

Quality of Life among Female Cancer Survivors in Africa: An Integrative Literature Review

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ABSTRACT

Quality of life (QOL) has been studied extensively among cancer populations in high income countries where cancer care resources are available to many. Little is known concerning the QOL of cancer groups residing in Africa where resources can be scarce. The integrative review of the literature explored and critically examined studies that had addressed QOL in female cancer survivors in Africa. The extent to which QOL studies incorporated a cultural perspective was also examined. Research studies published between 2005 and 2015 were retrieved from five databases: CINAHL, MEDLINE, SCOPUS, ProQuest dissertations and Theses full text, and GlobalHealth. Primary qualitative or quantitative studies regardless of sample size or setting were included. A total of 300 studies were identified and 28 full text studies were retrieved and assessed for eligibility. Eight studies met inclusion criteria. Factors that affected the QOL were socio-demographic especially age, education,

employment, income and residence; illness-related factors such as having advanced cancer and multiple symptoms; treatment-related factors associated with surgery and radiotherapy; psychosocial factors such as support and anxiety; and cultural factors including fatalism and bewitching. Practice implications entail increasing awareness among nurses and allied healthcare providers of the potential effects on QOL of a cancer diagnosis and treatment of female cancers such as pain, fatigue, sexual dysfunction, hormonal and body image changes, anxiety, depression and cultural practices. Failure to identify and deal with these may result in poor treatment adherence, low self-esteem, and ultimately poor QOL.

Key words: Africa, breast neoplasm, endometrial neoplasm, ovarian neoplasm, quality of life, uterine cervical neoplasm, vaginal neoplasm, vulva neoplasm

Introduction

Cancer is the leading cause of death worldwide and accounts annually for 8.2 million deaths (13%).^[1] More

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than 60% of all cancers occur in middle- and low-income countries, including Africa. These regions alone account for 70% of the world's cancer-related deaths.^[1] Breast and cervical cancers are among the five most common cancers diagnosed among women worldwide.^[1] Breast cancer is the most commonly diagnosed cancer among women in Africa, with an incidence rate of about 40/100,000.^[2] Breast and cervical cancer can be detected at an early stage with timely access to screening and diagnostic facilities.^[1] High breast cancer incidence and mortality rates have been reported in African countries such as the South African Republic and Algeria.^[2]

Cervical cancer is another frequently diagnosed gynecological cancer in Africa and the leading cause of death of women in Eastern Africa, accounting for about 12% of the total new cancer cases and 10% of cancer deaths in Eastern Africa.^[2] Eastern Africa, Zambia, Malawi, and Mozambique report the highest cervical cancer rates. Survival rates after a diagnosis of a female cancer are much lower in Africa than in Western countries.^[2] The 5-year survival rates for breast and other gynecological cancers in Africa are <50% and 30%, respectively,^[3] whereas the 5-year survival rates for breast and gynecological cancers in developed countries are 88% and 74%, respectively.^[4] The low 5-year survival rates in Africa are mainly associated with lack of early detection programs, adequate diagnosis, and treatment facilities, resulting in a high proportion of women presenting with late-stage disease.^[5]

Women diagnosed with gynecological cancer in Africa often face many challenges associated with cancer itself, cancer treatments and their health effects, cultural understandings, social and spiritual concerns, and financial constraints, among others. Their quality of life is thus compromised preventing them from being able to fully engage in meaningful life endeavors. Studies have examined the quality of life of African cancer survivors. Yet, to the best of our knowledge, no review has been conducted to develop a broader understanding of the quality of life among gynecological cancer survivors in this region. The purpose of this article is to report findings from an integrative literature review on quality of life among gynecological cancer survivors in African countries. In this article, gynecological cancers include cancers of the breast, cervix, ovary, uterus (endometrial), vagina, and vulva. Below, we present a discussion of quality of life in the context of cancer, followed by a description of the review process, findings, discussion, and nursing implications.

Quality of Life and Cancer

According to the World Health Organization, quality of life is defined as individuals' perceptions of their position

in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards, and concerns.^[6] Quality of life is the sentiment of general life fulfillment as dictated by the mentally alert person whose life is being assessed.^[7] The domains include "physical, functional, demographic, spiritual, social, and psychological/cognitive factors."^[8] Quality of life extends to include the performance of everyday activities that reflect well-being, satisfaction, functioning, and control over disease.^[9] Four parameters: physical, psychological, social, and spiritual well-being are commonly used to define quality of life in cancer survivors.^[10] A lack of a cultural dimension has been noted in the assessment of quality of life in cancer populations.^[11] According to Leininger, every person is described and viewed as a cultural being based on their cultural background.^[12] Gadamer states that one cannot isolate oneself from one's particular historical and cultural connection; it is through the transaction between existing personal knowing and values and the elements of other cultures that one develops knowledge.^[13] Studies tend to employ quality of life tools that have been developed in Western countries and may not reflect the cultural context of other settings. However, the World Health Organization Quality of Life Questionnaire is used often in these settings as it was developed in a wide range of cultural and clinical settings including oncology settings.^[14]

Incorporating a cultural perspective and cultural understanding when examining quality of life is most vital at the time of understanding how its various dimensions are expressed in a particular individual. Quality of life differs among individuals. This implies that people with the same health status may report a different quality of life because they may have different values and expectations.^[15] Many of the instruments used to assess quality of life have been criticized because they do not take into account the personal and active nature of perceived quality of life. They tend to focus on limitations and impediments rather than on the active and varied components that contribute to quality of life.^[16] In addition, health-care workers and relatives tend to have a more negative perception of how patients experience their health-related quality of life. An understanding of a patient's quality of life may be best obtained by asking about the patient's perspective and their experience of life, which may require a detailed understanding of their social, cultural, psychological, spiritual, and physical surroundings.^[15]

The quality of life of African women with gynecological cancers (breast, cervix, ovary, uterus, vagina, and vulva) may be affected by a multiplicity of factors. These may include the patient's sociodemographic characteristics such

as age, marital status, education, employment, residence, and income.^[17] Furthermore, quality of life may be affected by cancer type (breast, cervix, ovary, uterus, vagina, or vulva) and stage of disease progression.^[17] Side effects of cancer treatment (surgery, chemotherapy, and radiotherapy) may leave patients with physical problems, psychological and sexual dysfunctions, body image disturbances, hormonal changes, and fear over childbearing potential, which could have an important impact on their quality of life.^[18] The time following diagnosis and treatment of women with gynecological cancers also has a significant impact on their quality of life. Individuals who survive female cancer for 5 or more years have been reported to have either similar or higher quality of life than the general population.^[19-22] Although quality of life is an important aspect to consider in cancer care, it has not been examined in many low-income countries where a rising incidence of breast and gynecological cancers have been noted.^[19,23-25] Understanding quality of life among female patients with cancer in the African region who are attending specialized cancer care can provide information concerning areas of care that are in need of improvement and subsequently ease suffering among cancer patients.

Objective of the Integrative Literature Review

The purpose of this integrative literature review was to explore and critically examine what is known regarding the quality of life of survivors of gynecological cancers (breast, cervix, ovary, uterus, vagina, and vulva) in Africa. The ultimate aim was to reveal critical aspects affecting quality of life of gynecological cancer survivors in Africa that may require tailored interventions to improve physical, psychological, social, and spiritual well-being. The extent to which quality of life studies incorporate a cultural perspective was also examined. Through this review, we sought to generate valuable insights that may be used to inform nursing practice with female cancer survivors in Africa.

Methods

Integrative literature review process

An integrative literature review is a methodological tool that uses a systematic strategy to gather and summarize findings from studies on a given phenomenon to deepen and reinforce areas of scientific knowledge and support professional decision-making.^[26] The integrative review process includes problem formulation, literature search, evaluation of data, data analysis, and interpretation and knowledge synthesis.^[26]

Inclusion criteria

A well-defined search strategy about the topic of study was developed. Relevant qualitative and quantitative studies, theses or dissertations, and “grey” literature sources were considered for potential eligibility. Articles written in English that reported primary quantitative or qualitative studies on quality of life among African female cancer survivors were included regardless of participant’s age, sample size, and setting. Search dates covered the period of 2005–2015 because a period of 10 years would yield relatively recent articles about perspectives and changes in quality of life of female cancer survivors in Africa.

Literature search

Data for this integrative review were retrieved from a variety of sources comprising key electronic bibliographic databases covering research in biomedical fields, nursing, and allied health including CINAHL, MEDLINE, SCOPUS, ProQuest Dissertations and Theses full text, and Global Health. Furthermore, grey literature was searched, and this included unpublished manuscripts on the topic, reference lists from the selected articles and the World Health Organization website. Reference lists of articles retrieved were used to track authors or other relevant articles. The search terms used to retrieve pertinent studies from the databases included: (“Africa” OR “Northern Africa” OR “Eastern Africa” OR “Western Africa” OR “Southern Africa”) AND (“cancer” OR “tumor” OR “tumour” OR “malignancy” OR “neoplasm”) AND (“breast” OR “ovarian” OR “endometrial” OR “cervical” OR “vaginal” OR “vulva”) AND (“quality of life” OR “health related quality of life” OR “Quality of life”). Data from the primary sources were extracted using a table format [Table 1]; categories were identified based on commonalities or differences among the studies. The categories were then summarized. Data were then organized in a table in a clear and concise format to provide a detailed overview of each study and the review findings as a whole. A narrative synthesis was generated in a theme format to integrate the findings from included studies.

Results

The initial search yielded a total of 300 studies identified through database searches, manual extraction, and grey literature. Titles and abstracts were screened by one reviewer to determine if they met inclusion criteria. Twenty eight full-text studies were then retrieved and read in full to determine their eligibility for inclusion in the integrative literature review. Following careful examination of these

articles, only eight studies met inclusion criteria [Figure 1]. Reference lists of these eight included studies were then reviewed to search for additional studies that were potentially eligible. No other documents were found that met the inclusion criteria from this additional reference list analysis.

Characteristics of the studies

A total of seven studies and one dissertation met the inclusion criteria. A detailed summary of each study can be found in Table 1. Overall, the eight studies employed quantitative, nonexperimental methods and were conducted

Table 1: Quality of life among female cancer survivors in Africa

Authors	Setting	Research purpose	Sample demographics	Methods, design and data collection instrument	Findings
Katumba, Obore, and Kaye,(2013) ^[31]	Urban, Kampala, Uganda	To describe the health related quality of life among women with ovarian cancer at Mulago Hospital	36 women with confirmed ovarian cancer Mean age 50.7 ± 16.7 years, 58.4% married, 47.3% grand multiparas (having more than 5 children)	Quantitative Case series Non-experimental design World Health Organization Quality of Life Questionnaire	The majority (88.9%) had advanced disease 47.2% presented with multiple symptoms abdominal, urinary and constitutional Overall mean score on the World Health Organization Quality of life questionnaire was 27.5%, and the score was lowest in psychological domain 18.7% Poor psychological well-being was attributed to the anxiety and depression experienced by the cancer related morbidity, treatment induced menopausal symptoms, causing infertility, childlessness and disease effects on sexual function
Cooper and Mullin, (2008) ^[27]	Rural, South Africa	The need to identify how cultural factors affect the specific beliefs, attitudes and health related behaviors among cancer patients in underserved populations in South Africa	167 patients with breast cancer and ovarian cancer Mean age 47.3 ± 14.5 years, 41% married, only 28.4% employed, 80% low education and 60% lived with other adults and children	Quantitative Exploratory Non-experimental design The Functional Assessment of Cancer Therapy-General	Patient's quality of life was improved if they were employed, had a physical property such as cows, having a good relationship with children and extended family Patients had low scores in physical and emotional well-being scales since most of them had advanced cancer In these cultures stoicism and lack of expressiveness in the face of pain is an extremely salient value, and this has an impact on levels of pain expressed to others Patients evidenced high degree of fatalism and most believed in being 'bewitched' leading to isolation and fear Also external control over health decisions such as most of the women with breast cancer who wanted a mastectomy could not get one because their husbands refused to let them be 'disfigured' and 'unwhole.'
Jalyesimi, Sofelo, and Rufai, (2007) ^[29]	Urban, Ibadan, Nigeria	To assess the quality of life of Nigerian breast cancer patients and to investigate factors that influence/ determine their quality of life	35 post-surgical breast cancer patients with a mean age of 44.3 ± 11.9 years	Quantitative Cross sectional Descriptive Non-experimental design European Organization for Research and Treatment of Cancer Quality of Life Questionnaire	Overall quality of life was significantly related to physical, cognitive and social functioning On symptom scale, financial difficulty was the greatest concern 71.4% while pain 59.1% and fatigue 52.7% were the most troublesome symptoms The quality of life was also significantly related to scores of symptoms like fatigue, nausea, vomiting, pain, insomnia and financial difficulty Role functioning and social functioning also affected their quality of life
Awadalla, Ohaeri, Khalid, Hamad, and Jacob, (2007) ^[19]	Urban, Khartoum, Sudan	To assess the subjective quality of life of stable Sudanese women cancer outpatients and their family caregivers	181 women with breast, cervical cancer, and ovarian cancer Mean age 44.6 ± 11.2 years, 62.4% married, 82.9% not employed and only 31.5% had up to high school education and duration of illness on average was 3.2 years	Quantitative Cross sectional Descriptive Non-experimental design World Health Organization Quality of Life Questionnaire	Patients who were married, with higher education, better employment, had a higher quality of life Also, patients on radiotherapy had a higher quality of life scores The predictors of poor quality of life were physical unwellness, unemployment, low education and duration of illness

Contd...

Table 1: Contd...

Authors	Setting	Research purpose	Sample demographics	Methods, design and data collection instrument	Findings
Ogoncho, Omuga, Wakasiaka, and Muiva, (2015) ^[30]	Urban, Kisii, Kenya	To determine the predictors and factors associated with quality of life among gynaecological cancer patients on follow up at Kenyatta National Hospital, Kenya	108 women with ovarian, cervical, endometrial and vulva cancers Mean age 48±1.28 years Only 10% had tertiary level education, 43% were farmers, 55% married and 71% were earning less than 5,000 Kenya shillings per month	Quantitative Cross Sectional descriptive Non-experimental design The Missoula Vitas Quality of Life Index	Age, the level of education, marital status, occupation and monthly income were the socio-demographic factors significantly associated with quality of life scores, (<i>P</i> <0.05) The patients' type of cancer, type of cancer treatment, duration of illness and palliative care services were the clinical characteristics significantly associated with quality of life scores, (<i>P</i> <0.05)
du Toit, and Kidd, (2015) ^[28]	Urban, Stellenbosch, South Africa	To compare the quality of life for women with cervical cancer and treated with radiation or chemo radiation therapy at Tygerberg Hospital, South Africa	219 women with advanced cervical cancer Mean age 65±2.34 years, 54.5% married, employed were 55%, low education 47.5% and average income were 1749 ZAR (155 CAD\$)	Quantitative Descriptive comparative Non-experimental design European Organization for Research and Treatment of Cancer Quality of Life Questionnaire	Chemo radiation therapy resulted in statistically more improvement in the pain (<i>P</i> <0.05), fatigue (<i>P</i> <0.05), appetite loss (<i>P</i> <0.01), and nausea and vomiting (<i>P</i> <0.05) quality of life domains Pretreatment quality of life scores significantly higher in the radiation therapy group, implying a poorer quality of life status at the initiation of treatment With chemo-radiation. Peripheral neuropathy was reduced
Khalil <i>et al.</i> , (2015) ^[32]	Urban, Morocco	The aim of this study was to evaluate quality of life in cervical cancer survivors up to 10 years after the diagnosis	110 cervical cancer survivors and 80 healthy controls Mean age 34±17 years, 91% married, 56% not educated, and 72% unemployed	Quantitative Cross sectional descriptive Experimental design European Organization for Research and Treatment of Cancer Quality of Life Questionnaire	The most reported symptom was pain; financial fatigue problems were also highly reported Long term cervical survivors reported lower emotional functioning (<i>P</i> =0.0) and a higher rate of constipation 31% reported having no interest in sexual relations, Moreover, the fear of developing a relapse or an infection was reported by 41% of the cohort The predictors for quality of life in cervical cancer survivors included spiritual well-being, maladaptive coping, reproductive concerns, social, family, and intimate relationship
Chitashi, (2012) ^[33]	Urban, Zambia	To evaluate the impact of chemo-radiation treatment on quality of life and to determine what socioeconomic and demographic factors are closely related with quality of life decrements in Zambian women treated for cervical cancer	Mean age was 41 years, 52% married, 96% below college education and 86.4% were unemployed 45 women treated for cervical cancer with radiotherapy	Quantitative Cross sectional descriptive Non-experimental design European Organization for Research and Treatment of Cancer Quality of Life Questionnaire	4.4% presented at stage I, 53.3% at stage II and 42.2% at stage III Patients with advanced cervical cancer treated with chemoradiotherapy experienced a favorable quality of life and treatment were considered worthwhile by the majority of patients Women described problems with sexuality and marital relationships Low education and living without a partner were predictors of low quality of life

in hospital settings. Four studies employed the European Organization for Research and Treatment of Cancer Quality of Life Questionnaire-C30, two studies the World Health Organization Quality of Life-BREF Questionnaire, one the Missoula-VITAS Quality of Life Index, and one the Functional Assessment of Cancer Therapy-General questionnaire. Some of the similarities identified among the

quality of life tools were that each had an overall quality of life score and measured physical, psychological, and social well-being. Differences among the tools included the additional variables that they measured: For example, in the World Health Organization Quality of Life-BREF questionnaire and European Organization for Research and Treatment of Cancer Quality of Life Questionnaire-C30 and

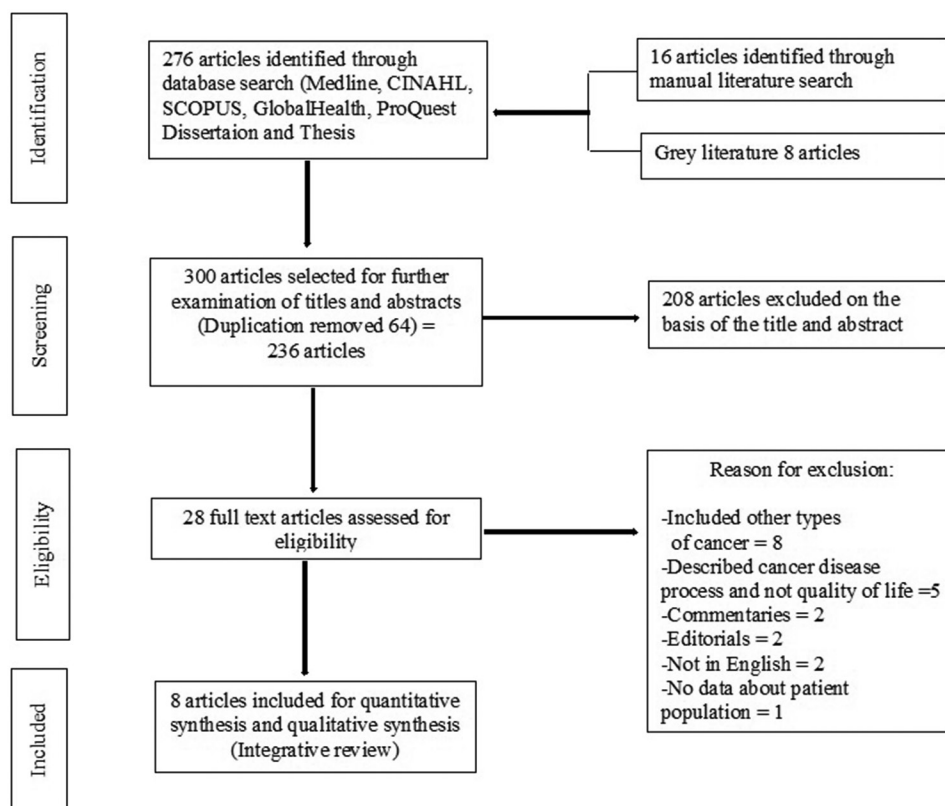


Figure 1: Flow diagram

Missoula-VITAS Quality of Life Index, specific symptoms such as pain, fatigue, nausea, vomiting, and insomnia were also assessed. The Functional Assessment of Cancer Therapy-General questionnaire also measured family relationships and culture; the World Health Organization Quality of Life-BREF questionnaire assessed environment and the European Organization for Research and Treatment of Cancer Quality of Life Questionnaire-C30 also assessed spirituality.

Two studies were conducted in the Republic of South Africa.^[27,28] Single studies were conducted from each of the following countries: Nigeria,^[29] Kenya,^[30] Sudan,^[19] Uganda,^[31] Morocco,^[32] and Zambia.^[33] In the following section, we present a synthesis of included studies.

Categories identified from the review

According to Whittemore and Knafel^[34] updated methodology on integrative literature reviews, the first stage in data analysis is the data reduction phase. In this stage, studies that met the inclusion criteria were classified into five subgroups or categories based on the factors that affected women's quality of life. These included sociodemographic, effects of lack of access to cancer screening and treatment, side effects related to gynecological cancer treatment, psychosocial, and culture-related factors. In what follows, each primary

category is described. The discussion section further expands this description with an in-depth analysis of the relationship between these factors and quality of life and a discussion of potential practice implications.

Social demographic factors

The total number of participants in this review was 838 and the sample sizes in the eight studies ranged from 36 to 219 adults diagnosed with breast and other gynecological cancers. The average age of the female cancer survivors in the eight studies presented in this review was 45.5 years; the majority of the participants were unemployed, had little or no education or income, and lived in rural areas.^[19,27-31]

Effects of lack of access to cancer screening and treatment

Most of the gynecological cancer patients presented with advanced cancer and generalized metastases to various organ systems; as a result, most women had several symptoms and had been sick for about 2 years before diagnosis, thus affecting their quality of life.^[19,32,35] The major physical symptoms reported by the gynecological cancer patients were abdominal pain, urinary problems, gastrointestinal symptoms, and fatigue.^[19,28,30-33] The physical symptoms commonly reported by breast cancer patients were fatigue, nausea, vomiting, and pain.^[19,27,29]

Side effects related to gynecological cancer treatment

The factors related to treatment that mainly affected quality of life were premature menopause, following surgery or radiotherapy, and this manifested with symptoms such as hot flashes, urinary incontinence, vaginal dryness and atrophy, diminished libido, sexual dysfunction, and depression.^[31-33] Furthermore, gynecological cancer patients receiving radiotherapy presented with multiple treatment-related factors and low scores for quality of life.^[28,30,32] However, chemoradiation therapy was reported to improve quality of life in domains of physical function, pain, fatigue, appetite loss, and social roles.^[28,32,33]

Psychosocial support

Several studies reported participants having very little psychosocial support and scoring very low on the quality of life tools in the psychological domain.^[19,31] In addition, low psychosocial support was expressed in lower scores for social functioning^[33] or lower emotional support^[32] or depression.^[29] Low psychosocial support was mostly reported among women who were not formally employed and those with lower income such as peasant farmers and casual workers.^[30] Further, lower psychosocial support was reported among patients who had no family caregivers involved in their routine clinical care subsequently, leading to poor psychosocial support and poor quality of life.^[19]

Cultural factors

Only one study was found where the cultural perspective was examined.^[27] Patients' ratings of their physical and emotional well-being subscales were low because the women's cultural beliefs did not allow them to express their perceptions and sentiments publicly. The women's belief in stoicism and lack of expressiveness in the face of pain was an extremely salient value, and this had an impact on levels of pain expressed to others.^[27] In addition, all the women in this study evidenced a high degree of fatalism and most believed that they were "bewitched" leading to isolation and fear. From a cultural point of view, women surrendered control over health decision-making to their spouses.^[27] Thus, most of these women could not undergo surgical procedures such as mastectomy to save their lives because their husbands regarded a woman with a missing body part "disfigured" and "unwhole."^[27]

Discussion

Findings from this review are similar to studies in other world regions, where a multitude of considerations impinge on the quality of life of study participants. The impact of socioeconomic factors on women's quality of life was predominant across research studies. In addition, the lack

of a cultural perspective in the analysis of quality of life was notorious. Below, we discuss findings under each of the review categories.

Sociodemographic factors

According to Tabano *et al.*,^[35] older women with female cancers often report poorer health and are more likely to have multiple complications with somatic complaints. Lack of employment, low education, low income, and rural residence of study participants in this review exposed them to a lack of knowledge about how they might manage their disease and lack of awareness of risk factors.^[19,30] In addition, their cancer and socioeconomic situation prevented them from obtaining income support to cover illness-related costs.^[19,30] These factors may exacerbate cancer, worsen symptoms, and cause suffering that will have an adverse effect on affected women and those close to them, thus affecting their quality of life.^[36]

Women in lower income countries are overrepresented in the unemployed sector and account for 60% of the world's working poor earning under one dollar a day.^[37] Low-income families have little money to spend on health care and many women are more likely to forgo treatment or self-treat rather than seek care at a health-care facility.^[38] This may be associated with the fact that women from low-income households tend to be less educated and cannot access health care because of financial constraints and poverty. In addition, most economically disadvantaged women living in rural areas in developing countries may pay little attention to their symptoms due to cost implications and/or distance.^[39] It is possible that many of them are not aware of the significance of screening for early detection of cancer.^[40] This leads to barriers to seeking early help even when women have a family history of breast or gynecological cancer. In addition, they may not be able to recognize the seriousness of symptoms when they occur. This poses the urgency to implement early detection programs that are accessible, affordable, comprehensive, and portable, particularly in Africa where a vast majority of women live in rural and remote areas.^[41]

Effects of lack of access to cancer screening and treatment

The majority of the women presented with advanced cancer.^[28,29,31,33] According to existing evidence, most of the gynecological cancers in the developing countries are likely to be diagnosed at a late stage, thus resulting in a poor prognosis due to delayed access to adequate therapy and follow-up.^[39] This limits affected women's chances of progression-free survival as well as overall survival, thus affecting their quality of life. Furthermore, for the majority of women in lower income countries, curative treatment

for breast and gynecological cancers is unfortunately often beyond their reach due to the late diagnosis and lack of resources.^[41,42] In the advanced stages, breast and other gynecological cancer patients may present with symptoms that result from long-term effects of untreated cancers. Advanced stages of breast and gynecological cancers will present with aggravating and enduring clinical symptoms that will prevent them from enjoying whatever time they have left. For these women, an urgent and needed therapeutic option is palliative care.^[41,42] While many efforts have been made to improve access to palliative care in Africa, severe gaps in access to these services continue to exist. Palliative care can significantly improve pain and symptom relief among these women as well as their quality of life and offer them a dignified death at a time of great suffering.^[41]

Side effects related to gynecological cancer treatment

Women with gynecological cancers experienced several side effects resulting from treatment therapies such as surgery, chemotherapy, and radiotherapy. The most common side effects reported by the women included hot flashes, urinary incontinence, vaginal dryness and atrophy, diminished libido, sexual dysfunction, and depression.^[19,29,31,32] Similar findings have been reported among gynecological cancer patients receiving chemotherapy and radiotherapy in an African population such as South Africa.^[18,43] For women with gynecological cancers, sexual functioning problems may have a deeper effect on quality of life as they reflect challenges with physical symptoms, self-esteem, self-perception, sense of well-being, satisfaction with life, and relationships with partners.^[43] This may be particularly distressing because the body parts involved are associated with femininity, sexuality, and childbearing, thus leading to negative consequences for intimate relationships.^[44] Studies have shown that women with gynecological cancer often find it difficult to discuss their sexual problems with anyone including partners, friends, family, or health-care professionals because they perceived the topic as sensitive and embarrassing.^[45]

Psychosocial factors

The issue of limited psychosocial support being available for female cancer survivors in Africa was reported in nearly all the studies. Some of the reasons for low social support among female cancer patients result from most women avoiding or being unable to seek social support from families, friends, and community because they are shunned or stigmatized. Another concern has to do with the effects of the cancer treatment on their sexuality, which has an impact on their self-identity as wives or mothers.^[18,43] Following completion of breast and gynecological cancer

treatment, social functioning, activity, or contact tend to be limited due to physical symptoms, such as pain, fatigue, and emotional difficulties encountered by many women.^[46]

One of the most significant aspects of establishing an effective social support system for female cancer patients is for them to have an intimate relationship with their families.^[19,32] When support exists, female cancer patients may feel at peace and have a sense of meaning in their lives.^[46]

Cultural factors

Different cultures may stress various aspects of their quality of life in various ways.^[47] For some patients, the psychological, emotional, and social limitations of their illness tend to become more important determinants of quality of life rather than the physical symptoms such as lower back pain, lymphedema, and urinary irregularities. du Cooper and Mullin^[27] reported that the cultural factors that were detrimental to the participants' quality of life included being fatalistic, a belief where all events are believed to be predetermined and therefore inevitable. In this study, most female cancer patients tended to believe that they were "bewitched" and this led them to feel isolated and fearful. In these cases, women may be reluctant to seek timely healthcare. Another cultural factor identified by du Toit and Kidd^[28] was the lack of expression in the face of pain, which could also limit their health-seeking behavior. In addition, their loss of control over health decisions mostly made by men prevented women with cancer from undergoing procedures such as hysterectomy because of their spouse's belief that they would become "unwhole." Similar findings were reported by Akinyemiju,^[38] among women from low-income countries including Africa. In countries such as Congo and Mali, if a woman lost her uterus due to the treatment of gynecological cancer or a breast due to breast cancer, this might affect her relationship with her partner. Men usually see these parts as defining a woman's identity. Divorce has been reported among women, following hysterectomy to treat gynecological cancer, and may have resulted from social stigma attached to the disease.^[48] This could lead to a sense of powerlessness in female cancer patients.^[48]

Nursing Implications

Diagnosis of cancer and its treatment is associated with high levels of distress and varying degrees of anxiety, depression, powerlessness, sadness, and fear depending on the stage of the disease and treatment.^[49] Nurses need to be responsive to the long-term consequences that present and linger such as pain, fatigue, sexual dysfunction, hormonal changes, body image concerns, and psychological

dysfunction; these can affect quality of life.^[18] Failure to identify and deal with this distress may reduce female cancer survivors' quality of life and can result in low adherence to treatment, thus leading to low self-esteem and negative feelings.^[49] Assessing quality of life among cancer patients helps nurses to identify whether a person has developed or is at risk of developing further distress or whether she is managing psychologically to adjust to her illness.^[50] Nurses can support the need for their patient's overall satisfaction by providing information about diagnosis and treatment and facilitating a therapeutic interpersonal relationship that can encourage cancer survivors to both participate in their care and achieve optimal quality of life.^[46] Further, incorporating knowledge of social inequalities such as gender, age, educational level, and income would also increase provider's sensitivity and their understanding of factors that may prevent them from being able to follow cancer-related therapies.

Early detection and treatment of gynecological and breast cancers can be increased using effective screening practices, surgery, chemotherapy, and radiotherapy; however, access to most of these may be limited or nonexistent in most low-income countries.^[38] Efforts should be made to emphasize the value of preparing healthcare professionals in these countries in prevention, early detection, diagnosis, treatment, and care of gynecological cancers so that they can support women to cope better with the impact of cancer and its treatment. For example, training would entail clinical assessment and diagnostic investigations. In addition, healthcare workers need to have the resources and ability to screen "at risk" patients; raise awareness of the known risk factors for female cancers; and have knowledge of signs, symptoms, and components of a healthy lifestyle.^[51] They can assist with prevention, lifestyle management, early detection of asymptomatic patients, and disease control.^[52] Improving awareness may result in a modification of behavior while improved knowledge of symptoms is critical to increasing early detection and reduction of chronicity and mortality rates related to cancer, thus improving the quality of life.^[52]

The integration of cancer programs into existing health care services in primary health-care facilities that are accessible to most women is one of the most reliable, cost-effective interventions that can be utilized.^[5] The incorporation of services and continuity of care might be easier in Africa because of robust and reasonably well-funded primary care systems.^[51] Further, in Africa and other lower income countries, there is universal health coverage that offers access to prevention, promotion, treatment, and recovery without the danger of money-related hardship when paying for them although this can vary from

country to country.^[53] At the primary care health facilities, management of symptoms should be integrated with prevention, diagnosis, treatment, and palliation of female cancer patients.^[5] In addition, the use of cost-effective screening and treatment interventions needs to be encouraged. For instance, screening for cervical cancer using acetic acid and early treatment with cryotherapy for removing precancerous tissue could be implemented at the community level.^[51] Breast examination techniques for early detection of breast cancer can also be implemented.^[54] These can be made timely using these low-cost tests to save lives and timely coordination with higher levels of care when needed. Moreover, the integration of services can utilize the team-based model that can address multiple conditions in one visit.^[5] The team-based model approach can adequately address prevention and screening as well as promote adherence to therapy for a range of chronic diseases; this would provide one-stop care and improve continuity of care for the patient.^[5] These approaches will help in early detection and successful treatment of gynecological cancers in earlier stages and minimize chronic illness resulting from complications and disabilities from untreated cancers, thus improving quality of life of female cancer survivors.

A focus on education to improve the understanding of both patients and themselves with regard to their disease and treatment effects needs to be mandatory for all healthcare providers involved in the care of female cancer survivors. In addition, receiving information on sexuality is deemed a high priority for women with gynecological cancers as one of the most important issues in the provision of health care.^[55] Nurse-led education and counseling group interventions have been reported to have a positive impact on various aspects for women experiencing gynecological cancers. These also need to include sexual functioning, because during the educational and counseling sessions, women may ask questions and discuss any issue that affects them if they are comfortable with their provider and believe that their confidentiality will be honored.^[56] The benefits of using chemoradiation therapy when appropriate, other than radiation alone, may improve quality of life and relieve symptoms among women with particular types of gynecological cancer.^[28,32,33] For patients with breast cancer, physiotherapy has proved useful in relieving symptoms of fatigue, pain, and insomnia.^[29]

According to Chitashi,^[33] focusing on increased social support and education would help patients to accept their disease and treatment effects. Establishing a strong social support system at home and in the health-care system is critical to enhancing their quality of life. This may include counseling the patients' relatives to provide continued social support so that they may be able to support their family

member through a difficult illness. In addition, healthcare providers should endeavor to incorporate families in the clinical management of symptoms and treatment plan to enable them to cope positively. Moreover, palliative care nurses need to be involved in managing patients' pain because pain is one of the biggest predictors of social functioning.^[57]

Healthcare providers need to be prepared to provide culturally and socially relevant educational material, and this must be provided to women in low-income countries. They need to have an understanding of how to present material to women who may have a low literacy level or speak a different language. Providers need to keep in mind that the majority of these women require one-on-one discussions and an opportunity to ask questions, seek answers, and seek assistance.^[39] Furthermore, healthcare providers need to become informed about and be open to their patient's cultures and should incorporate these cultural understandings into their treatment plan because greater knowledge of patients, their worldviews, and their perspectives on health-related quality of life can be helpful to improve cancer treatment.^[27] Adopting a culturally sensitive approach to identify good health practices offered by different cultures in healthcare can also be an effective way to improve patients' quality of life. In this review, only one article was found that addressed cultural issues and their influence on quality of life. A standardized tool was used to measure cultural aspects of quality of life. Some researchers believe that an individualized approach to the assessment of the quality of life is preferable to the use of standard questionnaires.^[58] In addition, there is need to further investigate aspects of female cancer survivors' quality of life, following qualitative interpretive and constructivist perspectives. This would help nurse and allied health-care researchers to further understand the cancer experiences from participants' perspectives as well as examine the interaction between women and the historical and cultural contexts that they inhabit.^[59]

Limitations

Limitations of this literature review included a limited number of studies that met the inclusion criteria. This may have to do with the scarcity of research conducted on the topic in developing countries or a lack of published studies in the English language. This prevents us from incorporating valuable insights and understandings from studies published in other languages. There is lack of identification of more specific locations in Africa as legislation is different among different countries and cultures/environments. Our aim was to generate a baseline understanding of the topic and further research is needed to continue to expand knowledge in the area.

Conclusion

Cancer-related quality of life is complex and multidimensional; physical, psychological, social, spiritual, and cultural factors all play a role in the quality of life of women with cancer. In this review, the quality of life of female cancer survivors in Africa was affected by multiple factors. The results of this review have the potential to inform the practice of health-care providers and the understandings of female cancer survivors with a view to addressing major concerns related to quality of life. Healthcare providers need to pay particular attention to the most vulnerable groups such as those with low education, limited social support, and the unemployed, as well as those with low income and living in rural areas. Further, attention should be given to women having advanced cancers and multiple symptoms to enhance their quality of life.

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Conflicts of interest

There are no conflicts of interest.

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