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Lived Experience Of Rural Indian Women With Low Socioeconomic Backgrounds Who Have Undergone Mastectomies For Breast Cancer

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Abstract

Back ground / Purpose

Breast cancer is now the most common cancer among women in most urban areas in India and the second most common in the rural areas. The aim of the study was to examine the lived experiences of rural women with low socioeconomic backgrounds who have undergone mastectomies for breast cancer.

Method: Using a phenomenological method, semi-structured interviews were conducted that asked about knowledge, challenges, coping and spirituality with 23 rural women from low socio-economic status and agricultural backgrounds. The interviews were analyzed for themes that described their experiences. Several themes emerged from the data. These included ignorance about the disease, feelings of guilt, financial crisis, fear of change in intimate relationships, importance of spirituality, poor support systems and financial hard-ship.

Conclusion: In India, there are very few cancer studies on rural populations yet the incidence of cancer in this population is increasing. Future studies need to focus on the rural population in order to educate them about the disease and to assist access to treatment, and psychological support. Emotional distress and lack of knowledge could be addressed by psychosocial education. Community based approaches are needed to develop culturally appropriate interventions empowering the women and enhancing their self – efficacy.

Key words: Self efficacy, Rural, Mastectomy, Cancer, Breast Cancer and Phenomenological

1. INTRODUCTION:

Breast cancer is the most common type of cancer among women, impacting over 21 million women each year and also causes the greatest number of cancer-related deaths among women [WHO, 2018]. Breast cancer affects women irrespective of age, socioeconomic status, domicile or ethnicity [Banning and Tanzila, 2014]. Life style hazards such as obesity, lack of physical exercise, drinking habits, drug addiction, hormone replacement therapy during menopause, ionization radiation in early age at first menstruation, having children late in marital life or not at all, prior history of breast cancer are considered as a cause of incidence of cancer among women [Breast Cancer Treatment NCI, 2014) Early detection is the advantageous strategy to improve breast cancer treatment outcomes and survival. The increased death rate among women with breast cancer can be attributed to reasons such as limited resource setting for screening and early diagnosis, lack of awareness regarding early signs and symptoms, and a working late referral to diagnosis and treatment and social stigma. currently some of the screening tools available for diagnosing breast cancer includes mammography, clinical breast examination and self breast examination.

Among the most type of cancers, breast cancer in the most widely studied type as it has a great impact on psychosocial aspects, high prevalence, complex and involve body part with greater significance to women and their partners [Rowland, 2009]. Hence it is very important for the health care systems to control the illness acknowledging the patients needs, hope and desire by building up a proper support plan in providing optimal care [Adler, 2008]. Breast cancer develops due to the abnormal proliferation of cells from breast tissue is generating a lump in the breast, change in breast size, unwanted secretion from the nipple, a newly inserted nipple or a red scaly patches of skin (Breast cancer NCI, 1980). There are about 18 other subtypes of breast cancer which can be clarified after taking a biopsy from concerning tissue and confirming the spread to other part though their effective treatment. The breast cancer treatment includes surgery, medication, Chemotherapy, Monoclonal Antibodies, radiation etc. followed by multi-disciplinary rehabilitation programs such as exercise, education and psychology can help women to cope up boosting their functional abilities, psychosocial adjustments and encourage social participation. [Khan et al, 2012]. The stage of breast cancer determines the effective prognosis than any other considerations. Metastatic breast cancer (i.e. spread to distant sites) results in poor prognosis and poorer survival rates.

1.1 Mastectomy and women with breast cancer:

Mastectomy is a type of surgical procedure involving the removal of the whole breast along with some of the surrounding tissue. Mastectomy, as the surgical treatment as an outcome of breast cancer treatment, results in a permanent change in the appearance of women. Though there are also alternatives available based on the desirability of the women like the breast reconstruction surgery, a type of plastic surgery, may then be performed to improve the aesthetic appearance of the operated site. Alternatively women use breast prosthesis to stimulate breast underclothing and choose a flat chest. In many cultures breast is considered a part of women identity. In India especially it represents femininity, sexuality, beauty, motherhood and feeding infants [Cebeci et al, 2011]. Mothers particularly have emotional memories connected with feeding. The loss of any of these attributes may lead to a change in body image and disturbance self worth among women [Garip, 2008]

1.2 Breast cancer and rural women:

While early screening and diagnosis is the key for successful treatment for breast cancer in women, majority of the women in rural India had not even heard of this deadly disease. This

implies the poor patient knowledge on four aspects of breast cancer like general awareness, risk factors, mammography and symptoms. Many women present themselves late to the treatment leading to failure in symptom control and disease burden. Further the rural inequalities in accessibility to healthcare, gender bias and social stigma play a very critical role to postpone an effective treatment among patients. The rural residents are less likely to get accessibility to diagnosis and treatment due to the geographical barriers to reach medical care settings. Risk is also higher in vulnerable populations like low-income racial and ethical minorities and those with low levels of education. [Martin and Vewman, 2007].Diagnosis of similar disease like cancer can cause a negative disturbance of emotions, poor self worth, guilt leading to negative body image which perceived a lost femininity and alterations in family dynamics. Keeping in mind the psychological impact, follow-up treatment and psychosocial care plays an identifying role in improving the overall survival and quality of life. Hence this phenomenological study aimed to study the real life perspectives of 26 rural women in their experience following breast cancer treatment protocol. We were interested in the following questions specifically for example what helped them to get back to their normal day to day life after mastectomy?. How were they received by the family and society? How much were the women aware of the effects of cancer and the self care? Etc.

2. METHOD:

Investigating phenomenology denotes approach to qualitative research that brings out the overall experience of a phenomenon gathered from a particular group. The fundamental goal of this approach is to arrive at a description of the nature of the particular phenomenon. [Creswell, 2013]. In-depth interviews were conducted among the patients to elicit a first handed brief knowledge about the situation to arrive at a profound understanding of the phenomena of bring out the experience of women after mastectomy.

2.1 Sample:

As we were interested in the particular lived experience of breast cancer among women living in rural agricultural backgrounds 26 women belonging to low socioeconomic status from agricultural background are purposively selected as study samples. The data were gathered using semi-structured interviews after obtaining informed consent to participate in the study. Data were collected in the regional language Tamil and were later translated into English. The researcher gathered the data until the stage of saturation point. 26 women who met the necessary inclusion criteria were selected.

2.2 Inclusion criteria

a) Women with a definitive diagnosis of breast cancer
b) Women belonging to rural agricultural background
c) Women both working and non-working
d) Treated with curative intent
e) Woman who have been diagnosed and treated of primary breast cancer treatment protocol
f) Permanent resident of the rural area

2.3 Exclusion criteria

a. Non regional language speakers
b. Women not willing to participate in the study.
c. Women belongings to stage IV cancer or were at end of life?
d. Women unaware of the diagnosis.

e. Women belonging to higher economic status and living temporarily in the rural area.
f. Indicating the demographic details of 26 rural women who participated in the study.

2.4 Data Collection:

Using purposive sampling technique 26 women who met the inclusion criteria were selected after obtaining informed consent (willingness to participate in the study). The women with the histological diagnosis of primary breast tumor who have undergone mastectomies and returned to the physician for their follow up for disease control were interviewed by the author (S.S) in the radiation oncology ward during their waiting period. It took about 45-60 minutes for the author to complete the interview and their responses were recorded and coded simultaneously. Each transcript was reread to ensure no data is overlooked. Further themes and subtheme are refined such that they bring out the clear story and capture the real experience and feelings of the women patients.

2.5 Tool for data collection:

The tool used for data collection was an interview schedule with open-ended Questions. It consists of 2 sections1) **S**tructured questionnaire-with questions about age, education, occupation, income, religion, type of family, number of children, siblings, support system and duration of disease; 2) An interview schedule with open ended questions about the lived experience of women with breast cancer.

2.6 Ethical consideration:

The proposed study was approved by the ethical committee of Tiruvarur medical Centre-Pondicherry cancer trust hospital and Annamalai University, Chidambaram. Informed consent was obtained from each study participant in their regional language Tamil before the start of data collection. Assurance was given to the subjects the anonymity of each individual would be maintained.

2.7 Data analysis:

One of the challenging tasks in a Qualitative research involves the transcription and translating of the responses as they determine the trustworthiness of the findings of the study (Birbili. M, 2000). Finally, the data collected from the participants were analyzed using Collaizzi's Phenomenological methodology, a method that ensures the credibility and reliability of the study results. (Tsai, 2004) Collaizzi's Phenomenological methodology helps in exploring the fundamental structure of an experience explored in a clear and logical way.

3. RESULTS:

Regarding the demographic variables, the majority of the women 20 (76.9) % were illiterate and 6 (23.07) % were literate. About 13 (50%) were working women and remaining 13(50%) were house wives. About 14(53.8%) came from low socioeconomic background whose monthly income was less than INR 5000 and 12(46.1%) earned more than 5000. Majority of the women 13 (50%) belonged to the age group 35-50 years about 8(30.76%) belonged to the age group of 5 to 6 years and 5(19.23%) belonged to the age group above 60 years. With respect to religion majority about 20(80.2%) were Hindus. Regarding the number of children and sibling almost all the women had more than 2 children and born with 2-3 siblings.

The themes were organized around three main categories

(1) Pre mastectomy effects
(2) Post mastectomy effects
(3) Perceived Challenges of elderly.

3.1 Pre mastectomy effects

3.1.1 Ignorance:

As reported by various studies the women in the rural are unaware of such a dreaded disease hence they ignore or unattend to the symptoms unless it caused a massive pain. Further women attribute the symptoms to the insect bite,fallacy of black magic and sorcery .misconceptions by its nature that the rural women have lesser chance of a obtaining the disease as they are not prone to lifestyle defective habits such as smoking, wear tight fitting bras, using strong soap and cosmetics. Illiteracy and insensitivity to the sociocultural affect of diagnosis and treatment is the major cause for the ignorance.

"One day as I was working in the field, an insect bit me and it developed into a lump and the doctor diagnosed it has cancer. I don't know what is cancer all these days I haven't heard of this term"

"I feel uncomfortable to talk about the disease concerning the private part (breast) to my neighbors because they might isolate me fearing that the disease might be contagious.

"I am scared to tell that I have a such a dread ful disease because people might attribute it to my sin as the cause of cancer"

3.1.2 Financial worries:

Financial worries were reported by almost all the women as they belong to low socioecomic status,daily wage earners.patients felt guilty that the treatment expense may cause financial burden leading to debts drift in the family. Many women spoke about depleting their savings and selling of their livestocks such as paddy fields, chickens, cows to over-come the financial hardship.

A few patients reported the following:

"Whatever I had been saving for all these years I am going to lose it for the treatment unfortunately"

"I feel guilty because I have a daughter to get her married but at this time I am going to be a burden to my husband and family causing unreasonable medical expense"

"I am planning to sell the livestock which I have been preserving all these years. Very unfortunate i acquired the disease I didn't do any sin''

3.1.3 Fear of reoccurrence:

Most of the women had the fear about the surgery, survivorship and living with fear for rest of their lives. Fear of reoccurrence caused restlessness ,insomnia and uneasy experience of living with breast cancer.

"I couldn't sleep properly in the nights something in me say I am going to die soon that too with pain. I don't understand what the reason I acquired the disease' "why me"?

"pain in me causes anger and am screaming at my family when they do everything for me. Am i going to depart my children helplessly? . what will they do without me''?

"Can I eat anything I wanted to as before or can I work and travel as I like did before ? the side effects of the drugs I take causes fatigue in me. ''I am not as active as earlier''

Perceptual disturbance like misperceptions, insecurity, illusions and hallucinations was the major impact of fear among the patients.

3.1.4 Spiritual attitude and existential concerns:

Spiritual attitude was an interesting theme emerged from women responses. At the beginning of uncovering, cancer diagnosis patients encountered a shock and denial that posed a critical question to the almighty "why me", but later on – in the journey of treatment the acceptance increased the hope of fighting against the disease and moved forward that

redefined the concept "purpose of life" . Patients with high spiritual wellbeing cope upped well with the disease with a positivity whereas patients with low spiritual being more likely encountered anger, frustration leading to depression and desire for hastened death. Some of the patients attributed "bad karma" (spiritual principle of cause and effect in the past as the influence of the future) is the incidence of cancer in the self.

"I believed inalmighty souly but he did not save me. may be he(almighty) is "examining me". This life is given by him so he has all right to take it away''

Another old women reported: -

All throughout my life time, I dint live comfortablely. God failed to bless me to even to obtain a peaceful death.

Another women reported: -

"I believe god" He has a reason for everyone's birth and death. Because he is the creator he has decided this suffering for me I happy to accept this.

One women reported: -

"*God has created me on this earth for a purpose. Neither men or anyone on this earth cannot change the way events will happen. Events may be good or bad all that is based on karma and it cannot be avoided".*

3.1.5 Life styles blames:

The results depicted another interesting theme namely life style blames that include patients are unaware of the reason for existence of such as disease cancer.several modifications in the lifestyle as a consequence of industrialization revolution in the form of changing food hahits,changing work routines,pollution,adulterated food may be the cause of increased prevalence of cancer. Many of them felt their ancestors who adopted the same lifestyle stayed healthy till their death.

One women reported: -

"*Till yesterday I dint have any pain or discomfort I just had this lump near my breast but today doctor says I have the dreadful disease ''cancer''. Its unbelievable….."*

Another women replied: -

"My neighbors say exposing myself too much to the sun can cause cancer in the form of radiation but our ancestors worked hard for many hours in the field they never are diagnosed with such a disease."

3.1.6 Self-attribution: -

"In my life I don't have any wrong not sin wrong not sin only one habit I have is I regularly chew the tobacco before entering the fields substitute the tiredness. Its very difficult for me to forgo this habit"

3.1.7 Geographical barriers

Many women reported that their rural domicile and lack of primary health centers with specialized doctors as the barrier to early diagnosis and treatment as they live in villages miles away from the town lacking timely transportation facilities. This appropriated to a significant theme namely the geographical barrier for late diagnosis.

"I live in a village it will take 20 kilo meters to reach the town and bus comes only twice a day and I should change 3 buses to reach the hospital. It's really hard for me to travel alone and in our town we don't have a specialized Centre for this disease".

3.1.8 Financial dependency

"I have to earn daily for my living and only if, I go to work I can feed my children I don't have pain let the lump Stay it forever" and fear of entering in to the hospital

bring about mental agony within myself. I don't have anybody to take me to Hospital for follow up. I have asked the neighbor when he is free to take me one day that time I Shall Visit the doctor."

3.2 Post mastectomy effects

3.2.1 Resilience accompanying Family vigor:

Many patients built their own resilience after the surgical procedure. Resilience can be defined as the capacity to recover from the adversity by promoting personal assets. Women with the help of the family support were able to positively adapt to the normal life. They were motivated to take up challenges and to return back to the work.

Working women said: -

"*Though god has punished me with this dreadful disease he has given me courage and confidence to overcome the distress and get back to normal. I want to go back to my work to fulfill my duties and responsibilities may be god has given a test and I passed it".*

Agricultural based working women said: -

"*I am a widow and I have two children to be taken care of. I have to work for our food daily if l am going to think about the distress caused by the disease my children may suffer due to hunger hence as soon as my radiation therapy is over I want to get back to work if am not able to do the hard work in the field I can choose some of the household work like clearing vessels etc."*

3.2.2 Benefit finding:

This is an another theme captured with women with breast cancer after mastectomy many women felt that they are happy and confident after the removal of their breast which caused so much distress in them from the time of diagnosis.

Here is an interesting response of a women which focused on the theme.

"Before the surgery and diagnosis, I had good memories of my breast by which I fed my child for years. I sometimes feel that I have lost something important but after the surgery I feel that I wanted to throw away my breast which is infected and caused so many worries in me. Now after mastectomy my sexual relation has not changed and I am least bothered about my body image."

3.2.3 Self-efficacy:

Another theme evolved post mastectomy was the increased acceptance that led to the improved faith in oneself. Further focusing on the positive rather than negative aspects in helpful to cope up with the disease effectively and also increased self-efficacy accompanied by the support extended by the family and society improved the self-management in cancer survivorship.

One of the literate women responded: -

"*This disease to me is the will of god he has some reason behind it. I have cried enough now, only thing I can do is adjust to the treatment in order to overcome the distress caused. God has given me strength to overcome this distress".*

Another house wife responded: -

"*I feel god gives trouble to people who can tolerate it and win the battle based on that he chooses me! all these day I don't care of myself I was busy sacrificing performing duties of the family now god has made me realize "I am important'' he had given me a painful rest. I have understood self-care is important".*

3.2.4 Sexual compromise and Body image:

Body image and perceived shift in sexual relationship after the removal of breast is the greatest concern for most of the women that gave rise to an emotional turbulence as according to a women breast more than an organ symbolized femininity, beauty, motherhood and attraction. Many women implied for a women breast is more than an organ as there are many sentiments, romanticism and emotionalism involved. Removal of a breast gave rise to a guilt feeling that there may a change in an intimate relationship with their partners.

A woman who is 35 years of age reported

"*At so early year of life my breast was removed and now my femininity is being challenged and on sexual attractive ness. Though my husband is supportive tome in my treatment plans I am concerned about fear of change, acceptance. In my sex life which though was so good before how can I expect it to be the same now".*

A 45 year women reported: -

"I have a difficulty in talking about this issue with my husband what he might think if am going to talk" about it after the removal of my breast. Hence report the communication challenges after mastectomy to discuss about the sexual concerns. However, age played a vital role in determining this factor. Few women reported their husbands are supportive partners are often concerned about not wanting to hurt or embarrass their partner about the removal of breast. Discussing sexual issues may be avoided with the good intention of trying to protect a partner.

3.2.5 Effectiveness of support groups:

Effectiveness of support group is essential theme that emerged from the responses as it contributes eventually to the Interventional Strategies to cope up with the disease. Almost all the women reported they felt comfortable to share their experience and feelings to a person who experienced same trauma helped them to fiddle with compassion and fellow humanity to unstrain the toughness and feel tickled.

"I understood everything about the disease from another patient who came with the same disease for treatment She explained to me about the disease and she shared her experience on how she overcame with the symptoms'' that helped me a lot in recovery and coping. We still talk in phone if I have any doubts".

3.2.6 Existential concerns:

Existential concerns are yet another theme that evolved from the experience. Social support resources are integral part to a patient's life often acting as a buffer against the psychological impact adding meaning. Value and new aspect of life.

A working woman with breast cancer reported

"*My life after the cancer diagnosis have completely changed I could hardly feel how valuable my health was, but now I want to enjoy every single moment of life cancer diagnosis had help me to discover the new meaning of life"*.

Another old woman reported: -

"*God has helped me to overcome the distress hence I want to devote myself to him. I want to help people who are suffering from cancer with informing them about their abilities and strengths. can help overcome the distress caused by the disease".*

Another women patient reported: -

"*I live in village with so many people they are born with me but they never helped me. people around me and my neighbors supported me to overcome the barriers, I now understand the reality, god has helped me to identify influence of relationship".*

3.3 Perceived Challenges of elderly

3.3.1 Impaired cognitive status

There were about five women in the study sample above the age of 60 years considered as elderly most of them were at their palliative stage with impaired cognitive status, characterizing commodities like diabetes, arthritis, Cardiovascular disorder. As aging involves greater physical impairments patients were highly distressed, reduced tolerance to stress and failure of multiple organs in the body system.

"I have tuberculosis and cancer and they removed my breast. Persistent cough cause pain in my chest. and I am not able to see properly hence I could not travel. Confusion and for getting is a part of me. There are no one to help me hence I wish to die as soon as possible".

Psycho social vulnerability

Majority of the elderly women reported loss of social relationship, limited or poor financial resources lack of home care services in rural area as the causes of end of life challenges. Perceived burden of care, loss of serenity was the most prominent theme that emerged from the interview

"*I face lot of challenges after my surgery at this age along with other symptoms like my children's and my selling support me in the treatment I feel guilty that I am a burden to them in disturbing the family function system. god shouldn't have given me this disease at my last few day of life".*

3.3.2 End of life challenges:

Yet another theme emerged from the elderly population are increased frustration, anger, low life satisfaction, existential threat, desire for hastened death and suicidal thoughts due to depression and fear of pain full-death.

"I committed suicide for more than 3 times but unfortunately I dint die. all my children's abandoned me from home now I don't have any money then one of the organization adopted me and barring financial support for the treatment. God has punished me badly I don't deserve this. I wish I should die soon. Why should I tolerate so much pain, I want to suicide myself"

4. DISCUSSION

Based on our knowledge, a very few studies in India focused on the lived experience of rural woman from agricultural backgrounds with poor socioeconomic backgrounds. Illiteracy, lack of awareness, Ignorance, Poverty, Social stigma and social misconception are the cause for women presenting themselves early to the health care system for early diagnosis and treatment. As a result women are prone to disease burden and poor quality of life. Majority of the women mis conceive the disease to be contagious and try to conceal if the symptoms persisted. setting up awareness campaigns in the rural areas can help the women to educate on the misconceptions associated with the disease. Existence of early screening programs can assist women to improve their readiness to approach the health care systems as early as possible.

The study participants explained their experience of living with breast cancer as a burden, curse, loss of serenity, living with fear, uncertainty, Fatalism, guilt before the surgery. post surgery they have learnt resilience, self management with upraised social support and human connectedness to overcome the social stigma and the distress imposed to better adapt to the disease and adjustment to treatment plan leading to better quality in cancer survivorship.

The most common reason among women for late diagnosis is the lack of pain and symptoms of the disease, fear of the trearment and high cost associated with the treatment. Geographical barrier is the second common reason for not availing trearment on time many o villages in

rural India lack specialists and advanced primary health care systems leading to poor accessibility to health care.
Indian societies also face another discrepancy in availing treatment is due to the disadvantaged concerns because of negligence in research, diagnosis and treatment of women's health care problems as women play a significant family role, disregard for women, overlooking her pain hence the treatment should be deliberated based on the humanity and not based on the gender discrimination . socially a lot of efforts is to be done to remove the conscious and the unconscious bias mandating equality irrespective of the gender in treatment.
Emotional breakdown was the immediate response among women immediately after diagnosis. However the healthcare professionals specializing in clinical aspects should also provide supportive care that address the psychosocial needs of the patients by encouraging patients to build, hope, resilience, confidence, adaptation that can help promote self love and bring in courage to fight the illness and efficient survival.
For younger women ranging from (35-50 years) breast cancer has caused psychologically negative effects conveying a great deal on body image and fear of reoccurrence ,where as for middle aged women engenders a positive change in their perspectives. however the elderly who age above 60 had worst impact due to their loss of functional control, comorbidities, poor cognitive disabilities and perceived burden of care which caused a existential crisis tied to depression, inevitably negative speculation on purpose of life, quit treatment plan and adherence to treatment.

The results indicated addressing psychosocial concerns of the patient might increase the satisfaction and decline the depression rates. Further enhancing optimism and spirituality may help build hope and positive coping strategies to reduce sense of hopelessness, anxiety, fear and psychological adjustment to cancer. Social support plays a vital role in patient's to face the challenge effectively, the efficiency of a cancer therapy lies in efficacious planning treatment plan and prompt decision making when constituted with a life threatening illness situation. Couples with intimate union will derive support from each other constructively remaining approachable comfortably for the role of care giving. Rural patients who are treated by indigenous medical professionals and quacks tend to delay the treatment and end up with advanced disease and worse prognosis leading to decrees the life expediency.
The present studies insist that along with the essentiality of follow up care, after primary breast cancer treatment such as regular laboratory test to detect metastases can improve the quality of life among survivors. Multidisciplinary rehabilitation programmes including exercise, education, encouraged social participation, improved self care can enhance the women's abilities to get well through the situation of adversity.

5. CONCLUSION:

The present study the explores the lived experience of women belonging to rural background who have undergone mastectomies for breast cancer inferred lack of education on availability of various screening programmes is major cause of ignorance. Patient advocacy and awareness campaigns has can be very successful at raising awareness of early breast cancer among the general public irrespective of the domicile. The second barrier is associated with the misconceptions and the cost of delivering care however advances in the government policy to implement screening programmes rather than appending on drugs to treat can minimize to the cost at to the health care system leading to availability of treatment at affordable price.

Establishing home care and visits in rural areas can help the elderly to over come geographical barriers, mobility restrictions and cognitive challenges .further proper address in symptom management can help the elderly to overcome conditions of comorbidities, depression and desire for hastened death.

As the majority of women reported they came to know about the dreadful disease only in television hence media can be used as a medium to disseminate information symptoms, prevalence and risk factors can promote early diagnosis and reporting utilizing BSE. understanding lived experience among patientscan help health care providers to yield proficient knowledge that meets the needs of patients overcome barriers such as income, language, social taboos, culture, education, gender, and geography highlighting every citizen has rights to access to treatment.

Study limitation & clinical implications:

Most of interviews happened in the clinical setting of oncology clinics, some patients were in hurry to visits their physicians and reach back to their places few patients failed to the participate in the interview due to psychological distress and fatigue after the radiation. Lack of interest and tiredness after the travel from long distance for medical treatment could be the cause for difficulty recruitment of participant in the study. Secondly the study was conducted among 4 districts of Tamil Nadu the small size of the study sample, like most of qualitative studies our findings are not generalizable to the broader population on all rural districts of Tamil Nadu.

Notable strength of this study include differentiation in age factor, effects of the illness, and open ended research questions in eliciting the deep layers of patient's responses and calmed patients to express their experience frankly. The study was able to bring about the challenges at end of life of the elderly and need for home care in rural areas that help in policy making to initiate home visit facilities to help the elderly.Future studies might focus on comparative study between women perspective on breast coping among urban and rural populations and effects of indigenous medicine hoax leading to disease advancement. Few studies can be done on elderly population to build better interventions to overcome the challenges met by the elders.

Conflict Of Interest

Author declared no conflict of interest during the period of the study.

Data availability statement:

The data are not publically available due to restriction containing information that could compromise the privacy of research participants. The data that support the finding of the study are available from the corresponding author, upon reasonable request.

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