, Sibert NT, Brucker S, Janni W, Wöckel A, et al. Current clinical practice and outcome of neoadjuvant chemotherapy for early breast cancer: analysis of individual data from 94,638 patients treated in 55 breast cancer centers. J Cancer Res Clin Oncol. 2023;149(3):1195–209. https://doi.org/10.1007/s00432-022-04312-3.
5. Al N, Prigerson HG, Curative. Life-Extending, and Palliative Chemotherapy: New Outcomes Need New Names. Oncologist. 2017;22(8):883–5. https://doi.org/10.1634/theoncologist.2017-0105.
6. Anand U, Dey A, Chandel AKS, Sanyal R, Mishra A, Pandey DK, et al. Cancer chemotherapy and beyond: Current status, drug candidates, associated risks and progress in targeted therapeutics. Genes Dis. 2023;10(4):1367–401. https://doi.org/10.1016/j.gendis.2022.04.004.
7. Liu L, Wu Y, Cong W, Hu M, Li X, Zhou C. Experience of women with breast cancer undergoing chemotherapy: a systematic review of qualitative research. Qual Life Res. 2021;30(5):1249–65. https://doi.org/10.1007/s11136-020-02750-w.
8. Uysal N, Toprak FÜ, Kutlutsürkan S, Erenel AS. Symptoms experienced and information needs of women receiving chemotherapy. Asia-Pacific J Oncol Nurs. 2018;5(2):178–83. https://doi.org/10.4103/apjon.apjon_13_18.
9. Okyere Asante PG, Owusu AY, Oppong JR, Amegah KE, Nketiah-Amponsah E. The psychosocial burden of women seeking treatment for breast and cervical cancers in Ghana's major cancer hospitals. PLoS ONE. 2023;18(8):e0289055. https://doi.org/10.1371/journal.pone.0289055.
10. Dong R, Mohamad Aun NS, Sofia Amin A, Hassan N. Psychosocial Factors Promoting Resilience in Breast Cancer Survivors: A Qualitative Study. SAGE Open. 2025;15(1):21582440251323654. https://doi.org/10.1177/21582440251323654.
11. Gbande S, Maree JE, Obiora OL. Supporting women receiving palliative chemotherapy for breast cancer. Int J Palliat Nurs. 2025;31(9):456–63. https://doi.org/10.12968/ijpn.2025.31.9.456.
12. Southwick SM, BG A, Catherine SMA P-B, and, Yehuda R. Resilience definitions, theory, and challenges: interdisciplinary perspectives. Eur J Psychotraumatology. 2014;5(1):25338. https://doi.org/10.3402/ejpt.v5.25338.
13. Aizpurua-Perez I, Perez-Tejada J. Resilience in women with breast cancer: A systematic review. Eur J Oncol Nurs. 2020;49:101854. https://doi.org/10.1016/j.ejon.2020.101854.
14. Afaya A, Anaba EA, Bam V, Afaya RA, Yahaya A-R, Seidu A-A, et al. Socio-cultural beliefs and perceptions influencing diagnosis and treatment of breast cancer among women in Ghana: a systematic review. BMC Womens Health. 2024;24(1):288. https://doi.org/10.1186/s12905-024-03185-z.
15. Mehrabizadeh M, Zaremohzzabieh Z, Zarean M, Ahrari S, Ahmadi A-R. Narratives of resilience: Understanding Iranian breast cancer survivors through health belief model and stress-coping theory for enhanced interventions. BMC Womens Health. 2024;24(1):552. https://doi.org/10.1186/s12905-024-03294-x.
16. Dědová M, Baník G, Vargová L. Coping with cancer: the role of different sources of psychosocial support and the personality of patients with cancer in (mal)adaptive coping strategies. Support Care Cancer. 2022;31(1):27. https://doi.org/10.1007/s00520-021-06692-0.
17. Konara Mudiyanselage SP, Wu Y-L, Kukreti S, Chen C-C, Lin C-N, Tsai Y-T, et al. Dynamic changes in quality of life, psychological status, and body image in women who underwent a mastectomy as compared with breast reconstruction: an 8-year follow up. Breast Cancer. 2023;30(2):226–40. https://doi.org/10.1007/s12282-022-01416-2.
18. Khalid S, Abbas I, Javed S. Psychological Support for Cancer Patients. In: Qazi AS, Tariq K, editors. Therapeutic Approaches in Cancer Treatment. Cham: Springer International Publishing; 2023. pp. 255–83. https://doi.org/10.1007/978-3-031-29497-6_14.
19. Evans Webb M, Murray E, Younger ZW, Goodfellow H, Ross J. The Supportive Care Needs of Cancer Patients: a Systematic Review. J Cancer Educ. 2021;36(5):899–908. https://doi.org/10.1007/s00432-022-04312-3.
20. Festerling L, Buentzel J, von Fischer L, Junghans C, Zomorodbakhsch B, Stoll C, et al. Resilience in cancer patients and how it correlates with demographics, psychological factors, and lifestyle. J Cancer Res Clin Oncol. 2023;149(8):5279–87. https://doi.org/10.1007/s00432-022-04312-3.
21. Falade B, Murire M. Health Communication and Disease in Africa: Beliefs, Traditions and Stigma. Springer Nature; 2021. https://doi.org/10.1007/978-3-030-74676-4.
22. Gutierrez-Rojas A, Manco-Herrera C, Nuñez-Escarcena X, Loayza-Ramirez L, Sanca-Valeriano S, Rodriguez-Pantigoso W, et al. The influence of spirituality on psychological resilience in cancer patients undergoing oncological treatment: a cross-sectional study. BMC Palliat Care. 2025;24(1):136. https://doi.org/10.1186/s12904-025-01584-3.
23. Dolcos F, Hohl K, Hu Y, Dolcos S. Religiosity and Resilience: Cognitive Reappraisal and Coping Self-Efficacy Mediate the Link between Religious Coping and Well-Being. J Relig Health. 2021;60(4):2892–905. https://doi.org/10.1007/s10943-021-01258-x.
24. Bonsu AB, Aziato L, Clegg-Lamptey JNA. Living with advanced breast cancer among Ghanaian women: emotional and psychosocial experiences. Int J Palliat Care. 2014;2014(1):403473. https://doi.org/10.1155/2014/403473.
25. Boatemaa Benson R, Cobbold B, Opoku Boamah E, Akuoko CP, Boateng D. Challenges, coping strategies, and social support among breast cancer patients in Ghana. Adv Public Health. 2020;2020(1):4817932. https://doi.org/10.1155/2020/4817932.
26. Üzar-Özçetin YS, Tee S, Kargın M. Achieving culturally competent cancer care: A qualitative study drawing on the perspectives of cancer survivors and oncology nurses. Eur J Oncol Nurs. 2020;44. https://doi.org/10.1016/j.ejon.2020.101704.
27. Leqi S, Kondo K, Bando T, Imai Y. Resilience in cancer care: What should nurses do? J Med Invest. 2023;70(12):1–6. https://doi.org/10.2152/jmi.70.1_2_1.
28. Thorogood N, Green J. Qualitative methods for health research. Qualitative methods health Res. 2018;1–440. https://doi.org/10.4135/9781529716616.
29. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. Int J Qual Health Care. 2007;19(6):349–57. https://doi.org/10.1093/intqhc/mzm042.
30. Polit D, Beck C. Essentials of nursing research: Appraising evidence for nursing practice. Lippincott Williams & Wilkins; 2020. https://doi.org/10.1097/01.NUR.0000676646.60275.9e.
31. Elliott R, Timulak L. Essentials of descriptive-interpretive qualitative research: A generic approach. American Psychological Association; 2021. https://doi.org/10.1037/0000216-000.
32. Shenton A. Strategies for Ensuring Trustworthiness in Qualitative Research Projects. Educ Inform. 2004;22:63–75. https://doi.org/10.3233/efi-2004-22107.
33. Creswell JW, Poth CN. Qualitative inquiry and research design: Choosing among five approaches: Sage publications; 2016. https://doi.org/10.1016/B978-0-323-28659-3.00010-8
34. Ashton K, Oney K. Psychological Intervention and Breast Cancer. Curr breast cancer Rep. 2024;16(3):311–9. https://doi.org/10.1007/s13689-024-00465-z.
35. Kiemen A, Czornik M, Weis J. How effective is peer-to-peer support in cancer patients and survivors? A systematic review. J Cancer Res Clin Oncol. 2023;149(11):9461–85. https://doi.org/10.1007/s00432-023-04753-3.
36. Adam A, Koranteng F. Availability, accessibility, and impact of social support on breast cancer treatment among breast cancer patients in Kumasi, Ghana: A qualitative study. PLoS ONE. 2020;15(4):e0231691. https://doi.org/10.1371/journal.pone.0231691.
37. DeAngelis T. Better relationships with patients lead to better outcomes. 50 (10): 38. 2019. https://doi.org/10.1037/e524102012-001
38. Azarabadi A, Bagheriyeh F, Moradi Y, Orujlu S. Nurse-patient communication experiences from the perspective of Iranian cancer patients in an outpatient oncology clinic: a qualitative study. BMC Nurs. 2024;23(1):682. https://doi.org/10.1186/s12912-024-02058-2.

39. Moudatsou M, Stavropoulou A, Philalithis A, Koukouli S. The Role of Empathy in Health and Social Care Professionals. Healthc (Basel). 2020;8(1). https://doi.org/10.3390/healthcare8010001.
40. Burke LA, Neimeyer RA. Meaning making. Oxford textbook of spirituality in healthcare. 2012:127 – 33. https://doi.org/10.1093/med/9780199227221.003.0016
41. Park CL. Spirituality and meaning making in cancer survivorship. American Psychological Association; 2013. https://doi.org/10.1037/14041-000.
42. Nkoana S, Sodi T, Makgahlela M, Mokwena J. Cancer survivorship: religion in meaning making and coping among a group of black prostate cancer patients in South Africa. J Relig Health. 2022;61(2):1390–400. https://doi.org/10.1007/s10943-021-01452-9.
43. Pargament KI, Koenig HG, Tarakeshwar N, Hahn J. Religious coping methods as predictors of psychological, physical and spiritual outcomes among medically ill elderly patients: A two-year longitudinal study. J Health Psychol. 2004;9(6):713–30. https://doi.org/10.1177/1359105304045366.
44. Balboni TA, VanderWeele TJ, Doan-Soares SD, Long KNG, Ferrell BR, Fitchett G, et al. Spirituality in serious illness and health. JAMA. 2022;328(2):184–97. https://doi.org/10.1001/jama.2022.9567.
45. Gutiérrez-Rojas A, Manco-Herrera C, Nuñez-Escarcena X, Sanca-Valeriano S, Rodriguez-Pantigoso W, Espinola-Sanchez M. The influence of spirituality on psychological resilience in cancer patients undergoing oncological treatment: a cross-sectional study. BMC Palliat Care. 2025;24(1):1–9. https://doi.org/10.1186/s12904-025-01584-3.
46. Daniels J, Glover ET, Kyei KA. The contribution of spirituality and religiousness to the quality of life of cancer patients treated with radiotherapy in Ghana: a cross-sectional study. ecancermedicalscience. 2025;19:1858. https://doi.org/10.3332/ecancer.2025.1858.
47. Akuoko CP, Armah E, Sarpong T, Quansah DY, Amankwaa I, Boateng D. Barriers to early presentation and diagnosis of breast cancer among African women living in sub-Saharan Africa. PLoS ONE. 2017;12(2):e0171024. https://doi.org/10.1371/journal.pone.0171024.
48. Magwesela FM, Kayange PA, Msemakweli DO, Madinda FG. Experiences of women with breast cancer in sub-Saharan Africa: A systematic review. East Cent Afr J Surg. 2023;28(3). https://doi.org/10.4314/ecajs.v28i3.1.
49. Maree JE, Wright SCD. Cervical cancer: does our message promote screening? A pilot study in a South African context. Eur J Oncol Nurs. 2011;15(2):118–23. https://doi.org/10.1016/j.ejon.2010.06.002.
50. Sakafu LL, Philipo GS, Malichewe CV, Fundikira LS, Lwakatare FA, Van Loon K, et al. Delayed diagnostic evaluation of symptomatic breast cancer in sub-Saharan Africa: A qualitative study of Tanzanian women. PLoS ONE. 2022;17(10):e0275639. https://doi.org/10.1371/journal.pone.0275639.

Publisher's Note