

Exploring the Socio-Economic Experiences of Women Post-Mastectomy in the Tamale Metropolis

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Abstract

Background: Breast cancer (BC) is the most commonly diagnosed cancer among females. Mastectomy is the treatment of choice in most African countries due to late reporting. The majority of women diagnosed with BC experience socio-economic challenges. This study explored the factors that affect the socio-economic well-being of women post-mastectomy in Ghana.

Methods: The study was conducted at the teaching hospital in the northern region of Ghana using descriptive exploratory qualitative design. A purposive sampling method was employed to recruit participants. Data was saturated with 15 participants aged between 28 and 78 years. The in-depth interviews were recorded and transcribed verbatim. Data were analyzed using thematic content analysis procedures.

Results: Participants isolated themselves as society frown on them after mastectomy. Some of the women loss their jobs/businesses and some did not get the needed support. The high cost of treatment placed a huge financial burden on them. Some of the participants felt rejected and loss their femininity, as their partners were not having sex with them after the operation.

Conclusion: Women post mastectomy faces several challenges and family support is vital to improve their wellbeing. There is a need to educate the public against the stigmatization of women post mastectomy.

Background

Breast Cancer (BC) is the most commonly diagnosed among females in the world accounting for 25% of all cancer cases and the leading cause of death (15%) [3, 4, 5]. It is estimated that about 1,050,000 new cases are reported annually across the world [6]. BC in men is rare, accounting for less than 1% in the US. In low-income countries, BC accounts for one in four diagnosed cancers and one in five cancer deaths among women with an increasing incidence which is projected to double by 2050 [7] and is the commonest malignancy among women in Ghana [15]. Averagely, 50–70% of women in Africa present with advanced diseases [7]. Rates of surgical treatment vary greatly across different countries in Africa ranging between 35–75% [14].

In Ghana, 35.3–90% of all BC cases confirmed by histopathology undergo mastectomy and 51% of these women are younger than 50 years [10, 15]. The primary focus of treatment for BC in Africa is surgical intervention [14]. About 68% of BC cases are managed with modified mastectomy and about 35% of all newly diagnosed cases in Nigeria undergo mastectomy and half of them have received some cycles of neoadjuvant systemic chemotherapy before the surgery [8]. The age of the patient determines the outcome of the treatment; thus, the younger the age, the poorer the outcome [15].

Most women delay seeking early treatment therefore mastectomy becomes the treatment of choice [8, 16]. The late presentation is due to stigmatization and financial difficulties [15]. The diagnosis mostly

affects all aspects of a woman's life as a result of the role the breast plays and the huge cost from both the financial and physical effects of treatment [11]. Again, the diagnosis and treatment can as well lead to problems in relationships, communication, sexual functioning, and intimacy [12]. Therefore, social support is important in improving the quality of life and maintaining health [15]. Most patients feel they are loved especially when they get more social care and believe they will be helped when there is a need [15]. However, after the surgical management of BC, most patients experience serious social effects such as lack of physical support from others, loss of femininity which further affects their sexual life [22].

Furthermore, majority of the Ghanaian women with BC are forced to keep their diagnosis and body after mastectomy to themselves because of rejection from closed people and society [17]. This negative attitude towards women post-mastectomy discourages them and limits their strengths of even sharing their experiences to encourage others going through a similar situation [17]. Some women isolate themselves postmastectomy because society will stigmatize and label them as deformed and their partners will reject them [17]. Some women also prefer to confine themselves to avoid social affairs [11]. Painfully, their feelings are not recognized [17].

Furthermore, other factors such as loss of a breast, scarring, and lymphedema after mastectomy, and sexual dysfunction are all associated with body changes, and these have a negative implication on the long and short-term social quality of life of the patient [18]. According to Koçan and Gürsoy [12], women were dissatisfied with their appearance after mastectomy and some describe themselves as deformed and having irregular appearances which affect them sexually [11]. Amro et al. [14] found that most women in Palestine stayed away from social gatherings at mastectomy.

In addition, most women post mastectomy believes that their sexual lives will be negatively affected because of new appearance [11]. Women in their childbearing age also are more concerned for they believe it will affect their breastfeeding [11]. The sexual satisfaction of most women after a mastectomy is based on how they perceive their body image and how their spouses perceived it as well [14]. However, the quality of life some of the women are affected negatively as they perceived a reduction in femininity and felt they were impotent [17, 18].

Furthermore, women who were employed post mastectomy had a better quality of life compared to women who were unemployed and women who were married had a poorer quality of life compared to women who were single, widowed, or divorced [19]. Women who were also engaged in other services or businesses had a better overall quality of life [20]. In some cases, mastectomy has an impact on the employment of women which is a very important aspect of their well-being[21]. Most of them are not able to work after the surgery and the cost of their treatment places financial distress on them [21] and most of the women cannot go back to their professional activities after the operation [22]. This is mostly due to a reduction in performing domestic activities after mastectomy and this is a result of physical complications after the surgery and they depend on others for support [23].

In addition, the impact of the economic burden can be great and thus affecting the overall well-being of the patient [24]. For instance, Hays et al. [25] in a study reported that most of the women complained that

the expensive cost of BC treatment has negatively affected them and their families. The social lives of these women are mostly poorest and it also affects their finances to the maximum level [26]. In Ghana, the national health insurance scheme is suppose to cover diagnosis and treatment of BC [27] however available data indicate the scheme does not fully support the full treatment of BC cases across treatment in centers in the country [27]. Despite the socio-economic impact of BC treatment, there is limited research information on the socio-economic well-being of women post-mastectomy in Ghana, especially in the Tamale Metropolis. This study, therefore, explored the factors that affect the socio-economic well-being of women post-mastectomy in the Tamale Metropolis.

Methods

Study design and setting

A qualitative exploratory descriptive method was to explore the socio-economic experiences of women post-mastectomy at the Tamale Metropolis in the Northern Region of Ghana. This design was considered apt as this seeks to give a better description of the experiences in a language that can easily be understood [23].

Tamale Metropolis is the third-largest city in Ghana. It is estimated to have a total population of about 400,000. Out of this 198,400 are males representing 49.7% and 201,600 females indicating 50.2% [24]. Tamale Teaching Hospital (TTH) is a tertiary level healthcare facility within the Tamale Metropolis. It serves as the referral hospital for the five regions of northern Ghana. The oncology unit of the Tamale Teaching Hospital was used as the recruitment center of participants. Since 2015, the unit has recorded an average of 1060 as patients seen per year at the unit.

Population and sampling technique

The study targeted were women who had undergone mastectomy either bilateral or unilateral and lived within the Tamale Metropolis. Participants who could speak English, Twi/Fante, or any of the northern languages and consented to take part in the study were included in the study. Women who had breast cancer but have not undergone mastectomy were excluded from the study. Women who had a mastectomy but at the terminal stage were as well excluded. Purposive sampling and snowball sampling were used to recruit the participants. These techniques were chosen because the interest of the researchers was in people with certain characteristics among the breast cancer population which one cannot easily identify. Fifteen participants were interviewed in this study.

Data collection tool and procedure

A semi-structured interview guide was used for data collection. This provided the participants the chance to freely express their feelings in their own words. The demographic characteristics of participants and

open-ended questions based on the study objectives were included in the study guide. Official permission was obtained from the facility before commencing the data collection process. Women who met the inclusive criteria were identified in the unit's record book by the first author with the help of the nurses at the unit. A telephone call was placed on each of them to explain the study and its intent. An appointment was booked at the convenience of the women who voluntarily accepted to participate in the study. The first author ensured the willingness of the participants on several occasions by placing a call to them before the interview day. The women who consented to participate in the study were interviewed in their homes and at the hospital respectively. An individual face-to-face approach with a semi-structured interview guide was used in English, Twi, Fante, and Mampruli. A research assistant was employed and trained to interpret the interviews in Dagbani and Mampruli. The quality of life model applied to breast cancer, literature review, and study objectives guided the interview guide. During the interviews, answers from participants were probed when necessary for further clarification and this allowed them to provide in-depth information about their experiences. Each interview lasted between 30-60 minutes and was audio recorded with the participant's consent. Snacks were served to participants whose interviews lasted more than 30 minutes. Facial expressions and other non-verbal expressions were noted and documented in a notepad during the interviews.

Data management and analysis

False names were given to the participants during the interviews to ensure confidentiality. The researchers purposefully separated the demographic data of the participants from the interview data. This was to ensure no linkage between the two. Hard copies of the transcriptions, audiotapes, notepad, and all documented information are under lock and key at the first author's office for five years. The researchers used a thematic content analysis approach to analyze the data. This helped the researchers to be familiar with the data by reading the transcripts several, coding transcript, and identifying themes. The data analysis was done concurrently with the data collection. This helped the researchers to ratify emerging themes in subsequent interviews. Data collected were transcribed verbatim and coded to enhance validity [25]. Similar ideas, words, and thoughts within the data were grouped and codes were assigned to them.

Rigour

The methodological rigour of the study was established by subjecting it to the criteria of credibility, transferability, dependability, and confirmability [26]. To ensure credibility, the first author visited the unit and worked with them for familiarization before the data collection. Again, the first author visited the homes of most of the participants with their consent. Participants were now friendly with the first author and they were able to freely share their experiences in-depth during the interviews. A semi-structured interviewing guide was used and a face-to-face interview guide was conducted and as well audio-recorded with participant's consent. To ensure accuracy of the description of the participants' experiences, the interviews were transcribed verbatim and this further increased the trustworthiness of the findings. In

addition, the participants were given ample time to share their experiences during the interviews. Furthermore, the researchers ensured that data collected were accurate, complete, and properly interpreted by reinstating the statements by the participants to clear any doubts. To also ensure the findings represented exactly what the participants described when interviewed, the researchers used the verbatim quotes [26]. To avoid subjectivities and biases in the study, an audit trail involving the processes leading to the finding kept for validity [27].

Ethical considerations

The obtained ethical approval from the Institutional Review Board of the Christian Health Association of Ghana (CHAG-IRB11032019) and the Department of Research & Development Unit of TTH (TTH/R&D/SR/049). All the information regarding the research was given to participants before data collection. This was done through phone calls by the first author to each participant before and on the day of the interview. This was to ensure the willingness of the participants. Informed consent was obtained on the day of the interview and the option to participate or to decline participation. They were also assured of confidentiality by ensuring anonymity during data collection. Finally, to ensure privacy, interviews were done in a quiet environment, which was safe for both participants and researchers.

Results

Table 1
Participants characteristics

No	Pseudonym	Age	Marital status	Educational background	Religion	Number of years/months post mastectomy	Occupation
1.	Woman 1	28	Married	Tertiary	Christian	3	Housewife
2.	Woman 2	30	Married	Basic	Islam	7 months	Trader
3.	Woman 3	37	Married	Basic	Christian	1	Hairdresser
4.	Woman 4	37	Married	Secondary	Christian	1	Cleaner
5.	Woman 5	37	Married	Tertiary	Christian	4	Caterer
6.	Woman 6	38	Single	Secondary	Christian	6 months	Trader
7.	Woman 7	40	Married	Tertiary	Islam	5 months	Accounts officer
8.	Woman 8	42	Married	None	Islam	4 months	Petty Trader
9.	Woman 9	45	Single	Secondary	Christian	5 months	Businesswoman
10.	Woman 10	46	Married	Basic	Christian	2	Trader
11.	Woman 11	52	Single	Secondary	Christian	2	Trader
12.	Woman 12	56	Married	None	Islam	4 months	Trader
13.	Woman 13	61	Married	None	Islam	1	Petty Trader
14.	Woman 14	70	Married	Tertiary	Islam	1	Businesswoman
15.	Woman 15	78	Single	Tertiary	Christian	2	Reverend Sister
Source: field data							

Social experiences of women post-mastectomy

It was evident that the majority of the women needed social support from other people especially the family members after the operation. For example, most of them could not wash, cook, fetch water, or even dress up so family members had to help them or do it for them. Some also needed the family members to take care of their children. Others isolated themselves because of privacy or low self-esteem. There were also variations in responses in terms of sexuality. For instance, some of the women feel rejected by their partners because of their condition and others feel they have lost their femininity.

Support

It was evident that the majority of the women needed the physical support of other people especially family members after the operation. For example, most of them could not wash, cook, fetch water, or even dress up, so family members had to help them or do it for them. Others also needed emotional support people to just find out how they are doing.

After the operation, my husband has to bath and dress me up. I could not bend my hand for almost three months (Woman 5).

I used to do all the laundry and Sobolobo (locally made soft drink) and take it round to sell. I cannot do any of them after the operation because of the pain. I have to call my sister for help now... (Woman 2).

...My family is taking good care of me and my husband gives me food. They come around to see how I am doing. I have not heard anyone talk ill about my sickness (Woman 13).

Unfortunately, some of the women did not get support from their family members. They have to do things themselves though it was not as they used to do but because some of them did not want other family members to know about their condition.

"I did not tell any family member about my operation except my husband because I did not want them to spread it. He also did not support so I used my savings" (Woman 10).

"After the operation, none of my family members visited me at the hospital or to ask about my well-being. None of my siblings have called to ask how I'm faring" (Woman 6).

The support was not all that good for me because I have to still perform the house duties, I am still going through it (Woman 3).

Isolation

Among the data collected, some of the women have stayed away from other people for various reasons. Some of them complained they are experiencing minor illnesses after the operation. Some of them felt they were not women again because they have lost one breast and wants to start a new life in a new environment.

I am unable to associate well with people and people do not want to be closer to me especially because of the cough and the sputum I spit out. This has affected me... (Woman 8).

.....I cannot come out because my hand is swollen after the operation, as you can see one is bigger than the other so people look at me and point fingers at me when I come out (Woman 6)

I could not walk after the operation, I had a swollen leg that crippled me, I cannot walk, I move with a stick. I do not get in touch with the people I used to interact with. I am always indoor... (Woman 14).

After the operation, I isolated myself from women. I cannot get close to people because it will pain me if someone avoids me due to my situation. I have "cut" my friends off, I am looking for a new place to rent. Change my environment and be a new person (Woman 6).

Some of the women also are avoiding people because they feel uncomfortable and did not want them to know they have gone for such surgery.

...After the surgery, when my friends are going out, I just support their lorry fare, but I will not go because I do not want people to know... (Woman 1).

...I did not withdraw from people but when I go somewhere and we all share a room. I cannot remove my brazier unless everyone is asleep. I remove the foam and get fresh air. Early morning, I fix the foam so no one will see (Woman 10).

...I cannot change when others are there. They will see you have one breast and will be discussing you with other people. I cannot remove my brazier and leave my one breast hanging... (Woman 7).

Some of the women go out freely because people do not know they have undergone such an operation.

No!!!! I can go to places freely; they do not know. Because of the thing I will put there they do not know my breast is cut off... (Woman 9).

No!!! I did not discuss it with any friend, not even my siblings. I decided I am fine and I think it has helped me a lot (Woman 11).

Sexuality

Some of the women had a negative perception about their bodies and this affected their desire for intimacy. The study revealed that there were challenges for women in terms of sexuality for various reasons. For example, some of the women feel rejected by their partners because of their condition although they have the desire and others feel they have lost their femininity.

...No sex after the operation. I think it is because of the operation, also we are many (referring to her rivals). I have feelings for sex but my husband showed no interest... (Woman 13).

At times I will have the feeling for sex but, I will be thinking of how to manage myself and have sex, I will feel shy lying down with one breast... (Woman 3).

I ask myself if I am a woman again to my husband. I cried the first time we had sex because he loves sucking my breast. And now it was one breast, he could not even touch the other one so after sex we will cry... (Woman 1).

Some of the women were feeling bad about themselves and did not want to undress before their partners. Some also cover the mastectomy site during sexual intercourse.

...I felt bad the first time for sex after the operation. I did not want to undress but my husband said he could play with the one. I was afraid that maybe my husband will leave me... (Woman 5).

Other women have not attempted for various reasons. For instance, someone feels the husband will hurt her and one woman has not gone to the husband's house after the operation. Another woman also said she did not want the husband to see the mastectomy site and mock her.

I have not had any sexual relations with my husband because I have not gone home. I am in my mother's house (Woman 8).

.... I have not had sex because I feel shy having one breast, I feel incomplete to stand in front of my husband(Woman 3).

We still have feelings for each other but we have never done it after the operation. Because I am sick and I am afraid he will hurt me... (Woman 2).

After the operation, I decided not to sleep with him, because I did not want him to see it and mock me or do something that will hurt me... (Woman 10).

One of the women is not having a partner and she sometimes feels she needs a man to be with but thinks she cannot go into a relationship.

Even with two breasts, a man will not stay with me how much more having one breast? I isolated myself from womanhood after the operation. However, as a young woman, sometimes I feel for a man but I cannot go into a relationship with one breast... (Woman 6).

Economic experiences of women post mastectomy

The study revealed that most of the women experienced economic hardship during and after their treatment. The hardship extended to their families because some were breadwinners of their families. Some of the women lost their jobs. Businesses of other women collapsed because they diverted the money to their treatment. It was also evidenced that the high cost of treatment placed a huge financial burden on them and their families.

Employment

The majority of the women were self-employed. The disease and the treatment have had an economic impact on most of the women. This ranges from their inability to trade and using their capital as sources of finance for treatment.

...My business has been affected greatly. I am unable to do much and most of my money has gone into the treatment. My business has collapsed... (Woman 8).

...It affected my work, the treatment cost is expensive. When I came back to work, all my stock had run out. I had two shops and I had to close one down... (Woman 10).

A lot!!!, I was a trader after retiring as a teacher. I travel to Togo, Accra to buy goods. After the operation, I cannot move for a mile, not even to market. I have locked my store. I am no longer doing anything... (Woman 14).

Some of the women in the formal sector lost their job.

Through the chemo, we used to go every month. I will have to write to my boss so sometimes it is as if they are fed-up with excuses. After the operation, I came and they said they have taken somebody... (Woman 1).

....I lost my job right after the operation because my hand was swollen after the operation and I could not work ... (Woman 7).

The study established that some of the women are breadwinners for their families. One of the women had just resumed her petty trading in sandals that was her business before the surgery. The business happens to be a family source of income.

...I have now started selling the sandals, this has been my business. Our only source of income. I used to also prepare Sobolo and Zimkom (locally made soft drinks) to sell but because of pain, I cannot do it again... (Woman 2).

Another woman has not resumed her work at all although she is a breadwinner.

Madam, I am a breadwinner in my family, I used to sell my banku with tilapia. I stopped after the operation because of my hand pain. So, for now, I want to pause... (Woman 6).

One woman has been relieved from her duties.

...I do not work in my community. They have left me free since 2017 up to date. I choose what I want to do... (Woman 15).

Financial burden

Almost all the women were complaining about the high cost of treatment and the burden it has placed on them and their families. Some of them have to change their children's school so that the fees will be reduced to meet the challenges of the family. Some families were frustrated about the cost involved in the treatment. The cost was unbearable to the extent some were selling their properties, closing down shops, and taking loans to take care of themselves.

It affected the family!!!! I changed my children's school because of money. After the operation, I still have to go for the chemo four times. My husband could not pay his fees again so he has to stop his school...

(Woman 5).

It affected me. My mom is a farmer and very old, she sends all the proceeds from the farm products to me. My husband does the same, his comments sometimes make me feel he is exhausted with the burden on his finances. I think they are tired of me... (Woman 8).

My family supported me, they were there for me, friends, and some students that I taught. I went in for a loan to take care of myself also. At a time, I sold my car to support.... (Woman 14).

Some of the women were also leaving on the benevolence of others since their families were poor and could not helpfully.

Oh, it is not easy. This sickness carries a whole lot of money. The expense alone in this sickness is not easy. Family members have been helping me, loved ones, and friends as well. I come from a very poor family. It is not easy for me... (Woman 11).

As for finances, it is not easy!!!! Financially by God's grace, my in-law has been supporting small, small (Woman 6).

The data revealed that one woman has defaulted in her treatment plan and there is nothing she can do about it again. The family has exhausted their money on her treatment because she was non-insured. The burden has even affected the feeding of the family.

...I needed laboratory investigations but my husband did not have money. My treatment has consumed a lot of money because I did not have health insurance. I do not have money for any treatment anywhere... (Woman 2).

Yes, it affected the family, no money again. It is only God who knows how we feed in this house. My husband lost his job so there is no support anywhere for me. We feed on sales from the sandals I sell... (Woman 15).

Discussion

The majority of the women in this study narrated how the surgery has affected their social and economic life. This study revealed areas such as sexuality, employment, their relationship with others, and the support they needed from others. Similar findings have been reported by several studies [9, 18, 27, 28, 29, 30]. All the women in this study needed the support of their family members after the operation. Most of the women were assisted by their relatives in performing house chores. This was due to pain when lifting the hand, swollen in the hand and minor illness after the surgery. This is inconsistent with the work of Dias et al. [31] where they reported that there was a reduction in performing domestic activities after mastectomy. Dias et al. [29] concluded it was right to consider those physical complications after mastectomy impedes performing activities of daily living. However, some of the women did not get the needed support from the family and they had to perform domestic activities themselves. This is

consistent with the findings of Agrawal et al. [33] which reported that most of the time some of the women do not get support from their family during their treatment process. This revealed that some of the families were not involved in the treatment process hence they showed no concern to the women

Some of the participants indicated they stayed indoors because they were very sensitive to the utterances and looks of other people. This corroborates the report of a study by Arroyo & Lopez [41]. The finding is also consistent with a study in Palestine by Amro et al. [42] where most women after mastectomy stayed away from sports and social gatherings. This is because they do not want people to know about the changes in their bodies and the pain they are going through, so they preferred to stay at home. This was confirmed in this study as most of the women isolated themselves from various activities they used to perform with others. Some of the women had kept both their diagnosis and the surgery to themselves to avoid being stigmatized which can affect their well-being and recovery. This has been documented by Arroyo & Lopez [41] that some kept their diagnosis and surgery secret to themselves so they cannot express their feelings. One of the women said she was looking for a new place to stay for her to start a new life. These were affecting their well-being as they lived a lonely life. Society has stigmatized breast cancer victims and this made the women felt not accepted in the society hence the secrecy.

Sexuality was also a major concern in this study. Most of the women had various challenges concerning sexuality. Most of them were concerned about their body image while others had a perceived reduction in femininity. This is in agreement with a study finding by Amro et al. [42] where sexual satisfaction of women after a mastectomy was based on how they perceive their body image as well as how their spouse's perceived it. Furthermore, the study found that some of the women did not resume sexual activities because they did not know how their spouse perceived their bodies after the surgery. For instance, one woman rhetorically asked what was she going to do in a relationship with one breast. Another woman also felt she was no more a woman to the husband. Again, this finding supported the work of Runowicz et al. [18] where most women who were sexually active were much concerned with their body image post-mastectomy. Though the women in this study had limitations with sexuality, it was not much important to them and therefore this did not affect their quality of life negatively. This can be attributed to the fact that most of the women were in a polygamous marriage. This contradicts the findings of Arraras et al. [45] where they reported that most at times, breast cancer survivors complain sexual limitations negatively affect their quality of life.

Furthermore, this study revealed that mastectomy had effects on the employment of women after they have spent lots of money on their treatment. Also, some of them were not working prior to the surgery, few of the women were able to resume their work after the surgery. Although they work with their hands, the workload on the hand was very minimal. One of the women was laid off because she asked for permission on several occasions to go for chemotherapy and the surgery and the other most of the women were not able to go back to their work. Some of the women had pains when lifting or using the affected hand, others felt pain in both the hand and at the site. Others experienced minor illness which restricted their activities. This conforms with findings by Dias et al. [29] which revealed impaired work and

daily life activities due to the body segment involved among women post-mastectomy. The effect of the surgery on the hand restricted some of the women from working after the surgery.

The negative impact of the mastectomy on women's employment largely affected their finances. This placed much financial burden on women. Similarly, Jagsi et al. [35] reported that mastectomy has a negative impact on the employment of women which is a very important aspect of financial toxicity. Majority of the women in this study narrated how the cost of treatment was a burden on them and even affected their family. For example, some of the women who were into trading had to close down their shops because they used their capital to settle medical bills. Although some family members and friends helped financially, it was still not enough. One of the women had to take a loan from the bank, sold her car, and had to add her trading capital to take care of herself. This confirms the finding of Blinder, Carrera, & Kantarijan [37] that the impact of economic burden is great and affects the perception of the overall well-being of the patient who has undergone a mastectomy. Banegas et al. [38] and Veenstra et al. [39] also reported that the financial burden may lead the patient and family into bankruptcy. Majority of the women in this study had the national health insurance which was supposed to cater to their treatment. Breast cancer diagnosis and treatment are supposed to be fully covered under the national health insurance scheme (NHIS) [40]. However, the response of all the women indicated that NHIS does not fully support their treatment.

Conclusion

The loss of the breast due to breast cancer is a heavy burden on the woman. Most of the women experienced isolation, loss of businesses, and loss of employment. However, most of the women consoled themselves in God as they were now praying fervently for their healing. It was recommended that a multidisciplinary team approach was needed in the management of women post-mastectomy and their partners or significant others must be involved in the care to improve their well-being. Nurses should acknowledge the need to provide holistic care for this group of patients and endeavor to achieve that. Also, nurses need to play a major role in educating the public against stigmatization from society and family members about the diagnosis of breast cancer and mastectomy.

Limitations

The study had few limitations which are; the smaller sample size did not allow for generalization for the findings. Although the study was conducted in teaching hospitals, the language (English, Twi, Fante, and Mampruli) was a restriction that prevents many several participants to express their views. Besides, the study was limited to the Tamale Metropolis

Declarations

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Availability of data and materials

The data backing this study are available on request from the corresponding author

Authors' contributions

EOA and LA conceptualized the idea and developed the proposal study. EOA collected the data, EOA, LA, and YP analyzed the data. EOA and YP drafted the manuscript. LA revised the manuscript by reading through the entire manuscript to ensure all the required corrections are made. All the authors read and approved the final version of the manuscript.

Ethical approval and consent to participate

The approval was sought and obtained from the Christian Health Association of Ghana (CHAG-IRB11032019) and the Department of Research & Development Unit of TTH (TTH/R&D/SR/049). All participants gave informed consent to take part in the study by signing the consent form.

Consent for publication

Not applicable

Competing interest

Authors have no competing interest

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