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St. Paul's Hospital Millennium Medical College

School of Public Health

Graduate Study Program

**Lived Experience of Breast Cancer Patients Undergoing Treatment
at Tikur Anbesa Specialize Hospital In 2025**

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Contents

Acknowledgements	iii
List of Tables	vi
Abbreviations	vii
Abstract	1
Chapter One	3
Introduction	3
1.1. Background of the study	3
1.2. Statement of the problem	4
1.3. Significant of the study	5
Chapter two	7
2. Literature Review	7
2.2. Treatment-Related Challenges	7
2.3. Stigma.....	8
2.4. Coping mechanisms.....	8
2.4. Methodological approaches in phenomenological research theme	9
2.5. Identified research gaps and justification	9
Chapter three	10
3. Objectives of the study.....	10
3.1. General Objective.....	10
3.2. Specific Objectives:.....	10
Chapter Four	11
4. Methods and materials	11
4.1. Study setting/area and period	11
4.2. Study Design	11
4.3. Population.....	12
4.3.1. Source Population.....	12
4.3.2. Study Population.....	12
4.3.3. Study Unit	12
4.3.4. Sampling Unit.....	12
4.4. Eligibility criteria	13
4.5. Sample size determination and sampling technique	13

4.5.1. Sample size determination.....	13
4.5.2. Sampling technique and procedures	13
4.6. Data collection tool, methods and procedures	14
4.7. Trustworthiness and Rigor	15
4.8. Data Management and analysis.....	16
4.9. Ethical considerations	17
4.10. Plan for dissemination of results	17
Chapter five.....	18
5. Results	18
5.1. Characteristics of the participants.....	18
5.2. Thematic Analysis	19
Chapter six	32
6.1. Discussion	32
Chapter seven.....	35
7.1. Limitation of the study	35
7.2. Strength of the study	35
7.3. Conclusion.....	35
7.4. Recommendation.....	36
8. References	37
Annex 1	40
Informed Consent Form and Information sheet	40
Annex 2	44
Questionnaires	44

List of Tables

Table 1: Eligibility Criteria.....	133
Table 2: demographic data.....	188
Table 3: list of themes and subthemes	209

Abbreviations

AAU: Addis Ababa University

BC: Breast Cancer

BRCA1: Breast Cancer Gene 1

BRCA2: Breast Cancer Gene 2

HDI: Human Development Index

IDI: In Depth Interview

IHRERC: Institutional Health Research Ethics Review Committee

IRB: Institutional Review Board

MPH: Master of Public Health

QoL: Quality of Life

SPH: School of Public Health

SPHMMC: St. Paul's Hospital Millennium Medical College

TASH: Tikur Anbessa Specialized Hospital

WHO: World Health Organization

Abstract

Background: Breast cancer is one of the most common cancer in the world, especially in females. Even though, prevention methods and treatment options are able to greatly lower mortality the effect of diagnosis and treatments continuous to impact many aspects of patient's lives including physical, emotional, social and spiritual aspects. Even though there are a lot of studies on the clinical aspects of the disease, there still is limited understanding of how women experience the path of therapy.

Objectives: The objective of this study is to explore the lived experience of breast cancer patients undergoing treatment at Tikur Anbesa Specialized Hospital (TASH), Addis Abeba, Ethiopia, 2025

Methods: This study used a qualitative phenomenological research design to explore the experience of patients diagnosed with breast cancer and undergoing treatment. The study was done in Tikur Anbesa Specialized Hospital from September to December 2025. 12 patients who are diagnosed with breast cancer and are receiving treatment were recruited by using maximum variation purposive sampling method. In depth interviews were used as the data collection method and the interview used Semi structured interview guide to collect data on the patients lived experience. The interviews were transcribed verbatim, translated, coded inductively and then concurrently analyzed by utilizing Atlas ti-8 by using thematic analysis.

Results: The thematic analysis of the data revealed five prominent themes: Navigating Diagnosis and Disclosure which captures the tumultuous journey from receiving the life-altering news to the strategic and emotional complexities of sharing it with others. Second: Committing to a Treatment Path which entails the resolute, proactive shift from shock to action, as patients embrace biomedical regimens while often seeking hope in complementary therapies. Third: Enduring the Multidimensional Toll of Treatment which encompasses the integrated physical suffering, psychological distress, and social strain inflicted by the therapy process. Fourth: Facing Systemic and Financial Barriers which highlights the exhausting external battle against institutional hurdles and the crushing economic burden of care. Finally, Sustained by Networks of Care and Support illustrates how patients are upheld through the practical and emotional sustenance drawn from family, healthcare providers, and spiritual faith.

Conclusion: The study findings highlights the complex and multidimensional experience of women with breast cancer, which mainly are emotional straggles felt due to the unexpected nature of the diagnosis and challenges face due to accessing treatment and also the bodily and psychological burden of the treatment itself. The results show the need for holistic, patient centered care for women with breast cancer. To improve their treatment experience it is essential to create a more supportive hospital setting, ensure the consistent availability of resources and actively prioritize patients' overall wellbeing.

Key Words: breast cancer, lived experience, qualitative study, Addis Abeba, Ethiopia

Chapter One

Introduction

1.1. Background of the study

Breast cancer is a disease in which certain cells in the breast become abnormal proliferating uncontrollably resulting in tumors(1). These cells can spread by breaking free from the primary tumor and entering blood or lymph arteries, which then move into tissues across the body, resulting in metastasis(2). Breast cancer is frequently caused by adenocarcinoma, a kind of carcinoma that begins in glandular tissue cells that produce milk(3). Breast cancer in its early stages is normally painless and has no obvious symptoms(4). As the cancer progresses, signs and symptoms can include a lump or thickening in or near the breast, a change in the size or shape of the breast, nipple discharge, tenderness, or retraction (turning inward),and skin irritation, dimpling, redness, or scaliness which may need professional screening like a mammogram or ultrasound to identify (5).

Breast cancer risk is impacted by both non-modifiable and modifiable variables. Female sex, increasing age, genetic mutations (BRCA1/BRCA2), a family history, past chest radiation, and specific reproductive variables (early menarche, late menopause, null parity, or late first pregnancy) are all non-modifiable risks. While Modifiable factors include obesity, alcohol use, physical inactivity, hormone medication, and oral contraceptive usage(6).Treatment depends on tumor characteristics and patient preference with options of surgery, radiation, chemotherapy, hormone and targeted treatments based on cancer stage and subtype(7).

Globally patients pass through different emotional, physical and social difficulties including feeling of loss, uncertainty, loss of confidence, fear, loss of sense of person, fatigue, nausea and inability to care for family through their treatment journey(8–10). In Africa including Ethiopia patients also go through physical side effects of treatments ,emotional distress including fear of reoccurrence, stigma and judgment, financial strains and heightened spirituality as a coping mechanism in their diagnosis and treatment journey(11). Studies also show the lack of wide and comprehensive physiological support patients get, a mixed study in Ethiopia shows only 11.1% of breast cancer patients received any form of psychosocial support, including counseling, emotional guidance, or diagnostic and treatment information. It states, while counseling and clear communication regarding tests, treatment types, combinations, duration, side effects, and regimens

are considered standard components of cancer care, some patients reported being unaware of their diagnosis and lacking sufficient information including details about the number of prescribed chemotherapy cycles highlighting a significant gap between intended and actual patient communication and support (12).

In Ethiopia, breast cancer treatment typically involves a combination of surgery (such as mastectomy), chemotherapy, radiation therapy, and hormonal therapy, depending on the stage and type of cancer(13). However, undergoing breast cancer treatment whether surgery, chemotherapy or radiation can have profound physical, emotional, and psychosocial effects on patients. Mastectomy, in particular, has been associated with body image concerns, loss of femininity, psychological distress, and impaired quality of life (5). Similarly, chemotherapy and radiation therapy bring side effects such as fatigue, pain, nausea, and emotional distress, further complicating patients' lived experiences(14).

1.2. Statement of the problem

Breast cancer is a major worldwide health issue, disproportionately impacting women in low- and middle-income nations, including Ethiopia(15). Breast cancer is the most prevalent cancer among women and the second most common cancer type worldwide (2). 1 in 20 women worldwide will be diagnosed with breast cancer in their lifetime(15,16). In sub-Saharan Africa, the burden of breast cancer is rising, with studies suggesting that one in three women may face a breast cancer diagnosis in their lifetime (3). In Ethiopia, breast cancer is a major public health concern with growing rates as it is already the leading type of cancer accounting for one third of all cancer cases in women and one in five of all cancer cases(4). Treatment pathways, including surgery, chemotherapy and radiation therapy, while aimed at survival and cure, are physically arduous and psychologically transformative (17,18).

The journey for breast cancer treatment is characterized by a series of significant obstacles. Patients have to deal with a complicated and frequently upsetting treatment plan from the time of diagnosis. A woman's body integrity and self-perception are directly attacked by the physical toll of treatments, including baldness, radiation induced damage, chemotherapy-induced exhaustion and surgical changes. Psychologically, prolonged medical interventions can cause severe emotional suffering due to the ongoing confrontation with mortality, treatment efficacy worry and

cumulative stress (19,20). Socially and economically, the demands of treatment can further isolate patients during a time of extreme vulnerability by upsetting familial roles, straining relationships, causing catastrophic financial burdens and inciting stigma (17).

The majority of Ethiopian research to date has been on clinical outcomes, survival rates, epidemiological patterns, and the quality of life related to particular stages of treatment, including chemotherapy or post-mastectomy (21,22). In-depth qualitative research on patients' real, subjective experiences while actively undergoing the entire range of treatment is, nevertheless, severely lacking. The existing collection of research offers little insight into how patients navigate relationships, deal with the unrelenting side effects, make sense of their changing identities, and find purpose during the ongoing and uncertain course of therapy. This gap is crucial because research indicates that treatment adherence, prognosis, and overall recovery can be strongly impacted by a patient's mental health and psychosocial well-being (23–25).

As a result, care models do not sufficiently address the inner lives of Ethiopian women facing the day-to-day challenges of breast cancer treatment. Healthcare objectives should be centered on preserving lives, but in order to offer truly comprehensive support, they must also incorporate an awareness of this lived experience. Without this knowledge, treatments might not address the main causes of distress, which could result in maladaptation, poor mental health outcomes and a lower quality of life. This study was conducted in order to better understand the lived experiences of breast cancer patients receiving treatment at Tikur Anbesa Specialized Hospital (TASH). The study aims to shed light on their challenges, resiliency and unfulfilled needs by giving voice to their personal stories. This will help shape the creation of more compassionate, all-encompassing and patient-centered supportive care procedures.

1.3. Significant of the study

This study will produce a specifically Ethiopian framework for the experience of breast cancer. It goes beyond using Western models of patient experience by specifically examining how a patient's lived reality at TASH is co-created by local cultural beliefs; such as stigma and spirituality as a primary coping mechanism, severe financial limitations, and particular health system difficulties like treatment delays. This advances a broader and more varied comprehension of phenomenology in cancer.

Clinically, the findings will offer evidence-based recommendations for improving patient-centered and compassionate treatment at TASH and other similar settings. The study will identify specific gaps in present services, focusing on psychological support and provider-patient communication during important therapy phases and possible justifications for integration of mental health services into regular oncology practices.

On a practical level, the study's findings will inform the development of targeted patient education materials that address identified treatment-related anxieties and misconceptions which inter will help with informed decision making and treatment adherence. Furthermore, the findings will serve as inputs for training programs to improve healthcare providers' communication abilities.

Chapter two

2. Literature Review

This chapter reviews the works of literatures related to the lived experience of breast cancer patients undergoing treatments. It has different subtitles under it.

2.1. Emotional and Psychological Impact

The first diagnosis step is the period which begins when a woman notices symptoms or seeks a check-up and ends with a medical diagnosis(26).This inevitably causes significant distress. According to a qualitative study conducted in Missouri on lived experience of breast cancer patients , 89% of patients on the study report experiencing first shock after being diagnosed and frustration throughout their treatment journey(27).The diagnosis also results to large emotional imbalance considered as an emotional crisis based on a qualitative study done in Norway, this affects the patients ability to continue with everyday life(28).Women also experience negative emotional impact due to worry about curability of the disease and treatment side effects including a sense of loss because of mastectomy according to a qualitative study in Ghana (29). Another systematic review on epidemiologic and clinical characteristics of breast cancer in Ethiopia also shows women experience fear of reoccurrence and thoughts of death at the time of diagnosis and treatment(30). A cross sectional study on women with and without cancer in Addis Ababa states that 4 out of 10 breast cancer patients experience symptoms of depression at their cancer journey compared to the others(31). Ethiopian women also report spirituality, with 63% seeking religious assistance upon diagnosis(22).

2.2. Treatment-Related Challenges

A study in TASH in 2017 shows that 74% of patients underwent surgery, with mastectomy accounting for 65.6%, radiation for 20.5% and chemotherapy for 89.2%(32).Treatment related physical side effects demonstrate cultural heterogeneity in perception. A phenomenological study done in Indonesia shows that women experience of nausea, vomiting and hair loss issues during treatment which may inter result in psychological difficulties (33).on the other hand Australian younger women relate chemotherapy with loss of self-identity and that it caused them immense physical difficulties to go on with life and take care of their families on a qualitative study of lived

experience on younger women (8). A phenomenological study in Nigeria also shows Nigerian survivors experience physical suffering during treatment which could also last even after treatment, additionally this women state they experienced financial strains to support their treatments and checkups leaving them in dire situations(11). On the same note patients from Wolayita, Ethiopian on a phenomenological study worry about disguising mastectomy surgical scars to prevent stigma in addition to the financial hardships they face (22). Systemic difficulties are also especially acute, a study shows that 78% of TASH patients report pharmaceutical stock outs delaying therapy on the systematic review mentioned above (13). Another systematic review and meta-analysis on proportion of early presentation of breast cancer patients in Ethiopia shows congested wards require 92% to wait more than 4 hours for infusions (34). These add to the universal sensations of weariness and discomfort reported in another study(22).

2.3. Stigma

Stigma appears differently across countries, patients in Jordan conceal their diagnosis from anybody other than their immediate family for the fear of stigma according to a qualitative study (14). Pakistani women's stigmatization is significant leading to shame, embarrassments, future apprehension, social withdrawal and fear of marital abandonment based on a qualitative study of perceptions and lived experiences of breast cancer survivor (35) and Ethiopian patients report occupational discrimination due to diagnosis based on the above systematic review and meta-analysis mentioned before (34).

2.4. Coping mechanisms

Family relations play a vital role in mediating experiences. Patients from Missouri in the qualitative study mentioned above state that the support of family, friends and co-workers play a significant role on their mental and physical health throughout their journey and addition to the professional support networks they receive at their setup (27). Increasing cognition on the disease and having positive attitude helps patients to cope with the straggles based on a study in Chania on stress and coping strategies of breast cancer(36) similarly 89% of the women from the qualitative study in Wolayita rely on family caregivers and religious community support to cope with all the straggles they face(22).

2.4. Methodological approaches in phenomenological research theme

Qualitative approaches for breast cancer research have advanced tremendously. Early phenomenological research in high-income context used single-interview designs (28). More recent research uses longitudinal methodologies to record changing experiences during therapy. The bulk of African studies have used cross-sectional designs, with a limited use of in-depth phenomenological approaches. Methodological reporting has evolved over time, with contemporary standards emphasizing reflexivity, triangulation, and member verification to assure rigor.

2.5. Identified research gaps and justification

This review identifies several important deficiencies. First, while phenomenological studies exist in Western contexts, comparable research in African settings is limited. Second, existing Ethiopian studies emphasize clinical outcomes over qualitative experiences (32). Third, few studies use approaches that capture experiences through combination of therapies. Finally, there is little research on how healthcare system constraints influence patient experiences in resource-constrained settings like Ethiopia.

This study addressed these gaps using a phenomenological approach, motivated by the theoretical viewpoint that disease experiences are socially created and context-dependent.

Chapter three

3. Objectives of the study

3.1. General Objective

To explore the lived experiences of breast cancer patients undergoing treatment at Tikur Anbessa Specialized Hospital (TASH) in Addis Ababa, Ethiopia in 2025.

3.2. Specific Objectives:

1. To explore the lived experiences of breast cancer patients at TASH, focusing on the emotional and social dimensions of their treatment journey, their coping mechanisms and the role of their support systems.
2. To assess patients' experiences and perceptions of the healthcare services at TASH, identifying key challenges and generating patient-centered recommendations to enhance breast cancer care.

Chapter Four

4. Methods and materials

4.1. Study setting/area and period

This study was conducted at Tikur Anbessa Specialized Hospital (TASH) in Addis Abeba, Ethiopia. Addis Abeba is the capital city of Ethiopia located at the heart of the country and it has 13 public hospital 5 of them under the bureau(37). TASH being one of them is established in 1964 and has around 700 beds and provides around 500,000 outpatient and 21,000 inpatient services annually making it the largest tertiary referral teaching hospital in Ethiopia; Additionally it has an adult oncology center with around 19 beds that serves around 10.000 patients annually with specialized comprehensive services including chemotherapy, surgery, palliative care and radiotherapy making it the only hospital giving these services in Ethiopia until recently (38).The hospital serves a diverse community from all over the country which gave the study an all in compassing perspective on patients lived experience. The study took around 4 months starting from September to December 2025, which passed through ethical clearance data collection and analysis.

4.2. Study Design

This study used a qualitative design with phenomenological approach to investigate the lived experiences of breast cancer patients who was being treated at Tikur Anbessa Specialized Hospital (TASH) in Addis Ababa, Ethiopia.

This qualitative methodology allows participants to express their personal experiences, emotions, and perspectives in their own words (20), resulting in rich and defined data about breast cancer patient's journey through treatment. The technique assisted in understanding the substance of patients' experiences while recognizing the variety of individual viewpoints offering insights into how patients interpret and give meaning to their treatment journey in relation to healthcare systems and given culture.

4.3. Population

4.3.1. Source Population

the source population for this study were individuals diagnosed with breast cancer in Tikur Anbessa Specialized Hospital.

4.3.2. Study Population

The study population for this study comprised breast cancer patients who were actively receiving treatment at Tikur Anbessa Specialized Hospital (TASH) during the 2025 data collection period and fulfill the inclusion criteria for the study.

4.3.3. Study Unit

Each individual breast cancer patient who were undergoing treatment at TASH and who voluntarily agreed to participate in the in-depth interviews served as the study unit. These participants shared their lived experiences, providing the primary data for analysis.

4.3.4. Sampling Unit

The sampling unit contained individual patients selected from the list of breast cancer patients who are undertaking therapy at the time of study. List of potentially eligible patients were generated from the oncology clinic appointment lists and ward registries. Initial screening was conducted through a review of medical records to confirm diagnosis and treatment status, then among the short listed patients some were eliminated based on the exclusion criteria and the eligible once were selected using a multiple variation purposive sampling approach. This method had ensured representation across key demographic and clinical variables, including different age groups which ranged from 35 to 60, cancer stages which includes early stages of I and II and late stages of III and IV, treatment modalities including surgery, chemotherapy, radiotherapy and hormonal therapy, treatment durations were women who are not long term patients meaning patients who are just recently diagnosed and had surgery or patients who are on late stages of treatment like radiotherapy and hormonal therapy but are not greater than 2 years since diagnosis are included, and socioeconomic backgrounds in which patients of different economic background which were

selected from both the private wing and regular clinic of the hospital are included also both patients from the rural and urban areas were included.

4.4. Eligibility criteria

Table 1: Eligibility Criteria

Inclusion criteria	Exclusion criteria
Female breast cancer patients with confirmed histological diagnosis	Patients with severe comorbidities
Age 18 and above	Critically ill patients/ patients taking palliative care
Patients who are actively taking treatment at TASH at the time of data collection	Patients with cognitive impairments or mental illness
Patients who were willing to participate	Patients who had reconstructive surgery
Patients who were able to speak Amharic	

Amharic is the national language of Ethiopia

4.5. Sample size determination and sampling technique

4.5.1. Sample size determination

The participants were recruited via purposive sampling among the breast cancer patients who had surgery, chemotherapy, radiation therapy, targeted therapy or a combination of these at TASH and fulfil the inclusion criteria. The final sample size was determined by thematic saturation, resulting in 12 participant's data analysis, since there were no new themes and subthemes emerging after the 10th interview and with the two-step test adding the last two interviews indicated the redundancy of theme.

4.5.2. Sampling technique and procedures

The study used purposive sampling to ensure representation across key demographic and clinical characteristics and to allow for the identification of both common patterns and unique variations in patients' experiences. Participants were selected on criteria based purposeful sampling to capture a range of treatment experiences at different stages of the cancer treatment journey, the participants have taken at least one form of treatment prior to the study and are still undergoing or planned to

continue treatment. There were 3 main group of samples based on their treatment stages: patients who have had surgery which were 3, patients who had surgery and are undergoing chemotherapy also 4, patients who had surgery and chemotherapy and now are undergoing radiotherapy which were 4 and the last 1 participant was a patient who had the above three and now is undergoing targeted therapy which could be considered as the fourth group.

The researcher collaborated with TASH oncology unit voluntary resident and nurses to identify eligible patients who meet the inclusion criteria and then initial screening was conducted through medical record review with permission from hospital administration and then the eligible patients were informed of the study and invited to participate at the clinics by the resident and supporting nurses. Those who were willing was approached by the researcher during their routine clinic visits at the OPD for surgical patients, at chemotherapy ward for patients taking chemotherapy and at the radiotherapy waiting area for patients taking radiotherapy at the time of data collection. The researcher then explained the study in more detail verbally and through an information sheet in Amharic to the participants before the informed consent was received and interview were resumed.

4.6. Data collection tool, methods and procedures

In-depth interview (IDI) was the main method to collect data for this study. This phenomenological method helps uncovering common themes while documenting unique experiences.

The interviews were semi-structured and utilize open-ended questions designed to elicit comprehensive narratives about participants' lived experiences. This format allowed for the systematic coverage of all key topics while being flexible to follow leads through probing and space for spontaneous emotional expressions, whether verbal or manifested through physical gestures, which may reveal crucial insights into the treatment journey. The open ended questions were arranged from general to specific with the sensitive topic introduced gradually in empathetic form. The questions were simple, clear and culturally appropriate allowing the patients to share their narratives of the experience. Probing questions were also included to explore deeper meanings.

An interview guide was prepared covering the emotional, physiological, physical and social experiences of women and the challenges they faced through treatment along with the interactions

they had with the health care workers and the hospital system with the help of the resident and nurses and it is sensitive to the emotional difficulties associated with talking about cancer treatment. The interview has covered three main areas. First sociodemographic and medical information. Second general perception of breast cancer and physical, emotional, social, spiritual and medical aspects related to diagnosis, treatments and side effects and lastly the coping mechanisms and the social support system will be probed.

To allow for validity of the tool items were adopted from a similar study (21) and the draft instrument was reviewed by the advisors in educational setup, who assessed item relevance and clarity. Additionally, an oncologist from TASH reviewed the guide for clinical relevance.

A pilot test was also done in similar settings in SPHMMC on two patients who were on a similar situation to evaluate the interview process, which allowed the questions to be arranged in an organized manner from general to specific topic and it also helped avoid very sensitive topics and this data was discarded after. The interviews were done in private settings at TASH and were performed in Amharic by the researcher trained on qualitative study. Each session was audio-recorded with consent and supplemented by field notes documenting significant non-verbal cues and contextual observations.

4.7. Trustworthiness and Rigor

To ensure the trustworthiness of this study different measures were used throughout the research process. Prior to data collection, pilot test was conducted to refine the interview protocol and survey instrument. This ensured questions were clear, relevant, and elicited rich information. Open ended reflective journal on a note book was taken to detect and suspend preconceived notions regarding breast cancer experiences to help with confirmability. Additionally, Credibility was ensured by applying prolonged engagement with the participants which was done prior to the in-depth interviews by observing around the treatment areas for 2 or 3 days and engaging in informal conversations with the participants. The IDIs by themselves took 23 to 45 minutes. During data collection transferability was supported through thick description of TASH's setting, detailed participant characteristics, and rich presentation of findings with representative quotes besides; taking field notes for contextual observations and nonverbal cues which were used to enrich and cross-verify interview data.

To ensure both credibility and dependability a portion of the transcripts was independently reviewed by other seasoned qualitative researchers in addition to, audit trails in which a manual line-by-line analysis of the first four transcripts was conducted using printed copies and colored pens to force deep immersion prior to using soft wear. Additionally, member checking in which a summary of key findings was presented to two participants in a follow-up interview was done. They validated the themes' accuracy and resonance and identified omissions. Their critical feedback was recorded and integrated into the final analysis, ensuring the findings reflected participant meanings. The researcher did the interviews, who has a degree in health and received formal training in qualitative research methods during her Master's program at SPHMMC, including coursework on in-depth interviewing and phenomenological analysis. Prior to data collection, she participated in mock interviews and pilot testing to refine interviewing techniques, ensure empathetic engagement, and practice non-leading probing. Her prior experience in health communication and patient engagement further supported her ability to conduct sensitive interviews with empathy and professionalism. The researcher also maintained a reflexive journal throughout the study to record personal assumptions, biases, and reflections, thereby bracketing preconceptions about breast cancer experiences.

4.8. Data Management and analysis

Several qualitative data analysis (QDA) methods exist, including thematic analysis, interpretative phenomenological analysis (IPA), grounded theory, and content analysis. For this study, thematic analysis using an inductive approach was selected. This approach aligns with phenomenological inquiry by identifying patterns of meaning across participant experiences, allows themes to emerge from the data (inductive), and is well-suited to exploring lived experiences in health-related contexts. The data analysis process was carried simultaneously with data collection allowing modification of the interview guide. The analysis began with verbatim transcription of all audio-recorded interviews in their original language (Amharic) then they were translated to English by freelancers with experience of transcription and translation on qualitative studies. The researcher then conducted multiple rereading's of the transcripts to achieve immersion in the data and identify initial patterns to systematically code it in to resulting in code book. Then related codes were positioned into significant clusters and broad themes that encapsulate the core of participants' experiences with inductive coding allowing new themes to emerge. The analysis was done

primarily using Atlas-ti 8 software in support of the manual data analysis. The thematic analysis process resulted in the emergence of five major themes and subthemes were also identified. The process began with deep familiarization through manual annotation of transcripts, followed by systematic coding to generate an initial codebook. Codes were then clustered into candidate themes and rigorously reviewed for coherence against the full dataset, a process strengthened by independent peer review. The final four themes and their sub-themes were clearly defined and named. The analytic findings were then presented in a narrative report supported by illustrative data extracts. Rigor was embedded throughout via an audit trail of analytical memos and validated through member checking with participants.

4.9. Ethical considerations

The study was conducted after formal approval was obtained from Institutional Review Board (IRB) at St. Paul's Hospital Millennium Medical College and support was asked from TASH oncology department. Informed consent had been filled by the participants and interviews took place in private rooms to preserve anonymity. The right of participants to halt or withdraw from interviews at any moment without affecting their medical care was respected. All electronic files were password-protected and stored on hard drive accessible only to the research team for a year until dissemination. Participants were assigned unique identification codes, with all personally identifiable information removed from transcripts and analyses and dissemination protects participant anonymity through careful review of all presentations and publications to prevent indirect identification.

All procedures were conducted with cultural sensitivity and respect for the vulnerable status of cancer patients, aligning with TASH's commitment to patient-centered care and ethical research practices.

4.10. Plan for dissemination of results

The result of the study will be presented to Saint Paul millennium medical college school of public health and Tikur Anbesa specialized hospital. A further attempt will be made to present the study at scientific conferences and to publish it in a national or international scientific journal.

Chapter five

5. Results

5.1. Characteristics of the participants

An in-depth interview was conducted on twelve women who are diagnosed with breast cancer and are undergoing treatment at the time of data collection. The women's age ranges from 35 to 60. Among the twelve, three had surgery recently and were appointed for chemotherapy, four had surgery and were undergoing chemotherapy at the time of data collection, four had both surgery and chemotherapy and were taking radiotherapy and one had all of the three before and were undergoing hormonal therapy. Among these 10 had mastectomy while 2 only had lumpectomy. In terms of education majority of them had completed primary school or higher. Ten of them were married and one was divorced and one widowed. Among the twelve six were orthodox, four were Muslim and 2 were Protestants religion followers. Five of the women were from Addis Ababa and the rest were from rural areas of the country. And five among the twelve were house wives, two were teachers but there rest are engaged in some private business. These demographic data is detailed on the table below (table 2).

Table 2: demographic data

participant	age	Marital status	children	residence	Educational level	occupation	religion
1	35	Married	3	A.A	Advanced certificate	Housewife	Protestant
2	60	Married	4	South region	none	Housewife	Orthodox
3	40	Married	3	A.A	degree	Teacher	Protestant
4	38	Married	1	Dre Dewa	none	Teacher	Muslim

5	38	Married	3	Debre Markos	10 th grade	Marchant	Muslim
6	60	Divorced	0	Shewa	12 th grade	Hairdresser	Orthodox
7	34	Married	3	A.A	10 th grade	Housewife	Orthodox
8	34	Married	2	A.A	10+2	Housewife	Orthodox
9	54	Married	6	A.A	10+3	Card writer	Orthodox
10	42	Married	4	Oromia	12 th grade	Women's Beauty salon	Muslim
11	45	Married	3	Amhara	10 th grade	Housewife	Orthodox
12	50	Widowed	4	Oromia	8 th grade	Merchant	Muslim

5.2. Thematic Analysis

The analysis of the in-depth interviews resulted in five main themes and other subthemes. The five themes are navigating diagnosis and disclosure, committing to treatment path, enduring the multidimensional toll of treatment, facing systemic and financial barriers and the last one sustained by network of care and support. The main themes and subthemes are listed on the table below (table 3).

Table 3: list of themes and subthemes

Theme	Subtheme
Navigating Diagnosis and Disclosure	Knowledge and beliefs about cancer before and after diagnosis First reactions: Shock, fear, and emotional turmoil The complex process of disclosing the diagnosis to family and others
Committing to a Treatment Path	Holding onto hope as a motivator for acceptance Agreeing to and preparing for biomedical treatment (surgery, chemo) Seeking and using traditional or alternative medicines
Enduring the Multidimensional Toll of Treatment	Suffering physical side effects (pain, fatigue, nausea, altered body image) Managing emotional and psychological distress (anxiety, sadness, uncertainty) Navigating strained social relationships and changed roles
Facing Systemic and Financial Barriers	Overcoming institutional hurdles and hospital service struggles Bearing the crushing burden of treatment costs and economic strain

Sustained by Networks of Care and Support	Drawing essential practical and emotional support from family and friends Relying on guidance and reassurance from healthcare professionals Finding strength, solace, and meaning through faith and spiritual beliefs
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Theme 1: Navigating diagnosis and disclosure

Participants describe experiencing of emotional turmoil at the time of diagnosis which is exacerbated by having low knowledge about breast cancer and its treatment path ways by the time of diagnosis. Almost all of them explain experiencing shock, fear and worry related to the anxiety and stress caused by the diagnosis and the oncoming path it entails.

Knowledge and beliefs about cancer before and after diagnosis:

This investigates the revolutionary change in patient's perceptions and comprehension of the illness. Before receiving a diagnosis, patients' knowledge was frequently restricted due to cultural misconceptions, anxiety and incomplete information, which resulted in presumptions that cancer was either extremely stigmatizing or necessarily fatal. This abstract understanding gave way to a concrete, intimate, and frequently urgent education after their diagnosis. Their relationship to their condition and their role in the treatment process were drastically changed by this transition from generalized belief to customized understanding.

Even though most participants in the study have heard the word cancer they have close to none understanding of the cause, symptoms and treatment options of breast cancer and the possible potential of they themselves being breast cancer patients. Among the participants only two of them have heard of some symptoms of breast cancer and that they feared the lump they felt on their breast may be an indication. Most in the study had no idea about screening tests and the treatment options and related side effects prior to diagnosis, which they learned through the hard way of being a patient.

“ this thing called breast cancer... I am a teacher, I teach children about various things, about Jesus, about different topics, but I had never known about this topic at all.” (p3)

A participant advice of women after personal experience.

“I advise all women to palpate themselves and look at the mirror, if they see or feel something they should go to a hospital right away because it is curable.”(p 11)

First reactions:

The participants describe experiencing intense emotions of shock, fear and worry at the time of breast cancer diagnosis. Due to the sudden and unexpected nature of the diagnosis the participants explain being left in a distressed and confused state. They also express the feeling of worry for their prognosis, treatment path and future.

Almost all participants express the experience of these feelings

“When the doctor told me my diagnosis the first time I was very shocked; I couldn't calm down, It took me 3 months to convince myself of what happened” (p 8)

“I was frightened. I thought about refusing the treatment and going to a holy water site.” (p9)

“ It's very difficult. I have 3 children, I live on a monthly salary. When I think about them, it burdens me. I was struck by a blood pressure I didn't have before” (p 7)

“I cried about it. I was thinking about my children. How would I tell my husband himself? How would I tell my family? That was what worried me., so it shock me.I thought I was going to die, The thought of being separated from my children bothered me a lot ” (p 3)

The participants describe experiencing fear of losing their breast, fear of severity of the disease and fear of less possibility for improvement and reoccurrence. Which also exacerbates the fear of leaving their loved once.

The complex process of disclosing the diagnosis to family and others:

This captures the deeply fraught and strategic journey participants undertake in sharing their news. It involves navigating intense emotions like fear and shame, anticipating and managing varied reactions from supportive to stigmatizing and making deliberate choices about what to disclose, to

whom and when. This process is not a single event but an ongoing negotiation that significantly impacts their sense of support, privacy and identity in the face of illness.

Most participants in the study believe that it is not necessary to talk about their condition unless they expect support from the other person and also they believe disclosing to other often times result in judgment and being pitied by others. Because of this they usually decide not to disclose their status to others if they are not very close and absolutely necessary. Even if people don't stop asking and that it causes them pain.

"I didn't tell people openly, I didn't want to talk it only result in pity." (p2)

"I didn't tell anyone outside of my close family. I handle everything by myself because I am an adult and I didn't want to experience any talk about me." (p6)

"It's difficult to tell others. Our life itself is difficult. Everything makes you hate it." (p7)

Few of the participants who have disclosed their status for people other than family describes feeling sad and discouraged by the people's reactions. one explains it like the following.

"They assume you are going to die and say "Woy, woy" (expressions of grief/sympathy), and it weakens you. I was thinking about stopping the treatment and going to a monastery because people were influencing me by saying, "Leave the treatment and turn to your religion."" (p8)

Theme 2: Committing to a Treatment Path

This entails the gradual acceptance process of breast cancer patients after learning they had cancer. They overcame the initial shock phase and took a determined approach to their disease. This change was characterized by a proactive search for knowledge, assistance and therapeutic alternatives that included both the acceptance of medical treatments and the investigation of traditional or alternative care options. This phase represents not merely passive acceptance, but a resolute, proactive effort to confront the disease and pursue every possible avenue toward healing.

Holding onto hope as a motivator for acceptance:

In addition to the negative affect emotions the women were experiencing they describe of feeling hope. Hope in this regard is about having to believe that positive things will come out of this in Gods will and that the treatments they are going to have will help which lead to better acceptance

of their status. This also is supported by the resilience they feel for the sake of their families and also themselves.

“I was thinking about how to overcome things with strength and I thought I could be saved through prayer and God which gave me hope.” (p3)

“I haven't given up hope. I will get better by God's will.” (p2)

Hope played a significant role as a coping mechanism. It helped women follow the treatment path and be resilient through all the difficulties they face. It creates an optimistic view of the future for the women which empowers them on the treatment decisions and recovery journey.

Agreeing to and preparing for biomedical treatment (surgery, chemo)

This is a crucial point at which individuals actively choose to adhere to the suggested treatment pathway, such as chemotherapy or surgery, and start preparing both practically and mentally for it according to the health care workers advice. Even though some in the study described of having minimal knowledge of what to expect during treatment, they were resolute on following the path to cure. A participant talked of following her physician's suggestions and accepting treatment as the best choice for her.

“I have to finish the treatment. I have finished eight rounds of chemo. I have five rounds of radiotherapy left; I will finish that too. I will finish my medications. I don't deviate from the doctor's orders.” (p 1)

Seeking and using traditional or alternative medicines

Traditional medicine is common in Ethiopia, people use it for different purposes. Some participants in the study described of resorting to herbal traditional medicine in hopes of supporting the modern medicine and eventually gaining cure. They explain that it is cheap, accessible and doesn't hurt to try.

“ I used traditional methods like rubbing herbs on my body and drinking a mixture of herbs. I thought it would help me.” (p4)

“ I used traditional medicine like drinking a mixture of crushed garlic and holly water (ፀጠል) to help me.” (p6)

“I used cultural medicines, like white garlic and black cumin to support the modern treatment.” (p10)

Theme 3: Enduring the Multidimensional Toll of Treatment:

Breast cancer patients experience transformation because of the diagnosis and treatment both physically and psychologically. The participants describe of experiencing body image effects and emotional wellbeing difficulties.

Suffering physical side effects (pain, fatigue, nausea, altered body image):

The participants in this study express on body changes because of treatments, which affects their physical wellbeing. The most prominent change they speak off is the body image change due to surgery. Almost all of the participants in the study have had full mastectomy unilaterally. They describe the loss of their breast as missing part of their feminine identity and some even see it as a disability.

“It was very scary to hear. I was told my entire breast would be removed, and the roots would be extracted.”(p4)

On the other hand the women in the study who had a lumpectomy (removal of the tumor only) describe the surgery with less apprehension than the once with mastectomy.

“I didn't feel anything different due to the surgery.” (p5)

In addition to these participants also express going through other side effects because of the medications they were taking. Most describes of feeling weak and fatigue at all times, feeling of nausea and vomiting, nail darkening (color change), numb sensation of the tongue, Pain around the palates, brittleness and appetite loss with aversion to the smell of food which may sometimes lead to ringing feeling of ears and blurry vision. The participants also describe the experience of skin peeling and darkening, ear brow and general hear loss leading to boldness which exacerbates the negative feelings they have about their body image.

“ It's not something to say "this is it" every single thing affects you. Hair loss, skin peeling, fatigue, nausea, vomiting, change in nail color, sometimes my ear rings, my vision gets blurry, my tongue gets numb, my sense of smell doesn't work, my palate also hurts.” (p1)

“ I didn't have knowledge about Chemo, but I had heard from people that it makes you cry. And it is true, food doesn't taste good, bitterness in the mouth, physical swelling on the back, hair loss, nail problems I have experienced a lot,” (p7)

“I was afraid of radiation; it felt like it would burn and suffocate me and it cause difficulties to lift my hand,” (p9)

“The radiation didn't burden me much at the time, but after I finished it, there was pain, burning, itching, and it caused irritability.” (p8)

Managing emotional and psychological distress (anxiety, sadness, uncertainty):

The participants experience psychological side-effects because of the treatments they undergo which mainly result in pessimistic view in life and negative effect on self-image and sadness. They express experiences of effects on their emotional wellbeing due to treatments and their side effects which mostly caused them uncertainty in the path. The main cause of this for almost all is the loss of breast. Participant relate breast as their feminine identity and sense of self and so the surgery results to sense of loss, hurt and significant emotional distress.

“That was difficult. For me, it was a part I loved very much. It was hard. I thought, 'Now I might become disabled, I might be missing something.' Considering the result, I accepted it. It was difficult, very much.”(p3)

Another participant also explains having problems with her husband because of the treatment.

“it caused conflict with my husband. I felt neglected by him, lacking the care I needed, and it seemed like he thought things could be solved only with money “ (p4)

In addition the side effects of chemo and radiotherapy like baldness, weakness and darkening of skin left them insecure in their body and unfit to be present in front of others.

Around 70% of the participants in this study didn't know anything about breast cancer and its treatment options in addition to the side effects they might face through those. Due to this

participants experience difficulties accepting their status and feeling of loneliness in this path. Some who had some knowledge and meet with other breast cancer patients said it helped them better prepare and that the side effects were not shocking.

“I had a friend who had cancer. She had taken chemo two or three times. It was with her that I took advice. Because I had heard about her, it wasn't as shocking as it was told, it lessened the severity and fear for me.” (p1)

Navigating strained social relationships and changed roles:

Breast cancer patients frequently experience a profound sense of isolation from friends and social networks. This social disengagement and loneliness are often driven by the discomfort of discussing their illness, the fear of being a burden to others, and changes in their self-perception following diagnosis. Additionally, many patients endure a significant degree of stigmatization, which severely exacerbates their psychological distress. This stigma manifests as feelings of embarrassment, shame, dependency, anxiety about the future, difficulty in disclosing their condition, social withdrawal, a desire to appear socially acceptable, avoidance of others, and a deep sense of inadequacy.

Participants in the study described deliberately withdrawing socially out of fear of disclosing their diagnosis and to avoid conversations about breast cancer and mastectomy. They also expressed significant difficulties in fulfilling their roles as wives, mothers, coworkers, or community members, whether in maintaining household responsibilities, meeting work demands, or upholding other societal obligations.

“I don't want to go to any social gatherings like ‘idir’ or such anymore because people look at me with pity and judgment.”(p 12)

“I find it very difficult to do all the house holed chores and fulfill my children's need as a mother because of all the tiredness and pain I feel through treatment. Thank God my husband helps me.”(p3)

“In my role, taking care of my children was burdensome for me.” (p8)

Theme 4: Facing Systemic and Financial Barriers

Breast cancer patients go through different challenges to access treatment. Among these challenges is financial struggles they face to get the medications and radiotherapy treatments they have to have. Besides this women have to go through waiting least, ques and unfavorable crowded hospital environment to access treatment. Below are the subthemes on this regard.

Overcoming institutional hurdles and hospital service struggles:

The participants express of having to wait in long lines to assess any form of service in the hospital, which may be ques for follow up evaluations, lines for chemotherapy and radiotherapy treatments and waiting lists for both surgery and radiotherapy. These always left them fatigued and frustrated sometimes even leading to anger and feeling of hopelessness. They also describe of having little time with the doctors and low consultations about the treatment path ahead.

“It happens. You wait for two hours; the doctor comes at four hours. Even when we take chemo, we come early at one o'clock or twelve, but the treatment you get is at four o'clock. Even though it's tedious, you sit bored because what else is there.” (p1)

“There was a waiting time with the radiation, due to a payment issues and also there are a lot of others on the list, which made me scared that my condition will worsen” (p5)

“I had experiences of delay with test results. Before the result of one CT scan arrives, another is ordered which left me sad.” (p7)

Another participant also explained the experience of having to face different physicians at each visit to the hospital during the time of diagnosis and treatment decision, which caused confusion on deciding better treatment options.

“Due to their lack of understanding or because I didn't go to the right doctor, it took me 2 months it was very crowded. The doctors who saw me were different; I saw three of them before my surgery was decided.” (p3)

Participants also describe experiences of medical and supplies shortage besides the crudes unkempt ward environments.

“I experienced medicine shortages, and tests get delayed, it frustrates me a lot, but since I have no other option, I just wait.” (p8)

Bearing the crushing burden of treatment costs and economic strain:

Financial hardship is a problem which was experienced by almost all of the participants in the study. Participants described of having to pay high amount of money in each visits to the ward for cards, laboratories and medications. They also express that due to long waiting times in the regular ward and lack of insurance they had to take both chemotherapy and radiotherapy in the private wing of the hospital which they describe as being very expensive. The participants explain that to afford that they had to borrow and take offerings from family, friends and even other people, which caused them stress and less worthiness. Some even described of having to sell belongings and taking lone. These all added exacerbated the overall emotional burden they may be experiencing.

“I faced financial problems, because I didn't have health insurance and I was forced to take borrowings from family and friends.” (p8)

“I was not able to afford the price for each chemotherapy and my radiotherapy but tank God my family helped me.” (p9)

“The prices of each medications were expansive, I had to sell the jewelries I had to get them. I want the government to control the price of medicine and make it affordable for us.”(p6)

Theme 5: Sustained by Networks of Care and Support

Breast cancer patients experience immense difficulties to cope with their diagnosis and treatment. They pass through different physical, emotional and psychological struggles especially due to treatment and treatment side effects, therefore patients practice different coping mechanisms and care and support systems to go through all the difficulties.

Drawing essential practical and emotional support from family and friends:

Almost all participants in this study describes of the help they get from families, close relatives and friends as a coping mechanism. They described of the emotional support they gate from these people uplifting and hopeful and that their families' and friends are always there to listen, feel together and lend a shoulder when they are sad. In addition because the treatments of breast cancer left them week and incapacitated, the physical help they get from those people be it in house hold chores or work environments saved them from the chaos in their lives. They also described the

financial help they received from those people as saving their lives, that without it for most of the participants it would have been impossible to gate the treatments they were supposed to receive.

“They supported me by being by my side. Because I think I am strong with them, they ensured I didn’t go alone. For some decisions, for example, when I was told I needed to have surgery quickly, to decide on going private, my brother and my husband were with me. The people I love very much come and enter deep sorrow, we comfort each other.” (p3)

“My children they helped me. They encouraged me, saying, “Don’t worry about the cost and anything else just get better” (p9)

“My family and my husband they supported me in so many ways, they are always advising me, helping me in the house and thinking about my children gave me hope.” (p8)

Participants also describe that community they build in the hospital wards and treatment waiting areas serves as source of empowerment and resonance for the participants. A participant also describes following other women who had passed the same path on social media and thinking that she is not the only one helped her to cope with treatment.

“I follow those who have passed through it on social media. Without ignoring them, I talk to people in person. I also have my children; I get through it by being encouraged by my children.” (p1)

Finding strength, solace, and meaning through faith and spiritual beliefs:

All the participants in the study are followers of a specific religion. Since they share spiritual beliefs, they gain substantial support from their religious communities. They express of having prayers, intercessory and fellowships from others in that religious practice which may be leaders, individual followers or community. They describe these experiences as uplifting and profoundly comforting in that it creates the feeling of community and support helping them cope and be resilient with all the struggles they face throughout treatment path. The experience builds emotional and spiritual wellbeing for the participants.

“Prayer helped me a lot. They prayed a lot. In our home, my family, my relatives, my work itself is within the church. They came and cried and prayed. This strengthened me a lot.” (p3)

“I went through all the treatment through prayer, by talking to the person I am closest to it made me strong.” (p7)

“Through all the straggles I faced my faith and holy water helped me. My family and the people in my church were praying for me.” (p8)

Relying on guidance and reassurance from healthcare professionals:

Most participants acknowledge health workers including doctors, nurses and others as an enigma who combines clinical knowledge with compassionate care. They explain that the professionals offer special knowledge, treatment options and guidance throughout their diagnosis and treatment path ways. The participants also state that besides the clinical guidance they give they are empathetic and that their emotional support gave them hope and strength alleviating stress and anxiety.

“My relationship with the health professional was very good; they treated me kindly and with great care. They gave me hope. There was no time I felt hopeless about the treatment.” (p9)

“The doctor gave me hope when he told me the disease was normal and that I could be cured. I felt like giving up when the disease was first told to me.” (p8)

“ The relationship I had with the health providers was good. It's nice. They had good conduct with me.” (p1)

On the other had some patients explain having a bad experience with a health provider in that it was degrading ,despairing and lacking in proper consultations and educations needed.

“I lost hope when one doctor told me, "Don't think you will survive completely” (p5)

Chapter six

6.1. Discussion

This study examined the experience of women undergoing breast cancer treatment. The diagnosis of breast cancer elicits the experience of a profound physical and emotional crisis for women. This journey is even challenging in contexts like Ethiopia where the cancer care system is still growing and where there are limited resources. This study illuminates the multidimensional challenges these women face and the sources of resilience for them.

Upon diagnosis participants describe immense emotional shock, fear and disbelief, which is marked by worry for treatment, prognosis and mortality, these findings align with others from different settings (28, 38). However the initial shock and fear is exacerbated due to the low prior knowledge women have about the disease and the upcoming treatment path coupled with the misconceptions the society has about the fate of women diagnosed with breast cancer in the study setting. These initial reactions are further compounded by financial burden and the fear of losing femininity due to mastectomy. This disease is considered as a great personal loss degrading confidence and initiating fear which also extends to patients' families' which is comparable with a study done on husbands of breast cancer patients in Bahrain (39). However, while research in high income settings often highlights reconstruction options, Ethiopian women's concerns were more immediately practical; hiding surgical scars to avoid stigma and managing financial toxicity. This contrast emphasizes how socioeconomic constraints reshape the psychological impact of treatment.

Treatment introduced a second layer of hardship through significant physical alterations. The loss of a breast profoundly impacted self-perception and femininity, while chemotherapy and radiotherapy induced side effects such as alopecia, nausea, and skin changes further eroded bodily image and emotional wellbeing, which are findings also supported by a study done in Wolaita (40). Additionally the study shows that these changes frequently led to social withdrawal, self-stigma, and reluctance to disclose their condition due to fear of cultural discrimination and societal judgment.

Additionally, these medical and psychological struggles are exacerbated by substantial systemic barriers, which is supported by a study done in Nigeria (11). Participants in this highlighted severe financial struggles, as the costs of medication, tests and treatments threatened economic stability forcing families to borrow from others and even to sell assets. Participants also describes of having to stop and think about decision of treatment because of financial burden. These was exacerbated by stressful clinic environments and drug shortages, creating an overwhelming burden that hinders consistent treatment access which are less highlighted by studies in high resource settings.

Despite these difficulties, women identified critical source of support that develops resilience and hope. Healthcare providers are described as a vital source of strength offering not only expert in treatment and clinical path but also compassionate guidance and emotional reassurance, which significantly reduced anxiety. Social support from family, friends and spouses provided indispensable practical and emotional sustenance. Some even described the experience of having to learn and create a community with other women who had the same experience.

According to most participants medical professionals were not just treatment experts but vital emotional anchors. They maintained patient hope by providing clear medical advice, managing side effects and offering consistent and compassionate reassurance, which directly reduced anxiety and instilled hope and confidence. This is comparable to the findings in other studies (29,40)

Emotional and practical assistance from loved ones especially husbands, children and close families was indispensable. A study done in Indonesia on breast cancer lived experience also states that the support of husbands and immediate families helped the participants go through treatment (32). However, the study states that this network provided daily reassurance, empathy, communication, and tangible help in the form of house holed assisted and work related help, forming a crucial buffer against the stress of the illness. Finally, spiritual faith and religiosity served as a foundational coping mechanism, with many participants framing their hope for healing within a context of divine will and intervention, which is also similar in other studies (20, 41). For many participants in the study though, spiritual faith and religious community were foundational coping mechanisms. Hope was often framed through belief in divine will or intervention, providing a profound sense of solace, meaning, and resilience beyond medical or social avenues. On the other hand some participant's state having to delay treatment for some time in favor of faith related healing. This finding underscores the need for healthcare providers to recognize and respectfully

engage with patients' spiritual frameworks while ensuring clear communication about treatment benefits.

Chapter seven

7.1. Limitation of the study

The study has several limitations that should be considered. First of all, the study used a small sample of participants from a specific hospital, which may limit our generalization. So, for future reference more sample could be beneficial. Second the study did not include the perception of men, especially important men for the participants like the husband whose perspective may add to the experience of these women, so future inclusion may add value. Last this study only included breast cancer patient's experiences in that it may not be the exact representation for other cancer patient's challenges and experiences.

Despite all the limitations the study contributes to the existing literature gap and it shows the experience of women with breast cancer.

7.2. Strength of the study

This study's strength lies in its methodological rigor and contextual relevance. Using a phenomenological approach with purposive maximum variation sampling, it captured rich, nuanced narratives directly from breast cancer patients at Tikur Anbessa Specialized Hospital, ensuring authentic representation of their lived experiences. The rigorous application of trustworthiness criteria enhances the credibility and dependability of the findings, while its focus on a major Ethiopian referral hospital provides practical insights that are immediately applicable to improving patient-centered cancer care in similar resource-constrained settings.

7.3. Conclusion

This study concludes that the lived experience of breast cancer treatment at Tikur Anbessa Specialized Hospital is shaped by two intertwined dimensions: deeply personal emotional and sociocultural struggles, and significant systemic healthcare challenges. Patients navigate profound emotional distress, stigma, and identity loss, relying primarily on family and faith rather than formal support systems, reflecting a culturally embedded journey where coping is relational and spiritual. Simultaneously, their treatment journey is hindered by systemic barrier including; financial strain, drug shortages, long waits, and inconsistent provider communication which,

compound their suffering and impede care continuity. These findings collectively underscore that improving breast cancer care in this setting requires an integrated approach that addresses not only the medical and emotional needs of patients but also the structural and communicative gaps within the healthcare system.

7.4. Recommendation

The study has tried to access women's experience throughout breast cancer treatment. In line with this even though the participants express great gratitude and help from health professional some also experienced of misconducts, so based on the need of those participants the health professionals should conduct a compassionate and empathetic care. Additionally, it is recommended to establish a patient navigation system to guide women through diagnosis, treatment scheduling, and follow-up, reducing delays and confusion. They also suggested the need of psychological help and clinics along with the consultations for treatment path. In addition to that most women described of having less to none prior knowledge before their diagnosis, in that regard it is recommended to spread knowledge.

Participants also had expressed the need for improvement in the oncology clinics suggesting of managing over crowdedness by providing separate area for each cancer patients, providing clean utilities around wards and managing lines and weighting lists. The availability of medications, supplies and testes (supply chain management) in addition to the affordability of treatments is also suggested for improvement by the hospital management.

Over all this shows the need to establish an integrated, patient-centered breast cancer care pathway at TASH that combines clinical treatment with structured psychosocial, financial, and navigational support. A coordinated care pathway that addresses medical, emotional, informational, and logistical needs simultaneously is essential to reduce suffering, improve adherence, and enhance the quality of life for breast cancer patients in this setting.

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Annex 1

Informed Consent Form and Information sheet

Title: Lived Experiences of Breast Cancer Patients Undergoing Treatment at Tikur Anbessa Specialized Hospital (TASH), 2025

Institution: St. Paul's Hospital Millennium Medical College, School of Public Health

Principal investigator: Bisrat Yenealem

1. Introduction

You are invited to participate in a research study exploring the lived experiences of breast cancer patients during treatment. This form explains the study's purpose, procedures, risks, and benefits. Your participation is voluntary.

2. Purpose of the Study: This study aims to explore the physical, emotional, and social challenges faced by breast cancer patients undergoing treatment. The findings may help improve patient-centered care and support services at TASH.

3. Study tools and methods

Primary Tool: Semi-structured interview guide with open-ended questions

Data Collection: One confidential in depth interview will be taken which will last around 60-90 minutes and it will be in Amharic. The interview will be audio recorded with permission for accurate documentation and additionally field notes will be taken to capture non-verbal cues.

Analysis: interview will be thematically analyzed from transcripts using excel software.

4. Participant selection: You were invited because you:

- ✓ Are ≥ 18 years old
- ✓ Have a confirmed breast cancer diagnosis
- ✓ Are currently receiving treatment at TASH
- ✓ Can communicate experiences in Amharic

5. Procedures: You will participate in a 60–90 minute interview (in-person, private room). Questions will cover your diagnosis, treatment experiences, coping strategies, and

suggestions for care improvements. Interviews will be audio-recorded (with your permission) and transcribed anonymously.

6. Risks and Discomforts: Risks may include emotional distress when discussing sensitive topics and at those times you may pause or skip questions or withdraw at any time without penalty.

7. Benefits: Your insights may help improve support for future breast cancer patients and you will receive a summary of findings if desired.

8. Confidentiality: Your name and identifiers will not appear in transcripts or reports. Data will be stored securely, accessible only to the research team. Additionally audio recordings will be deleted after transcription.

9. Voluntary Participation; you may refuse to answer questions or withdraw anytime without affecting your medical care.

10. Contact Information

For questions, contact:

Researcher: Bisrat Yenealem , Email – bisratyenealem@gmail.com /Phone- 251-925-322-885

Consent Statement

I have read this form (or had it read to me) and understand the study. I voluntarily agree to participate.

Participant's Name: _____

Signature: _____ Date: _____

Researcher's Name: _____

Signature: _____ Date: _____

እምነት ፎርም እና የመረጃ ወረቀት

ርዕስ: በጥቁር አንበሳ ልዩ ሆስፒታል ህክምና በሚያገኙ የጡት ካንሰር ታዳሚዎች የተሞከረ ጥናት

ተቋም: በቅድስት ጳውሎስ ሆስፒታል ሚሌኒየም ሜዲካል ኮሌጅ፣ የህዝብ ጤና ት/ቤት

ዋና ተመራማሪ: ብስራት የነዳለም

1. መግቢያ

የጡት ካንሰር ታዳሚዎች በህክምና ላይ በሚገኙበት ጊዜ ያላቸውን የተሞከረ ግኝት የሚመረምር ጥናት ለመሳተፍ ተጋብዘዋል። ይህ ፎርም የጥናቱን ዓላማ፣ ሂደት፣ አደጋዎች እና ጥቅሞች ያብራራል። ተሳትፎዎ በፈቃደኝነት ላይ የተመሰረተ ነው።

2. የጥናቱ ዓላማ: ይህ ጥናት የጡት ካንሰር ታዳሚዎች በህክምና ሂደት የሚጋፈጧቸውን አካላዊ፣ ስሜታዊ እና ማህበራዊ ተግዳሮቶች ለመመርመር ይፈልጋል። የጥናቱ ውጤቶች በታሽ ሁኔታ ለታዳሚ ማእከላዊ ዕርዳታ እና የድጋፍ አገልግሎቶች ለማሻሻል ሊረዱ ይችላሉ።

3. የጥናት መሳርያዎች እና ዘዴዎች

ዋና መሳርያ: በከፍተኛ ጥያቄዎች የተዘጋጀ በክፊል-የተዋቀረ የቃለ መጠይቅ መመሪያ

የመለጃ ስብሰባ: አንድ ሚስጥራዊ ጥልቅ ቃለ መጠይቅ ይወሰዳል እሱም ለ ፳-፶ ደቂቃዎች ይቆያል፤ በአማርኛ ይካሄዳል። ቃለ መጠይቁ በትክክለኛ ሰነድ ለማድረግ በፈቃድዎ ድምጽ ይመዘገባል፤ በተጨማሪም በቃል ለማይነገሩ መረጃዎች የመስክ ማስታወሻዎች ይወሰዳሉ።

ትንተና: ከቃለ መጠይቁ ከተፃፉት ጽሑፎች (transcripts) በExcel ሶፍትዌር በመጠቀም በመደብ በመደብ (thematic) ይተነተናል።

4. ተሳታፊ ምርጫ: የተጋባዥነት ምክንያቶች:-

- ከ 18 ዓመት በላይ ዕድሜ ኖት
- የጡት ካንሰር ምርመራ ተደርጎለታል
- አሁን በሆስፒታሉ ህክምና እየተቀበሉ ነው?
- ተሞክሮትን በአማርኛ መናገር ትችላሉ

5. ሂደት: በ 60_90 ደቂቃ የሚቆይ ቃለ መጠይቅ (ከግል በቀጥታ፣ በግል ክፍል) ይሳተፋሉ። ጥያቄዎቹ ምርመራዎን፣ የህክምና ተሞክሮዎችን፣ የመቋቋም ስልቶችን እና ለዕርዳታ ማሻሻያ ሐሳቦችን ያጠቃልላሉ። ቃለ መጠይቁ (በፈቃድዎ) ድምጽ ይቀረፃል እና ማንነት ሳይጠቀስ ይፃፋል።

6. አደጋዎች እና አስቸጋሪ ሁኔታዎች: አደጋዎቹ ስለ ሚስጥራዊ ርዕሶች በሚያወሩበት ጊዜ ስሜታዊ ጫና ሊኖር ይችላል። በእንደዚህ አይነት ሰዓቶች ማረፍ ፣ ጥያቄዎችን ማለፍ ወይም በማንኛውም ጊዜ ያለቅጣት ከመሳተፍ መውጣት ይችላሉ።

7. **ጥቅሞች፡** የእርስዎ ግኝቶች ለወደፊት የጡት ካንሰር ታዳሚዎች ድጋፍ ለማሻሻል ሊረዱ ይችላሉ። ከፈለጉ የጥናቱን ውጤት ማጠቃለያ ይቀርብሎታል።

8. **ሚስጥራዊነት፡** ስምዎ እና ማንነትዎን የሚገልጹ መረጃዎች በተፃፉት ጽሑፎች ወይም ሪፖርቶች ላይ አይጠቀሱም። መረጃው በደህንነት ይከማቻል እና ለጥናት ቡድኑ ብቻ ይሰጣል። በተጨማሪም የድምጽ መዛግብቶቹ ከጥናቱ በኋላ ይወገዳሉ።

9. **ፈቃደኛ ተሳትፎ፤** ጥያቄዎችን ለመመለስ ማስተናገድ ወይም በማንኛውም ጊዜ ያለ ህክምናዎ ተጽዕኖ ተሳትፎዎን ማቆም ይችላሉ።

10. የመገኛ መረጃ

ለጥያቄዎች የሚከተሉትን ያግኙ፡-

ተመራማሪ፡ ብስራት የነዳለም፣ ኢሜይል – bisratyenealem@gmail.com / ስልክ - 0925322885

የእምነት መግለጫ

ይህንን ፎርም አንብቤዋለሁ (ወይም ለእኔ ተነቦልኛል) እና ጥናቱን ተረድቻለሁ። በፈቃደኝነት በጥናቱ ለመሳተፍ እስማማለሁ።

የተሳታፊ ስም፡ _____

ፊርማ፡ _____ ቀን፡ _____

የተመራማሪ ስም፡ _____

ፊርማ፡ _____ ቀን፡ _____

Annex 2

Questionnaires

Introduction

Thank you for agreeing to participate in this interview. The purpose of our conversation is to better understand the experiences of individuals who have been diagnosed with breast cancer. We want to learn about the emotional, physical, and practical aspects of your journey to help improve support and care for others in similar situations.

Your participation is entirely voluntary, and you can choose not to answer any question or stop the interview at any time. Everything you share will be kept confidential and will be used only for this research.

Demography:

Name: ----- Age: ----- Marital Status: -----

Place of residence: -----

Education -----

Occupation -----

Interview guide:

1. How did you feel emotionally upon receiving your breast cancer diagnosis?
2. Can you describe the physical and psychological changes you experienced as a result of the cancer and its treatment?
3. What challenges did you face in accessing therapy for your breast cancer, such as hospital conditions?

4. How have healthcare providers, family, and friends supported you during your breast cancer journey?
5. Can you share any moments or experiences that have given you hope or helped you cope with the challenges of breast cancer?
6. How do you manage the day-to-day emotional and psychological impact of breast cancer?
7. What coping strategies or resources have been particularly helpful to you in dealing with the challenges of breast cancer?
8. Have you encountered any difficulties in communicating your needs and concerns to healthcare providers?
9. How has the breast cancer diagnosis and treatment affected your relationships with family, friends, and others in your support network?

Conclusion

Thank you so much for your time, openness, and for sharing your personal story with me today. Your insights are incredibly valuable and will help us understand the real-life experiences of people with breast cancer much better.

Is there anything important about your experience that we didn't discuss that you would like to add? Do you have any questions for me?

Again, thank you for your contribution. Your voice matters. We wish you all the very best on your continued journey.

መጠይቅ

ለዚህ መጠይቅ በመሳተፍዎ እናመሰግናለን። የዚህ ውይይት ዓላማ የጡት ካንሰር ምርመራ ያገኙ ሰዎች ተሞክሮ በተሻለ ሁኔታ ለመረዳት፣ በተለይም ስሜታዊ፣ አካላዊ እና ተግባራዊ የሆኑትን ገጽታዎች መከታተል ነው። ይህ እውቀት ለሌሎች በተመሳሳይ ሁኔታ ላይ ላሉ ሰዎች ድጋፍ እንከብካቤ ለማሻሻል ይረዳናል።

ሙሉ በሙሉ ፈቃድዎ ላይ የተመሰረተ ነው። ማንኛውንም ጥያቄ ለመመለስ ወይም ውይይቱን በየትኛውም ጊዜ የማቆም መብት አለዎት። የሚያካፍሉት ሁሉ መረጃ ሚስጥራዊ ይሆናል እና ለዚህ ጥናት አላማ ብቻ ይውላል።

የዲሞግራፊ መረጃ

ስም: _____

ዕድሜ: _____

የጋብቻ ሁኔታ: _____

መኖሪያ ቦታ: _____

የትምህርት ደረጃ: _____

የሥራ መደብ/ሙያ: _____

1. የጡት ካንሰር ታካሚ መሆኑን ሲያውቁ ምን ተሰማዎት? (ስሜትዎ እንዴት ነበር?)
2. በ ካንሰሩና በ ህክምናው የተነሳ በሰውነትዎና በሃሳብዎ ላይ ምን ለውጦች አይተዋል?
3. ለካንሰሩ ህክምና (ለምሳሌ በሆስፒታል ውስጥ) ሲገኙ ምን አይነት ችግሮች አጋጥሟችኋል?
4. በዚህ በህመም ጉዞ ላይ ዶክተሮች፣ ቤተሰብ፣ ጓደኞችዎ እንዴት እርዳታ አድርገውሎታል?
5. በዚህ ከባድ ጊዜ ውስጥ ተስፋ የሚያሰጥሉ ወይም ልባችሁን የሚያረጋጉላችሁ ልዩ አጋጣሚዎች ነበሩ?
6. የካንሰሩን ዕለታዊ ስሜታዊ እና አእምሮዊ ጫና እንዴት ትቆጣጠራላችሁ?
7. በዚህ ሁሉ ችግር ውስጥ ልብ ሊባል የሚገባ አስተዋጽኦ ያደረገላችሁ ነገር አለ? (ለምሳሌ፣ የምትደረጉት ነገር፣ የሚያግዝዎት ሰው፣ ወይም የሚያገኙት መረጃ)

8. ለዶክተሮችዎ የሚያሳስባችሁን ነገሮች ለመናገር ችግር አጋጥሟችኋል?

9. የጡት ካንሰር ምርመራውና ህክምናው ከቤተሰብ፣ ከጓደኞችና ከሌሎች ሰዎች ጋር ያሎትን ግኑኝነት እንዴት ለወጠ?

የመጠይቅ ማጠቃለያ

በጣም እናመሰግናለን ለሰጡን ጊዜ፣ ለከፍት ልብዎ እና የግል ታሪክዎን ለማካፈልዎ። ያጋራችሁን እይታ ከፍተኛ እሴት አለው እና የጡት ካንሰር ታካሚዎች ትክክለኛ የህይወት ተሞክሮ እንድንረዳ በጣም ይረዳናል።

ለማካፈል የሚፈልጉት ተጨማሪ ተሞክሮ ካለ መጨመር ይችላሉ፣ ለእኔ ምን ጥያቄ አለዎት?

እንደገና፣ ለድምጽዎ እና አስተዋፅኦዎ እናመሰግናለን። ድምጻችሁ ትልቅ እሴት አለው። በቀጣይ ጉዟችሁ ላይ ሁሉንም የተሻለ ነገር እንመኛለን።

Annex III: Assurance of Investigator

I , the undersigned investigator agree to accept all responsibilities for the scientific, ethical and technical conduct of the research project and for provision of required progress reports as per terms and conditions of the Research and Publication Directorate and /or Department of Public Health of St. Paul's Hospital Millennium Medical College.

Name of the Investigator: Bisrat Yenealem

Signature: _____

Date: _____

Approval of Advisors

Primary Advisor: Simegnew Hondabo

Signature: _____

Date: _____

Co-Advisor: Dr. Mitku Getu

Signature: _____

Date: _____

Dr.

Signature: _____

Date: _____

