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A phenomenological study of the cultural lived experiences among Angolan women with breast cancer

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ABSTRACT

Purpose: This study aims to explore and describe the lived experiences of Angolan women with breast cancer, considering the socio-cultural context and health care challenges they face.
Method: Eighteen semi-structured interviews were conducted among Angolan women with breast cancer. Purposeful sampling was utilised to select participants with diverse age groups and ethnic backgrounds. We performed a qualitative study using Giorgi's descriptive phenomenological approach.
Results: The present study found cultural views of breast cancer, family support, and religious-spiritual coping to be essential themes. The results offer significant insights into the cultural framework of health in Angolan society, encompassing the information, perceptions, and cognitions employed to describe, comprehend, and elucidate illness, as well as the pursuit of therapy that seldom aligns biological criteria.
Conclusions: The present study has implications for nursing, as it recognises that individuals have unique behaviours and thoughts related to their current understanding of the illness, their personal experience with the illness, and their specific beliefs about health and healing.
The findings of this study provide essential insights into how Angolan women's cultural beliefs and practices shape their experiences with breast cancer, offering nurses a foundation to develop culturally competent care approaches.

1. Introduction

A neoplasm is the process resulting in the abnormal, uncontrolled, and progressive proliferation of tissue through cellular growth. A neoplasm that is malignant is referred to as cancer (Baloch et al., 2023). The literature shows that the emergence of malignant cancer is associated with modifiable (alcohol consumption, obesity, overweight, physical inactivity, and stress) and non-modifiable factors (genetics, number of genetics, the number of gestations, combined hormonal therapy, and family history (Clinton et al., 2020).

Breast cancer has emerged as a significant global public health concern, affecting both developed and developing countries (Adeoye, 2023; Sung et al., 2021). Breast cancer in Angola represents the most prevalent type of cancer among women, with a number of new cases in 2022, of 2989 for all ages (20.8 %) and a mortality rate estimated of 8,6 (1333) percent (International Agency for Research on Cancer, 2024).

Sociocultural factors such as poverty, inadequate healthcare, stigma, low health literacy, and low levels of public awareness influence health behaviours around cancer, making it impossible to detect it in the early stages, as observed in some African nations (Agodirin et al., 2020; Espina et al., 2017), like Angola. While numerous studies have addressed breast cancer in developed regions, little is known about how women in Angola experience and manage this disease, particularly concerning their cultural, economic, and social realities.

Despite statistics showing a significant increase in breast cancer cases in Angola, categorised by elevated mortality and incidence rates

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(International Agency for Research on Cancer, 2024), there remains a scarcity of studies addressing the subjective aspects of the disease. Current approaches tend to focus on biomedical aspects, epidemiological considerations, and current therapies, while the lived experiences, including their perceptions, emotions, and social and cultural implications remain largely underexplored.

The insufficient attention to Angolan women hinders a comprehensive understanding of the challenges and specifications associated with cancer. Conversely, Angolan women encounter socio-economic, historical, and cultural factors that may affect their experience of the disease, encompassing diagnosis, treatment, and recovery. Consequently, stigma, healthcare accessibility, and cultural challenges affect their coping mechanisms about the illness (World Health Organization, 2012). In this context, meanings associated with cancer in general and women's bodies in particular, along with their lived experiences, shape women's representations of breast cancer. Moreover, some studies strongly suggest that cultural characterisations (language, social structure, world view, and religion) directly influence the perception and knowledge of cancer disease among the different segments of society by members of the cultural community (Kalaitzi et al 2019).

Therefore, this perspective understands that the encounter with breast cancer is a transformative journey that forces the person to reorganise their existence, as it demands a multidimensional transformation, namely on an emotional and psychological level, leading to the development of resilience and the reassessment of priorities, on a relational and social level, altering interpersonal relationships by revealing the depth or fragility of these relationships, on a physical level since breast cancer causes significant changes to the body that impact on personal identity and self-image, and on a spiritual and existential level, allowing beliefs, values, and the way life and death are perceived to be re-evaluated. Within this context, a person creates a construct of this issue based on their ethnic and social group's cultural framework and develops strategies to address it (Kedida et al, 2024). Based on these assumptions and considering the nature of the problem, this study aims to explore and describe the lived experiences of Angolan women with breast cancer, considering the socio-cultural context and health care challenges they face.

According to Henriques et al. (2021), the holistic approach to nursing care considers the individual's life experiences, necessitating the advancement of scientific knowledge such as phenomenological studies. Phenomenological studies contribute to the construction and understanding of perceptions, ideals, and views that align with the conception of nursing care. These studies impact the subjectivity of a particular social group through characterizations or symbols, allowing the individual to navigate their environment (Shorey & Ng, 2022).

Thus, understanding the lived experience of Angolan women with breast cancer will improve nursing practice in Angola by enabling a person-centered care practice that encompasses the cultural and social dimensions of patients. In many contexts, nursing practice is focused predominantly on the technical and biomedical aspects of care, neglecting the subjective and psychosocial realities of patients, which results in incomplete care that does not address the fundamental aspects of the illness experience, such as emotional suffering, insecurities, and the challenges experienced.

Therefore, by investigating and understanding women's experiences, we will enable nursing care to be more holistic. Consequently, it allows nurses to adapt their practices and promote a culturally congruent approach to care. Integrating lived experiences into care improves prevention and awareness strategies by reducing fears, ignorance, and associated myths, and facilitates adherence to treatment and ongoing care.

Hence, we believe that this study provides valuable data to guide nursing practice, enable professionals to adopt empathetic and personalised attitudes, and allow for the development of education and training programmes that address cultural aspects and not just biomedical care. In Angola, this study will make it possible to improve nursing practice that is more humanised, efficient, and adapted to local realities with clinical results and quality of life, by allowing needs and challenges to be recognised and taken into account.

Accordingly, the phenomenological approach in this context seeks to address the existing gap by focusing on the lived experience of Angolan women with breast cancer, contributing to the development of effective interventions tailored to real needs, and assisting the health workers, especially nurses, in delivering care that considers the socio-cultural context of each woman.

This study aims to explore and describe the lived experiences of Angolan women with breast cancer, considering the socio-cultural context and health care challenges they face.

2. Methods

2.1. Study design

Among various qualitative research approaches, a phenomenological approach is best for analysing a given phenomenon through the perspectives of the person living the experience, as this method allows for deep exploration of the subjective experiences of participants, which is crucial in understanding the impact of cultural and social context on Angolan women's experiences with breast cancer.

When applied to the health sciences, especially nursing, the phenomenological approach makes it possible to understand the meanings of the lived experience of health and illness based on the individual's description without prejudice while remaining faithful to the facts (De Chesnay, 2014). Considering the sociocultural context and the particularities of the study, the researchers ensured that the interpretation of the data was as faithful as possible to the subjective experience of the participants, i.e., the researchers wanted to record and interpret the lived experiences as accurately and authentically as possible, applying *epoché*. On the other hand, ethnic diversity, social contexts and age groups ensured that the multiple dimensions of the experience were represented in a balanced way. Thus, reflexivity, the application of *epoché*, and the diversity of the sample ensured that the interpretation of the experiences of Angolan women with cancer was presented without external impositions.

Hence, considering the phenomenon of the lived experience of Angolan women diagnosed with breast cancer and the objective of understanding the meanings that these women attribute to their experience, we chose to use the descriptive phenomenological method developed by Amadeo Giorgi as a reference for describing the phenomenon under study as precisely as possible.

2.2. Setting

Angola is a low—to middle-income country located on the west coast of Africa. Despite providing free healthcare to the population, the Angola National Health system has structural problems, namely insufficient and inadequate national coverage and maintenance of health structures; a fragile referral and counter-referral system; the reduced qualitative and quantitative expression of human and technical resources in rural and suburban areas; diminished financial resources; and weaknesses in the health management system, including information, education, and communication (Macosso et al, 2022). This lack of specialised units and the centralisation of treatment in a single unit in the capital, along with social, economic, and cultural challenges, profoundly impact the quality of life of Angolan women.

Therefore, the country's only public cancer treatment facility hosted the study. This public cancer treatment facility, located in Luanda, provides tertiary-level services and is characterised by having experienced professionals, chemotherapy facilities, radiotherapy facilities, and diagnostic capabilities (Lopes et al., 2015). A diverse group of people with demographic, socioeconomic, and geographical diversity accesses the hospital as a national referral centre (Lopes et al., 2012).

2.3. Data collection

Sample data collection took place in Luanda, the capital of Angola, between September 2019 and January 2020. We used a purposive sampling strategy to achieve maximum variation in demographic characteristics and ensured that the study included a range of experiences and perspectives, representing various social, cultural, and personal backgrounds. Knowing that Angola has several ethnic groups, which include the Ovimbundu, Ambundos, Bakongo, Cokwe, Ngangela, and others, each with unique beliefs, values, and practices (Martins, 2020; Tvedten, 2018)

These differences impact health practices and resource access due to geographical, social and historical factors. Conversely, age is a crucial demographic factor, as Angola's population is predominantly young, with a life expectancy of 64.90 years (Angola Health Observatory, 2025). The younger women adhere more to formal healthcare than the older and possess greater access to education and information compared to older women. Demographic characteristics such as the Angolan ethnic group and age were considered relevant factors that can influence Angolan women's lived experience of the disease and care practices in particular.

However, we considered the following eligibility criteria: a) having a breast cancer diagnosis; b) being enrolled in a breast cancer treatment program or having completed the treatment program, as confirmed by a doctor; c) not having psychiatric disorders or mental disabilities that impede their capacity to engage in the interview procedure; and d) being 18 years of age or older.

This study used a homogeneous sample size of 18 subjects to achieve theoretical saturation of the information collected. Furthermore, theoretical saturation occurs when there is enough information to reproduce the study, and no additional information emerge from the data or additional coding is no longer achievable (Saunders et al., 2018). Indeed, theoretical saturation considers that during data collection, there is a transfer of psychocultural meanings from their original environment of individuals to the environment of the researcher (Nascimento et al, 2018).

In this study, data analysis began immediately after the first interviews, and as the themes related to the experience of Angolan women with breast cancer, such as diagnosis, treatment, the emotional and social impact, and the challenges faced in the various stages of the disease, began to consolidate after a certain number of interviews, and new participants did not bring new elements. Although we acknowledge the variability of cancer experiences based on generational and ethnic differences, we believe that the sample accurately represents the phenomenon, given the study's aim to explore the central experiences and recurring themes. All the participants filled in demographic information on ethnic origin, education, and family structure and completed the interview sessions, so there was no additional need to include more participants.

To guarantee access to participants who met the eligibility criteria, one of the researchers spent four months in the clinical environment with the doctors and patients, participating in medical screening, diagnosis, and follow-up appointments to learn more about the phenomenon, become orientated to the situation, and build trust with the participants so that they were open and willing to share their experiences. During this time, the medical doctors helped to identify the potential research participants; subsequently, the researcher provided the information to establish their interest in joining the research study.

The interviews were conducted with the help of a semi-structured script because it allowed for some flexibility, focused on the interview procedure, and could be altered in following interviews as divergent concepts emerged.

Additionally, the interviews were conducted in a private manner, which allowed the participants to speak freely about their feelings, thoughts, attitudes, and knowledge about breast cancer. The interviews were conducted at the hospital, except one that was conducted at the participant's home, according to her preference. As for the duration of the interview, each interview lasted approximately 30–60 min.

In addition to the interview script, the researchers used an audio recording device for more accurate information. At the end of the interviews, notes on the environment, facial expressions, and body language were captured.

2.4. Data analysis

As a research approach, phenomenology analyses the phenomenon of consciousness, how the person experiences the phenomenon, and what experiences appear to form the phenomenon. Consequently, Giorgi's descriptive phenomenological method comprises a gradual analytical process to understand the significance of the individual's lived experiences.

For Giorgi (2009), descriptive analysis tries to reveal the essence of the phenomenon, it does not go beyond what is given, and the gaps are not filled by theoretical speculation as in interpretive analysis but by collecting more data. Therefore, to initiate the stages of analysis, the researcher must be within the context of the phenomenological method, i.e., it is important to consider all observations from the perception of how they are experienced by the subject (Giorgi, 2009).

In this sense, Giorgi (2009) defined a modified version of Husserl's philosophical phenomenological method, of the three stages necessary to conduct descriptive analysis, namely: 1) reading the meaning of the whole, 2) determining the units of meaning, and 3) transforming the natural expressions of the participant into phenomenological expressions with greater psychological sensitivity.

So, the first stage in data analysis was to elicit an initial feeling for the individual's lived experiences and get a sense of the whole, while integrating phenomenological attitude. In this phase, the researchers bracket their presuppositions, theoretical, cultural experiences, knowledge, or judgments about the phenomenon under study, thus allowing the data to be observed as new and free of any preconceptions or prejudgments.

Additionally, to get a sense of the whole experience, the researchers listened to all the records several times and read the transcribed descriptions many times, separately and at different periods. Throughout the review and reading procedure, emphasised notes were placed in the transcriptions about changes in the participants' emotions and dialects, such as silence, laughter or evidence of emotional distress. The transcriptions were compared with the audio to ensure accuracy.

Hence, this stage aims for the researchers to read the naïve description provided by the participant's, to get a sense of the whole experience while cautiously discerning the intentional objects without a critical reflection of the experience (Giorgi, 2009), as this sense provides a basis for the subsequent data analysis.

We want to emphasise that, due to the lived experience of two of the researchers as Angolans, the phenomenological reduction was used throughout the research so as not to influence the results. The phenomenological reduction technique aims to describe and understand lived experiences directly without distortions introduced by pre-existing theories. In employing phenomenological reduction, the researcher must assume an attitude of suspension (*epoché*), i.e., the researcher must set aside previous knowledge regarding the phenomenon under study and remain receptive to a direct experience devoid of interpretations (Bernet, 2016; Smith, 2005; Berghofer, 2018).

In other words, the first researcher was aware that her own cultural identity can affect how she related to participants and how they interpret their experiences. However, the cultural sharing between the participants and the interviewer (the principal investigator) facilitated empathy and understanding of the experiences reported.

After transcribing the interview and once an overall sense of the whole experience has been gained, it is possible to formally engage with the data treatment to quotation the meaning units that establish the participants' experiences. The "units of meaning" are determined, read, and reread to identify the “lived experiences.” This stage aims to identify manageable portions (units of meaning) within the description and associate them with the phenomenon of breast cancer.

To initiate the second step, the researchers analysed every modification from text and separated into manageable portions, each description was re-read. We tagged each part of the text and every declaration, expression, segment, and section in each description was analysed to elicit statements related to the phenomenon, as they are presented in the participants’ own words. To determine the units of meaning from the participants’ descriptions, the researchers re-read and listened the relevant declarations of the lived experiences and checked each statement, conferring the two criteria recommended by Moustakas (1994): understanding the phenomenon under study is essential, and the statement can be abstracted and labelled.

At this stage, the researchers went through the data with a phenomenological attitude, which means that the researchers stayed in a bracketing mode and were as descriptive as possible regarding the participants’ descriptions of their lived experiences.

The third and final stage of this analytical method was the transformation of the participant’s usual attitudes and languages into expressions with greater psychological sensitivity concerning the phenomenon under study. These natural attitudes and expressions can then be described as “regular” or everyday reflections of being in the world.

Additionally, this stage takes a long time and results in an exact account of the characteristics of how the lived experiences present itself in the consciousness of the research subject (Giorgi, 2009). At this stage, the researchers returned to the units of meaning several times and examined them to construct an explanation of the texture of the lived experience from the gathered meaning units, as it provides a rich, dense description of each participant’s experience. After constructing textural descriptions for each participant, the researchers were in an interpretative attitude to recognise the structure of the textual description (the theme that could involve the complete textural description). The interpretative attitude is imperative in this method, since it includes a profound observation and reflection on the textural description to apprehension of the structural meaning.

To avoid inappropriate subjective judgements, the researchers requested to expert qualitative analysis to examine and check the reliability of the themes nominated, as this step helps to categorise the textural account of the participant’s experience (Moustakas, 1994). The selection process for expert qualitative analysts considered previous experience with qualitative analyses, in particular with the application of the phenomenological approach, and training in the field of health. First author is an Angolan nurse.

Moreover, during this phase, the researchers describe the phenomenon under study in general terms, and a final, single overall analysis is made, integrating and synthesising the experience (Giorgi, 2009). Consequently, this framework allowed us to comprehend how cultural characterizations shape the lived experiences of Angolan women with breast cancer.

Thus, the effectiveness of this approach requires the researcher to maintain a phenomenological attitude and sensitivity towards the phenomenon under study during the process of identifying the units of meaning that will result in a general structure of the participants’ experiences (Giorgi, 2009).

2.5. Rigour

Rigour in qualitative research aims to describe the experiences of the study participants accurately. Therefore, Lincoln and Guba (1985) determined that trustworthiness (internal validity), transferability (external validity or generalizability), dependability, and confirmability (objectivity) are necessary to establish reliability. As the literature is uncertain whether all these aspects are necessary to establish reliability (Morse, 2015), Creswell and Poth (2017) recommend that at least two of the strategies mentioned above be employed to establish reliability. To guarantee the reliability of the data, member checking was used to establish credibility (Lincoln and Guba, 1985), participants were allowed to review the transcripts and make any changes or added new information during this process. At this point, none of the participants considered making any changes or added new information.

Conversely, to achieve transferability, the semi-structured interview guide with open questions was used to guide and simplify the dialogue, allowing for the incorporation of investigative questions to obtain thicker and richer descriptions of the phenomenon under study. In addition, the team met several times to discuss the generation of themes and sub-themes.

Ethical statement

Ethical clearance was obtained from the Institutional Review Board of the Angolan Institute of Cancer Control in December 03, 2015. The researchers explained the objectives of the study, the study results, the interview record, and the informed consent procedure. During this process, participants were encouraged to raise any doubts and questions to ensure the comprehension of the study. Informed consent was given to participants who joined the research study. After this period, participants were given a signed copy of the consent form. The participants were reminded that the process was voluntary and that they could withdraw any time, even after consenting. All the participants signed the informed consent before the interviews. To maintain confidentiality, all participants were identified with codes related to their cities of origin and age. The recordings, transcripts, and data were stored in restricted access using two-factor authentication systems and access control lists.

In this research study, researchers assured the confidentiality and anonymity during data collection and publication of results in accordance with the Declaration of Helsinki.

3. Findings

The purpose of this descriptive phenomenological study was to describe, from a cultural perspective, the lived experience of Angolan women with breast cancer. Consequently, the Giorgi (2009) method, a modification of the Hursselian phenomenological method, was used to organise the themes that characterise how culture manifests itself in the consciousness of the study participants (see Table 1).

The population of this study included 18 Angolan women with breast cancer using the purposive sampling technique. In conclusion, Table 2 summarises the demographic characterisation of these 18 participants, with an age range from 22 to 76 years. As for their level of education, the majority have a secondary education or less. In terms of ethnicity, the majority belongs to the Ambundu group. Regarding family history of cancer, we found that the majority had no relatives with cancer.

Finally, during our analysis of the participants’ experiences, three

Table 1
Example of units of meaning and phenomenological expressions.

Participant’s narrative	Units of meaning	Phenomenological expression
“People refer to it as mbasso. It’s a Bakongo disease. My mom is a Bakongo, and she knows this disease well. It causes a big wound. It comes from other people’s hearts; it’s envy; that’s what I know.”.”	Mbasso … Bakongo disease.	Cultural view of breast cancer
“My father’s family did this to me so that I would die, and my children would suffer. This disease belongs to my father’s family; because I’m a born child, it shouldn’t affect me. I don’t belong to their tribe; I belong to my mother’s. I was just born there”	Tribal … their tribe	

Table 2
Socio-demographic characteristics of the participants.

Socio-demographic characteristics	N	%
Age		
≤30	3	17
31–40	3	17
41–50	7	39
51–60	3	17
≥61	2	11
Family history of cancer		
Yes	6	33
No	7	39
Unknown[a]	5	28
Relationships		
Married/marital partnership	11	61
Single	6	33
Widow	1	6
Children		
Yes	17	94
No	1	6
Education		
Secondary or less	14	78
Degree or more	4	22
Ethnicity		
Ambundu (Bengo; Luanda and Malanje)	10	56
Ganguela (Benguela)	1	6
Ovimbundu (Bié and Huambo)	3	17
Cokwé (Kwanza Norte)	2	11
Bakongo (Uíge and Zaire)	2	11

[a] Participants do not provide this information.

key themes emerged: (1) cultural view of breast cancer, (2) family support, and (3) religious-spiritual coping.

3.1. Cultural views of breast cancer

The first essence discovered was the cultural view of breast cancer. In African culture, health encompasses not only the proper functioning of bodily organs, but also of mental, physical, spiritual, and emotional stability of oneself, family members, and community; this holistic perspective on health is based on the African unitary view of reality. Traditionally, Africans have several interpretations regarding the aetiology of sickness. Therefore, the traditional explanation of chronic illnesses like breast cancer heavily relies on the cultural view of external forces and fatalism, which directly influences the perception and treatment of the illness. In this sense, it is practised in Africa, particularly in Angola, to seek a system of healing that looks for the organic and physical cause, which is complemented by divination of the spiritual cause of the illness.

Therefore, when asked about the meaning attributed to breast cancer, the majority of the participants had a traditional view that was closely linked to death, pain, and suffering.

> *"Cancer is a dangerous disease. Sometimes, I think I'm going to die because this disease has already taken the lives of many people."* [E 6 Malanje, 41 years old]

> *"It's a very painful disease; I've never seen a disease that's so malignant. When they told me I had cancer, I thought my life was over."* [E9 Luanda, 50 years old]

Nevertheless, when questioned about the disease's origin, we verify that some participants held a fatalistic viewpoint, attributing the occurrences to external forces. Participants often use phrases like "tribal," "traditional situations," "god's will," and "envy" to describe external factors.

> *"People refer to it as mbasso. It's a Bakongo disease. My mom is a Bakongo, and she knows this disease well. It causes a big wound. It comes from other people's hearts; it's envy; that's what I know."* [E3 Bié, 42 years old]

> *"My father's family did this to me so that I would die, and my children would suffer. This disease belongs to my father's family; because I'm a born child, it shouldn't affect me. I don't belong to their tribe; I belong to my mother's. I was just born there."* [E16 Uíge 42 years old].

However, participants frequently expressed negative perceptions of being observed and evaluated.

> "*I went completely dark; I lost my hair. I was disfigured. People who didn't know about breast cancer said, 'That's it! It's AIDS!"* [E16 Uíge, 48 years old]

> "*Oh, I hide it because people stare at me like that, and so they don't stare too much, I have to cover it up."* [E7 Huambo, 54 years old]

On the other hand, some participants expressed that being diagnosed with breast cancer was closely linked to experiencing stigma. They believed that making their illness public would be equivalent to being exposed and considered a failure. Consequently, participants recognise that it is better to conceal the illness rather than disclose information about breast cancer diagnoses to others.

> *"When I go to the hospital, if a professional asks for my left arm, I say it can't be, and if they ask why, I say I have a contraceptive implant. I lie so as not to expose my condition, to avoid defamation and exposure."* [E18 Huambo, 48 years old]

When questioned about the treatments used for the reported illness, the majority of study participants stated that they had received encouragement to seek traditional treatment, which involves using prayers and other techniques.

> *"My cousins wanted me to go to the Church of the Spirit because my situation would only be resolved with spiritual treatment because what I had was caused by demons.*" [E17 Bengo, 58 years old].

> *"My grandmother told me to put ashes on, comb my chest, and breastfeed the baby on the same breast that was inflamed."* [E1 Luanda, 24 years old]

Traditional beliefs and stigmas strongly influence the cultural view of breast cancer in African culture, particularly in Angola, and directly influence family and social attitudes towards the disease. Breast cancer is often associated with death and suffering, and depending on the region and religion, it can be associated with a curse or divine punishment. So, the way women understand cancer directly influences their relationship with their family and their search for support. On the other hand, the culture of stigma within the family will have a negative influence on the woman's ability to seek emotional support.

3.2. Family support

Family support appears in our study as the second theme. This theme highlights the importance of family cultural values and is characterised by providing emotional support, fulfilling family obligations (providing tangible care), and relying on interpersonal community reflection to define the self (family as a reference). Therefore, the data analysis exposed that the participants had a solid sense of the importance of family support during their experience, confirming that family support was transversal for all of them. However, these relationships also had challenges, especially concerning to the children.

> *"One day, my five-year-old son's school requested a guardian, but I was the only one available. When I announced that I would be taking him to school, he broke down in tears and expressed his reluctance. When I questioned him about his reasons, he said, "I don't want a bald mom; my friends will laugh at me; my friends will say that my mom is barraba. His words resonated deeply with me, prompting me to reflect on my situation. It was only then that I realised that they weren't doing well because of me either!"* [E12 Luanda, 33 years old]

3.3. Religious-spiritual coping

The religious-spiritual coping was the third and final essence discovered during the data analysis. The majority of the Angolan population is catholic. Around a quarter of the population belongs to the protestant churches introduced during the colonial period: Baptist churches, rooted mainly among Bakongo; Methodists, concentrated in the Ambundu area; and Congregationalists, implanted among the Ovimbundu, in addition to smaller communities of Reformed Protestants and Lutherans. Lastly, we have two syncretic churches: Kimbanguism churches, which originated in the Democratic Republic of Congo, and tochoist churches, which were formed in Angola, both with relatively small communities. Practitioners of traditional African religions are a small, residual minority, but among the Christians, there are often beliefs and customs inherited from those religions.

The medical journey for those facing breast cancer can be long and full of difficulties and challenges. Thus, the combination of traditional African beliefs and Christianity offers a unique coping model by strengthening survival strategies, emotional resilience, and coping with social stigma. Subsequently, religious and spiritual coping provides hope and strengthens faith, a sense of protection and belonging, emotional self-care through meditation and prayer, and support from the religious community. Hence, during the data analysis, we found that the participants strongly valued religion and spirituality for their prominent role in physical and mental well-being during the diagnosis and treatment stages.

> *"Before my hospitalisation for surgery, my brothers and I established a prayer chain. When I'm feeling distressed, I pull out my Bible, select some themes, and read them. I have a book, Power of Prayer III; it has some advice, so I feel fine."* [E8 Zaire, 29 years old]

Conversely, a family with a distinct perspective will recognise the woman's need for assistance and positively influence her quest for emotional support. Regarding religious-spiritual coping, religion plays a fundamental role because the illness is considered something related to spirituality, and only prayer, religious rituals, spiritual counselling, and visits to religious leaders are needed We emphasise here that the family is often involved, and if they share the same religious outlook, the support will be stronger, i.e., the support manifests itself through collective prayers or the continuous encouragement of trust in divine healing.

4. Discussion

This study aimed to explore and comprehend how Angolan women experience breast cancer. In this context, the researchers studied the perception and processing of breast cancer across various ethnic groups in Angola. The data analysis revealed that the study participants' lived experiences of breast cancer influenced their perceptions of the disease and its cultural context.

In Angola, chronic illnesses such as breast cancer are often interpreted as the result of external forces rather than a medical condition, which leads people to seek traditional healers, spiritual leaders, or religious practices before going to the medical doctor. These findings align with other studies in which participants interpreted breast cancer as the result of external forces rather than a medical condition (Yeom et al, 2022; Malope et al., 2024). However, this practice leads to resistance to treatment, late diagnosis, and an increased mortality rate. On the other hand, the relationship between beliefs and conventional care practice presents challenges for health professionals that often include conflicts of values in the sense that many of these practices include the use of herbs or healing rituals that can present risks since there is a lack of knowledge about their side effects (Ghayebie Motlagh et al, 2023).

The traditional Angolan medicine is an autochthonous African healthcare system that is not characterised as an alternative to conventional medicine (Elewonibi & BeLue, 2019). Inequalities in access to the healthcare system, high costs of care, and inability to access medicines, as well as misinformation, influence the decision and search for traditional treatments in the Angolan context. Therefore, cultural beliefs often result in a refusal to diagnose due to fear of stigma and discrimination, which leads to neglect of the proposed conventional treatment. On the other hand, it is common to integrate ancestral and spiritual practices with medical treatment to obtain a cure on all levels (Ngubane & De Gama, 2024).

Stigma related to breast cancer is a significant factor that has social and psychological consequences ranging from marginalisation and social isolation, low self-esteem and feelings of guilt, anxiety, and psychological trauma to delays in diagnosis and treatment associated with a lack of information and resources (Warmoth et al, 2020; Stangl et al., 2019). Consequently, stigma becomes a barrier to accessing treatment due to a lack of awareness and information and the fear of rejection, which, combined with the scarcity of infrastructure and health resources, create a scenario in which the search for help only arises when the symptoms of the disease become more serious (Omosigho et al, 2023), i.e., when the disease is already in advanced stages. Some strategies such as community education, family-centered outreach and awareness programmes, and health policies that involve community and religious leaders can prove effective in reducing stigma and improving access to healthcare (Oystacher et al, 2018).

Researchers have recognised the numerous emotional and physical benefits of social support for women with breast cancer. In Angolan culture, as well as in African culture, family networks are extended and play an essential role, so the results of our studies corroborate the results presented by previous studies (Akuoko et al, 2022; Aprilianto et al., 2021) in the sense that family support has a protective factor in women with breast cancer, helping them to overcome the stress associated with the diagnosis and treatment, as well as the feeling of appreciation provided by physical and psychological comfort. Therefore, the greater the family support, the greater the self-esteem and ability to cope with the disease. This is because the family plays an important role as a strategy to prevent and reduce stress, which positively impacts the self-esteem of people with chronic diseases like breast cancer. Family support is crucial when dealing with pathologies that lead to a sense of finitude, such as breast cancer (Babore et al, 2023). However, family dynamics often have a negative impact on the decision to seek care, exacerbating stigma and hindering access to treatment. Angola is a patriarchal society and, women are often considered primarily responsible for maintaining the home and the well-being of their children and husbands and must always be strong, resilient, and available (Hen et al., 2024; Babore et al., 2023). This expectation leads to personal sacrifice on behalf of the family, putting family responsibilities first and neglecting their needs for fear of being considered weak and selfish, running the risk of being returned to their parents or abandoned by their spouses, as the diagnosis and treatment affect the family's economic and emotional stability. On the other hand, the woman may be pressured into following a treatment that the family considers more viable and acceptable. However, the absence or limited of family support increases the isolation and vulnerability of these women due to the dearth of practical support in accessing healthcare, increases stigma and rejection through the attribution of guilt and shame, and difficulty in decision-making, which contributes to increased feelings of insecurity and anxiety, culminating in non-adherence and the search for appropriate treatment.

The relationship with God as an essential coping strategy in stressful situations experienced by people with breast cancer has been effective in dealing with the disease and treatment consequences (Harbali & Koç, 2022). Participants expressed that religion and spirituality has a prominent role in physical and mental well-being during the breast cancer journey. This is similar to result of previous studies that reported that faith and trust in God are described as providers of physical, functional, spiritual, and emotional well-being, i.e., by finding solace in prayer, the person shifts their focus away from stressful thoughts and profound emotional experiences and, more significantly, helps them to move on with their lives (Leão et al, 2021).

Therefore, spiritual and religious coping plays a fundamental role in the face of emotional, psychological, social, financial, and health difficulties. Although it is a predominantly Christian country, religious syncretism and seeking support from spiritual leaders and religious communities are quite common and accessible to everyone. If we compare it with other cultures, we see that in Angola, spirituality is a culturally rooted coping mechanism because of mistrust, stigmas, and the lack of access to services such as psychotherapy and other professional emotional support mechanisms (Gall and Bilodeau, 2020; Kraus, 2022).

In addition to cultural beliefs and family support, factors such as unequal access to health care, poverty, illiteracy, misinformation, and lack of health awareness, limited access to medication, long and difficult treatment, lack of professional and psychological support, economic and social factors, and the absence of mandatory screening programmes all influence the way Angolan women experience breast cancer.

Religion and traditional beliefs take on disproportionate weight in individual identity (Okeke, 2020). The social networks woven around religious identity make it possible to soften the weight of the individual identity of Angolan women. Health professionals can involve patients' spiritual leaders, educate, inform, and communicate the coexistence of traditional and medical treatment, thus demonstrating the benefits of conventional medicine and offering a more holistic and culturally sensitive system of care (Peprah et al, 2023). Integrating traditional and religious beliefs into the treatment plan allows for greater adherence to treatment and promotes and respects cultural and religious identity (Swihart et al, 2024).

In Angolan women, breast cancer has significant social and psychological consequences that create profound barriers to timely treatment. Previous study reported that cultural views about breast cancer, stigma, the family dynamics, combined with the financial and logistical obstacles (such transportation and accommodation) contribute to delaying seeking care and hinder adherence to medical treatment affecting the prognosis (Agyemang et al, 2021).

In this study, we aimed to understand how culture influences the breast cancer experience, but a more comprehensive analysis must also consider such as healthcare limitations, economic factors, educational barriers, and political and legal factors as well. By broadening a perspective to include various factors that intersect and interact in complex ways, we can develop a holistic approach, culturally effective interventions, policies, and support systems for Angolan women with breast cancer.

To make the approach more effective and meet the needs of Angolan women with breast cancer, it is essential that the recommendations extend to several levels: healthcare providers, policymakers, and community leaders.

The recommendations for health care providers involve training health professionals adapted to the cultural context of patients, raising awareness of women's cultural and emotional needs, developing treatment protocols adapted to the local reality, considering economic limitations, lack of infrastructure and available resources, implementing regular screening and early detection programmes in communities and local health units such as community centers or mobile health units to reach rural and hard-to-reach populations.

Recommendations for policymakers involve ensuring public policies that promote early diagnosis and universal access to breast cancer treatment, developing and implementing legislation that protects the rights of women with breast cancer by guaranteeing continued access to medical care and essential medicines, and promoting culturally relevant public awareness campaigns to demystify cancer and combat stigma.

The recommendations for community leaders involve training to become a health advocate in their communities. This can include promoting dialogues about breast cancer prevention and treatment, organising educational sessions such as lectures or support groups where women can discuss their concerns and obtain reliable information. In addition, developing community support groups for sharing experiences and seeking emotional support. These groups can be facilitated by community leaders and healthcare providers, creating an environment of trust that helps reduce stigma and increase adherence to treatment. Train religious, community, and traditional leaders to act as allies in disseminating health information, demystifying breast cancer, and encouraging the use of preventive practices such as self-examination and regular visits to the doctor. Sensitising men and family members is crucial to ensuring that women receive comprehensive support during treatment. Community leaders can act to involve men in the educational process, helping to deconstruct taboos and reinforce the importance of family support and solidarity.

4.1. *Implications for nursing*

The findings of this study provide essential insights into how Angolan women's cultural beliefs and practices shape their experiences with breast cancer, offering nurses a foundation to develop culturally competent care approaches.

By recognising the unique sociocultural factors influencing health behaviours, nurses can create personalised care plans that respect patients' spiritual and traditional beliefs while promoting evidence-based treatments, such as creating safe spaces for open discussions about the disease, acknowledging and respecting the patient's cultural beliefs while providing evidence-based guidance on medical treatments. This may include integrating spiritual counselling, addressing family dynamics in care, and offering education sensitive to cultural perceptions.

To achieve this, nursing education programs should prioritise cultural competence training, ensuring nurses can navigate the complex interplay between traditional beliefs and modern medical practices. Nursing curricula should include training on cultural competence, incorporating topics like traditional healing, stigmatisation, and religious coping mechanisms to prepare nurses for working with diverse populations.

Furthermore, healthcare institutions should implement policies that foster inclusive care environments where patients feel safe discussing their beliefs without fear of judgment. Such approaches can help mitigate the stigma associated with breast cancer, which has been identified as a barrier to timely care. Additionally, this study underscores the need for future nursing research to explore how cultural beliefs influence health-seeking behaviours across diverse populations.

By bridging the gap between qualitative and quantitative research, nurses can contribute to a more holistic understanding of patient care, ultimately leading to improved health outcomes. In this context, nurses must also advocate for culturally responsive care within multidisciplinary healthcare teams, ensuring that patients' cultural and spiritual needs are respected and integrated into the treatment process. Nurses should incorporate culturally relevant educational materials, integrate traditional healing practices where appropriate, and collaborate with community leaders to provide holistic care.

We emphasise that the adoption of models and theories that consider the particular cultural needs of patients is essential for the provision of culturally competent care, such as Purnell's (2002) model, which provides a comprehensive framework that allows nurses to consider the sociocultural context of patients, addressing traditional norms and conventional health practices.

On the other hand, Leininger's theory of diversity and universality of care allows nurses to analyse cultural practices and adapt their interventions accordingly, such as the integration of religious rituals and traditional healing practices. In turn, Leininger's (1995) theory of transcultural nursing will help nurses to address the cultural specificities of patients and ensure that care meets common needs, such as psychological support.

4.2. Limitations

Our study's main limitations stem from the interview process and its brevity. Despite repeated assurances of confidentiality and accurate representation, the participants found it difficult to openly share all their experiences during the interview process due to feelings of mistrust. Another limitation was the briefness of the interviews, primarily because they took place in a hospital environment while participants awaited their appointments, potentially complicating the exchange of more details. Additionally, some participants exhibit reluctance to divulge details, resulting in briefly or ambiguous descriptions.

5. Conclusions

Our study reveals that Angolan women, when confronted with life-threatening situations like breast cancer, seek significance in their existence. Consequently, cultural views of breast cancer, stigma, family support, and religious-spiritual coping are cultural issues that align their respective social and ethnic groups influence on this search, ultimately determining the strategies and resources they employ to cope with and overcome disease diagnosis and treatment stages.

As a result, this study provides valuable insights into the cultural system of health that exists in Angolan society, which comprises the knowledge, perceptions, and cognitions used to describe, understand, and explain illness and seek therapy that rarely reflects biomedical definitions.

We would like to emphasise that, given the scarcity of studies in this field carried out in Angola by nurses, this is, as far as we know, the first study to use phenomenology as a research method. Furthermore, we believe that this methodology is the most suitable and reliable choice for describing the experience of Angolan women diagnosed with breast cancer, particularly from their cultural perspective, to enhance cultural competence in nursing.

In consequence, considering the relevance of the topic, the development of this study is essential for the production of future studies that can address this issue. It is therefore suggested that other studies be carried out with the same or identical objectives, different methodologies and a larger sample, so that the results can be replicated and policies/programmes can be implemented at a national level.

Finally, we conclude that the results of the study show that Angolan women's experience of breast cancer is profoundly influenced by cultural, socio-economic, and structural factors such as cultural beliefs, unequal access to healthcare, limited access to medication, misinformation, and the lack of mandatory screening programmes, among others.

In short, the adoption of an integrated approach involving healthcare providers, political decision-makers, and community leaders to implement education and awareness programmes, improve access to healthcare, promote public policies that intervene to reduce social and economic inequalities, and strengthen psychosocial support are crucial steps towards improving the experiences of women with breast cancer in Angola.

The scarcity of production on the subject in Angola and the relevance of the subject at the present time make the development of this study essential for the production of future studies that can address this issue.

CRediT authorship contribution statement

Naira Sousa-Martins: Writing – original draft, Project administration, Methodology, Formal analysis, Data curation, Conceptualization. **Luís Azevedo:** Writing – review & editing, Validation, Supervision, Conceptualization. **Lygia Vieira Lopes:** Validation, Supervision, Conceptualization. **Maria do Céu Barbieri-Figueiredo:** Writing – review & editing, Validation, Supervision, Formal analysis, Data curation, Conceptualization.

Declaration of competing interest

The authors declare no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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