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Surviving Cancer Surgery, Rebuilding Life: A Qualitative Exploration of Cancer Survivors' Lived Experiences From a Developing Country

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Research Article

Keywords: cancer survivorship, cancer surgery, psychosocial adjustment, quality of life, financial toxicity, Nigeria

Posted Date: August 14th, 2026

DOI: https://doi.org/10.21203/rs.3.rs-10118362/v1

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Additional Declarations: No competing interests reported.

SURVIVING CANCER SURGERY, REBUILDING LIFE: A QUALITATIVE EXPLORATION OF CANCER SURVIVORS' LIVED EXPERIENCES FROM A DEVELOPING COUNTRY

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Type of Manuscript: Original Article

Clinical trial number: not applicable.

Source(s) of Support: The study was not supported by any organization or agency. It was sponsored by the researchers.

Funding Declaration: The was not funded by any organization. It was funded by the researchers.

Conflict of Interest: This is to state that the manuscript has been read and approved by all the authors and all authors met the requirements for authorship and that each author believes that the manuscript represents honest work of all the contributors. There is no known conflict of interest about this manuscript.

Acknowledgement: The authors acknowledged the authority of the teaching hospitals where the data were collected. The patients that participated in this study and the statistician are hereby appreciated.

Abstract

Purpose: This study explored the experiences of cancer surgery survivors in Osun State, Nigeria, with attention to psychosocial adjustment, quality of life, economic burden, spiritual meaning-making, and coping after surgery.

Methods: A qualitative exploratory design guided the study. Nineteen adult survivors of breast, ovarian, cervical, prostate, and colon cancers were purposively recruited from three tertiary hospitals in Osun State. Data were collected through in-depth, semi-structured interviews and analysed using inductive thematic analysis, supported by Atlas.ti version 25. The Biopsychosocial Model of Wellness and the Adversity–Restoration–Compatibility framework informed interpretation.

Results: Four themes were identified: emotional reaction and spiritual interpretation of illness; psychosocial coping and resilience; economic burden and financial coping strategies; and resilience in the recovery journey. Participants described denial, sadness, fear, and existential disruption after diagnosis and surgery. Over time, acceptance, cognitive reframing, family support, and faith-based meaning-making supported emotional

adjustment. Financial toxicity, disrupted employment, treatment costs, and dependence on relatives or charitable assistance shaped recovery and quality of life.

Conclusions: Cancer survivorship after surgery in this setting extends beyond physical recovery. Survivors negotiated psychological distress, spiritual interpretation, social role disruption, and financial strain while reconstructing identity and hope.

Implications for Cancer Survivors: Surgical oncology services in Nigeria should integrate psychosocial assessment, culturally sensitive spiritual care, financial counselling, and structured survivorship support to improve long-term wellbeing and quality of life.

Word count: 220 words

Keywords: cancer survivorship; cancer surgery; psychosocial adjustment; quality of life; financial toxicity; Nigeria.

Introduction

Cancer remains a major public health problem, but its burden is not measured only by incidence and mortality. In 2022, an estimated 20 million new cancer cases and 9.7 million cancer deaths were recorded globally, with low-resource settings carrying a substantial share of avoidable late diagnosis, treatment delay, and poor survival [1]. Sub-Saharan Africa continues to experience a rising cancer burden, with 801,392 new cases and 520,158 deaths estimated in 2020 [2]. Nigeria reflects this regional pattern. Recent evidence shows that cancer diagnosis and treatment in Nigeria remain constrained by late presentation, limited diagnostic and treatment facilities, insufficient oncology workforce, and high out-of-pocket expenditure [3]. These conditions shape not only survival but also the quality of life of people who undergo cancer treatment.

Surgery remains a central treatment for many solid tumours, including breast, ovarian, cervical, prostate, and colorectal cancers. It can support disease control, symptom relief, and survival, but it can also introduce new physical, emotional, social, and economic challenges. Evidence from a systematic review and meta-analysis shows that even a four-week delay in cancer treatment is associated with increased mortality across surgical, systemic, and radiotherapy indications [4]. This confirms the importance of timely surgical care. At the same time, surviving surgery does not automatically mean restored wellbeing. After surgery, survivors may face pain, fatigue, altered body image, fear of recurrence, disrupted family roles, employment loss, financial strain, and changes in self-understanding.

Cancer survivorship research has increasingly moved beyond survival endpoints to examine how people rebuild life after diagnosis and treatment. The Adversity, Restoration, and Compatibility framework describes living with and beyond cancer as a process in which survivors first confront disruption, then work towards readjustment, and later try to reconcile cancer with their sense of self and future [5]. Recent evidence also shows that psychosocial factors such as depression, anxiety, distress, coping, social support, and resilience are closely associated with quality of life among cancer survivors [6]. These concerns are especially important in settings where survivorship services, psycho-oncology support, financial counselling, and structured follow-up care are not routinely available.

Recent African and Nigerian studies have begun to document the emotional and social burden of cancer survivorship. A mixed-methods systematic review of women living with and beyond breast cancer in Africa found persistent symptoms, emotional distress, spiritual interpretation, informational needs, and health-system barriers across the cancer trajectory [7]. In Nigeria, breast cancer survivors have described concealment of diagnosis, painful treatment journeys, spiritual coping, treatment navigation difficulties, and dependence on family or peer support [8]. Another Nigerian phenomenological study showed that long-term breast cancer survivors experienced suffering across physical, emotional, social, financial, and spiritual domains [9]. These studies are valuable, but they remain concentrated largely on breast cancer and do not sufficiently explain post-surgical survivorship across different cancer types.

A more specific gap therefore remains. In Nigeria, limited qualitative research has examined how cancer surgery survivors across multiple malignancies interpret and manage life after surgery, particularly in relation to psychosocial adjustment, perceived quality of life, spiritual meaning-making, financial toxicity, work disruption, and coping. Financial toxicity is especially relevant because recent evidence from south-western Nigeria shows high financial toxicity and psychosocial distress among breast and cervical cancer patients, with treatment cost, income loss, and negative body image contributing to distress [10]. Despite growing recognition that psychosocial care should form part of cancer care from diagnosis through survivorship [11], the voices of cancer surgery survivors remain insufficiently represented in Nigerian survivorship research.

This study therefore explored the lived experiences of cancer surgery survivors in Osun State, Nigeria, with attention to psychosocial adjustment, quality of life, economic burden, spiritual meaning-making, and coping after surgery. By focusing on survivors of breast, ovarian, cervical, prostate, and colon cancers recruited from tertiary hospitals, the study extends Nigerian survivorship research beyond single-cancer accounts and foregrounds the post-surgical phase as a distinct survivorship concern. Its contribution lies in producing context-specific qualitative evidence that can inform patient-centred surgical oncology, psychosocial assessment, culturally sensitive spiritual support, financial counselling, and structured survivorship care in Nigeria.

Methods

Study design

This study used a qualitative exploratory design to examine the experiences of adult cancer surgery survivors in Osun State, Nigeria. The design was appropriate because the study sought to understand how survivors interpreted diagnosis, surgery, recovery, psychosocial adjustment, quality of life, economic burden, spiritual meaning-making, and coping after surgery [12]. The study was guided by the Biopsychosocial Model of Wellness and the Adversity, Restoration, and Compatibility framework. The Biopsychosocial Model, first advanced by Engel, supported attention to the interaction between biological, psychological, and social dimensions of health [13]. In this study, biological concerns included pain, fatigue, surgical complications, and functional limitation; psychological concerns included fear, anxiety, sadness, fear of recurrence, and emotional distress; and social concerns included family support, stigma, work disruption, financial strain, and social reintegration. The Adversity, Restoration, and Compatibility framework supported interpretation of survivorship as a process moving from disruption after diagnosis and surgery, through physical and emotional readjustment, to longer-term reconciliation with life after cancer [5]. Reporting was organised with attention to the Consolidated Criteria for Reporting Qualitative Research [14]. This qualitative study was not a clinical trial. The conceptual framework that guided data collection and interpretation is presented in Fig. 1.

Fig. 1 should appear here.

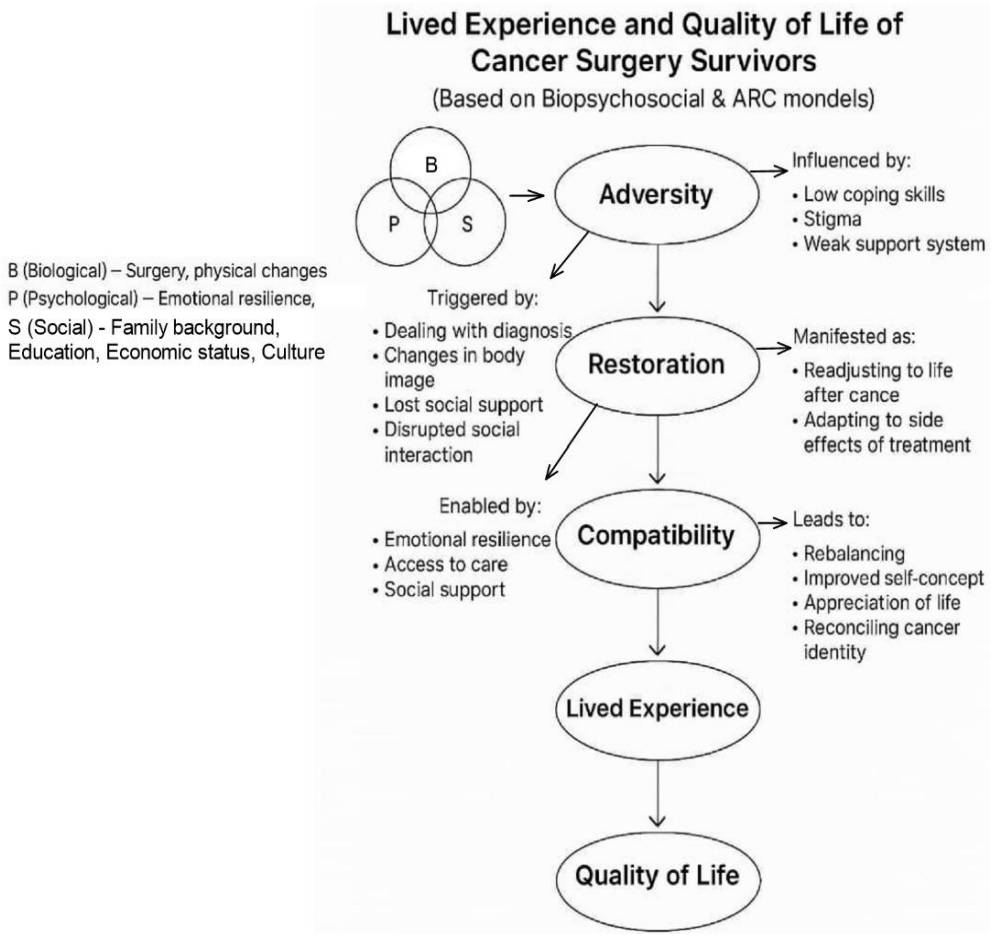

Fig. 1. Conceptual framework showing how the Biopsychosocial Model and the Adversity, Restoration, and Compatibility framework informed the study.

Participants

Participants were adult male and female cancer surgery survivors who had been diagnosed with and surgically treated for breast, ovarian, cervical, prostate, or colon cancer. They were recruited from three tertiary healthcare facilities in Osun State, Southwest Nigeria: Obafemi Awolowo University Teaching Hospitals Complex, Ile-Ife; Wesley Guild Hospital, Ilesa; and UNIOSUN Teaching Hospital, Osogbo. Recruitment took place in the surgical outpatient and gynaecological outpatient clinics during routine follow-up visits. Participants varied by cancer diagnosis, stage at diagnosis, type of surgical treatment received, and duration of survivorship. All participants had survived at least four weeks after surgery.

Sampling

Purposive sampling was used to recruit participants with direct experience of cancer surgery and the capacity to provide detailed accounts of life after treatment. This approach was suitable for qualitative inquiry because it allowed the researcher to select information-rich participants whose experiences were closely aligned with the study aim [15]. Nineteen participants were recruited across the three hospitals. Recruitment continued until data saturation was reached, defined as the point at which additional interviews no longer generated new themes or substantially different insights [16].

Instruments and data collection

Data were collected through one-on-one, in-depth, semi-structured interviews. The interview guide was developed from the study aim, the literature on cancer survivorship, and the guiding theoretical framework. It contained two sections. Section A collected sociodemographic information, while Section B explored participants' experiences of cancer surgery, psychosocial effects, perceived quality of life, economic burden, spiritual meaning-making, and coping strategies.

The interview guide was translated into Yoruba by language experts to support participants who preferred to express themselves in Yoruba. Back-translation into English was conducted after data collection to support consistency and meaning preservation. Interviews were conducted over a period of up to three months and were arranged to coincide with participants' routine clinic appointments in order to reduce participant burden. Each interview took place in a private setting at the clinic to protect confidentiality. With participants' consent, interviews were audio-recorded and later transcribed verbatim for analysis. Audio recordings and transcripts were stored securely and access was restricted to the research team.

Data analysis

Data were analysed using inductive thematic analysis, following the principles described by Braun and Clarke [17]. The researcher first listened repeatedly to the audio recordings and read the transcripts to become familiar with the data. Transcripts were checked against the recordings to support accuracy and completeness. Initial open coding was then conducted by identifying meaningful units, recurring expressions, and patterns relevant to the study aim. Atlas.ti version 25.0 was used to organise transcripts, codes, categories, and analytic notes.

Codes were compared across transcripts and refined through repeated review. Related codes were grouped into categories and then developed into themes and subthemes that represented shared patterns in participants' accounts. The final themes were reviewed for coherence, distinctiveness, and alignment with the study aim and theoretical framework. Atlas.ti supported data management and organisation, but theme development remained an interpretive process led by the researcher.

Rigour and reflexivity

Trustworthiness was strengthened using Lincoln and Guba's criteria of credibility, transferability, dependability, and confirmability [19]. Credibility was supported through purposive recruitment of participants with direct experience of cancer surgery, use of in-depth interviews, careful transcription of audio-recorded data, and repeated engagement with the transcripts during analysis. Transferability was supported by describing the study setting, participant characteristics, recruitment process, and Nigerian tertiary-care context in sufficient detail for readers to judge relevance to other settings. Dependability and confirmability were supported through an audit trail documenting recruitment, interview procedures, transcription, coding, category development, and theme refinement.

The researcher also engaged in reflexivity throughout the study. Reflexivity was important because the researcher's health-research orientation, expectations about psychosocial survivorship, and interpretation of participants' accounts could influence the interview process and analysis [18]. To reduce this risk, the researcher used open-ended questions, allowed participants to describe experiences in their own terms, and avoided imposing predetermined categories during initial coding. Reflexive notes were used to examine assumptions, emotional responses, and analytic decisions during data collection and analysis. Participants' direct quotations were retained in the findings to preserve survivor voices and support authenticity.

Ethics approval

All procedures performed in this study involving human participants were in accordance with the ethical standards of the institutional and/or national research committees and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards [20].

Formal ethical approval was obtained prior to the commencement of data collection from the relevant institutional review boards. Approval was granted by the Ethics and Research Committee of the Obafemi Awolowo University Teaching Hospitals Complex, Ile-Ife, Osun State (Protocol No. ERC/2024/08/14). Additional ethical clearances were secured from the Health Research Ethics Committee of the Federal Medical Centre, Owo, Ondo State (Protocol No. FMCOWO/HREC/2024/89) and the Research Ethics Committee of the UNIOSUN Teaching Hospital, Osogbo, Osun State (Protocol No. UTH/REC/2025/01/1092).

All participants were provided with comprehensive information regarding the study's objectives, procedures, and potential risks. Written informed consent was obtained from all individual participants included in the study prior to their participation. Participants provided separate written consent for the audio recording of interviews. All individuals were explicitly informed of their right to withdraw from the study at any stage without providing a reason and without any adverse consequences to their medical care or professional standing.

Participant confidentiality and data privacy were rigorously maintained. All personal identifiers were removed from the data and replaced with unique pseudonyms to ensure participant anonymity. Study materials, including raw audio files and transcripts, were stored securely in password-protected digital repositories and locked physical cabinets, accessible only to the primary research team. This study adheres to the reporting guidelines and ethical principles established by the Committee on Publication Ethics (COPE) and the International Committee of Medical Journal Editors (ICMJE).

Results

Socio-demographic characteristics of participants

Nineteen cancer surgery survivors participated in the study. Participants were aged between 20 and 60 years, with a mean age of 43.6 years. Most participants were aged 40–49 years (n = 7, 36.8%), followed by those aged 50–60 years (n = 6, 31.6%). Four participants were aged 30–39 years (21.1%), while two were aged 20–29 years (10.5%). The overall socio-demographic profile is summarised in Table 1, and the supplementary participant-characteristics table is provided as Table S1.

Educational attainment varied across the sample. Eight participants had secondary education (42.1%), six had tertiary education (31.6%), three had no formal education (15.8%), and two had primary education (10.5%). The sample was predominantly female, with 15 women (78.9%) and four men (21.1%). Participants also differed by occupation. Traders formed the largest occupational group (n = 5, 26.3%), followed by unemployed participants (n = 4, 21.1%), civil servants (n = 3, 15.8%), retirees (n = 3, 15.8%), students (n = 2, 10.5%), and clergy (n = 2, 10.5%).

Table 1 should appear here.

Table 1: Socio-demographic Characteristics of survivors that participated in the In-depth Interview (n = 19)

	Frequency (n)	Percentage (%)
Age: Mean = 43.6 years		
20-29	2	10.5
30-39	4	21.1
40-49	7	36.8
50-60	6	31.6
Educational background		
No formal education	3	15.8
Primary	2	10.5
Secondary	8	42.1
Tertiary	6	31.6
Sex		
Male	4	21.1
Female	19	78.9
Occupation		
Students	2	10.5
Civil servant	3	15.8
Trader	5	26.3
Clergy	2	10.5
Unemployed	4	21.1
Retired	3	15.8
Total	**19**	**100.0**

Overview of themes

Thematic analysis generated four major themes: emotional reaction and spiritual interpretation of illness; psychosocial coping and emotional resilience; economic burden and financial coping strategies; and resilience in the recovery journey. These themes captured participants' accounts of diagnosis, surgical decision-making, recovery, social adjustment, financial strain, spiritual interpretation, and coping after cancer surgery. Supplementary Tables S2–S5 provide representative quotations and analytic notes supporting the four themes.

Theme 1: Emotional reaction and spiritual interpretation of illness

This theme describes participants' immediate emotional responses to cancer diagnosis and surgical recommendation. Participants spoke of denial, fear, crying, sadness, spiritual questioning, and difficulty accepting the need for surgery. Two subthemes were identified: initial denial and avoidant coping; and profound sadness, existential shock, and emotional disruption. Supporting quotations and analytic notes for Theme 1 are provided in Table S2.

Subtheme 1: Initial denial and avoidant coping

Several participants described disbelief when they were told they had cancer or needed surgery. For some, the diagnosis conflicted with their spiritual expectations, while others avoided treatment temporarily before returning to care. One participant described withdrawal from treatment before later resuming hospital care:

"Living with a chronic illness is like an invisible weight. I ran away at first then came back later to receive treatment. I cannot believe this happened to me because I serve a living God." (S2, female)

Another participant described crying and almost refusing surgery before receiving encouragement from her husband:

"I was crying when I heard it. It really affected me. I almost refused it but my husband encouraged me. Imagine, I was even praying and singing during the surgery." (S3, breast cancer survivor)

A male participant also described initial refusal followed by acceptance after further explanation:

"I refused at first, but I was later called and some things were explained to me. My faith has really helped me and I prayed and God saw me through." (S8, male)

Subtheme 2: Profound sadness, existential shock, and emotional disruption

Participants also described sadness, emotional exhaustion, and a sense of personal disruption after diagnosis and surgery. Some described the emotional pain as more difficult than the physical pain. One participant linked emotional distress to concern for family members:

"The hardest part was not the physical pain; it was the emotional toll. Seeing the worry in my family's eyes and feeling like a burden was sometimes worse than the illness itself." (S19, male)

Another participant described diagnosis and treatment as a sudden disruption of imagined future plans:

"I felt like the ground had been pulled out from under me. The future I had envisioned suddenly vanished, replaced by a series of daunting medical terms and a seemingly endless cycle of treatments." (S19, male)

Participants who had undergone removal or alteration of a body part described sadness, helplessness, and frustration. Their accounts showed that surgery affected them emotionally as well as physically.

Theme 2: Psychosocial coping and emotional resilience

This theme describes how participants coped with diagnosis, surgery, emotional distress, and the need to adjust to life after treatment. Four subthemes were identified: resigned acceptance and surgical decision-making; spiritual attribution and biomedical confirmation; coping with frustration and rebuilding strength; and faith-based and communal strategies for mental stability. Supporting quotations and analytic notes for Theme 2 are provided in Table S3.

Subtheme 1: Resigned acceptance and surgical decision-making

Some participants described a gradual movement from fear or resistance to acceptance of surgery. This acceptance often followed explanation from healthcare workers, personal reflection, or recognition that surgery offered the best chance of survival. One female participant described asking whether her breast could be saved before accepting the surgical recommendation:

"When I was told, it was hard to accept at first, but I asked the doctors and nurses if there was something they could do to save my breast. There was not, so I was convinced later through persuasion and accepted my fate." (S10, female)

Another participant described seeking information after the doctor's explanation but still feeling discouraged by the severity of the condition:

“At first, I did not know how bad the situation was, but after the doctors explained to me, I went online too to read about my condition. Seeing how the whole thing was going, I was greatly discouraged. I felt like my life cannot remain the same again.” (S5, female)

A participant with colon cancer described the decision as difficult but necessary:

“It was not an easy decision, but I had to prioritise my long-term health. I had already endured so much pain and suffering, and I could not bear the thought of prolonging my agony any further.” (S17, female, colon cancer survivor)

Subtheme 2: Spiritual attribution and biomedical confirmation

Some participants initially interpreted their symptoms as spiritual or supernatural before receiving a hospital diagnosis. This was especially evident when symptoms began as lumps or bodily changes that participants or people around them did not immediately recognise as cancer-related. One participant described the movement from local and spiritual explanations to hospital diagnosis:

“I saw a small lump on my body, but I did not think much of it, thinking it would go away on its own. Over time, it started growing larger, and at first, people suggested it might be a spiritual issue. I tried several local remedies, but when it did not improve, I decided to visit the hospital. That was when I found out I had cancer, and the lump was a symptom of it.” (S19, female)

Another participant described the illness as an attack on the body:

“I felt like my body was under attack, and I could not figure out why it was happening to me.” (S10)

A third participant linked the first interpretation of illness to cultural and religious belief systems:

“Because I grew up in a culture where spiritual beliefs are very strong, my first thought was that my illness was caused by something otherworldly. I went to traditional healers and religious leaders for help, hoping they could find a way to make my pain go away.” (S18)

Subtheme 3: Coping with frustration and rebuilding strength

Participants described frustration, adjustment, and a gradual effort to rebuild confidence after surgery. Some described the need to reconcile spiritual beliefs with medical explanations. Others focused on regaining independence and resuming daily life. One participant stated:

“I had to make sense of my beliefs and scientific explanations, which made me face my own wrong ideas about health and illness.” (S10, male)

Another participant described physical and emotional adjustment after surgery:

“There was a period of adjustment, both physically and emotionally. But I never wavered in my belief that I had made the right decision. I worked hard on getting better and getting my independence back, determined to make the most of my new life.” (Patient 8, male, 51 years old)

Participants also reported drawing strength from relatives, friends, faith, and confidence in the care they received:

“I relied on my faith and the help of my family and friends. Their support gave me the strength to deal with whatever came next.” (S11, female)

“I was surprisingly calm. I was okay with what was going on and knew I was in good hands. It was a relief to know that the surgery would make my condition better in the end.” (S17, female)

Subtheme 4: Faith-based and communal strategies for mental stability

Participants identified prayer, worship, religious rituals, faith communities, and encouragement from others as strategies for maintaining psychological stability. One participant described returning to worship as part of daily coping:

“One of the first things I did was reconnect with my faith. Going to my worship centre became a very important part of my daily life. It gave me a safe place to find peace and comfort in the middle of the chaos of my health problems.” (S1, female)

Another participant described the support received from a faith community:

“Being a member of a faith community gave me a support system. It was very helpful to hear the prayers, encouragement, and stories of other people who had been through the same things. It made me remember that I was not alone on my journey.” (S16, female)

A male participant described prayer and hymns as calming practices:

“Praying, singing hymns, and taking part in religious rituals helped me clear my mind and feel calm inside. It was a way to turn my worries and fears into something good and healing.” (S8, male)

Theme 3: Economic burden and financial coping strategies

This theme captures the financial challenges participants faced during and after cancer surgery. Participants described high treatment costs, difficulty sustaining work, dependence on relatives, support from charitable organisations, and practical strategies for managing limited resources. Three subthemes were identified: treatment costs and access to care; employment disruption and functional limitation; and financial stress and resource management. Supporting quotations and analytic notes for Theme 3 are provided in Table S4.

Subtheme 1: Treatment costs and access to care

Participants described the cost of medicines, hospital visits, investigations, and other medical supplies as a major burden. One participant stated:

“The cost of medicines, doctor’s visits, and other medical supplies can add up quickly, making it a big financial burden.” (S7, female)

Some participants described actively searching for cheaper treatment options and seeking support from organisations that assist cancer patients:

“Being resourceful became a big part of my plan. I began to look for ways to cut costs on health care. I looked at the prices at different pharmacies to find the best deals on my drugs. I also got in touch with different groups and charities that help people with cancer pay for things.” (S3, female)

Another participant described receiving support from a non-governmental organisation during treatment:

“I did not have much trouble in accessing care because an NGO took the care from the beginning to radiotherapy session. But before coming for my last clinic, I was financially unstable, but I have been helped out in a lot of ways.” (S5)

Subtheme 2: Employment disruption and functional limitation

Participants reported that surgery and recovery affected their capacity to work, perform physically demanding tasks, and sustain normal activities. Some experienced fatigue, breathlessness, pain, and difficulty returning to their usual work. One participant described a period away from work before eventual return:

“I get tired easily and it is difficult to catch breath. I stopped working for almost two years but now I am better. I have even gone back to work.” (S12, ovarian cancer survivor)

Another participant described the effect of surgery on informal work and financial dependence:

“It has not been easy financially. I used to hawk goods, but since then I tried it once and it was not easy. I had pains in my legs and had to stop it. I have been depending on my daughter’s husband, and she is really trying. I pray God bless her.” (S17)

Some participants also reported gradual improvement after surgery. One male participant described focusing on recovery and independence:

“I had to get used to things, both physically and emotionally. I focused on getting better and getting my independence back.” (S8, male)

Another participant described mild limitations after recovery:

“Not so much weakness after the surgery. Like I said earlier, I got well so quickly. I only experience some stress when I engage in some activities.” (S10)

Subtheme 3: Financial stress and resource management

Participants managed financial stress through budgeting, reducing expenses, comparing medication prices, seeking charitable help, and relying on family and friends. One participant described adjusting the household budget because of medical expenses:

“Sometimes I would have to change my budget because of unexpected medical costs. This often meant spending less on things that were not necessary or finding other ways to make money.” (S3, female)

Family and friends also provided encouragement and material support. One participant stated:

“I also relied on the support of my family and friends. Their encouragement and faith in my strength were very helpful.” (S1, female)

Across participants’ accounts, financial coping involved both personal resourcefulness and dependence on social support networks.

Theme 4: Resilience in the recovery journey

This theme describes participants’ accounts of recovery after cancer surgery. Participants spoke about hope, gratitude, renewed strength, scars, survival, family support, faith, and gradual return to normal activities. Two subthemes were identified: healing, survival, and restored functioning; and hope and positive reframing during recovery. Supporting quotations and analytic notes for Theme 4 are provided in Table S5.

Subtheme 1: Healing, survival, and restored functioning

Participants described healing through physical recovery, faith, and renewed strength. Some saw survival after surgery as evidence of divine help. One participant described a critical postoperative moment:

“My faith had really helped. After the surgery, I almost died on the ward. When I gained consciousness, I saw doctors and nurses surrounding me. I did not know how it happened. I know it was mercy I received to be revived and alive till then.”

Another participant described rapid recovery and return to routine activities:

“I recovered quickly. After the surgery I stayed back in Ife for one week because I needed to come to the hospital for wound dressing. Before that time, I had already started bathing myself and removing my clothes. I am not taking glory now, I am actually a very strong woman. When I returned back, I could drive and go to work. God has given me energy. There has not been any time I have been down. God has been faithful. I have been very energetic as I have always been.” (S16)

Participants linked recovery with regaining strength, caring for themselves, moving around, and resuming work or daily activities.

Subtheme 2: Hope and positive reframing during recovery

Participants described hope and positivity as important during recovery. Some interpreted scars as evidence of survival and endurance. One participant stated:

"I also relied on the support of my loved ones. Their encouragement and faith in my strength helped me stay focused on my goals and look ahead to the future. Each scar told a story of a battle fought and won, a reminder of my ability to endure and overcome." (Patient 1, 48 years old, female)

Another participant described scars as symbols of survival:

"They were not just scars on my skin anymore; they were badges of honour that I wore with pride. Every day was hard, from the physical pain to the emotional toll of dealing with a condition that seemed never-ending. But I chose to focus on the promise of tomorrow on purpose. I told myself that every little thing I did to get better was a win, even if it did not seem like a big deal at the time." (Patient 8, 51 years old, male)

Participants' accounts showed that recovery was marked by continuing physical and emotional challenges, but also by hope, support from loved ones, personal encouragement, and positive reframing of bodily changes after surgery.

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Discussion

This study explored the experiences of cancer surgery survivors in Osun State, Nigeria, with attention to psychosocial adjustment, quality of life, economic burden, spiritual meaning-making, and coping after surgery. The findings show that survivorship after cancer surgery extended beyond wound healing or return to clinic follow-up. Participants described an early period of denial, sadness, fear, and existential disruption, followed by gradual acceptance, spiritual reflection, family support, financial adjustment, and efforts to restore daily functioning. Taken together, these findings show that cancer surgery survivorship in this setting involved psychological, social, spiritual, economic, and embodied forms of adjustment.

The findings also demonstrate how the Biopsychosocial Model and the Adversity, Restoration, and Compatibility framework shaped interpretation of the themes. The Biopsychosocial Model was reflected in the interaction between physical limitations after surgery, emotional distress, social support, financial strain, and changes in work and family roles [12]. The ARC framework further helped to organise the survivorship trajectory described by participants. The adversity phase was reflected in denial, fear, sadness, and spiritual questioning after diagnosis and surgical recommendation. The restoration phase was reflected in participants' efforts to re-engage with treatment, manage postoperative limitations, seek family and faith-based support, and rebuild daily routines. The compatibility phase was reflected in survivors' accounts of hope, acceptance, scar reinterpretation, gratitude, and a reconstructed sense of self after cancer surgery [5].

The first major finding concerns emotional reaction and spiritual interpretation of illness. Participants described diagnosis and surgical recommendation as deeply distressing events that disrupted their sense of certainty and control. Denial and temporary avoidance did not appear simply as refusal of care. They functioned as early emotional responses to fear, bodily threat, and uncertainty. This interpretation aligns with recent Nigerian evidence showing that breast cancer survivors often experience treatment as emotionally painful, socially isolating, and spiritually charged, while still trying to find meaning and remain engaged with care [8,9]. Similar evidence from a mixed-methods systematic review of women living with and beyond breast cancer in Africa shows that emotional distress, limited knowledge, religion, traditional medicine, and health-system barriers often shape women's experiences across the cancer trajectory [7]. The present study extends this evidence by showing that emotional

and spiritual interpretation also marked the post-surgical experiences of survivors across breast, ovarian, cervical, prostate, and colon cancers.

Spiritual meaning-making was central to participants' accounts. Some survivors initially interpreted illness as inconsistent with their faith or as a possible spiritual attack, while others relied on prayer, worship, and faith communities to manage fear and uncertainty. This finding is consistent with recent psycho-spiritual research from Ghana, where women with breast cancer after radiotherapy described anxiety, distress, increased prayer, religious coping, and social engagement as part of their recovery process [21]. It also corresponds with Nigerian studies in which survivors described spirituality as a source of strength, meaning, and endurance during and after treatment [8,9]. The finding does not suggest that spirituality should replace biomedical care. Instead, it shows that culturally sensitive cancer care in Nigeria needs to recognise spiritual interpretation as part of how many survivors make sense of diagnosis, surgery, and recovery.

The second major finding concerns psychosocial coping and emotional resilience. Participants moved from resistance, confusion, and frustration towards acceptance and practical decision-making. For some, acceptance came after explanation by doctors and nurses. For others, it came through family persuasion, personal reflection, or the belief that surgery offered the best chance of survival. This movement from fear to acceptance is consistent with survivorship literature showing that coping, social support, and resilience are strongly associated with quality of life among cancer survivors [6]. Nigerian evidence also supports this pattern. Chidebe et al. found that breast cancer survivors relied on spirituality, concealment, endurance, and treatment navigation strategies while coping with the burden of care [8]. Nwozichi et al. similarly showed that suffering among Nigerian female breast cancer survivors crossed physical, emotional, social, financial, and spiritual domains, with resilience supported by spirituality and support systems [9].

The third major finding concerns economic burden and financial coping. Participants described treatment costs, medication expenses, transport needs, work interruption, dependence on relatives, and support from charitable organisations. These accounts show that financial toxicity was not only a matter of direct medical expenditure. It also affected psychological wellbeing, household stability, occupational identity, and dependence on family members. Recent evidence from south-western Nigeria supports this finding. Busari et al. reported high financial toxicity and psychosocial distress among breast and cervical cancer patients, with treatment cost, income loss, and negative body image contributing to distress [10]. A systematic review and meta-analysis also found that financial toxicity is associated with poorer health-related quality of life among cancer patients and survivors [22]. The present study adds qualitative depth by showing how survivors manage these pressures through budgeting, price comparison, family support, charity, and reduced work activity.

Employment disruption was especially important for participants whose occupations required physical effort or daily trading. Some survivors stopped working for long periods, while others returned gradually but reported fatigue, breathlessness, pain, or reduced stamina. This finding is consistent with evidence that cancer survivors face difficulties returning to work, especially when physical symptoms, psychological distress, negative illness perceptions, and physically demanding jobs affect work productivity after treatment [7]. In the Nigerian context, where many people work in informal or physically demanding occupations and may lack adequate paid sick leave or financial protection, postoperative work disruption can intensify economic vulnerability. This finding strengthens the case for survivorship care that includes occupational counselling, rehabilitation guidance, and financial support.

The fourth major finding concerns resilience and recovery. Participants did not describe recovery only as clinical improvement. They described it as a process of regaining strength, accepting bodily changes, finding hope, reinterpreting scars, and restoring a sense of direction. Some framed survival as divine mercy. Others viewed scars as evidence of endurance. This pattern aligns with psychosocial survivorship literature showing that hope, coping, resilience, and social support influence quality of life [6]. It also aligns with evidence that spiritual wellbeing and psychological resilience can reduce supportive care needs among women with breast cancer [8]. The present

findings indicate that resilience among cancer surgery survivors in Osun State was relational and culturally grounded. It drew on family support, faith, personal resolve, and gradual restoration of daily function.

The study contributes to cancer survivorship scholarship in three main ways. First, it provides qualitative evidence from Nigeria, where post-surgical survivorship remains underexplored compared with diagnosis, treatment access, and survival outcomes. Second, it moves beyond a single-cancer focus by including survivors of breast, ovarian, cervical, prostate, and colon cancers. Third, it shows that psychosocial adjustment, spiritual meaning-making, financial toxicity, and work disruption are interrelated dimensions of post-surgical survivorship. These findings support calls for survivorship care that integrates psychosocial assessment, spiritual care, financial counselling, rehabilitation, and structured follow-up as part of oncology services [11].

Strengths

This study has several strengths. It foregrounds the accounts of cancer surgery survivors in a Nigerian setting, where qualitative survivorship evidence remains limited. Recruitment from three tertiary hospitals allowed the study to capture experiences from different referral centres in Osun State. The inclusion of survivors across five cancer types broadened the range of post-surgical experiences represented. The use of in-depth interviews enabled participants to describe emotional, spiritual, social, and economic aspects of recovery in their own words. The study also applied a clear theoretical orientation through the Biopsychosocial Model and the ARC framework, while the use of reflexivity, audit trail, verbatim transcription, and thematic analysis strengthened trustworthiness.

Limitations

Several limitations should be considered when interpreting the findings. First, the study was conducted in three tertiary referral hospitals in Osun State, Southwest Nigeria. Although these hospitals serve a broad catchment population, the sample may not fully represent cancer surgery survivors in rural communities, primary or secondary care facilities, or other geopolitical regions of Nigeria. Survivors who attend tertiary follow-up clinics may differ from those lost to follow-up, those unable to access specialist care, or those who disengaged from treatment.

Second, the sample was relatively small, although sufficient for qualitative saturation. The sample was also predominantly female, which may have shaped the emphasis on body image, caregiving roles, faith-based coping, and relational support. Male perspectives, particularly among prostate and colorectal cancer survivors, may therefore be underrepresented. The inclusion of five cancer types enriched the study, but it also limited cancer-specific analysis of distinct surgical and psychosocial concerns.

Third, participants were recruited from outpatient follow-up clinics and had survived at least four weeks after surgery. The study therefore does not capture the experiences of those who developed severe postoperative complications, died early, or completely disengaged from care. The findings may reflect the accounts of survivors who were stable enough to attend follow-up appointments.

Fourth, the study was cross-sectional and based on retrospective accounts. Although the ARC framework helped interpret survivorship as a process of adversity, restoration, and compatibility, longitudinal data would have allowed closer examination of how survivors moved between these phases over time. Future studies should follow survivors from diagnosis through surgery, adjuvant treatment, rehabilitation, and longer-term survivorship.

Fifth, the study relied on self-reported narratives. Recall bias and social desirability bias may have influenced participants' accounts, especially in relation to faith, strength, family support, and coping. Cultural expectations about resilience and religious trust may also have shaped how participants described their experiences. The researcher used reflexive notes and an audit trail to reduce this risk, but qualitative interpretation still reflects the researcher's analytic judgement.

Finally, the study did not triangulate survivor interviews with caregiver accounts, clinical records, or validated quality-of-life measures. Such triangulation could provide a more layered understanding of postoperative function, psychosocial distress, financial toxicity, and family-system adjustment.

Implications for cancer survivors and survivorship care

The findings suggest that cancer surgery survivors in Nigeria need care models that address more than surgical recovery. Routine follow-up should include assessment of emotional distress, fear of recurrence, body image concerns, family and social support, financial hardship, and return-to-work difficulties. Spiritual concerns should also be approached respectfully, especially when survivors interpret illness through religious or cultural frameworks. Oncology teams do not need to provide religious counselling themselves, but they should create space for discussion, identify distress linked to spiritual struggle, and refer survivors to appropriate psychosocial, chaplaincy, peer-support, or community resources where available.

The findings also point to the need for financial counselling and social protection as part of cancer care. Survivors who depend on informal work, trading, family assistance, or charitable support may face prolonged economic instability after surgery. Financial distress can affect treatment adherence, clinic attendance, psychological wellbeing, and household stability. Screening for financial toxicity should therefore accompany psychosocial assessment, especially in settings where out-of-pocket payment remains common.

Conclusion

This qualitative study examined the experiences of cancer surgery survivors in Osun State, Nigeria, with specific attention to psychosocial adjustment, quality of life, economic burden, spiritual meaning-making, and coping after surgery. The findings answer the study objective by showing that survivorship after cancer surgery does not end with physical recovery or clinic follow-up. Survivors described surgery as a major turning point that affected their emotions, bodies, relationships, work, finances, faith, and sense of future. Their accounts show that cancer surgery survivorship in this setting involves a continuing process of adjustment, not a single event of treatment completion.

The first major finding was that many survivors experienced denial, sadness, fear, and emotional shock after diagnosis and surgical recommendation. These responses were often shaped by spiritual interpretation, family concerns, and the fear of bodily change. The second finding was that survivors gradually developed coping strategies through acceptance, faith, support from relatives, communication with healthcare workers, and personal determination to continue treatment. The third finding was that financial strain formed a central part of survivorship. Participants reported treatment costs, medication expenses, transport costs, work interruption, dependence on relatives, and support from charities or non-governmental organisations. The fourth finding was that recovery was shaped by hope, spiritual confidence, family encouragement, renewed strength, and the effort to resume ordinary life after surgery.

These findings have direct implications for cancer care in Nigeria. Surgical oncology services should not treat survivorship as a purely medical outcome. Follow-up care should include routine assessment of psychological distress, fear of recurrence, body image concerns, social support, financial hardship, and return-to-work difficulties. Healthcare teams should also recognise spiritual concerns as part of patients' coping, while ensuring that spiritual interpretation supports, and does not replace, timely biomedical care. Hospitals should develop referral pathways for counselling, peer support, social welfare assistance, rehabilitation, and financial guidance. Such support may improve treatment adherence, reduce distress, and strengthen long-term quality of life after cancer surgery.

The study also points to areas for future research. Longitudinal studies are needed to follow survivors from diagnosis through surgery, adjuvant treatment, recovery, and long-term survivorship. Larger multi-centre studies across different Nigerian regions would help clarify how culture, rurality, income, gender, and healthcare access shape post-surgical survivorship. Future studies should intentionally recruit more male survivors and examine cancer-specific concerns among prostate, colorectal, gynaecological, and breast cancer survivors. Mixed-methods

research should combine survivor narratives with validated measures of distress, quality of life, financial toxicity, fear of recurrence, and functional status. Studies involving caregivers and family members would also deepen understanding of family burden, relational coping, and economic support after cancer surgery.

Overall, this study shows that cancer surgery survivors in Osun State rebuild life through a demanding process of emotional adjustment, social support, spiritual meaning, financial negotiation, and renewed hope. Cancer care systems should respond to this reality by making survivorship support a routine part of oncology practice.

Statements of Declaration

Conflict of Interest: This is to state that the manuscript has been read and approved by all the authors and all authors met the requirements for authorship and that each author believes that the manuscript represents honest work of all the contributors. There is no known conflict of interest about this manuscript. The authors consider moving some tables to an appendix or supplementary material.

Source(s) of Support: The study was not supported by any organization or agency. It was sponsored by the researchers.

Authors Contribution

1. Ifeoluwa Temilola AJILEYE involved in study conceptualization/design, data collection, and drafting of the manuscript
2. Olufemi Oyebanji OYEDIRAN involved in conceptualization/design drafting, editing and proof reading.
3. Esther Kikelomo AFOLABI involved in editing and critical reviewing of the manuscript
4. Funmilola Adenike FAREMI involved in proof reading of the manuscript
5. Iyanuoluwa Oreofe OJO in critical reviewing of the manuscript
6. Emmanuel Olufemi AYANDIRAN involved in data curation and proof reading of the manuscript

Data Availability Statement

The data can be made available on request.

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Appendix A. Supplementary tables

Table S1 should appear here.

Table S1: Emotional reaction and spiritual interpretation of illness.		
Subthemes	**Direct quote**	**Note / Emphasis**
Feeling of denial	*"Living with a chronic illness is like an invisible weight, I ran away at first ... because I serve a living God (S 2, female).* *"I was crying when I heard it.it really affected me, I almost refused.., I was even praying and singing during the surgery(S 3, breast)* *"I refused at first at first but I was later called and some things were explained to me. My faith has really helped me and I prayed and God see me through".(S 8 male)*	The participants shared that they had and initial fear and found themselves in a state of denial as surgery was mentioned as part of their treatment regimen. Some even stopped attending clinic but after sometimes got back to continue their care.
Sad and inconsolable	*"The hardest part wasn't the physical pain; it was the emotional toll." . Seeing the worry in my family's eyes and feeling like a burden was sometimes worse than the illness itself. Hummm I felt like the ground had been pulled out from under me. The future I had envisioned suddenly vanished, replaced by a series of daunting medical terms and a seemingly endless cycle of treatments." (S 19, male)*	Some of the participants further shared that the felt deeply saddened and inconsolable due to the fact that the ailment led to the remover of a part of the body. They also talked about how helpless and frustrated they felt because of the new situation.

Table S2 should appear here.

Table S2: Psychosocial coping and emotional resilience.		
Subthemes	**Direct quote**	**Note / Emphasis**
Resigned to Fate	*"...when I was told It was hard to accept at first but I asked the doctors and nurses ... and in accepting my fate." (S 10, female)* *"...at first, I didn't know how bad the situation was but after the doctors explained to me, I went online too to read about my condition and seeing how the whole thing was going I was greatly discouraged I felt like my life can't remain the same again." (S 5, female)* *"It wasn't an easy decision, but I had to prioritize my long-term health. I had already endured so much pain and suffering, and I couldn't bear the thought of prolonging my agony any further." (S 17 ,colon female)*	Many of the participant resigned to fate when it became obvious that there would be a need for surgery and remove part of them in order to save the other. They expressed a profound acceptance of the situation, acknowledging the necessity of the decision for their overall health and well-being. They spoke with a sense of calmness and resilience, reflecting on the challenges they had already faced and the difficult choices they had been forced to make:
Blamed on a spiritual attack	*"I saw a small lump on my body, but I didn't think much of it, thinking it would go away on its own." ... That's when I found out I had cancer, and the lump was a symptom of it." (S 19, female)* *I felt like my body was under attack, and I couldn't figure out why it was happening to me. (S 10)* *"Because I grew up in a culture where spiritual beliefs are very strong, my first thought was that my*	In the interview, some people talked about how they dealt with their illness, saying that at first they believed it was a spiritual attack, but later it was confirmed in the hospital to be cancer. They told the story of how they went from not believing to being confused to finally accepting the change from spiritual

	illness was caused by something otherworldly. …. (S 18)	interpretation to medical diagnosis
Coping with frustrations and resilience	*"I had to make sense of my beliefs and scientific explanations, which made me face my own wrong ideas about health and illness." (S 10, male)* *"there was a period of adjustment, both physically and emotionally. … I worked hard on getting better … (Patient 8, male, 51 years old)* *"I relied on my faith and the help of my family and friends... (S 11, woman)* *"It was a relief to know that the surgery would make my condition better in the end. (S 17, female)*	In the middle of all the anger and helplessness, the surgical patient found comfort in their own strength. They come back from the depths of despair like phoenixes rising from the ashes, with new strength and courage, moving forward with grace.
Strategies for maintaining mental health and resilience	*"One of the first things I did was reconnect with my faith. Going to my worship center became a very important part of my daily life.... (S 1, woman)* *"Being a member of a faith community gave me a support system... It made me remember that I wasn't alone on my journey. (S 16, woman)* *"Praying, singing hymns, and taking part in religious rituals helped me clear my mind and feel calm inside.". (S 8, male)*	Some people interviewed also talked about how they came up with different ways to stay mentally healthy and strong after getting the diagnosis and information about surgery and the problems that came with it. Going to a worship center on a regular basis was one of the most important ways people learnt to deal with their problems.

Table S3 should appear here.

Table S3: Economic burden and financial coping strategies.

Subthemes	**Direct quote**	**Note / Emphasis**
Cost of medical care and treatment	*"The cost of medicines, doctor's visits, and other medical supplies can add up quickly, making it a big financial burden." (S 7, woman)* *"Being resourceful became a big part of my plan." "I began to look for ways to cut costs on health care… This often meant spending less on things that weren't necessary or finding other ways to make money. (S 3, woman)* *"...an NGO took the care from the beginning to radiotherapy session. But before coming for my last clinic I was financially unstable, but I have been helped out in a lot of ways"(S 5)*	Some persons who were interviewed talked about their experience getting money for cancer treatment and how they deal with these problems. Medicines were very expensive and money hard to get. Some got assistance from NGO who cater for all their treatment.
Employment challenges and disability	*"I had to get used to things, both physically and emotionally... I focused on getting better and getting my independence back..." (S 8, man)* *I get tired easily and difficult to catch breath. I stopped working for almost 2 years but now, I am better, I have even gone back to work.(S12 Ovarian Ca)*	Some of the people who were interviewed also said that it was hard for them to do their normal activities and work while they were recovering from surgery. They said it was hard to get out of bed and lift heavy things, and that it was hard to keep up with their work and daily life.

	“It has not been easy financially, I used to hawk goods, but since then I tried it once but it was not easy, had pains in my legs , had to stop it. I have been depending on my daughter husband then, and she's really trying. I pray God bless her”(S 17).	
Financial stress and resource management	*"I also relied on the support of my family and friends. Their encouragement and faith in my strength were very helpful." (S 1, woman)* *"Being resourceful became a big part of my plan." ... "Sometimes I would have to change my budget because of unexpected medical costs." This often meant spending less on things that weren't necessary or finding other ways to make money. (S 3, woman)*	Some of the people who answered talked about how they dealt with money problems by using personal strategies, making a budget, and asking for help.

Table S4 should appear here.

Table S4: Resilience and journey to recovery.

Subthemes	**Direct quote**	**Note / Emphasis**
Perspectives on healing and recovery	*With hope as my guiding light, i continue to move forward, embracing each new day with the confidence that I can conquer whatever challenges lie ahead.* “*My faith had really helped, after the surgery, I almost died on the ward, when I gained consciousness I saw doctors and nurses surrounded me, I didn't know how it happened, I know it was mercy I received to be revived and alive till then”* *“ I recovered quickly. After the surgery I ... have been very energetic as I've always been”.(S. 16)*	Most of the participants trust God and hopeful that they will overcome at last, no matter how challenging the situation might be.
Maintaining hope and positivity amidst challenges	*"...I also relied on the support of my loved ones. Their encouragement and faith in my strength helped me stay focused on my goals and look ahead to the future." ... (Patient 1, 48 years old, female)* *“They weren't just scars on my skin anymore; they were badges of honour that I wore with pride…. (Patient 8, 51 years old, male)*	