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Lived Experiences of Prostate Cancer Patients Receiving Care at Cancer Diseases Hospital in Lusaka, Zambia

Salome Musanse[1,2], Patricia Katowa Mukwato[3], Victoria Mwiinga Kalusopa[2]

[1]Cancer Diseases Hospital, University Teaching Hospital, Lusaka, Zambia
[2]Department of Basic and Clinical Sciences, School of Nursing Sciences, University of Zambia, Lusaka, Zambia
[3]Mulungushi University, Kabwe, Zambia
Email: sally.musanse21@gmail.com

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Abstract

Introduction: Prostate cancer is an increasing health concern among men, and its diagnosis and treatment can affect physical, psychological, social and emotional well-being. In Zambia, qualitative evidence describing how men experience and cope with prostate cancer within the healthcare system remains limited. **Aim**: This study explored the lived experiences of men diagnosed with prostate cancer receiving care at Cancer Diseases Hospital (CDH) in Lusaka, Zambia. **Design and Methods**: An exploratory qualitative study using a descriptive phenomenological approach was conducted among 13 men diagnosed with prostate cancer. Participants were recruited through purposive sampling followed by snowball sampling. Data were collected through semi-structured, in-depth, face-to-face interviews using an interview guide. Interviews were audio-recorded with consent, transcribed verbatim and analysed concurrently using thematic analysis. Bracketing was employed to minimise the influence of researcher preconceptions. **Results**: Four major themes emerged from the study: emotional and psychological impact, physical health challenges, social and relationship dynamics, and navigating healthcare systems. Participants described fear and anxiety following diagnosis, including fear of death, uncertainty about treatment outcomes and concerns about their families. Physical challenges included persistent fatigue, urinary incontinence, gastrointestinal disturbances, pain, mobility difficulties and sexual dysfunction, with consequences for independence and quality of life. Family members provided emotional, financial and practical support, although participants also described stigma, social isolation, reluctance to disclose their diagnosis and difficulties maintaining social and occupational roles. Participants further reported barriers to specialised cancer care, including transportation costs,

long travel distances, financial constraints and prolonged waiting times. Limited information and inconsistent communication with healthcare providers contributed to uncertainty and distress. Spirituality, family support and personal resilience were important coping resources. **Conclusion and Recommendations**: Men living with prostate cancer experienced interconnected physical, psychological, social and healthcare-related challenges that extended beyond diagnosis and treatment. Prostate cancer care should therefore incorporate comprehensive psychosocial support, clear communication, effective symptom management, rehabilitation, sexual-health support, family involvement and measures to reduce practical barriers to accessing specialised services.

Keywords

Prostate Cancer, Lived Experiences, Psychosocial Support

1. Introduction

Prostate cancer is a major global health concern among men. The 2022 GLOBOCAN estimates recorded approximately 1.5 million new prostate cancer cases and 397,000 deaths worldwide, making prostate cancer the second most frequently diagnosed cancer globally and a leading cause of cancer mortality among men [1]. The burden is particularly important in sub-Saharan Africa, where mortality rates remain high and access to early detection and specialised treatment can be uneven [1].

The consequences of prostate cancer extend beyond disease control. Diagnosis may disrupt men's sense of security and introduce concerns about mortality, treatment, future health and changing roles. King *et al.* identified psychological, physical, social and informational needs among men living with prostate cancer, while Prashar *et al.* similarly highlighted the importance of supportive care across the cancer trajectory [2] [3]. These findings suggest that understanding prostate cancer requires attention not only to clinical outcomes but also to how men interpret and adapt to the illness.

Within Zambia, the experience of cancer care may be shaped by the organisation of specialist services, economic circumstances, geographical distance and family involvement. Research conducted at Cancer Diseases Hospital (CDH) among women caring for husbands with cancer identified emotional distress, socioeconomic difficulties, mobility challenges, information needs and spiritual concerns, with prayer, family relationships and social support described as important coping resources [4]. However, this evidence concerns caregivers rather than men living with prostate cancer themselves. Context-specific evidence on men's experiences is therefore needed to inform patient-centred prostate cancer care in Zambia.

The psychological burden of prostate cancer can be substantial. Matheson *et al.*

linked psychological distress among prostate cancer survivors to perceived losses involving the self, physical functioning, social connection and control [5]. Chambers *et al.* likewise identified fear and uncertainty about the future as important elements of men's experiences of advanced prostate cancer [6]. Coping may involve acceptance, emotional regulation, maintaining everyday activities and drawing on social relationships [7]. Spirituality may also have an important role. Walton and Sullivan identified praying, receiving support and coping with cancer as central dimensions of spirituality among men with prostate cancer [8], while Lepherd described spirituality as a resource through which men with advanced prostate cancer could make sense of their illness and sustain meaning [9].

Physical symptoms and treatment effects can further shape everyday functioning. Systematic reviews have documented urinary, sexual and bowel symptoms and broader quality-of-life consequences following treatment for localised prostate cancer [10]-[12]. Fatigue may be particularly disruptive because it can restrict mobility, work and independence [13]. Exercise-based interventions have shown potential for improving fatigue, quality of life and psychological outcomes among men treated for prostate cancer [14]. Treatment-related changes may also affect masculine identity and emotional help-seeking. Goodwin *et al.* found that masculine norms can influence psychological and emotional help-seeking among men with prostate cancer, while Salifu *et al.* described disruptions to masculinity among men living with advanced disease [15] [16].

The social experience of prostate cancer is similarly complex. Family members may provide emotional, practical and financial assistance, yet stigma and fear of disclosure may contribute to concealment and social withdrawal. Ettridge *et al.* identified perceptions of stigma and social isolation among men with prostate cancer, while Buote *et al.* described stigma as an important part of men's experiences of the disease [17] [18]. Research involving men and their partners also indicates that prostate cancer can alter communication, intimacy and roles within relationships [19] [20]. Healthcare experiences represent another important dimension. Men may need information that is timely, understandable and relevant to their individual circumstances. Chen *et al.* demonstrated that men affected by prostate cancer have specific information and communication needs [21]. Chambers *et al.* also highlighted the importance of supportive care, communication and care coordination [6].

Mazzarello Moore *et al.* further emphasised the need to strengthen supportive care for men with prostate cancer, particularly because supportive-care needs may remain inadequately addressed within conventional treatment pathways [22]. Psychological interventions may also have a role in supporting men living with prostate cancer. Nnate *et al.* found evidence supporting mindfulness-based approaches for psychological well-being and quality of life among men with prostate cancer [23]. Similarly, survivorship interventions addressing educational and psychological needs may improve health-related quality of life for men receiving long-term prostate cancer treatment [24].

Despite growing international evidence, there remains limited qualitative research describing how men in Zambia experience prostate cancer across psychological, physical, social and healthcare domains. This study therefore explored the lived experiences of men with prostate cancer receiving care at CDH in Lusaka, with particular attention to the challenges they encountered and the resources they used to cope.

2. Materials and Methods

2.1. Study Design, Setting and Participants

An exploratory qualitative study employing a descriptive phenomenological approach was undertaken to understand the lived experiences of men with prostate cancer receiving care at Cancer Diseases Hospital (CDH) in Lusaka, Zambia. CDH is a specialised tertiary cancer hospital with a bed capacity of 252 and serves as the principal referral centre for cancer care in Zambia. Purposive sampling was initially used to identify participants who met the eligibility criteria, followed by snowball sampling to identify additional eligible participants. Initially, four men who met the study eligibility criteria were identified by the healthcare team at Cancer Diseases Hospital (CDH). Their clinical records were reviewed by the research team to confirm that they met the predefined eligibility criteria before they were invited to participate. Healthcare staff informed eligible patients that a study on the experiences of men receiving care for prostate cancer was being conducted and asked whether they would be interested in receiving further information about the study. Following confirmation of eligibility, the first author approached the potential participant, explained the study objectives, procedures, potential risks and benefits, and obtained written informed consent before the interview was conducted.

Snowball recruitment was subsequently used to identify additional eligible participants. Each of the initial participants was asked whether they knew another man with prostate cancer who might meet the eligibility criteria and be interested in hearing about the study. The participants recommended eligible colleagues, who were subsequently approached and invited to participate after their eligibility had been confirmed. Healthcare staff also continued to identify potentially eligible men and inform them about the study. Recruitment therefore involved both participant referrals and continued identification of eligible participants by healthcare staff. Recruitment continued until the thirteenth participant had been interviewed. At this point, the researcher observed that no substantially new information was emerging from the interviews, and data saturation was considered to have been reached. Data collection was therefore discontinued after 13 participants.

The study population comprised men diagnosed with prostate cancer and receiving care at CDH. Participants were eligible if they were aged 18 years or older, had a confirmed diagnosis of prostate cancer and were receiving care at CDH, irrespective of disease stage. Men who were critically ill or unavailable at the in-

stitution during the study period were excluded.

2.2. Data Collection Procedure

Data were collected through semi-structured, in-depth, face-to-face interviews using an interview guide developed from the study objectives and relevant literature. Interviews were conducted in a private and confidential setting at CDH. Probing and follow-up questions were used to encourage detailed descriptions and clarify participants' responses. With participants' consent, interviews were audio-recorded. Field notes were maintained throughout the data-collection process. Participants were encouraged to describe their experiences in their own words, while the researcher avoided imposing predetermined clinical interpretations on their accounts.

2.3. Researcher Positioning and Reflexivity

The first author conducted all interviews. At the time of data collection, the researcher was a registered nurse with a Bachelor of Science in Oncology Nursing and was pursuing a Master's degree in Oncology. The researcher was employed as a registered nurse at Cancer Diseases Hospital (CDH) and therefore had clinical experience within the study setting. The researcher had no prior personal relationship with the participants beyond providing routine nursing care where applicable. Participants were informed of the researcher's role and the purpose of the study before the interviews. Interviews were conducted in English, Nyanja, or Bemba, depending on the participant's preference. Each interview lasted between 25 and 37 minutes. Interviews conducted in Nyanja and Bemba were translated into English during the transcription process by a multilingual journalist. The resulting English transcripts were subsequently counter-checked by the third author, who supervised the research process, to verify the accuracy and consistency of the transcribed and translated accounts with the original interview recordings. All interviews were audio-recorded with participants' consent.

2.4. Instruments

An in-depth semi-structured interview guide was used for data collection. The guide consisted of questions on participants' characteristics and open-ended questions addressing their experiences of living with prostate cancer and receiving care at CDH. The interview guide allowed participants to describe their experiences in their own words while enabling the researcher to probe issues emerging during the interviews. Questions explored participants' emotional and psychological experiences, physical challenges, social and relationship experiences, experiences of accessing healthcare, communication with healthcare providers and strategies used to cope with prostate cancer.

2.5. Data Analysis and Bracketing

Data were analysed inductively using thematic analysis guided by Braun and

Clarke [25]. Given the descriptive phenomenological design, the first author was conscious of the potential influence of his clinical experience as an oncology nurse working at Cancer Diseases Hospital. Bracketing was therefore approached as a process of consciously recognising and minimising the influence of pre-existing clinical assumptions during data collection and interpretation. Participants were encouraged to describe their experiences in their own words, and the researcher avoided imposing clinical interpretations or predetermined explanations on their accounts. Open-ended questions and probing were used to allow participants to elaborate on experiences that were meaningful to them.

Following each interview, the transcript was prepared and reviewed alongside the field notes. The transcripts were read repeatedly to facilitate familiarisation with the participants' accounts. Meaningful segments of the transcripts were identified and coded inductively, with codes remaining closely grounded in participants' descriptions. Similar codes were compared and grouped, and patterns across participants' accounts were examined to develop categories, subthemes and overarching themes.

The three authors participated in reviewing and interpreting the emerging findings. The authors compared the developing codes, categories and themes and discussed areas of similarity and difference in interpretation. Through this iterative process, the researchers refined the emerging themes and agreed on the final thematic structure and interpretation. This process helped maintain a close connection between the themes and the participants' accounts while reducing the influence of any single researcher's interpretation on the final findings. NVivo version 14 was used to support the organisation and coding of the qualitative data. Data collection and analysis occurred concurrently, allowing the researcher to assess the adequacy and depth of information obtained throughout the study.

2.6. Trustworthiness

Trustworthiness was addressed using the criteria of credibility, dependability, confirmability and transferability described by Lincoln and Guba [26]. Credibility was supported by recruiting participants who had direct experience of prostate cancer care, using a semi-structured interview guide, probing during interviews, audio-recording interviews and transcribing the interviews verbatim. Dependability was supported through consistent application of the data-collection procedures and maintenance of interview recordings, transcripts and field notes. Confirmability was strengthened through reflexive awareness of the first author's clinical background, inductive coding grounded in participants' accounts, maintenance of field notes, and collaborative review of the emerging codes and themes by all three authors. The researchers compared and discussed their interpretations throughout the analytical process to ensure that the final themes remained grounded in the participants' descriptions rather than being driven solely by the researchers' pre-existing clinical assumptions. Transferability was supported through detailed description of the study setting, participants, sampling proce-

dures and data-collection processes.

2.7. Ethical Considerations and Participant Safety

Ethical approval was obtained from the University of Zambia Biomedical Research Ethics Committee (UNZABREC), reference number 5884-2024. Permission to conduct the study was obtained from the National Health Research Authority and Cancer Diseases Hospital. Written informed consent was obtained from all participants after the study purpose, procedures, potential risks and benefits had been explained. Participation was voluntary, and participants were informed of their right to withdraw from the study at any time without consequence. Confidentiality and anonymity were maintained throughout the study. Participant information was securely stored and accessed only by the researcher.

Before obtaining informed consent, participants were informed about the potential psychological and emotional impact of discussing their experiences of prostate cancer and its treatment. The researcher psychologically prepared participants for the possibility that some questions might evoke emotional responses and emphasised that participation was voluntary. Participants were informed that they could decline to answer any question, pause the interview, take a break, or terminate the interview at any time without any consequences to the care they received.

Although no participant experienced significant psychological distress requiring clinical intervention during the interviews, the researcher remained attentive to participants' emotional responses throughout the interviews. Where a participant appeared particularly emotional, the interview was paused, a break was offered, and reassurance was provided before determining whether the participant wished to continue. Psychological support was readily available within the clinical setting, and participants could have been referred for appropriate psychological or clinical support if significant distress had occurred. Fortunately, no participant required such referral or intervention.

3. Results

Four major themes emerged from the study. The first theme describes the emotional and psychological impact of prostate cancer. The second theme explores the physical health challenges experienced by participants. The third theme describes social and relationship dynamics, particularly family support and stigma. The fourth theme discusses participants' experiences of navigating healthcare systems, including access to specialised care and communication with healthcare providers. The key statements from participants led to the development of subthemes, which were subsequently grouped into the major themes as shown in **Table 1**.

3.1. Demographic Characteristics

Face-to-face, in-depth interviews were conducted with 13 men diagnosed with

prostate cancer and receiving care at CDH. Participants were aged between 49 and 71 years. Most were married, while others were single, widowed or divorced. Participants had diverse occupational and educational backgrounds, including farming, business, skilled employment and retirement. The time since diagnosis ranged from 12 to 60 months, providing accounts from men at different points in their prostate cancer journey.

Table 1. Demographic characteristics of participants (n = 13).

Participant	Age (years)	Marital status	Occupation	Education level	Time since diagnosis (months)
P1	52	Married	Farmer	Primary	24
P2	65	Married	Retired Civil Servant	Secondary	36
P3	58	Widowed	Business Owner	Tertiary	18
P4	71	Married	Retired Teacher	Tertiary	48
P5	49	Single	Mechanic	Secondary	12
P6	67	Divorced	Security Guard	Primary	30
P7	54	Married	Shopkeeper	Secondary	20
P8	62	Married	Farmer	Primary	40
P9	50	Separated	Electrician	Tertiary	15
P10	70	Married	Retired Accountant	Tertiary	60
P11	59	Widowed	Carpenter	Secondary	25
P12	68	Married	Retired Doctor	Tertiary	36
P13	55	Single	Taxi Driver	Secondary	18

3.2. Major Themes, Subthemes and Key Statements from Participants

Four major themes and their corresponding sub-themes emerged from the participants' lived experiences of prostate cancer and are presented in Table 2. The themes were: Emotional and Psychological Impact, Physical Health Challenges, Social and Relationship Dynamics, and Navigating Healthcare Systems.

Table 2. Major themes, subthemes and key statements from participants.

Main theme	Subtheme	Key statement
Emotional and Psychological Impact	Fear and Anxiety	"When I heard the word 'cancer,' my first thought was, 'This is how I'll die.' It felt like a death sentence" (P4).
	Coping Mechanisms	"Whenever I feel overwhelmed, I just pray. It gives me strength" (P5).
Physical Health Challenges	Treatment Side Effects	"I always have to carry extra clothes when I go out, just in case. It's humiliating" (P6).
	Pain and Discomfort	"The radiation left me with constant pain in my bones. I can't sit for long or even walk properly" (P8).

Continued

Social and Relationship Dynamics	Family Support	"My wife keeps telling me to stay strong. I don't think I would have made it this far without her" (P9).
	Social Stigma	"People act like cancer is contagious. Some of my friends don't visit me anymore" (P6).
Navigating Healthcare Systems	Access to Care	"Coming to Lusaka for every check-up is not easy. Sometimes, I don't have transport money, so I just stay home" (P2).
	Communication with Providers	"One nurse told me everything step by step, and I felt better. But the next time, someone else just told me to sit and wait" (P4).

The four themes demonstrate that the experience of prostate cancer extended beyond the physical effects of the disease. Participants described interconnected emotional, physical and social challenges, while their experiences of the healthcare system influenced their ability to understand and manage their condition.

1) Emotional and Psychological Impact: The diagnosis of prostate cancer was associated with substantial emotional and psychological distress. Participants described fear of death, uncertainty about their prognosis and concerns about the effectiveness of treatment. For some, the diagnosis immediately generated thoughts of death and perceptions that cancer was inevitably fatal. One participant stated: "*When I heard the word* '*cancer*,' *my first* thought was, 'This is how I'll die.' It felt like a death sentence" (*P*4). Similarly, another participant described the diagnosis as a profound disruption to his sense of security: "*When I heard the doctor say I have* cancer, my whole world shattered. I thought this was the end for me" (*P*8). Another participant described persistent preoccupation with mortality: "*I couldn't stop thinking about death*. *It* felt like I had already been given a final date" (*P*1).

Fear was not limited to the initial diagnosis. Participants also experienced continuing anxiety about whether treatment would be successful and whether the disease might progress. The uncertainty surrounding treatment outcomes contributed to feelings of helplessness and emotional distress. One participant stated: "*I always ask myself*, '*What if this* treatment doesn't work? What if I go through all this pain for nothing?'" (*P*10). Another explained: "*Even though the doctors are treating me*, I'm always afraid that one day they'll tell me it has spread, and there's nothing more they can do" (*P*11). Participants' concerns extended beyond their own survival to the wellbeing of their families. The possibility of death was closely linked to concerns about who would care for their spouses and children and how the family would cope in their absence. One participant stated: "*I'm not worried about myself as much as I am about my family*. *If I die*, *who will take care of them?*" (*P*2).

Another expressed uncertainty about being present for his children: "*I see my*

children and wonder if I will be there to watch them grow" (*P*6). Despite these challenges, participants described several mechanisms for managing emotional distress. Spirituality was particularly important, with prayer and faith providing reassurance and a sense of hope. One participant stated: "*Whenever I feel overwhelmed*, *I just* pray. It gives me strength" (*P*5). Another explained:

"*I believe God has a plan for me*. *Whether I live or die*, *I put my trust in Him*" (*P*12). Family support was another important source of emotional resilience. Spouses, children and relatives provided encouragement and helped participants maintain hope during difficult periods. Some participants also used distraction, work or hobbies to avoid constantly thinking about their illness:

"*I try to keep my mind occupied*. *The more* I think about cancer, the worse I feel" (*P*9).

"*I take it one day at a time*. *Worrying* too much will only make things worse" (P11). Overall, the emotional experience of prostate cancer was characterised by fear, uncertainty and concerns about family wellbeing, but participants demonstrated resilience through spirituality, family support and strategies that helped them maintain hope.

2) Physical Health Challenges Participants described substantial physical challenges associated with prostate cancer and its treatment. These challenges affected energy levels, bodily functioning, mobility, independence and quality of life. The principal experiences included fatigue, urinary incontinence, gastrointestinal disturbances, sexual dysfunction, persistent pain and mobility difficulties.

Fatigue substantially reduced participants' ability to undertake activities they had previously performed routinely. One participant who had previously been physically active stated:

"*I was always on the move*, *working on my farm*. *Now*, *after a few steps*, *I need to sit down*. *I feel like a shadow of myself*" (*P*13). Another participant described persistent exhaustion despite adequate sleep: "*Even when I sleep for long hours*, *I wake up feeling tired*. *It's like my body has no energy left*" (*P*9). Urinary incontinence was particularly distressing because it affected participants' confidence and willingness to participate in public activities. One participant explained: "*I always have to carry extra clothes when I go out*, *just in case*. *It's humiliating*" (*P*6). For another participant, concerns about urinary control resulted in withdrawal from church:

"*I stopped attending church because I can't control my bladder*. *I don't want to risk an accident in public*" (*P*11). Participants also reported gastrointestinal problems that interfered with eating and contributed to physical weakness. One participant stated: "*After every treatment*, *my stomach feels upset*. *I can't eat properly*, *and I keep losing weight*" (*P*5). Sexual dysfunction represented another important physical and relational consequence of the disease and treatment. Participants described changes in sexual functioning as affecting their intimate relationships and sense of masculinity: "*I feel like less of a man*. *My wife tries* to *be understanding*, *but it's difficult*" (*P*7). "*I avoid intimacy because I don't want to*

disappoint my partner" (*P*2). Persistent pain and reduced mobility further compromised independence. One participant reported: "*Even after my surgery*, *I still feel pain in my lower stomach. It's always there*, *making it hard to sleep*" (*P*10). Another participant described persistent pain that he associated with his experience of radiation treatment and its effects on mobility: "*The radiation left me with constant pain in my bones. I can't sit for long or even walk properly*" (*P*8).

This account reflects the participant's perception of the relationship between treatment and his physical symptoms and is not interpreted as establishing a clinical causal relationship between radiation therapy and bone pain. Participants responded to these physical challenges by resting, reducing physical activity, using prescribed pain medication and modifying their diets. Some also reported using herbal or traditional remedies when they perceived inadequate symptom relief. Dietary adjustments included reducing meal size and avoiding foods that worsened gastrointestinal symptoms: "*I try to eat small meals*, *so my stomach doesn't hurt too much after treatment*" (*P*6). However, participants indicated that many of these strategies were undertaken without adequate professional guidance. They expressed a need for improved pain management, nutritional support and physiotherapy to help maintain function and quality of life.

3) Social and Relationship Dynamics Prostate cancer affected participants' relationships with spouses, children, relatives, friends and members of their communities. Family support emerged as a major source of emotional, financial and practical assistance. Spouses and children provided encouragement, accompanied participants during treatment and assisted with activities that participants could no longer perform independently.

One participant stated: "*My wife keeps telling me to stay strong. I don't think I would have made it this far without her*" (*P*9). Another explained: "*Even when I feel like giving up*, *my children remind me that I have a reason to keep fighting*" (*P*3). Family members also helped participants meet the financial and practical demands associated with cancer treatment. One participant reported: "*My son takes care of my hospital bills. Without him*, *I wouldn't be able to afford this treatment*" (*P*8). Another described the practical assistance provided by his wife:

"*My wife does everything for me cooking*, *cleaning*, *even helping me dress. It's not easy*, *but she never complains*" (*P*2). In contrast, participants described stigma and social isolation associated with their diagnosis. Some reported that friends and community members avoided them because of misconceptions about cancer. One participant stated: "*People act like cancer is contagious. Some of my friends don't visit me anymore*" (*P*6). Participants also described reluctance to disclose their diagnosis because of fear of gossip, judgement or pity. One participant explained:

"*Only my family knows I have cancer. I* don't want the neighbours to start talking" (*P*7).

Workplace discrimination was another social challenge reported by participants. Some participants experienced difficulties continuing employment because

of their reduced physical capacity. One participant stated: "*I was let go because my boss thought I wouldn't be able to handle the workload anymore*" (*P*11). Participants responded to stigma through selective disclosure and withdrawal from some social activities. At the same time, family relationships remained an important source of support. Religious and community spaces also provided opportunities for acceptance and social connection. One participant stated: "*Church gives me a sense of peace. People there pray with me and don't judge me*" (*P*4).

Thus, participants' social experiences reflected a contrast between strong family-based support and stigma or exclusion within wider social environments. 4. Navigating Healthcare Systems Participants' experiences of cancer care were shaped by difficulties accessing specialised services and by variations in communication with healthcare providers. These challenges were particularly evident in relation to travel, transportation costs, waiting times and the availability of information about diagnosis and treatment.

Participants who travelled from outside Lusaka described financial and logistical difficulties associated with attending appointments. One participant stated: "*Coming to Lusaka for every check-up is not easy. Sometimes, I don't have transport money, so I just stay home*" (*P*2). Another explained the extent to which access depended on family financial support: "*I live far away. My son pays for my transport. If he has no money, I skip the hospital*" (*P*7). Long waiting times further contributed to frustration and exhaustion. One participant stated: "*Sometimes I arrive at* 06:00, *and I'm only seen after lunch or not at all. It's exhausting*" (*P*10).

Communication with healthcare providers was mixed. Although participants valued healthcare workers who explained their condition and treatment clearly, some reported receiving limited information about their diagnosis, treatment plans and prognosis. One participant stated:

"*The doctor just told me*, '*You have* cancer,' b*ut didn't explain much. I had to ask my son to search on the internet*" (*P*5).

Another participant reported: "*I didn't even understand the kind of treatment I was getting. They just said*, '*This is what we'll do*'" (*P*9). In contrast, clear communication was associated with greater reassurance and trust. One participant described the difference between supportive and limited communication: "*One nurse told me everything step by* s*tep, and I felt better. But the next time, someone else just told me to sit and wait*" (*P*4). These accounts indicate that access barriers and inconsistent communication affected participants' experiences of cancer care.

Difficulties with transportation and waiting times could disrupt access, while inadequate information contributed to uncertainty and anxiety. Conversely, clear and compassionate communication helped participants feel more informed and supported in managing their illness.

The findings demonstrate that the lived experience of prostate cancer among men receiving care at CDH was multidimensional. Participants experienced considerable emotional and psychological distress, particularly fear of death, uncertainty about treatment and concerns about their families. These challenges were

accompanied by physical limitations and treatment-related symptoms, including fatigue, urinary incontinence, sexual dysfunction, gastrointestinal problems, pain and impaired mobility. At the social level, family support provided an important source of emotional, financial and practical assistance, while stigma, isolation and workplace discrimination created additional challenges. Finally, participants' experiences of the healthcare system were influenced by transportation and financial barriers, long waiting times and inconsistencies in communication.

4. Discussion of Findings

This study shows that living with prostate cancer at CDH involved a complex interaction between emotional distress, physical symptoms, social relationships and healthcare access. Rather than occurring as separate problems, these experiences appeared to reinforce one another. Fear and uncertainty were intensified by physical changes and limited information; physical limitations increased dependence on family; and transport and financial difficulties could disrupt access to care. This interpretation is consistent with broader evidence that prostate cancer affects multiple dimensions of men's lives and generates supportive-care needs beyond medical treatment [2] [3].

4.1. Emotional and Psychological Impact

Fear of death and uncertainty were prominent in participants' accounts. Some initially understood cancer as a death sentence, while others remained concerned about treatment failure, disease progression and their ability to remain present for their families. Chambers *et al.* similarly identified fear and uncertainty about the future among men living with advanced prostate cancer [6], while Matheson *et al.* linked psychological distress to losses involving self, physical function, social connection and control [5]. The present findings extend these observations by showing how concerns about mortality were intertwined with men's perceived responsibilities towards spouses and children.

Uncertainty was particularly evident when participants did not fully understand their diagnosis, treatment or prognosis. This suggests that psychological support cannot be separated from effective communication. Providing information that is understandable, timely and tailored to the patient's circumstances may help men make sense of the illness and participate more confidently in decisions about their care. Chen *et al.* identified specific information and communication needs among men affected by prostate cancer, supporting the importance of communication as part of supportive care [21].

Spirituality was another important coping resource. Participants described prayer and trust in God as sources of strength and reassurance. Walton and Sullivan identified praying, receiving support and coping with cancer as central dimensions of spirituality among men with prostate cancer [8]. Lepherd similarly found that spirituality could help men with advanced prostate cancer interpret their illness and sustain meaning during a difficult period [9]. The consistency

between these findings and the present accounts suggests that spirituality may have particular relevance within the Zambian context. Importantly, spirituality should be understood as a resource that participants themselves identified, rather than as a substitute for professional psychological care.

Family support also strengthened participants' ability to cope. Spouses and children provided reassurance, practical assistance and financial support. This is consistent with evidence that prostate cancer affects patients and their partners and may alter roles, communication and intimacy within relationships [19] [20]. At the same time, the extent of family assistance observed in this study may indicate the burden placed on households when formal supportive services or financial resources are limited. Family involvement should therefore be incorporated into supportive care while avoiding an expectation that relatives should replace professional services.

The findings also suggest that psychological support should be integrated into routine prostate cancer care. Evidence from psychological and survivorship interventions indicates that structured support can contribute to improved psychological well-being and quality of life among men living with prostate cancer [23] [24].

4.2. Physical Health Challenges

Physical symptoms were not experienced simply as medical complications; they influenced independence, confidence and social participation. Fatigue limited mobility and everyday activities, while urinary incontinence contributed to embarrassment and withdrawal from public and religious activities. Systematic reviews have documented persistent urinary, sexual and bowel symptoms and broader quality-of-life effects following prostate cancer treatment [10]-[12]. The present findings demonstrate how these symptoms become meaningful within men's everyday lives.

Fatigue was particularly disruptive for participants who had previously valued work, mobility and independence. Luo *et al.* identified fatigue as a common concern among men treated for prostate cancer [13], while Vashistha *et al.* found that exercise interventions may improve fatigue, quality of life and psychological outcomes [14]. In the present study, however, reduced physical capacity appeared to have consequences beyond physical discomfort, including dependence on others and a diminished sense of self. Rehabilitation and appropriately graded physical activity may therefore need to be considered alongside routine symptom management.

Urinary incontinence illustrates the interaction between physical and social experiences. Participants described carrying spare clothing and withdrawing from church because of fear of an accident. Such accounts suggest that continence problems can restrict social participation and undermine confidence.

Similarly, sexual dysfunction affected both intimate relationships and perceptions of masculinity. Goodwin *et al.* showed that masculine norms can shape emotional help-seeking among men with prostate cancer [15], while Salifu *et al.* de-

scribed disruptions to masculine identity among men with advanced disease [16].

Sexual-health counselling should therefore address emotional and relational consequences as well as physiological function. Participants also used informal strategies, including dietary modification, rest and, for some, herbal or traditional remedies. These responses demonstrate active attempts to manage symptoms, but they also point to gaps in professional support. Accessible symptom-management education, nutritional advice, continence care, rehabilitation and sexual-health counselling could help men manage treatment effects more safely and maintain independence.

4.3. Social and Relationship Dynamics

The findings reveal a dual social experience. Family relationships were strongly protective, providing emotional, financial and practical assistance, while stigma and fear of judgement contributed to concealment and withdrawal. This coexistence of support and isolation is important because the presence of family support does not necessarily eliminate the social consequences of prostate cancer.

Participants relied heavily on spouses and children for transport, treatment costs, household activities and emotional encouragement. Evidence from qualitative research involving men with prostate cancer and their partners indicates that the disease can affect roles, communication and intimacy within relationships [19] [20]. In this study, dependence on relatives also reflected functional limitations and the financial demands of treatment. Family support was therefore both a coping resource and an indicator of the wider burden of illness.

Stigma influenced disclosure and social participation. Participants described concerns about gossip, judgement and misconceptions, including perceptions that cancer was contagious. Ettridge *et al.* and Buote *et al.* similarly identified stigma, social isolation and concerns about disclosure among men with prostate cancer [17] [18]. The present findings add that treatment-related symptoms, particularly urinary incontinence, may reinforce stigma because men anticipate embarrassment in public settings.

Masculinity provides an additional lens for understanding these experiences. Reduced strength, dependence on others and sexual difficulties may conflict with expectations of male independence and sexual capability. Goodwin *et al.*

demonstrated that masculine norms can influence help-seeking [15], while Salifu *et al.* showed how advanced prostate cancer and its treatment can disrupt masculine identities [16]. Supportive care should therefore create opportunities for men to discuss identity, sexuality, emotional distress and dependence without framing these concerns as personal weakness.

Religious communities were experienced differently by different participants. While some participants withdrew from social settings because of urinary symptoms or fear of judgement, others described church as a place of acceptance and prayer. This variation suggests that community and faith-based settings can either reinforce isolation or provide meaningful social connection, depending on the

level of understanding and acceptance.

4.4. Navigating Healthcare Systems

Access to specialist cancer care was shaped by distance, transport costs, financial constraints and waiting times. Participants travelling to Lusaka sometimes depended on relatives to finance transport and reported missing appointments when that support was unavailable. These findings suggest that access is not determined solely by whether specialised services exist; it also depends on whether patients can reach and remain engaged with those services.

Family members were consequently central to continuity of care. This reliance reflects the practical importance of family support but may also shift the financial burden of cancer care to households. Supportive-care planning should therefore consider the resources required to attend appointments, particularly for patients travelling from outside Lusaka.

Communication was another important determinant of the care experience. Participants valued healthcare workers who explained treatment step by step, whereas brief or unclear explanations left some seeking information elsewhere. Chen *et al.*

demonstrated that men affected by prostate cancer have distinct information and communication needs [21]. Chambers *et al.* likewise highlighted the importance of supportive care and communication [6]. The present findings suggest that communication quality is not simply a matter of providing more information; patients need information that is understandable, individualised and delivered in a way that allows questions and concerns to be expressed.

The findings also reinforce the importance of strengthening supportive care within prostate cancer services. Mazzarello *et al.* highlighted continuing gaps in supportive-care provision for men with prostate cancer [22]. In the Zambian context, strengthening supportive care should include attention to transportation and financial barriers as well as psychosocial, informational and symptom-management needs.

Taken together, these findings support a holistic approach to prostate cancer care at CDH. Medical treatment remains essential, but participants' accounts indicate the need for integrated psychological support, symptom management, rehabilitation, sexual-health counselling, family engagement and effective patient communication. Reducing practical barriers such as transportation difficulties, financial constraints and prolonged waiting times may further improve continuity of care and men's ability to adapt to living with prostate cancer.

5. Conclusions

This study has shown that the lived experiences of men with prostate cancer extend beyond the physical effects of the disease. Participants experienced fear of death, anxiety and uncertainty, accompanied by fatigue, pain, urinary incontinence, gastrointestinal disturbances, mobility difficulties and sexual dysfunction.

These physical effects had social and psychological consequences, while stigma, reduced social participation and concerns about relationships further shaped men's experiences. At the healthcare-system level, transportation difficulties, financial constraints, long waiting times and inconsistent communication created additional barriers to care. Despite these challenges, participants demonstrated resilience through spirituality, family support and personal coping strategies such as keeping occupied and taking one day at a time.

The findings support a holistic model of prostate cancer care in which physical treatment is accompanied by psychosocial support, clear patient education, symptom management, rehabilitation, sexual-health care and attention to family needs. For CDH and similar services, strengthening communication and supportive care while addressing practical barriers to access may improve men's ability to engage with treatment and maintain quality of life.

6. Study Limitations

A strength of this study is its focus on the lived experiences of men receiving prostate cancer care at a specialised cancer institution in Zambia. The phenomenological approach and in-depth interviews provided detailed accounts of emotional, physical, social and healthcare-related experiences, including coping resources that may be less visible in quantitative research. The findings also contribute to the limited context-specific evidence on men's experiences of prostate cancer in Zambia.

However, the study was conducted at a single specialised cancer institution and included 13 participants; the findings should therefore not be interpreted as representative of all men with prostate cancer in Zambia. Purposive and snowball sampling may also have favoured men who were accessible and willing to discuss their experiences. The sensitive nature of prostate cancer, particularly issues relating to sexuality, urinary symptoms and emotional distress, may also have influenced participants' willingness to disclose some experiences.

Detailed clinical information on disease stage, treatment history and current treatment status was not systematically available for all participants at the time of analysis. Consequently, the findings were interpreted primarily from participants' accounts of their lived experiences rather than according to specific clinical subgroups. Where participants described particular treatments or treatment-related experiences, these accounts were presented as reported experiences or perceptions rather than as clinically established causal relationships.

As with qualitative research, interpretation is influenced by the research process, although bracketing, systematic thematic analysis and discussion among researchers were used to strengthen analytic rigour. The findings are therefore best understood as contextually grounded insights that may be transferable to settings with similar characteristics. Future research should consider including multiple cancer-care institutions and participants from different geographical and socioeconomic backgrounds. Further studies could also explore the experiences of

spouses and other family caregivers, as well as interventions designed to address psychological distress, treatment-related symptoms, stigma, communication and barriers to accessing specialised cancer care.

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Declaration

During manuscript preparation, the authors used Claude solely for limited language editing of selected sentences in order to improve clarity. No Al tool was used to generate research content, analyze data, interpret results, or prepare references, the ideas, arguments, and intellectual contribution of the paper are entirely original. All AI-assisted suggestions were reviewed, revised where necessary, and approved by the authors, who take full responsibility for the final manuscript.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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List of Abbreviations

CDH: Cancer Diseases Hospital HCP: Healthcare personnel