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REVIEW ARTICLE

Experiences of women with breast cancer in sub-Saharan Africa: A systematic review

Faraja M. Magwesela[1], Peter A. Kayange[1], Doreen O. Msemakweli[2], Frank G. Madinda[1]

[1]Department of Surgery, Arusha Lutheran Medical Center, Arusha, Tanzania
[2]Department of Surgery, Kilimanjaro Christian Medical Center, Moshi, Tanzania

Correspondence: Dr Faraja M. Magwesela (fm3magwesela@gmail.com)

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Abstract

Background
Breast cancer is the most prevalent cancer and a principal cause of cancer-related morbidity and mortality among women worldwide. The experience of living with breast cancer is individualized and shaped by sociocultural factors. Its adverse effects extend beyond the socioeconomic status of the affected individuals, influencing their emotions, psychology, and physical well-being. This review aimed to identify and synthesize data exploring the experiences of women with breast cancer in sub-Saharan Africa.

Methods
MEDLINE, Embase, Scopus, and CINAHL databases were searched for articles published on the subject from inception to March 2022, following PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) guidelines. Additionally, forward citation tracking, manual reference searches, and the examination of relevant journals were conducted. A thematic synthesis was performed on the 'Results' sections (or equivalent) of the identified qualitative articles, followed by a multisource synthesis incorporating quantitative findings.

Results
Of 10 637 records identified, 52 were included in the review (23 qualitative studies and 29 quantitative studies), representing 6964 women from 10 countries in sub-Saharan Africa. Thematic synthesis revealed 4 major themes and 10 subthemes. The major themes were 'Could I have cancer?', 'Now what?', 'Living with the scars', and 'Coping with breast cancer'.

Conclusions
This review offers insights into the reported experiences and quality of life of women with breast cancer in sub-Saharan Africa. These experiences are influenced by factors such as family and community support, culture, and beliefs. The findings suggest that encouraging and providing comprehensive support—social, financial, and spiritual—to women with breast cancer could significantly enhance their quality of life.

Keywords: breast neoplasms, quality of life, thematic analysis, health services accessibility, social support, sub-Saharan Africa

Introduction

Breast cancer was the most diagnosed malignancy and the second leading cause of cancer-related deaths among women globally in 2020, accounting for 2.3 million diagnoses and 6.9% cancer-related deaths.[1],[2] The distribution of breast cancer varies between countries, with low- and middle-income countries experiencing low incidence and high mortality rates relative to high-income countries.[3]-[5] In sub-Saharan Africa, breast cancer is the second most common malignancy and the leading cause of cancer-related deaths among women, with the age-standardized incidence rate being higher in Eastern Africa than Western Africa, although the age-standardized mortality rate is higher in Western Africa than in Eastern Africa.[1]-[3] Low- and middle-income countries face a disproportionately high burden of disease compared with other countries, mainly due to the majority of patients presenting with advanced disease.[6]-[8]

A holistic, patient-centred approach to cancer care necessitates that treatment and survival be taken into consideration, and the patient's quality of life needs to become an important outcome measure in breast cancer survivorship.[9]-[11] The impact of breast cancer on women's health-related quality of life and experiences change

Table 1. Search terms used with electronic databases

Participant-related	Experience-related	Location
(breast OR mammary) AND (cancer OR carcinoma OR tumour OR tumor OR malignancy OR neoplasm)	adaptation, attitudes, anxiety, barrier, belief, believe, coping, culture, depression, enduring, expectation, experience, health knowledge, idea, lived experience, motivation, narrative, perception, perspective, psychological, quality of life, social support, survivor, view	Burundi, Cameroon, Central African Republic, Chad, Congo, Democratic Republic of the Congo, Equatorial Guinea, Gabon, São Tomé and Principe, Djibouti, Eritrea, Ethiopia, Kenya, Rwanda, Somalia, South Sudan, Sudan, Tanzania, Uganda, Angola, Botswana, Eswatini, Lesotho, Malawi, Mozambique, Namibia, South Africa, Zambia, Zimbabwe, Benin, Burkina Faso, Cabo Verde, Côte d'Ivoire, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Togo, Comoros, Madagascar, Mauritius, Seychelles

Table 2. Eligibility criteria

Category	Inclusion	Exclusion
Study design	Original research with qualitative or quantitative design published in peer-reviewed journals	Review articles, theses, books, conference articles, posters, letters to the editor, and opinion pieces
Language	Published in English	Not English
Focus	Experiences of breast cancer	Other cancers or impossible to disaggregate information relating to breast cancer
	Experiences and quality of life of women with breast cancer	Experiences of relatives, caretakers, healthcare professionals, or men with breast cancer
Context	Women living in sub-Saharan Africa	Immigrant African women living outside of sub-Saharan country

over time, influencing treatment adherence and perceptions of breast cancer among those around them.[12],[13] The diagnosis of breast cancer is highly distressing for women, evoking feelings of lost control over their lives and fears that their lives may never be the same again.[12],[14] Living with breast cancer is a unique, individualized experience for each woman, influenced by factors such as family, culture, beliefs, healthcare access, and many others; the experience is dynamic, evolving with the stages of the disease, whether it advances or enters remission.[15],[16] These experiences encompass physical, emotional, socioeconomic, and psychological aspects, which are predominantly negative. Physical experiences include changes in body image, pain from the tumour or treatment, and treatment side effects, such as nausea, vomiting, and lymphoedema.[10],[17]-[19] Socioeconomic aspects include social support, stigma, treatment costs, loss of independence, job loss, and the inability to engage in social and community activities.[11],[14],[20] Psychological and emotional effects include loss of femininity and sexuality following mastectomy, decreased self-esteem, increased reliance on spiritual support, depression, anxiety, and fatalism.[10],[19],[21],[22]

Many primary studies have been conducted in sub-Saharan Africa to explore the experiences of women with breast cancer and their associated health-related quality of life. Health-related quality-of-life scales have been used to assess overall quality of life, as well as functional, social, physical, and emotional well-being. Furthermore, breast cancer experiences have been documented through in-depth discussions with breast cancer patients, their families, caretakers, and healthcare providers. Understanding women's experiences of breast cancer in sub-Saharan Africa can be enriched with collective systematic analyses of data to provide a deeper, richer understanding of such a broad topic. We were unable to identify a synthesis of studies exploring the experiences of women with breast cancer in sub-Saharan Africa. Consequently, this review aimed to identify and synthesize the available literature exploring sub-Saharan women's experiences of breast cancer from both qualitative and quantitative perspectives. This was guided by the review question, 'What is the experience of sub-Saharan African women with breast cancer?'

Methods

This review followed the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) guidelines.[23]

Search strategy

A comprehensive electronic database search was conducted in March 2022 using CINAHL, MEDLINE, Embase, and Scopus. To complement the database search, forward citation tracking and examination of reference lists of relevant articles were conducted. Finally, a manual search for articles was conducted using the following resources: African Journals Online, DiscoverEd (University of Edinburgh), and the Pan-African Medical Journal.

Search terms are shown in Table 1 (the search strategy for MEDLINE can be found in Supplementary File 1). To maximize retrieval of all relevant articles, our search strategy did not impose a limitation on the year of publication. Boolean operators 'OR' and 'AND' were used to include and restrict search terms, respectively.

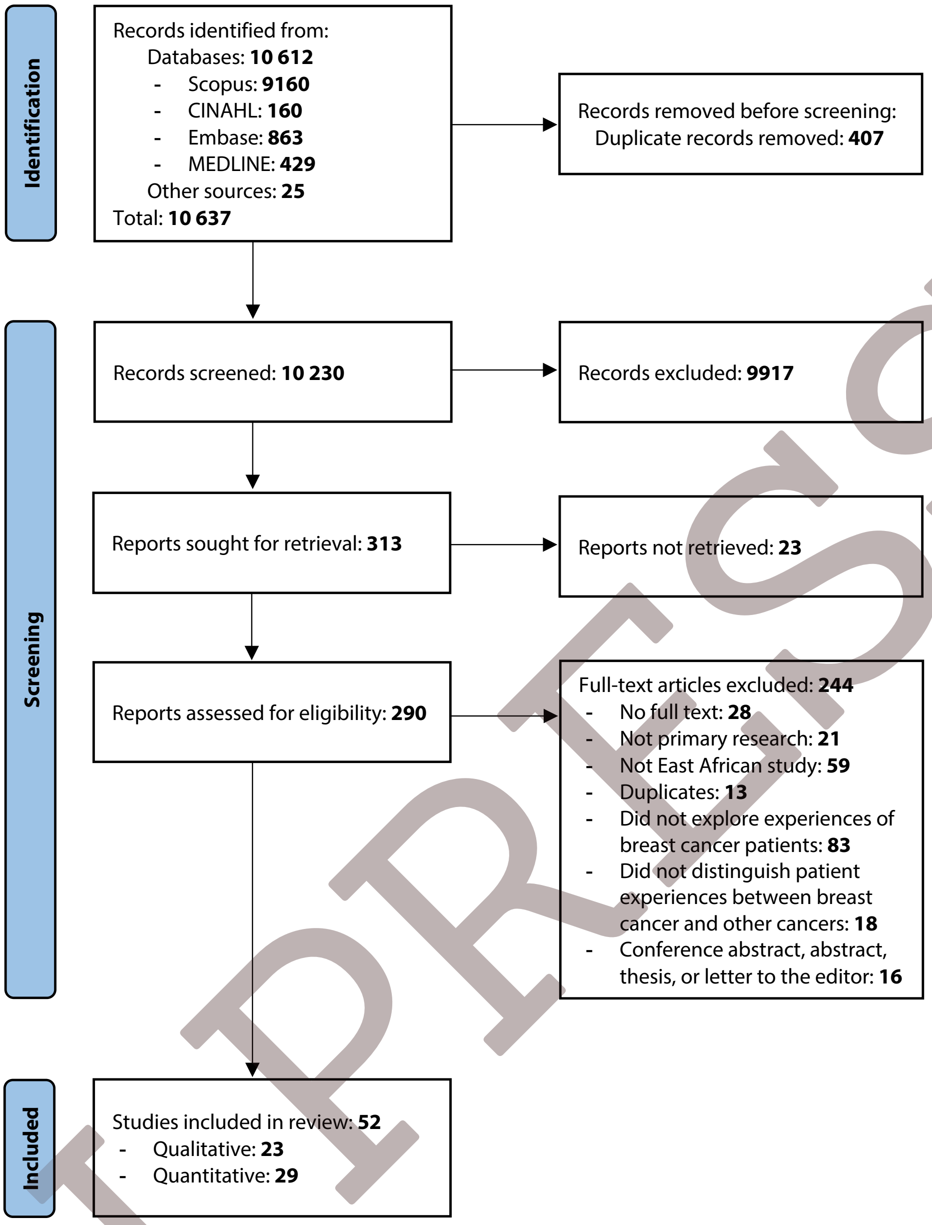

Figure. PRISMA flow diagram depicting the article selection process

Selection criteria

Articles were included in the review if they met the eligibility criteria in Table 2.

Study selection

All articles retrieved through the electronic search process were entered into an EndNote 20 (Clarivate, Philadelphia, PA, USA) bibliographic database. After duplicates were removed, all articles' titles and abstracts were screened for eligibility. Subsequently, full-text versions of the articles that met the eligibility criteria, as well as those requiring further assessment, were retrieved.

Quality assessment

Qualitative studies were assessed using the CASP (Critical Appraisal Skills Programme; OAP Ltd, Oxford, UK) quality assessment tool. Quantitative studies were appraised using the JBI's cross-sectional critical appraisal tool for cross-sectional studies.[24] Two independent reviewers conducted the quality assessment of the included articles (Supplementary File 2). No articles were excluded based on the quality assessment; rather, the assessment contributed to the confidence in each finding.

Data extraction and synthesis

Key data from each of the included papers were extracted using a template. Extracted data included the name of the first author, year of publication, country of study, study aims, design, setting, demographics, data collection methods, sample size, and main findings.

Data extraction, analysis, and synthesis for qualitative studies followed Thomas and Harden's thematic synthesis approach.[25] Quantitative data were synthesized using a narrative synthesis approach. Identified qualitative themes were examined for interconnectedness with included quantitative studies, and the findings from the quantitative articles were integrated within the themes using the multisource synthesis method.[26]

Results

Study characteristics

The initial search yielded 10 637 articles, out of which 52 were selected for inclusion in the study (Figure). Of the 52 included articles, 23 report on qualitative studies, and 29 report on quantitative studies. These articles encompass data from 6964 participants from 10 countries.

Qualitative studies

Nearly all of the qualitative studies used interviews as their primary data collection method, with 1 study opting for focus group discussions (Table 3). The sample sizes ranged from 7 to 50, totalling 429 participants. The quality of the included studies varied from fair (n=13) to good (n=10).

Quantitative studies

Among the quantitative studies, 25 were cross-sectional studies, 2 were surveys, 1 was quasi-experimental, and 1 was a randomized controlled trial (Table 4). The sample sizes ranged from 33 to 1476, totalling 6535 participants. The quality of the included studies was categorized as fair (n=6) and good (n=23).

Thematic analysis

Four major themes were identified: (1) 'Could I have cancer?', (2) 'Now what?', (3) 'Living with the scars', and (4) 'Coping with breast cancer' (Table 5).

Theme 1. 'Could I have cancer?' The diagnosis

1a. Identifying the symptoms: 'I didn't know what it was'.

The majority of women included in our review discovered their symptoms coincidentally rather than through screening.[27]-[30] Dano et al.[31] showed that up to 99% of breast cancer patients discovered their symptoms by chance. This period is characterized by uncertainty for many women, as well as multiple visits to traditional healers and health facilities.[32],[33] This is exemplified by a response from a 45-year-old woman:

> *I started to be afraid. I showed it to many people. Some said, 'Maybe you are approaching menopause'; others said that it is nothing… I showed it to a pharmacist… He told me it is a furuncle, and taking antibiotics will prevent it from growing. I talked to my husband who said that I have nothing and that I talk too much.*[30]

1b. The process to confirm the diagnosis: 'I started at a prayer camp'.

Upon identifying symptoms, women adopt a variety of approaches to assessing and understanding their health concerns. Between 23.6% and 27% of women in our review used alternative treatments (traditional and spiritual) before presenting to health facilities.[31],[34]

The time from symptom discovery to diagnosis was between 8 and 29.64 months (average, 20.4 months).[31],[35]-[38] This suggests that many patients either choose not to pursue immediate investigation upon symptom recognition or encounter delays in obtaining comprehensive evaluations at healthcare facilities.

1c. Reactions to a cancer diagnosis: 'I thought my life was over'.

Receiving a breast cancer diagnosis results in a mixture of emotional reactions such as shock, fear, sadness, disbelief, and anxiety; some women refute the diagnosis and seek alternative care, and few accept the diagnosis with positivity[28],[29],[33],[39]-[44]: 'I thought my life was over. It was the least I ever expected to happen to me'.[38]

Negative reactions to breast cancer diagnoses are associated with the absence of a family history of cancer, being young, fearing social isolation, and fatalism.[28]-[30],[32],[39],[41],[42],[44]-[46] This illustrates the need for counselling patients, their families, and their social circles about breast cancer treatment and survival, as this has been shown to decrease the negative psychological effects of a cancer diagnosis.[47]-[50]

Theme 2. 'Now what?' What next after a cancer diagnosis?

2a. Disclosure of diagnosis: 'Why should anybody know?'

Few women are open to sharing their breast cancer diagnosis with others.[29],[33],[42],[44],[51],[52] Instead, many choose to share this sensitive information exclusively with trusted individuals who can offer confidentiality, as well as social and spiritual support.[29],[30],[44],[46],[52],[53] Women often want to maintain secrecy to avoid negative social consequences, such as gossip and stigma.[29],[52],[54] This attitude is shown by a response from a 62-year-old: 'Why should anybody know that I have breast cancer? They will also add their own story and spread it. It will become like a stigma on me, and people will not get close to me anymore'.[55]

2b. Decision on treatment: 'How can I part with my breast?'

The decision to have a mastectomy is difficult for most women. A 48-year-old woman commented, 'A woman's glory is her breast; so what is your use if one of your breasts is not there? I will rather die with my two breasts than live with one'.[53]

Fear of mastectomy is related to fear of death (27.5%-61.8%),[34],[56] fear of surgery (30.3%-86.3%),[34],[56],[57] fear of stigma (5.6%-77.5%),[34],[56] fear of financial costs (25.8%),[34],[57] fear of subsequent treatment side effects (4.5%-65.4%),[34],[57] and fear of negative relations with spouses (5.6%-38.8%).[34],[56] Fear has been noted to be more common among young patients (premenopausal), those with dependents, and those with low levels of education.[34],[56],[57]

Although desiring a collaborative dialogue regarding treatment options, most participants noted that the decision was often made unilaterally by either their doctors or spouses.[28],[32],[33],[46] Shared decision-making has been shown to increase treatment compliance and improve treatment satisfaction and outcomes.[58]-[60]

Theme 3. Living with the scars

3a. The bad side of treatment: 'Just live with it'

Breast cancer treatment is challenging for most women.[43],[61],[62] In our review, between 65.2% and 71% of participants experienced chemotherapy side effects,[31],[34],[63] and 7.9% to 75% experienced surgical complications.[34],[64],[65] Associated changes in physical appearance, including the loss of a breast, hair loss, changes in skin pigmentation, and fluctuations in weight, are sources of considerable distress for many patients.[43],[45] Severe nausea and vomiting lead some patients to discontinue treatment.[31],[63] Managing these complications presents financial, emotional, and physical challenges: 'I visited the doctor once a month, and each time I told him there is something wrong, but he just said, "it will go away"… nobody listens! I hate it when they say it will go away!'.[61]

Treatment complications are sources of frustration, unhappiness, and depression as they hinder some patients from performing their routine chores, engaging in economic activities, participating in social functions, and wearing clothes they like. Women's coping strategies with physical changes include wearing large clothes to mask body changes, wearing wigs to hide alopecia, using artificial breasts to mask mastectomy, seeking assistance for daily living activities, and—at times—choosing self-isolation.[46],[52],[62]

3b. Changing roles: 'It limits your duties'

Study participants described experiencing significant shifts in their domestic, professional, and communal roles following their breast cancer diagnoses.[32],[43],[45],[52],[54],[61],[66] A substantial proportion, ranging from 54.3% to 89.7%, indicated a low quality of life after receiving therapeutic interventions.[35],[67]-[69] Factors associated with low quality of life scores included having a low education level, poor social network, undergoing chemotherapy, anxiety, depression, low income level, and being single.[31],[35],[38],[68]-[70] Quality of life improved over time and among patients with positive coping mechanisms.[71]-[75]

Furthermore, the removal of a breast can profoundly impact a woman's sense of femininity.[41],[44]-[46] Between 67.9% and 70% of the study participants felt less feminine, and 18.8% to 62.5% had low self-esteem after undergoing mastectomy.[56],[76],[77] Some women, in response to changes in their bodies, opt for self-isolation by changing neighbourhoods, erecting physical barriers, and choosing not to engage in social functions.[41],[46],[52] Alterations in body image were reported to affect between 16.6% and 77.21% of patients, predominantly impacting those who were younger, married, not employed, had lower levels of education, and resided in urban areas.[67]-[69],[76]

Additionally, 17.78% to 85.8% reported experiencing sexual difficulties after their diagnoses.[45],[46],[67]-[69],[76] Between 34.5% and 37.5% of married women experienced negative spousal reactions, and marital relationships were reported to be negatively impacted in 41.3% to 58.1% of cases following mastectomy.[56],[76] Also, 67.9% to 71.3% of women reported being psychologically affected after undergoing mastectomy, with younger and married women being particularly susceptible.[56],[76]

3c. Economic burden of breast cancer: 'It's a money-intensive thing'

The financial burden of breast cancer treatment can jeopardize the economic stability of patients and their families. Financial difficulties often contribute to treatment delays or postponement,[27],[33],[39],[44],[45],[52],[53],[66] as evidenced by the experience of a 67-year-old patient:

> *I did not go for the remaining treatments because I have not gotten the money—that's one. Because it's a money-intensive thing. And the doctor told me that after this one, there's another one that costs ten thousand cedis (US$ 2175) that I have to do. I asked myself… what is this? So, I decided to hold on and see what the Lord will do.*[66]

Patients encounter varied experiences with health insurance coverage, with several policies lacking provision for critical treatment components, notably chemotherapy and radiotherapy.[27],[45],[52],[53] Furthermore, many patients are compelled to cease employment or are dismissed owing to complications arising from treatment or prolonged postoperative recovery periods. In some cases, caregivers have to stop working to provide the necessary support.[41],[45],[52],[53],[66] The quantitative data included in our review reveals that between 71.9% and 72% of women found themselves unable to continue working as a direct consequence of their treatment and its adverse effects.[31],[36],[78]

Some women cope with financial difficulties by seeking help from religious organizations, institutions, and individuals.[40],[46] Data from our systematic review indicated a wide range of personal contributions towards treatment costs, with 6% to 68.7% of patients financing their own care, 81% to 84.3%, depending on family support, 12.4% to 15% turning to friends, and 7.5% to 18% using insurance coverage.[31],[34] The cost of cancer treatment, as reported by some studies, can result in the exhaustion of savings, collapse of businesses, and loss of employment. This highlights the need for social protection and labour protection, especially for chronic illnesses such as cancer.

Theme 4. Coping with breast cancer

4a. Changing attitudes and perceptions: 'I'm grateful'

Patients employ various forms of coping mechanisms to deal with the stress of breast cancer diagnosis, treatment, and survival. These mechanisms include acceptance, religious coping, avoidance, distraction, isolation, resignation, blame, keeping busy, and finding support.[40],[41],[46],[62],[72] The studies included in our review found that 72.5% to 85% of women coped through religion.[56],[71] Despite the negative experiences with diagnosis and treatment, many patients were grateful to have survived, or to be surviving, finding their sense of gratitude through belief in God and prayer.[42],[46],[54],[61]

4b. Navigating breast cancer with support: 'I really needed support'

Support from families, friends, institutions, and healthcare providers plays a pivotal role in the lives of women battling breast cancer.[33],[40],[42],[45],[53] The nature of this support can vary greatly, with some women receiving positive reinforcement while others face negative reactions and associated complications.[29],[30],[32],[33],[40],[42],[45],[46],[51],[54],[61] Complications associated with the need for social and familial support include emotional, physical, and sexual abuse by intimate partners,[40]-[42],[46],[53]which can be associated with dependence on partners.

A lack of social support can affect treatment decisions.[28],[32],[41] Between 50.8% and 60.5% of women who participated in the studies included in the review indicated they experienced a lack of necessary social support,[75],[79] and 55.4% to 68.5% reported having unmet healthcare needs.[34],[75] Common unmet healthcare needs were counselling (88.8%-96.6%), information, and financial assistance.[34],[36],[56],[75]

Positive experiences with healthcare providers were found to be sources of hope and encouragement for patients.[32],[45] Positive attitudes, empathy, and openness to discussion from healthcare workers contributed to patient satisfaction and adherence to treatment.[39],[45]

Breast cancer support groups elicited mixed feelings among participants of the included studies. While some found these groups to be a source of positivity and hope, others felt that discussions within these groups intensified their fears and depression.[39],[43],[45],[54]

Discussion

This review has generated an understanding of how breast cancer is experienced by women in sub-Saharan African countries. It has illustrated how women's experiences are an interplay of individual, social, and healthcare factors. The main finding was that women had negative experiences when they lacked social, financial, or spiritual support. Despite this, the findings reveal a progression towards improvement over time, with many women ultimately achieving a satisfactory quality of life.[15] Other important findings dealt with the economic burden of breast cancer and how women cope with breast cancer.

Social support was a recurrent theme in several studies. Appreciating the social roles of women in the African context is important in understanding how breast cancer affects their lives. African women have multiple roles, such as being mothers, caretakers, and carrying out most of the duties in the home.[80] The studies have demonstrated that robust social support networks enhance the overall quality of life for women with breast cancer, enabling them to navigate their individual challenges more effectively.[81]-[84] This support encompasses not only assistance in managing daily life but also fostering acceptance rather than isolation. In many African communities, cancer continues to be stigmatized, adversely affecting patients' social integration and participation in family or community activities, which, in turn, hampers their rehabilitation after diagnosis and during treatment.[83],[85]-[88] Moreover, patients with cancer are at an increased risk of facing abuse from partners or caregivers—a concern highlighted in this review.[89],[90]

The majority of Africans still live in poverty, and breast cancer demands financial commitment in terms of money paid to access the services and the amount of time one has to spend out of work to recuperate during or after treatment or due to symptom burden.[91]-[93] The articles included in this review reveal that many women depend on financial support from others for their treatment, while many lose their businesses or jobs due to their condition. Few women who participated in the included studies had health insurance, and among those insured, few reported that their policies adequately covered medical treatments. Therefore, making cancer treatment more affordable through subsidies is imperative in sub-Saharan Africa, ensuring all patients can access and complete necessary care.[92] Furthermore, implementing labour protections to financially support individuals unable to work during and after treatment is crucial, allowing them to return to work post-recovery without financial distress.[94],[95]

Lastly, adopting positive coping strategies has been linked to enhanced quality of life for patients.[96]-[98] Religion stood out in our review as a predominant coping mechanism among women, influencing their perceptions of health and illness. For instance, some women view their breast cancer journey as a divine challenge to their faith, while others perceive it as an opportunity to reassess their priorities in life.[82],[99],[100]

Strengths

To our knowledge, this is the first review to systematically analyse studies investigating the experiences of women with breast cancer in sub-Saharan Africa. An extensive literature search was conducted without temporal restrictions. Both qualitative and quantitative studies investigating the experiences or quality of life of women with breast cancer were included. A thematic synthesis, together with a multisource synthesis of the qualitative and quantitative data, was conducted. Additionally, we performed a quality appraisal of the included studies, and no study was excluded based on its quality.

Limitations

This review had some limitations. First, we found no data from 44 sub-Saharan African countries, leaving a gap in our understanding of breast cancer experiences in these regions. Second, there was variation in methods and measurement scales among quantitative studies, which precluded a meta-analysis of quality of life measures. Third, the exclusion of articles not published in English, unpublished reports, grey literature, review articles, conference abstracts, and theses may have omitted relevant information.

Conclusions

This review underscores the diversity of experiences among women with breast cancer in sub-Saharan Africa while also identifying a notable scarcity of evidence from certain regions. It lays the groundwork for further investigations into these experiences, facilitating a more in-depth exploration of the subject matter.

Improving support to breast cancer patients and survivors may be the most effective strategy for improving the quality of life of such patients in sub-Saharan Africa. Additionally, public education about breast cancer should be provided to reduce stigma and improve early detection and presentation. There is also a need to strengthen investment in healthcare to make cancer treatment more affordable and accessible. Enhanced research efforts are also needed to sufficiently address the existing and increasing need for cancer services.

Table 3. Characteristics of qualitative studies

First author	Year	Country	Research focus	Methods	N	Demographics	Themes	Quality rating
Adejoh & Olorunlana[39]	2016	Nigeria	Experiences of cancer patients	In-depth interviews	20	Patients receiving treatment in private hospitals of Lagos	Breast cancer diagnosis and communication of treatment procedures Fear of death and financial concerns Involvement in decision-making Information sharing and feedback	Fair
Adejoh et al.[51]	2021	Nigeria	Experiences of family members' reactions to breast cancer diagnoses and the role of family support in managing breast cancer	Semistructured interviews	15	Married women in Lagos receiving treatment at a private hospital	Reactions of family members to breast cancer diagnosis Family support	Fair
Agbeko et al.[27]	2020	Ghana	Symptom appraisal and medical health-seeking behaviour	In-depth interviews	15	Women with either locally advanced or metastatic breast cancer attending breast clinic at Komfo Anokye Teaching Hospital, Kumasi	Personal phase of health seeking Health system phase	Fair

Continued

Table 3. Continued

First author	Year	Country	Research focus	Methods	N	Demographics	Themes	Quality rating
Amoo et al.[40]	2020	Nigeria	Coping strategies	In-depth interviews	9	Ever-married patients without spouses	Social support from institutions or community Husband support and coping strategies among women with breast cancer Support and coping strategies among women without spouses Coping mechanism among the survivors without husbands Seeking medical help Resort to fate Determination to survive	Fair
Aziato & Clegg-Lamptey[28]	2014	Ghana	Reactions to breast cancer and factors influencing treatment decisions	Semistructured interviews	12	Women attending Korle-Bu Teaching Hospital, Accra, who had undergone mastectomy	Identification of breast lesion Confirmation of diagnosis Reaction to diagnosis Factors influencing treatment decisions	Fair
Bonsu & Ncama.[29]	2019	Ghana	Reasons for delayed presentation	Semistructured interviews	11	Women with advanced breast cancer at the palliative care clinic of Komfo Anokye Teaching Hospital, Kumasi	Symptom experience Knowledge about breast cancer Role of social life and network Coping with a breast cancer symptom Intent to seek health care	Good
Bosire et al.[41]	2020	South Africa	Comorbid suffering	Key informant interviews	50	Women with medical comorbidities in Soweto	Social and economic dynamics of family Meaning, metaphor, and the distorted body	Fair
Grosse Frie et al.[30]	2018	Mali	Barriers throughout a breast cancer patient's pathway from symptom recognition to treatment	Focus group discussions	25	Breast cancer survivors and breast cancer patients	Barriers during appraisal interval: low level of breast cancer knowledge among women, their families, and medical professionals Barriers during help-seeking interval: mistrust in the community healthcare centres and economic hardships Barriers during diagnosis interval: low quality of healthcare services and lack of social support Barriers during pretreatment interval: high costs and lack of specialized services	Good

Continued

Table 3. **Continued**

First author	Year	Country	Research focus	Methods	N	Demographics	Themes	Quality rating
Gonzaga[42]	2013	Uganda	Experiences of women living with breast cancer	In-depth interviews	12	Women with breast cancer reporting to the radiology department of Mulago Hospital, Kampala	Thoughts of death Strength to live Loss of female identity and sexuality Coping mechanisms	Fair
Iddrisu et al.[52]	2020	Ghana	Socioeconomic impact of breast cancer	Semistructured interviews	12	Women 15-49 years of age undergoing breast cancer treatment at University of Ghana Hospital, Accra	Perceptions and beliefs Economic concerns Secrecy	Fair
Kudjawu et al.	2021	Ghana	Experiences of women with breast cancer undergoing chemotherapy	Semistructured interviews	8	Women undergoing chemotherapy at Ho Teaching Hospital	Physiological experiences with undergoing chemotherapy Psychosocial experiences with undergoing chemotherapy Experiences with social support systems	Good
Kugbey et al.[66]	2021	Ghana	Lived experiences (physical, psychosocial, economic, and relational)	In-depth interviews	11	Women receiving breast cancer treatment at the Nuclear Medicine and Radiology Department of the Korle-Bu Teaching Hospital, Accra	Burdens of medical treatment Social burden Alternative medicine Breast cancer stigma	Good
Kugbey et al.[54]	2020	Ghana	Illness perceptions and coping strategies among women receiving care for breast cancer	Semistructured interviews	11	Women receiving breast cancer treatment at the Radiotherapy and Nuclear Medicine Department of the Korle-Bu Teaching Hospital, Accra	Illness presentation Coping with breast cancer	Good
Lambert et al.[45]	2020	South Africa	Experiences of diagnosis, treatment, and follow-up	In-depth interviews	50	Women seeking care at Chris Hani Baragwanath Academic Hospital, Johannesburg, and enrolled in the South African Breast Cancer Study Soweto	Breast cancer perceptions Treatment: fear and its repercussions Disfigurement Loss of independence Faith related to religion and medical care Mistrust of traditional healers Support and coping Perception that cancer will get worse despite treatment	Fair

Continued

Table 3. ***Continued***

First author	Year	Country	Research focus	Methods	N	Demographics	Themes	Quality rating
Maree & Beckmann[61]	2016	South Africa	How people living with breast cancer related lymphoedema experience this complication	Unstructured interviews	9	Women with breast cancer–related lymphoedema	'Just live with it': lymphoedema the unknown and the unspeakable 'My arm is painful': living with the physical consequences of lymphoedema 'You cannot hide it': living with an altered body 'I am grateful': coping with the lymphoedema	Good
Maree & Mulonda[32]	2015	Zambia	Experiences of women with advanced breast cancer	In-depth interviews	10	Women (29-66 years of age) with advanced breast cancer admitted to the University Teaching Hospital, Lusaka	Experiencing the signs and symptoms of breast cancer: 'I thought the lump would go away' Learning about the diagnosis and treatment: 'Breast cancer is the end of someone' Undergoing the treatment: 'I don't even know how I can express in words what I went through' Living with advanced breast cancer: 'My experience has been a terrible one'	Good
Martei et al.[53]	2018	Ghana	Sociocultural factors associated with delayed presentation	In-depth interviews	31	Breast cancer patients seen at the Korle-Bu Teaching Hospital, Accra	Women delay treatment because of the fear of mastectomy due to self and societal stigma Role of the church as a social support system given the societal stigma associated with breast cancer Study participants expressed some awareness of breast cancer, but with varying depths of breast cancer knowledge encompassing both myths and misconceptions about breast cancer Most patients present late because they do not associate a 'painless' breast lump with possible breast malignancy Delayed presentation linked to significant financial burden associated with breast cancer treatment	Fair

Continued

Table 3. Continued

First author	Year	Country	Research focus	Methods	N	Demographics	Themes	Quality rating
Meacham et al.[101]	2016	Uganda	Role of stigma in delaying cancer service engagement	Semistructured interviews	20	Women with breast cancer in Kampala	Symptom discovery to screening Diagnosis to treatment initiation Navigating treatment completion	Good
Olasehinde et al.[46]	2019	Nigeria	Impact of mastectomy on psychosocial life	In-depth interviews	15	Women 45 years of age and younger	Decision for mastectomy Body image change Relationship with husband and sexual life Postmastectomy transition Social support Coping with life postmastectomy	Good
Pruitt et al.[33]	2014	Nigeria	Social barriers to diagnosis and treatment	Semistructured interviews	31	Patients who presented to University College Hospital, Ibadan	Barriers to diagnosis: dismissal of symptoms, seeking alternative care, seeking orthodox medical care, declined treatment, inappropriate medical care Delays in treatment: denial, fear of surgery, strikes by hospital staff, cost	Fair
Stecher et al.[43]	2019	South Africa	Lived experiences of women after mastectomy	Semistructured interviews	7	Women in the Cape Metropole after mastectomy	Psychological impact of breast cancer diagnosis and treatment Impact of an altered body image Concern for family members and reliance on them for support Stigmatization within the Xhosa culture	Good
Van Wyk & Carbonatto[62]	2016	South Africa	How breast cancer affects the functioning of a woman as an individual, mother, and wife	Semistructured interviews	8	Women 30-70 years of age with breast cancer	Changes experienced in personality Feeling like a woman Changes in spiritual aspects Changes with regard to self-image	Fair
Zwane[44]	2020	South Africa	Breast cancer perceptions	Semistructured interviews	30	Women (22-82 years of age) from underprivileged areas of KwaZulu-Natal	Devouring vs acceptance Breast cancer as an entryway to other illnesses Breast cancer as shame inducing Breast cancer as a biomedical health issue Breast cancer as an invasion of privacy Breast cancer as an expensive venture Breast cancer as a loss of femininity Health system failure	Fair

Table 4. Characteristics of quantitative studies

First author	Year	Country	Research focus	Study design	N	Data collection method/tool(s)	Experiences identified	Quality rating
Abebe et al.[67]	2020	Ethiopia	Mastectomy-related QoL among female breast cancer patients	Cross-sectional	86	EORTC QLQ-C30 and EORTC QLQ-BR23	• EORTC QLQ-C30 global health status/QoL scale – mean score, 48.3 • Future perspectives about health – mean score, 40.3 • Sexual functioning and enjoyment – mean scores, 85.3 and 71.2, respectively • Symptom scales – mean scores ranging from 19.1-24.5. • 57% did not want breast reconstruction	Fair
Aberaraw et al.[35]	2020	Ethiopia	Social networks and QoL among female breast cancer patients	Cross-sectional	214	EORTC QLQ-C30 and EORTC QLQ-BR23	• Participants who had children (AOR, 5; 95% CI, 1.3-21; COR, 6) and other relatives (AOR, 6; 95% CI, 1.2-30; COR, 7) were more likely to have good social networks • Participants who were not married (AOR, 0.02; 95% CI, 0.03-0.28), had no living parents (AOR, 0.1; 95% CI, 0.02- 0.4), no close friends (AOR, 0.06; 95% CI, 0.01-0.4), and no neighbours (AOR, 0.09; 95% CI, 0.03-0.5) had poor social networks • Affected QoL, n=48 (22.4%); affected functional scale, n=150 (70.1%); affected symptom scale, n=192 (89.7%)	Good
Akin-Odanye et al.[102]	2011	Nigeria	Pattern and predictors of depressive symptoms among breast cancer patients receiving chemotherapy	Cross-sectional	33	BDI-II	• 13 (39.4%) had minimal depression, 12 (36.4%) had mild depression, 3 (9.1%) had moderate depression, and 5 (15.2%) had severe depression • Average BDI-II score, 16.09, indicated mild depression • Multivariate analysis: being informed about breast cancer, average monthly income, cancer stage, and educational level significantly predicted participants' level of depression	Fair
Akuoko et al.[36]	2022	Ghana	Perceived supportive care needs and health service needs of women with advanced breast cancer	Cross-sectional	176	SCNS-LF59, SNAP, and CSRI	• 96.6% had financial and counselling needs; 92.1% had at least 1 spiritual need; 90.3%-96.6% had health system issues and information needs • Younger women reported greater psychological (*P*=0.002) and sexuality (*P*<0.001) needs and less religious needs (*P*=0.048)	Good

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Table 4. ***Continued***

First author	Year	Country	Research focus	Study design	N	Data collection method/tool(s)	Experiences identified	Quality rating
Anim-Sampong et al.[56]	2020	Ghana	Psychosocial impact of mastectomy on female breast cancer patients	Cross-sectional	80	5-section, semistructured questionnaire designed following a literature review, addressing patient demographics, psychological and emotional factors, QoL, social factors, and ways to improve well-being	• After mastectomy: 56·7% felt less feminine; 71% experienced psychological distress; 63% had loss of self-confidence; 63·8% reported lifestyle changes; 58% felt stigmatized	Good
Asuzu & Elumelu[71]	2013	Nigeria	Relationship between cancer patients' QoL dimensions and coping strategies	Cross-sectional	237	Brief COPE and FACT-G	• Inverse correlation between Physical Well-Being with Behavioural Disengagement, Venting, Planning and Self-Blame ($P<0.05$) • Social/Family Well-Being linearly correlated with Active Coping, Emotional Support, Positive Reframing, Instrumental Support, Acceptance, and Religion ($P<0.05$) • Emotional Well-Being inversely correlated with Behavioural Disengagement and Self-Blame ($P<0.05$) • Functional Well-Being linearly correlated with Active Coping, Instrumental Support, and Acceptance ($P<0.05$).	Good
Belay et al.	2020	Ethiopia	Effects of interpersonal psychotherapy on anxiety, depression, and QoL among breast cancer patients	Randomized controlled trial	114	EORTC QLQ-C30	• Patients in the intervention group exhibited significant improvements in anxiety (coefficient = –3.68; 95% CI, –5.67 to –1.69; $P<0.001$), depression (coefficient = –3.22; 95% CI, –4.7 to –1.69; $P<0.001$), physical functioning (coefficient = 10.55; 95% CI, 3.13-17.98; $P=0.006$), health-related QoL (coefficient = 21.85; 95% CI, 14.1-29.59; $P<0.001$), insomnia (coefficient = –19.56; 95% CI, –31.87 to –7.25; $P=0.002$), and fatigue (coefficient = –11.37; 95% CI, –21.49 to –1.24; $P=0.028$).	Good

Continued

Table 4. Continued

First author	Year	Country	Research focus	Study design	N	Data collection method/tool(s)	Experiences identified	Quality rating
Boucheron et al.[64]	2021	Namibia, Nigeria, Uganda, Zambia	Frequency and determinants of arm and shoulder problems after a breast cancer diagnosis	Cohort	1476	EORTC QLQ-BR23 and a baseline, interviewer-administered questionnaire covering sociodemographic characteristics, comorbidities, breast cancer risk factors and health attitudes, and knowledge and beliefs	• 43% (95% CI, 40-46), 36% (95% CI, 33-38), and 23% (95% CI, 20-25), respectively, self-reported having experienced arm/shoulder pain, stiffness, and arm/hand swelling at least once	Good
Clegg-Lamptey et al.[34]	2009	Ghana	Experiences and impressions of breast cancer survivors with regard to treatment obtained	Survey	89	Questionnaire about types of treatment, counselling received, and how treatment was paid for	• Chemotherapy (n=58, 65.2%) was the most unpleasant aspect of treatment, and 27 (30.3%) reported not being warned about complications of treatment • 38 (42.7%) reported being afraid (frightened or terrified) at the diagnosis; other reactions were shock, devastation, weeping, and depression • 22 (24.7%) reported receiving no counselling • 15 (18.5%) reported not having an opportunity to express fears of death, mastectomy/deformity, and financial incapability • Frequencies of fears: death, n=55 (61.8%); mastectomy/deformity, n=27 (30.3%), financial incapability, n=23 (25.8%) • 44 (49.4%) used alternate 'treatment', mainly prayer camps (n=25) and herbs (n=22), before and during hospital treatment • Use of alternate treatment led to delays in treatment in 23 women	Fair
Dano et al.[31]	2019	Senegal	QoL during chemotherapy	Cohort	120	FACT-B	• Total FACT-B scores significantly improved over time (β=1.58; 95% CI, 0.50-2.67; *P*=0.01). • Nausea and vomiting were significantly associated with a decrease in total FACT-B scores (β=−16.89; 95% CI, −29.58 to −4.24; *P*=0.012; and β=−13.44, 95% CI, −25.15 to −1.72, *P*=0.028, respectively).	Good

Continued

Table 4. **Continued**

First author	Year	Country	Research focus	Study design	N	Data collection method/tool(s)	Experiences identified	Quality rating
Degu & Kebede[63]	2021	Ethiopia	Drug-related problems among patients with breast cancer	Cross-sectional	107	Review of medical records	• 203 drug-related problems identified (prevalence, 71.03%) • Adverse drug reactions (48.6%), need for additional drug therapy (45.8%), and nonadherence (32.7%) were most prevalent • Patients with concurrent comorbidities were more likely (AOR, 2.97; P=0.035) to experience drug-related problems than those without comorbidities • Patients treated with neoadjuvant chemotherapeutic regimens were less likely (COR, 0.34, P=0.023) to have drug-related problems than those treated with adjuvant chemotherapy regimens	Good
Elumelu et al.[72]	2014	Nigeria	Impact of active coping, religion, and acceptance on the QoL of patients with breast cancer	Cross-sectional	110	FACT-B and Brief COPE	• Active Coping, Religion, and Acceptance were significantly associated (P<0.05) with overall QoL and some of the QoL dimensions	Fair
Fatiregun et al.[103]	2016	Nigeria	Anxiety disorders and their determinants among patients with breast cancer	Cross-sectional	200	SCAN	• 38 participants (19%) were categorized as having anxiety disorders • Low income, absence of previous history of breast cancer, and early stage of breast cancer were the significant determinants (P<0.05) of anxiety disorders	Good
Hassen et al.[68]	2019	Ethiopia	QoL and associated factors among patients undergoing chemotherapy	Cross-sectional	404	EORTC QLQ-C30 and EORTC QLQ-BR23	• The average QoL score of patients with breast cancer under chemotherapy treatment was 52.98±25.61 • Most patients had scored poorly in terms of emotional functioning, sexual functioning, and financial difficulties • College-level education and above, being divorced, higher household income, and higher scores of physical and social functioning were associated with significantly better QoL • Lower scores regarding fatigue, insomnia, financial difficulties, and systemic therapy side effects were all associated with better scores regarding QoL • Patients receiving ≤2 cycles of chemotherapy had significantly lower QoL scores	Good

Continued

Table 4. **Continued**

First author	Year	Country	Research focus	Study design	N	Data collection method/tool(s)	Experiences identified	Quality rating
Kagee et al.[37]	2017	South Africa	Predictors of distress and depression	Cross-sectional	201	CES-D Scale, HSCL, and BSSS	• More than one-third of participants scored in the elevated ranges on the CES-D Scale and HSCL, indicating that distress and symptoms of depression were a concern for a sizable minority of participants • Regression analysis showed that body change stress and perceived social support were significant predictors of both psychological distress and symptoms of depression	Good
Kramer et al.[65]	2018	South Africa	The burden of shoulder pain and disability	Cross-sectional	349	SPADI	• 3 in 4 patients reported the presence of any pain or disability, while only 9% experienced severe pain and disability • Multivariable ordinal logistic regression analysis identified race, tumour laterality, axillary surgery status, chemotherapy status, and age as significant predictors of pain, as well as chemotherapy as a significant predictor of disability	Good
Kugbey et al.[38]	2019	Ghana	Direct and indirect influences of health literacy and access to health information on QoL	Cross-sectional	205	Questionnaire adapted from HLS-14, HADS, and FACT-B	• Access to health information and health literacy had significant indirect effects on QoL through depression and anxiety	Good
Kugbey et al.[73]	2019	Ghana	Whether cancer-specific coping strategies influence QoL	Cross-sectional	205	Mini-MAC scale and FACT-B	• Helplessness–hopelessness negatively correlated with physical well-being, emotional well-being, functional well-being, and additional concerns related to breast cancer • Anxious preoccupation negatively correlated with all the domains of QoL • Fighting spirit positively correlated with emotional and functional well-being • Cognitive avoidance positively correlated with functional well-being • Fatalism positively correlated with all QoL domains	Good

Continued

Table 4. ***Continued***

First author	Year	Country	Research focus	Study design	N	Data collection method/tool(s)	Experiences identified	Quality rating
Kugbey et al.[70]	2019	Ghana	Direct and indirect effects of depression and anxiety on QoL through social support and religiosity	Cross-sectional	205	FACT-B, MSPSS, SCSORF, and HADS	• There were significant direct negative effects of depression and anxiety on QoL • Depression had a significant, negative, and indirect effect on QoL through social support (b=−0.247; 95% CI, −0.482 to −0.071); anxiety had a significant, positive, and indirect effect on QoL through social support (b=0.142; 95% CI, 0.011-0.324). • Depression and anxiety did not have any significant, indirect effect on QoL through religiosity	Good
Odigie et al.[76]	2009	Nigeria	Psychosocial effects of breast cancer on married women	Cross-sectional	81	Self-administered, semistructured questionnaires (×2: baseline survey on sociodemographic characteristics and history of psychiatric disorder, then follow-up querying how adequate the participant felt as a woman in terms of her femininity, self-esteem, body image, the frequency of conjugal relations per week and the reasons for changes, frequencies of separation or divorce, the effect of treatment on sexual interest and ability to care for children; marital status (monogamy/ polygamy; separated/ divorced, number of new marriages/ wives taken up by their spouse) also updated for up to 3 years after mastectomy	• 6 months after mastectomy: 67.9% felt less feminine, 79% experienced decreased conjugal relations • 3 years after mastectomy: 38.3% were divorced/separated	Good

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Table 4. **Continued**

First author	Year	Country	Research focus	Study design	N	Data collection method/tool(s)	Experiences identified	Quality rating
Odikpo et al.	2021	Nigeria	Effects of exercise on QoL	Quasi-experimental	94	EORTC QLQ-30, version 3	• The preintervention mean overall functional QoL domain scores were 59.2±21.98 for the intervention and 67.0± 20.13 for the control; the overall mean scores for the symptom domain were 31.8±10.89 for the intervention and 29.8±10.24 for the control • The postintervention overall mean generic functional domain scores were 89.0±11.1 for the intervention and 51.2±17.8 for the control; under the symptoms domain, the overall mean scores were 16.4±10.2 for the intervention and 35.4±12.4 for the control • Compared with the control group, the intervention group had significantly higher mean QoL scores associated with all of the postintervention functional domain subscales (all *P*<0.001); the intervention group also had significantly higher mean overall symptoms (*P*<0.001) and global health status/QoL scores (*P*<0.001)	Good
Okoli et al.[74]	2019	Nigeria	Measures of QoL	Cross-sectional	60	FACT-B	• Among the 60 enrolled participants, the mean total score of the 5 domains (n=144) was 74.59±17.72, the mean FACT-G score (n=108) was 53.49±12.56, the mean Trial Outcome Index (n=112) was 49.20±13.13, the mean Physical Well-Being score (n=28) was 10.95±6.37, the mean Social/Family Well-Being score (n=28) was 18.41±6.48, the mean Emotional Well-Being score (n=24) was 6.98±4.15, the mean Functional Well-Being score (n=28) was 17.15±7.12, and the mean Breast Cancer Subscale score (n=36) was 21.10±8.93 • Emotional Well-Being was significantly lower among postmastectomy patients on adjuvant chemotherapy (*P*=0.031) and premenopausal women (*P*=0.041), as well as among patients <40 years old (relative to patients >50 years old, *P*=0.049).	Good

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Table 4. **Continued**

First author	Year	Country	Research focus	Study design	N	Data collection method/tool(s)	Experiences identified	Quality rating
Popoola & Adewuya[79]	2011	Nigeria	Rate and correlation of depressive disorders	Cross-sectional	124	MINI	• 16.9% had major depressive disorder, while 23.4% had minor depressive disorder (40.3% depression prevalence) • Not being married (OR, 3.09; 95% CI, 1.30-7.2), poor social support (OR, 5.38; 95% CI, 1.88-16.63), and advanced disease (OR, 3.22; 95%CI, 1.31-8.26) were independently associated with depression	Fair
Rayne et al.[57]	2016	South Africa	Psychosocial stresses affecting women with breast cancer	Cross-sectional	263	2-part, self-report questionnaire (first part queried demographics, socioeconomic status, educational background, work, transport, and religious affiliations; second part queried feelings of fear and concern at diagnosis about issues related to patient care, social circumstances, or prognosis)	• Fears related to treatments and prognosis, particularly radiation, loss of hair, and loss of breast, were far stronger than those related to socioeconomic barriers • The RR values associated with most fears were higher among women <40 years old, including fears about treatment affordability (RR, 1.80; 95% CI, 1.26-2.56), hair loss (RR, 1.48; 95% CI, 1.12-2.95), and surgery (RR, 1.31; 95% CI, 1.02-1.68) • Difficulty taking time off work predicted fear of job loss (RR, 2.59; 95%CI, 1.59-4.21) and missing appointments because of family commitments (RR, 2.46; 95% CI, 1.52-3.96) or a lack of transport (RR, 2.46; 95% CI, 1.52-3.96) or • Black women and women with dependents were more afraid of dying (RR, 1.79; 95% CI, 1.33-2.24 and RR, 1.73; 95% CI, 1.03-2.90, respectively); however, socioeconomic status in this sample was a strong confounder of race and explained most of the racial differences in levels of fear	Good

Continued

Table 4. **Continued**

First author	**Year**	**Country**	**Research focus**	**Study design**	**N**	**Data collection method/tool(s)**	**Experiences identified**	**Quality rating**
Shaikh et al.[75]	2022	Kenya	Needs assessment of women with metastatic breast cancer	Cross-sectional	114	SCNS-SF34 and FACT-B	• 114 women living with metastatic breast cancer were interviewed • Psychological needs (63%), physical support needs (60%), and health care system needs (55%) were leading areas of which the levels of need increased with rural residence (P=0.001), less education (P=0.003), and aggressive treatments (P=0.008) • Better QoL scores were associated with urban residence (P=0.002), Internet access (P=0.010), and stable disease (P=0.042)	Good
Sibhat et al.[69]	2019	Ethiopia	Health-related QoL	Cross-sectional	404	EORTC QLQ-C30, EORTC QLQ-BR23, and EQ-5D-5L	• The mean scores for global QoL and Euroqol visual analogue scale were 59.32±22.94 and 69.94±20.36, respectively, and the mean utility score was 0.8±0.25 • Predictors of global QoL were stage of cancer (AOR, 7.94; 95% CI, 1.83-34.54), cognitive functioning (AOR, 2.38; 95% CI, 1.32-4.31), pain (AOR, 7.99; 95% CI, 4.62-13.83), financial difficulties (AOR, 2.60; 95% CI, 1.56-4.35), and future perspective (AOR, 2.08; 95% CI, 1.24-3.49)	Good
Teshome et al.	2021	Ethiopia	Perceived barriers to timely treatment initiation and social support status	Cross-sectional	196	MSPSS and structured questionnaire designed based on Penchansky and Thomas's dimensions of access; where possible, clinical data from patient charts were linked to data generated through interviews	• 34% used alternative medicine before starting treatment • 66% were not able to pay for treatment services • 38% feared treatment side effects • The mean MSPSS score was 73±13.63 (84 is the highest possible total score)	Good
Van Oers & Schlebusch[77]	2021	South Africa	Differences in psychological experiences of patients with breast cancer and those with other cancers	Case–control	160	Demographic questionnaire, BDI, RSES, and SSCL	• Patients with Breast cancer experienced notably higher levels of hopelessness and suicidal ideation • Patients expressed their stress through behavioural and psychological responses that resemble anxiety symptoms	Good

Continued

Table 4. **Continued**

First author	Year	Country	Research focus	Study design	N	Data collection method/tool(s)	Experiences identified	Quality rating
Wondimagegnehu et al.[78]	2019	Ethiopia	Magnitude of depression and its association with social support	Cross-sectional	428	PHQ-9 and MSPSS	• The prevalence of depression among breast cancer patients was 25% (107/428); 70/428 (16.4%), 30/428 (7.01%), and 7/428 (1.64%) had moderate, moderately severe, and severe depression, respectively • Age, occupation, type of health facility treated, severity of pain, hormonal therapy, and employment/family problems were significantly associated with depression The mean total MSPSS score was 70.35±16.81 • Women with moderate and severe depression had lower mean MSPSS scores than women with no depression or minimal depression (*P*=0.002)	Good

AOR, adjusted odds ratio; BDI, Beck Depression Inventory; BSSS, Berlin Social Support Scales; CES-D, Center for Epidemiological Studies Depression; CI, confidence interval; COPE, Coping Orientation to Problems Experienced; COR, crude odds ratio; CSRI, Client Service Receipt Inventory; EORTC, European Organization for Research and Treatment for Cancer; EQ-5D-5L, EuroQol 5-dimensional, 5-level; FACT-B, Functional Assessment of Cancer Therapies – Breast; FACT-G, Functional Assessment of Cancer Therapy – General; HADS, Hospital Anxiety and Depression Scale; HLS-14, 14-item Health Literacy Scale; HSCL, Hopkins Symptom Checklist; MINI, Mini-International Neuropsychiatric Interview; Mini-MAC, Mini–Mental Adjustment to Cancer; MSPSS, Multidimensional Scale of Perceived Social Support; OR, odds ratio; PHQ-9, Patient Health Questionnaire–9; QLQ-BR23, breast cancer–specific Quality of Life Questionnaire (EORTC); QLQ-C30, Quality of Life Questionnaire Core 30 (EORTC); QoL, quality of life; RSES, Rosenberg Self-Esteem Scale; RR, relative risk; SCAN, Schedule for Clinical Assessment in Neuropsychiatry; SCNS-LF59, Supportive Care Needs Survey – Long Form 59; SCNS-SF34, Supportive Care Needs Survey – Short Form 34; SCSORF, Santa Clara Strength of Religious Faith Questionnaire; SNAP, Spiritual Needs Assessment for Patients; SPADI, Shoulder Pain and Disability Index; SSCL, Stress Symptom Checklist

Table 5. Thematic themes and subthemes

Theme	Subtheme	Relevant qualitative studies	Relevant quantitative studies
'Could I have cancer?' – The diagnosis	'I didn't know what it was' – Identifying the symptoms	[27]-[30], [32], [33], [45]	[31]
	'I started at a prayer camp' – Process of care to confirm the diagnosis	[27]-[30], [45]	[31], [34]-[38], [63], [64], [68], [69], [74], [79], [103]
	'I thought my life was over' – Reactions to cancer diagnosis	[28]-[30], [32], [39]-[45]	[34], [78], [79], [102]
'Now what?' – What next after cancer diagnosis	'I just want to keep my condition to myself' – Disclosure of diagnosis	[29], [30], [33], [44], [46], [51]-[54], [66]	
	'How can I part with my breast?' – Decision on treatment	[28], [32], [33], [44], [46], [53]	[34], [56], [57]
Living with the scars	'Just live with it' – Treatment side effects	[43], [45], [46], [52], [61], [62], [66]	[31], [34], [38], [63]-[65]
	'It limits your duties' – Changing roles	[32], [41], [43], [44], [46], [52], [54], [61], [62], [66], [101]	[31], [35], [38], [56], [67]-[77]
	'It's a money-intensive thing' – Economic burden	[27], [33], [39]-[41], [44]-[46], [51]-[53], [66]	[31], [34], [36], [78]
Coping with breast cancer	'I'm grateful' – Changing perceptions	[45], [54], [61]	[56], [71]
	'I really needed support' – Navigating breast cancer with support	[28]-[30], [32], [33], [39]-[43], [46], [51], [53], [54], [61], [66]	[34], [36], [56], [75], [79]

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