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Coping with breast cancer in Ghana: a qualitative study of women's lived experiences following breast cancer diagnosis

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Abstract

Objective Breast cancer remains a global concern as the most common diagnosed cancer and the leading cause of cancer death among women. In Sub-Saharan Africa, although breast cancer accounts for the highest burden of mortality in women, there is little documentation on the experience of living with breast cancer. This article explores the lived experiences of a group of Ghanaian women receiving breast cancer treatment at the Korle Bu Teaching Hospital and the National Radiotherapy, Oncology and Nuclear Medicine Center in Ghana.

Materials and methods The findings presented here, are drawn from a broader mixed methods study on breast cancer and fertility preservation that employed an explanatory sequential design. This article focuses on the qualitative phase of this work. A total of fifteen women were purposively sampled to take part in semi-structured interviews, following their participation in the quantitative phase of the study. The semi-structured interviews were audio-recorded, transcribed, and analysed using Braun and Clarkes analysis framework.

Results The diagnosis of breast cancer constituted a pivotal point in the lives of these women. This precipitated an acute focus on survival and triggered a cascade of initial psychological responses, including catastrophic thinking and an overwhelming preoccupation with mortality and worst-case scenarios, eliciting anxiety and sadness. The ramifications of cancer treatment further exacerbated the emotional and physical toll, manifesting in a myriad of challenges, including reproductive health concern, impaired daily functioning, diminished social, occupational, and educational performance. Despite this life-altering circumstance, some participants demonstrated adaptive coping as they navigated the recovery trajectory, utilizing coping strategies largely influenced by personal choice, religious faith, trusted social support networks, and medical expertise.

Conclusion The women's narratives highlight a journey of recovery characterized by initial grief reactions, acceptance, adaptation, and the hope of recovery. Religious beliefs and social connections played vital roles in the recovery process, underscoring the need to incorporate these into existing service delivery care models.

Impact statement By amplifying the voices and experiences of women living with breast cancer, we can culturally inform routine services and targeted strategies to enhance support, education, and resources for individuals and communities affected by breast cancer in Ghana.

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Introduction

Breast cancer is a critical public global health challenge, significantly impacting the health and overall well-being of many middle-aged women and contributing substantially to cancer-related mortality [1]. In the year 2022, 157 out of 185 countries recorded breast cancer as the most commonly diagnosed cancer among women [1]. In 2020, Ghana recorded 4645 new cases of breast cancer and 2233 fatalities [2]. In low- and middle-income countries (LMICs) such as Ghana, a convergence of compounding factors, including a lack of awareness, late presentation, inadequate access to quality healthcare and resources, cultural beliefs, and stigma, adversely affect health-seeking behaviour, adherence to treatment, and ultimately, survivorship [3–8].

Women diagnosed with breast cancer often face a range of physical, psychological, social role and occupational challenges. Significant physical complaints, psychological distress, tensed social relationships, functional impairment and a disruption to self-care activities (e.g. bathing, dressing, feeding), family and work roles are common experiences for some survivors [9–13]. Financially, breast cancer also imposes significant costs, including medical expenses and lost income [14–16], exacerbating existing inequalities in gaining access to care [17]. Given these multifaceted challenges, breast cancer is a tasking and difficult condition to cope with.

Lazarus and Folkman's Transactional Model of Stress and Coping sheds light on how women interpret, respond to and cope with a breast cancer diagnosis and treatment [18]. Upon receiving a breast cancer diagnosis, women appraise the significance and implications of their condition, including perceived threats to their health and well-being. In essence, they evaluate the perceived threat posed by breast cancer, often resulting in the experience of shock, anger, fear and despair. This is followed by a secondary appraisal, where women evaluate available coping resources and social support. Coping strategies may be emotion-focused (e.g. seeking social or spiritual support) or problem-focused (e.g. the adoption of healthy lifestyle choices and adherence to medical advice). The use of these strategies is dynamic and context specific, women continuously evaluate their condition and adjust their strategies in response to the illness's shifting physical, psychological and social demands [18].

Despite the high prevalence of breast cancer in Ghana, research on the experiences of women living with breast cancer in Ghana remains limited [4], creating a major knowledge gap. This study therefore sought to explore the lived experiences of breast cancer survivors, their perceived challenges and the coping strategies they employ.

Method and materials

Research design

The findings presented here are drawn from a broader explanatory sequential mixed-methods research design study on breast cancer and fertility preservation [19]. In this article, we focus on the qualitative phase of the study which was designed to explore in depth the lived experiences and coping strategies of women following a diagnosis of breast cancer.

Study setting and participants

Women were recruited from two health facilities in Ghana: the Breast Clinic of Korle Bu Teaching and the National Radiotherapy, Oncology & Nuclear Medicine Center. Women receiving treatment between November 2023 and January 2025 at were eligible to participate.

A total of 15 women were purposively sampled from a larger survey cohort based on their willingness to participate in a qualitative arm of the study.

Data collection

Data was collected using a semi-structured interview schedule guide, purposely developed and designed by the research team (see supplementary file 1). This guide was pretested with two women, revised and refined for final use. Details of this guide have previously been published [19]. All interviews were held in private secured rooms within each research sites to ensure adequate privacy and the participants' comfort, audio-taped with consent, and lasted between 45 and 90 min. Data collection ceased when data saturation was achieved, with no new themes emerging from the interviews.

Data analysis

The audio tapes were transcribed verbatim, and analysed using Braun and Clarkes analysis framework, with the support of NVIVO analysis software. An initial coding framework was developed based on the interview guide and research questions, followed by inductive coding to capture emergent themes from the data. To ensure rigor, two members of the research team with a background in qualitative research coded the transcripts independently, and subsequently the inter-coder reliability assessed. Discrepancies between the researchers were resolved through discussion and consensus. The resulting data is presented using themes and sub-themes, in a thematic table, supported with direct quotes from participants.

Ethical considerations

Ethical approval was obtained from the Institutional Review Board of the Korle Bu Teaching Hospital

Table 1 Participants' demographic characteristics

No.	Identity	Age	Year diagnosed	Occupation	Educational level	Children
1	Patient 1	Undisclosed	2016	Undisclosed	Tertiary	1
2	Patient 2	41	2022	Undisclosed	Undisclosed	Undisclosed
3	Patient 3	44	2023	Unemployed	JHS	3
4	Patient 4	42	2019	Businesswoman	JHS	Undisclosed
5	Patient 5	37	2020	Nurse	Tertiary	3
6	Patient 6	44	2021	Businesswoman	JHS	4
7	Patient 7	44	2022	Policewoman	Tertiary	Undisclosed
8	Patient 8	48	2017	Businesswoman	JHS	2
9	Patient 9	46	2021	Unemployed	JHS	4
10	Patient 10	43	2023	Entrepreneur	SHS	Undisclosed
11	Patient 11	44	2022	Caterer	JHS	Undisclosed
12	Patient 12	39	2018	Unemployed	No education	None
13	Patient 13	49	2021	Administrator	Tertiary	None
14	Patient 14	49	2021	Unemployed	SHS	1
15	Patient 15	32	2022	Trader	JHS	2

SHS Senior High School, *JHS* Junior High School

Table 2 Summary of thematic analysis

No	THEME	SUBTHEMES
1	Initial reactions to diagnosis	Catastrophic thinking Preoccupation with sadness and anxiety
2	Emerging challenges and disabilities	Reduced capacity to work and function Reproductive health concerns
3	Building resilience	Living and coping Healthy adaptation

(KBTH-IRB/00039/2023). Prior to their involvement in the study, all participants provided informed consent, and appropriate measures were put in place to uphold privacy and anonymity.

Results

Participant characteristics

The study results show a profile of women aged between 32 and 49 years who had been diagnosed with cancer between 2016 and 2023. Most (7) of them had a basic level of education and occupations included businesswomen, nurses, policewomen, caterers, administrators, and traders, among others. Some participants had no children, while others had up to four children (See Table 1 for more details).

Three major themes emerged from the qualitative data: (1) Initial reactions to diagnosis; (2) Emerging challenges and disabilities; and Building resilience (See Table 2 for details).

Theme 1: initial reactions to diagnosis (primary appraisal)

Upon receiving a breast cancer diagnosis, participants commonly appraised the illness as a profound and immediate threat to survival, bodily integrity, fertility, and family responsibilities. This primary appraisal was marked by catastrophic thinking and intense emotional reactions.

Subtheme 1: catastrophic thinking

Many women described imagining worst-case scenarios immediately following diagnosis, particularly the possibility of death. Worrying and intrusive thoughts were prominent features of this early appraisal phase. One participant explained:

> *"I was most worried in the beginning because I didn't think it would happen to me" (Patient-11, 44 years, 2022).*

Another recalled persistent rumination:

> *"Hmm at the time, … I used to think about it a lot" (Patient-4, 42 years, 2019).*

Catastrophic interpretations were often reinforced by societal narratives and myths surrounding breast cancer and its treatment. One woman noted:

> *"People say that treatment can either kill you or spoil your chances of ever having children. So as soon as someone is diagnosed, their mind is immediately filled with several thoughts" (Patient-9, 46years, 2021).*

Participants described intrusive thoughts about mortality, bodily disfigurement, and recurrence during this early period:

> *"I used to think that I will not stay long in this world, … that I would die early since I have cancer, those were the particular thoughts on my mind" (Patient-8, 48years, 2017).*

My breast, that's what I think about often because I don't want them to cut it (Patient-15, 32years, 2022).

Even when fear of death was less pronounced, concerns about bodily loss and recurrence persisted:

"Even though I knew how it can affect others, I wasn't really scared aside from losing one breast" (Patient-11, 44years, 2022).
"Psychologically too, it's been stressful. Like, you are always thinking of it that it might even recur" (Patient13, 49 years, 2021).

Women also appraised the diagnosis in relation to future roles and responsibilities, particularly motherhood. One participant stated:

"I think of the fact that I may not be able to take care of my children further in their lives; that thought comes to mind a lot" (Patient-3, 44 years, 2023).

Another, who was pregnant at the time of diagnosis, recounted cognitive overload and fear for her unborn child:

"In the beginning phase my mind was just floating... I was pregnant during diagnosis, and I was more concerned if the pregnancy would still hold" (Patient-1, 2016).

These accounts illustrate primary appraisal of breast cancer as an overwhelming threat shaped early emotional responses.

Subtheme 2: preoccupation with sadness and anxiety

Following catastrophic appraisal, participants described sustained emotional distress characterised by sadness, anxiety, and feelings of abandonment. These emotional responses reflected the perceived severity of the diagnosis and uncertainty about the future.

"Oh, it wasn't easy. I cried that day, I really cried. I was greatly sad in this world I came to" (Patient 2, 41years, 2022).
"I was anxious, I was afraid...I thought was just going to die" (Patient-5, 37years, 2020).

Some women also described relational distress, as anticipated or experienced withdrawal of support and how it intensified emotional suffering:

"When you are told you have cancer, not all people will sympathize with you .... the people you think will be there for you might not be there" (Patient-13, 49years, 2021).

Together, these accounts highlight how early emotional responses were closely tied to women's appraisal of breast cancer as a life-threatening and socially disruptive illness.

Theme 2: emerging challenges and disabilities: (ongoing appraisal and stressors)

As treatment commenced, participants described ongoing stressors that reinforced distress and required continued appraisal. Breast cancer and its treatment resulted in significant functional impairments affecting work, education, family life, and reproductive health.

Subtheme 1: reduced capacity to work and function

Fatigue, pain, and emotional stress were commonly cited as factors limiting a women's ability to work and perform daily activities. One participant stated:

"I'm not strong like I used to be" (Patient 13, 49years, 2021).

Another explained:

"Before I went through chemo, I was strong but now I get tired when I walk for a bit" (Patient 15, 32years, 2022).

Participants described how pain and exhaustion undermined work capacity:

"It's the pain that has affected me the most. I'm in so much pain that I can't even work again (Patient 9, 46 years, 2021).
"How I could work previously, I can't work like that now, the strength I have now is not like before" (Patient 14, 49 years, 2021).

For some women, prolonged treatment resulted in job loss or business closure:

"It's a long process of treatment .... I'm not working again because of the process" (Patient 13, 49 years, 2021).
"I used to have a provisions shop ...when I was sick, I couldn't do anything to help myself, so I even sold it. It brought me a lot of issues that pushed me back (Patient-8, 48 years, 2017).

Others described disrupted educational and career aspirations:

"It has changed my life drastically.... in a lot of ways ... I mean, you have a plan, and then later you realize you have cancer, everything has come to a standstill ...you have to go through treatments, and it takes a while (Patient10, 43 years, 2023).
"I was planning to go back to school. I was planning to get a job ... all of these things had to change it has affected my future. (Patient 13, 49 years, 2021).

Treatment-related disability also affected family dynamics, requiring adjustments by relatives:

My firstborn was supposed to be in the boarding house in 2017, but because of my illness, he went to day school so that he could take care of me. (Patient 8, 48years, 2017)

Subtheme 2: reproductive health concerns

Reproductive health emerged as a major stressor. Participants described confusion, fear, and inadequate preparation for fertility-related consequences of treatment.

"What I don't understand is, how can the eggs be stored if the womb and ovaries are to be removed?" (Patient 9, 46 years, 2021).
"They couldn't give me protection for the womb .... they said that I will have to become menopausal ... I agreed to go menopausal for the treatment to happen" (Patient 2, 41 years, 2022).
"It was after the chemo that I told the doctor that my menses was not coming and he said that it would not come" (Patient 6, 44 years, 2021).

These accounts suggest gaps in anticipatory guidance and contributed to distress during treatment, even for women who already have children of their own.

Theme 3: building resilience (secondary appraisal and coping)

Despite substantial challenges, participants demonstrated secondary appraisal processes through which they assessed available resources and gradually adopted coping strategies.

Subtheme 1: living and coping

Women described mobilising coping resources, including religious faith, selective disclosure, social support, and trust in medical advice. Faith played a central role in reframing the illness:

"Because of my standing in Christ, I began to worry and fear less. (Patient 11, 44years, 2022)
"God is the healer and so he is the one I am looking up to" (Patient-3, 44years, 2023).

Selective disclosure also emerged as a deliberate coping strategy. Women evaluated the risks of stigma and unsolicited advice and chose to limit disclosure:

I didn't really tell that many people. It was private for me. (Patient 11, 44 years, 2022)
I didn't tell many people; just my family and siblings. Even where I work, all they know is that my breast hurt. They don't know what became of that or what I was diagnosed with. (Patient-12, 39 years, 2018)
"I also didn't tell others, you see when you tell people around what it is, someone may tell you to do medication, go to herbal medications and others and so I didn't want anyone to give me such ideas. What I knew to do was to go to the hospital ... It was just my sister, mother and sister who knew I had such a problem. (Patient-2, 41years, 2022)

Selective disclosure seemed to allow the participant to maintain control over their health status, while allowing them privacy and autonomy over their recovery process. Having control over who was involved in care seemed empowering. Focusing on close allies, family, and healthcare professionals, participants noted the benefits of social support and medical reassurance in buffering emotional distress:

Close family members and friends supported me physically and spiritually, so it didn't have that much of an effect on me. (Patient 11, 44years, 2022).
My family was a great support. My mother, my siblings, my external relations, they all supported me throughout the process of the treatment (Patient 13, 49 years, 2021).

Similarly, medical reassurance also facilitated coping:

"What I could do was to follow the recommendations of the doctor" (Patient-2, 41 years, 2022).
The doctor reassured me that the surgery was safe and I would come out alive to take care of my family. So, I thanked him for reassuring me. What he told me really made me happy, and made me so calm. (Patient 9, 46years, 2021)

Subtheme 2: healthy adaptation

Some women described regaining physical strength and emotional stability over time, with others reporting minimal disruption to daily life:

"There was some weakness when I first started chemo ...you get tired after ... but God being so good, after my first rounds of chemo, I saw that I had recovered.

Table 3 Mapping study themes to Lazarus and Folkman's transactional model of stress and coping

Transactional Model Component	Analytic Category	Study Theme / Subtheme	How Women Utilised This in Their Own Situation	Illustrative Participant Quotes
Primary Appraisal	Perceived threat and meaning of diagnosis	Theme 1: Initial Reaction	Women interpreted breast cancer as an immediate threat to survival, fertility, bodily integrity, and family roles, triggering intense emotional responses.	"I used to think that I will not stay long in this world… that I would die early since I have cancer." (Patient-8, 48 yrs, 2017)
Primary Appraisal	Catastrophic interpretation	Subtheme: Catastrophic thinking	Participants imagined worst-case outcomes (death, recurrence, mastectomy, infertility), often influenced by societal myths about cancer.	"People say that treatment can either kill you or spoil your chances of ever having children." (Patient-9, 46 yrs, 2021)
Primary Appraisal	Emotional response to perceived threat	Subtheme: Preoccupation with sadness and anxiety	Women experienced fear, sadness, anxiety, and emotional overwhelm as a direct response to how threatening they perceived the diagnosis to be.	"I cried that day, I really cried… I was greatly sad." (Patient-2, 41 yrs, 2022)
Ongoing Appraisal	Evaluation of illness-related stressors	Theme 2: Emerging Challenges and Disabilities	As treatment progressed, women reassessed stressors such as fatigue, pain, loss of income, educational disruption, and fertility concerns.	"How I could work previously, I can't work like that now." (Patient-14, 49 yrs, 2021)
Secondary Appraisal	Assessment of available resources	Theme 3: Building Resilience	Women evaluated internal (faith, acceptance, hope) and external (family, doctors) resources to manage the illness and its consequences.	"Because of my standing in Christ, I began to worry and fear less." (Patient-11, 44 yrs, 2022)
Emotion-Focused Coping	Meaning-making and emotional regulation	Subtheme: Living and coping (religion)	Religious faith was used to reframe the diagnosis, reduce fear, and cultivate hope and endurance.	"God is the healer and so He is the one I am looking up to." (Patient-3, 44 yrs, 2023)
Emotion-Focused Coping	Social buffering	Subtheme: Living and coping (social support)	Emotional and practical support from family and friends helped women manage distress and maintain psychological stability.	"My family was a great support… they all supported me." (Patient-13, 49 yrs, 2021)
Problem-Focused Coping	Active engagement with treatment	Subtheme: Living and coping (medical advice)	Women relied on medical information and professional reassurance to reduce uncertainty and regain a sense of control.	"What I could do was to follow the recommendations of the doctor." (Patient-2, 41 yrs, 2022)
Secondary Appraisal	Evaluation of social risks and benefits	Subtheme: Selective disclosure	Participants assessed potential stigma and unsolicited advice, choosing selective disclosure to protect emotional wellbeing and autonomy.	"I didn't want anyone to give me such ideas… I knew what to do was to go to the hospital." (Patient-2, 41 yrs, 2022)
Adaptive Outcome	Psychological adjustment and resilience	Overall coping trajectory	Over time, women demonstrated resilience, improved emotional regulation, and functional recovery despite ongoing challenges.	"The trauma wasn't okay but now it's okay." (Patient-7, 44 yrs, 2022)

It hasn't really affected my day-to-day dealings. It didn't really weaken me or change a lot of things in my life" (Patient 11, 44 years, 2022).
"With me, nothing has changed. I've been doing the same things I was doing before my diagnosis, like working in the house." (Patient-12, 39 years, 2018).

Others reflected gradual emotional and physical recovery:

"The trauma I went through it wasn't okay but now it's okay. (Patient-7, 44years, 2022).
I am okay. I am strong. I am fit. My life is fine. There is nothing wrong going on. You see at first when I did the surgery …I couldn't lift things but now I can do so (Patient-6, 44years, 2021).
I had to stop work for some time just to take treatment and all of that, and I then I resumed. So, in the beginning, it was a little rough but then, we've come so far. (Patient-1, 2016)

With time, as illustrated above, participants seemed to show healthy adaptation, signs of resilience and positive growth. In the quote below, Patient 10, demonstrates how the experience of living with breast cancer had fostered growth and strengthened relationships.

"It has strengthened the relationships I have with friends, relationship with family. I had a lot, a lot of support, massive love. So, if anything, it has strengthened the relationship." (Patient-10, 43 years, 2023).

As outlined in this section, women's experiences of breast cancer involved a dynamic process of stress appraisal and coping, with initial catastrophic interpretations giving way to mobilization of coping resources (religious faith, social support, trust in medical guidance), gradual adjustment and a sense of resilience (See Table 3 for further details).

Discussion

This study examined the lived experiences of women undergoing breast cancer treatment in Ghana. Participants' accounts revealed a dynamic process of stress appraisal and coping following a breast cancer diagnosis. While initial interpretations were largely catastrophic, over time, patients gradually showed signs of adjustment and resilience as they reassessed available resources and mobilised coping strategies.

From a theoretical perspective, the findings from this current study align strongly with Lazarus and Folkman's Transactional Model of Stress and Coping [18, 20]. Primarily, women interpreted the diagnosis as catastrophic - an immediate existential threat - and responded by ruminating and imagining the worst possible outcomes. Similar catastrophic thinking has been widely documented about survivors of breast cancer and is associated with symptoms of anxiety, depression and heighten stress [21–23]. In this current study, overthinking and worrying over potential consequences – mortality, social stigma, bodily changes, work disruption, fertility and child welfare concerns - evoked a range of intense negative emotions including sadness, anxiety and feelings of abandonment. The perceived severity of disease and the survivor's interpretation of the diagnosis strongly shaped subsequent emotional responses.

As treatment progressed, participants experienced reoccurring stressors such as fatigue, pain and financial strain that required ongoing appraisal. These challenges often resulted in a reduced work capacity and disrupted life plans, findings that mirror existing literature on the disabling effects of cancer treatment on occupational functioning and the quality of life [24–26]. Similar setbacks were reported about educational pursuits, some women in this study noted disruptions that derailed educational aspirations, goals and plans at critical points in their life. Similar research work highlights the difficulties survivors have preserving their careers, balancing work and personal obligations, and encountering unsupportive managers and colleagues [27–32].

Reproductive health concerns emerged as a particularly salient concern, even for participants that already had children. Participants' narratives revealed confusion and inadequate preparation for treatment-related fertility loss, echoing broader evidence that breast cancer treatments pose significant risks to fertility and reproductive autonomy [33, 34]. As reported in previous Ghanaian studies, the threat of infertility carried deep psychosocial meaning, often linked to disrupted expectations of social identity, particularly in relation to marriage and motherhood [35, 36]. The lack of clear, anticipatory communication around fertility preservation highlights an important gap in survivorship care and underscores the need for integrated fertility counselling as part of routine oncology services.

Despite identified challenges, the women in this study showed evidence of gradually adjusting to their health situation as they received treatment and appraised their situations, actively assessing available resources and support to help manage their condition. Religious support, selective disclosure, social support and relying on medical advice were deliberate strategies used by these women to navigate their journey of recovery. Religious faith and practices functioned as a central emotion focused coping mechanism, allowing survivors to reframe their diagnosis, reduce fear, and cultivate hope and endurance. This finding aligns with related studies from Ghana and similar contexts that highlight religious practices as a key source of comfort and strength when making meaning of difficult life circumstances [37], such as a diagnosis of breast cancer.

Consistent with prior qualitative studies in Ghana [36, 38], participants described selective disclosure of their diagnosis as a deliberate coping strategy. Rather than reflecting avoidance or withdrawal, selective disclosure functioned as an adaptive response aimed at preserving privacy, avoiding unsolicited advice—particularly regarding alternative therapies—and maintaining psychological control. This strategy allowed women to maintain a sense of control over their illness experience, reinforcing autonomy and psychological safety [39].

Social support from family and trusted relationships further buffered emotional distress, reinforcing evidence that supportive networks play a critical role in psychological adjustment among women with breast cancer [40, 41]. Women who felt supported by their loved ones reported feeling better able to maintain a positive outlook on their recovery. Problem-focused coping strategies were also evident, particularly through reliance on medical advice and adherence to treatment recommendations. Trust in healthcare professionals provided reassurance, reduced uncertainty, and fostered a sense of control, consistent with transactional stress theory and prior empirical findings. Together, these coping strategies facilitated gradual emotional stabilization, functional recovery, and, for some women, post-diagnosis growth.

Conclusions

A breast cancer diagnosis triggered a cascade of psychological and functional challenges for women in this study, beginning with catastrophic primary appraisal and evolving through sustained stressors related to treatment, work, education, and fertility. Over time, women actively mobilised culturally grounded coping resources—particularly faith, selective disclosure, social support, and medical reassurance—to adapt and regain a sense of control. These findings underscore the importance of embedding

psychosocial, fertility-related, and culturally responsive support within routine breast cancer care in Ghana.

Implications for healthcare practices and support services

The findings highlight an urgent need for integrated psychosocial care within Ghana's oncology services. Healthcare professionals should pay attention to women's early catastrophic appraisals and emotional distress and provide timely psychological support, clear communication, and anticipatory guidance—particularly around fertility preservation, even if they have children. Respecting patient autonomy, privacy, and cultural beliefs while strengthening supportive care pathways may enhance adjustment, treatment adherence, and overall quality of life.

Limitations and future research directions

This qualitative study provides in-depth insight into women's lived experiences of breast cancer in Ghana but is limited by a small sample size and recruitment from urban tertiary facilities. Although thematic saturation was achieved, future studies should include larger and more diverse samples, including rural populations. Further research is needed to examine healthcare-seeking behaviours and to evaluate interventions that address psychosocial distress, fertility concerns, and culturally grounded coping processes among women with breast cancer in Ghana.

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12885-026-15857-y.

Supplementary Material 1.

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Authors' contributions

Conceptualization: PES and DAA. Methodology: PES, DAA, and JN. Investigation: PES, JN, and DAA. Data curation and analysis: DAA. Data validation: PES, JN. Drafting of manuscript: DAA and PES. Editing of manuscript: JN, PES, and DAA. Final revision and approval of manuscript: All authors have read and approved the manuscript for submission. Correspondence Author: PES.

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Data availability

The detailed data supporting the findings presented here are available upon reasonable request from the corresponding author.

Declarations

Ethics approval and consent to participate

Ethical approval was obtained from the Institutional Review Board of the Korle Bu Teaching Hospital (KBTH-IRB/00039/2023). Prior to their involvement in the study, all participants gave informed consent, and appropriate measures were taken to uphold their privacy and anonymity. All participants provided informed consent prior to being enrolled in the study. The study was implemented in compliance with the ethical principles outlined in the Declaration of Helsinki, and the ethical guidelines and applicable laws and regulations in Ghana.

Consent for publication

All participants provided informed consent prior to being enrolled in the study, as well as consent for publication of the study findings without any identifiers or personal information.

Competing interests

The authors declare no competing interests.

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References

1. World Health Organisation. Breast cancer. 2024. Available from: https://www.who.int/news-room/fact-sheets/detail/breast-cancer.
2. Anaba EA, Alor SK, Badzi CD, Mbuwir CB, Muki B, Afaya A. (2024) Drivers of breast cancer and cervical cancer screening among women of reproductive age: insights from the Ghana Demographic and Health Survey. BMC Cancer 24, 920 (2024). https://doi.org/10.1186/s12885-024-12697-6.
3. Biritwum RB, Mensah G, Yawson AE, Minicuci N. Study on Global Ageing and Adult Health (SAGE) Wave 1: The Ghana National Report. Geneva: World Health Organization; 2013.
4. Donkor A, Lathlean J, Wiafe S, Vanderpuye V, Fenlon D, Yarney J, et al. Factors contributing to late presentation of breast cancer in Africa: a systematic literature review. Archives Med. 2015;8(22):1–10.
5. Galukande M, Wabinga H, Mirembe F. Breast Cancer Survival Experiences at a Tertiary Hospital in Sub-Saharan Africa: A Cohort Study. World J Surg Oncol. 2015;13:1–8. https://doi.org/10.1186/s12957-015-0632-4.
6. Kugbey N, Meyer-Weitz A, Oppong Asante K, Yarney J, Vanderpuye V. Lived experiences of women receiving medical treatments for breast cancer in Ghana: a qualitative study. Sage Open. 2021;11(3):21582440211045077. https://doi.org/10.1177/215824402110450.
7. Jedy-Agba E, McCormack V, Adebamowo C, Dos-Santos-Silva I. Stage at diagnosis of breast cancer in sub-Saharan Africa: a systematic review and meta-analysis. Lancet Global health. 2016;4(12):e923–35. https://doi.org/10.1016/S2214-109X(16)30259-5.
8. Marlow LA, Waller J, Wardle J. Barriers to Cervical Cancer Screening among Ethnic Minority Women: A Qualitative Study. J Family Plann Reproductive Health Care. 2015;41(4):248–54.
9. Ax AK, Johansson B, Carlsson M, Nordin K, Börjeson S. Exercise: A positive feature on functioning in daily life during cancer treatment–Experiences from the Phys-Can Study. Eur J Oncol Nurs. 2020;44:101713. https://doi.org/10.1016/j.ejon.2019.101713.
10. Iddrisu M, Aziato L, Dedey F. Psychological and physical effects of breast cancer diagnosis and treatment on young Ghanaian women: a qualitative study. BMC Psychiatry. 2020;20(1):353. https://doi.org/10.1186/s12888-020-02760-4.
11. Mehra S, Kumar P, Soni A. Physical Functional Impairment in Breast Cancer Patients: A Cross-Sectional Expert Survey. Cureus. 2024;16(3):e57364. https://doi.org/10.7759/cureus.57364.
12. van Leeuwen M, Husson O, Alberti P, Arraras JI, Chinot OL, Costantini A, et al. Understanding the quality of life (QOL) issues in survivors of cancer: towards the development of an EORTC QOL cancer survivorship questionnaire. Health

Qual Life Outcomes. 2018;16(1):114. https://doi.org/10.1186/s12955-018-0920-0.
13. Yang Y, Hendrix CC. Cancer-related cognitive impairment in breast cancer patients: influences of psychological variables. Asia-Pacific J Oncol Nurs. 2018;5(3):296–306. https://doi.org/10.4103/apjon.apjon_16_18.
14. Donkor A, Atuwo-Ampoh VD, Yakanu F, Torgbenu E, Ameyaw EK, Kitson-Mills D, et al. Financial toxicity of cancer care in low- and middle-income countries: a systematic review and meta-analysis. Supportive care cancer: official J Multinational Association Supportive Care Cancer. 2022;30(9):7159–90. https://doi.org/10.1007/s00520-022-07044-z.
15. Kedida BD, Mukacho MM, Alemayehu M, Samuiel S, Kussa S, Sisay Y, et al. Women's experiences with breast cancer during diagnosis and therapy, Wolaita, Ethiopia: a qualitative study. BMC Womens Health. 2024;24(1):176. https://doi.org/10.1186/s12905-024-03016-z.
16. Richter-Ehrenstein C, Martinez-Pader J. Impact of breast cancer diagnosis and treatment on work-related life and financial factors. Breast Care. 2021;16(1):72–6. https://doi.org/10.1159/000507313.
17. Wheeler SB, Spencer JC, Pinheiro LC, Murphy CC, Earp JA. Financial impact of breast cancer in Black versus White women. J Clin Oncol. 2018;36(17):1695–701. https://doi.org/10.1200/JCO.2017.77.6310.
18. Lazarus RS, Folkman S. Stress, appraisal, and coping. Springer Publishing Company; 1984.
19. Sefogah PE, Attah DA, Swarray-Deen A, Nsaful J, Oppong SA, Moyer CA. Perspectives on fertility preservation among women living with breast cancer in Ghana. BMC Womens Health. 2025;25:409. https://doi.org/10.1186/s12905-025-03963-1.
20. Bray F, Ferlay J, Soerjomataram I, Siegel RL, Torre LA, Jemal A. Global Cancer Statistics 2018: GLOBOCAN Estimates of Incidence and Mortality Worldwide for 36 Cancers in 185 Countries. CA: A Cancer Journal for Clinicians, 2018; 68(6): 394–424.
21. Mitchell AJ, Ferguson DW, Gill J, Paul J, Symonds P. Depression and anxiety in long-term cancer survivors compared with spouses and healthy controls: A systematic review and meta-analysis. Lancet Oncol. 2013;14(8):721–32. https://doi.org/10.1016/S1470-2045(13)70244-4.
22. Bigatti SM, Steiner JL, Miller KD. Cognitive appraisals, coping and depressive symptoms in breast cancer patients. Stress Health. 2012;28(5):355–61. https://doi.org/10.1002/smi.2444.
23. Budisavljevic A, Dedic Plavetic N, Klaric K, Kelemenic-Drazin R, Letica-Crepulja M. The Impact of Newly Diagnosed Early Breast Cancer on Psychological Resilience, Distress Levels, and the Perception of Health. Int J Environ Res Public Health. 2024;21(6):677. https://doi.org/10.3390/ijerph21060677.
24. Kasgri KA, Abazari M, Badeleh SM, Badeleh KM, Peyman N. Comprehensive Review of Breast Cancer Consequences for the Patients and Their Coping Strategies: A Systematic Review. Cancer Control. 2024;31. https://doi.org/10.1177/10732748241249355.
25. 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.
26. Lovelace DL, McDaniel LR, Golden D. Long-term effects of breast cancer surgery, treatment, and survivor care. J Midwifery Women's Health. 2019;64(6):713–24. https://doi.org/10.1111/jmwh.13012.
27. National Cancer Institute. Breast cancer treatment (PDQ®)–Patient version. 2022. Retrieved from https://www.cancer.gov/types/breast/patient/breast-treatment-pdq.
28. Lyons KD, Newman RM, Sullivan M, Pergolotti M, Braveman B, Cheville AL. Employment concerns and associated impairments of women living with advanced breast cancer. Archives Rehabilitation Res Clin Translation. 2019;1(1–2):100004. https://doi.org/10.1016/j.arrct.2019.100004.
29. Silvaggi F, Mariniello A, Leonardi M, Silvani A, Lamperti E, Di Cosimo S, et al. Psychosocial factors associated with workability after surgery in cancer survivors: An explorative study. J Health Psychol. 2023;28(11):999–1010. https://doi.org/10.1177/13591053231151286.
30. Sun W, Chen K, Terhaar A, Wiegmann DA, Heidrich SM, Tevaarwerk AJ, et al. Work-related barriers, facilitators, and strategies of breast cancer survivors working during curative treatment. Work. 2016;55(4):783–95. https://doi.org/10.3233/WOR-162449.
31. Maggio A, Guerrieri-Gonzaga A, Gulisano M, Magni P, Mano MP, Sporchia A. Unmet needs of breast cancer survivors: The importance of quality attention devoted to the young. Breast. 2020;49:175–82.
32. Mahlaq S, Lahlou L, Rammouz I, Abouqal R, Belayachi J. Factors associated with psychological burden of breast cancer in women in Morocco: cross-sectional study. BMC Womens Health. 2023;23(1):590. https://doi.org/10.1186/s12905-023-02769-3.
33. Sisk BA, Fasciano K, Block SD, Mack JW. Impact of cancer on school, work, and financial independence among adolescents and young adults. Cancer. 2020;126(19):4400–6. https://doi.org/10.1002/cncr.33081.
34. Lambertini M, Peccatori FA, Demeestere I, Amant F, Wyns C, Stukenborg JB, et al. Fertility preservation and post-treatment pregnancies in post-pubertal cancer patients: ESMO Clinical Practice Guidelines. Ann Oncol. 2020;31(12):1664–78. https://doi.org/10.1016/j.annonc.2020.09.006.
35. Rodriguez-Wallberg KA, Eloranta S, Krawiec K, Lissmats A, Bergh J, Liljegren A. Safety of fertility preservation in breast cancer patients in a register-based matched cohort study. Breast Cancer Res Treat. 2018;167(3):761–9. https://doi.org/10.1007/s10549-017-4555-3.
36. Bonsu AB, Aziato L, Clegg-Lamptey JNA. Living with advanced breast cancer among Ghanaian women: emotional and psychosocial experiences. Int J Palliat Care. 2014;2014:1–9. https://doi.org/10.1155/2014/403473.
37. Alfano CM, Leach CR, Smith TG, Miller KD, Alcaraz KI, Cannady RS, et al. Equitably improving outcomes for cancer survivors and supporting caregivers: A blueprint for care delivery, research, education, and policy. Cancer J Clin. 2019;69(1):35–49. https://doi.org/10.3322/caac.21548.
38. Teye-Kwadjo E, Goka AS, Ussher YAA. Unpacking the psychological and physical well-being of Ghanaian patients with breast cancer. Dialogues Health. 2022;1:100060. https://doi.org/10.1016/j.dialog.2022.100060.
39. Agyemang LS, Wagland R, Foster C, McLean C, Fenlon D. To disclose or not to disclose: an ethnographic exploration of factors contributing to the (non) disclosure of Ghanaian women's breast cancer diagnosis to social networks. BMC Womens Health. 2023;23(1):366. https://doi.org/10.1186/s12905-023-02508-8. Published 2023 Jul 10.
40. Benson R, Cobbold B, Opoku Boamah B, Akuoko E, C. P., Boateng D. Challenges, coping strategies, and social support among breast cancer patients in Ghana. Advances in Public Health, 2020; 1–11. https://doi.org/10.1155/2020/4817932.
41. Tan Y, Qin M, Liao B, Wang L, Chang G, Wei F, et al. Effectiveness of peer support on quality of life and anxiety in breast cancer patients: a systematic review and meta-analysis. Breast Care. 2023;18(1):49–59.

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