Athens Journal of Health and Medical Sciences

Quarterly Academic Periodical, Volume 13, Issue 1
Published by the Athens Institute
URL: https://www.athensjournals.gr/ajh Email: journals@atiner.gr
e-ISSN: 2241-8229 DOI: 10.30958/ajhms

March 2026

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Front Pages

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The *Athens Journal of Health and Medical Sciences* (AJHMS) is an Open Access quarterly double-blind peer reviewed journal and considers papers from all areas of medicine (including health studies and nursing research). Many of the papers published in this journal have been presented at the various conferences sponsored by the Health & Medical Sciences Division of the Athens Institute for Education and Research (ATINER). All papers are subject to ATINER's Publication Ethical Policy and Statement.

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ISSN NUMBER: 2241-8229 - DOI: 10.30958/ajhms
Volume 13, Issue 1, March 2026
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Athens Journal of Health and Medical Sciences

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President's Message

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The current issue is the first of the thirteenth volume of the *Athens Journal of Health and Medical Sciences (AJHMS)*, published by the Health & Medical Sciences Division of ATINER.

Gregory T. Papanikos
President
Athens Institute

25th Annual International Conference on Health Economics, Management & Policy, 22-26 June 2026, Athens, Greece

The Health Economics & Management Unit of Athens Institute will hold its **25th Annual International Conference on Health Economics, Management & Policy, 22-26 June 2026, Athens, Greece s**ponsored by the Athens Journal of Health and Medical Sciences. The aim of the conference is to bring together academics, researchers and professionals in health economics, management and policy. You may participate as stream leader, presenter of one paper, chair of a session or observer. Please submit a proposal using the form available (https://www.atiner.gr/2026/FORM-HEA.doc).

Academic Members Responsible for the Conference

- **Dr. Paul Contoyannis**, Head, Health Economics & Management Unit, Athens Institute & Associate Professor, McMaster University, Canada.
- **Dr. Vickie Hughes**, Director, Health & Medical Sciences Division, Athens Institute & Assistant Professor, School of Nursing, Johns Hopkins University, USA.

Important Dates

- Abstract Submission: **3 March 2026**
- Acceptance of Abstract: 4 Weeks after Submission
- Submission of Paper: **25 May 2026**

Social and Educational Program

The Social Program Emphasizes the Educational Aspect of the Academic Meetings of Athens Institute.

- Greek Night Entertainment (This is the official dinner of the conference)
- Athens Sightseeing: Old and New-An Educational Urban Walk
- Social Dinner
- Mycenae Visit
- Exploration of the Aegean Islands
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4-8 May 2026, Athens, Greece

The Medicine Unit of Athens Institute is organizing its **15th Annual International Conference on Health & Medical Sciences, 4-8 May 2026, Athens, Greece** sponsored by the Athens Journal of Health and Medical Sciences. The aim of the conference is to bring together academics and researchers from all areas of health sciences, medical sciences and related disciplines. You may participate as stream leader, presenter of one paper, chair a session or observer. Please submit a proposal using the form available (https://www.atiner.gr/2026/FORM-HSC.doc).

Important Dates

- Abstract Submission: **20 January 2026**
- Acceptance of Abstract: 4 Weeks after Submission
- Submission of Paper: **6 April 2026**

Academic Member Responsible for the Conference

- **Dr. Vickie Hughes**, Director, Health & Medical Sciences Research Division, Athens Institute & Assistant Professor, School of Nursing, Johns Hopkins University, USA.
- **Dr. Carol Anne Chamley**, Head, Nursing Research Unit & Associate Professor, School of Health and Social Care, London South Bank University UK.
- **Dr. Andriana Margariti**, Head, Medicine Research Unit, Athens Institute & Lecturer, Centre for Experimental Medicine, Queen's University Belfast, U.K.

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- Ancient Corinth and Cape Sounion

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Advancing Health Equity Through Community-Centered Initiatives: Lessons from Project Ricochet's Barbershop and Beauty Salon Initiative

*By Abeni El-Amin**

This research explores the design, implementation, and outcomes of Project Ricochet's Barbershop and Beauty Salon Initiative (BBSI), a culturally grounded, community-centered public health program serving African American communities in Central Kentucky from 2023-2025. Drawing on data from 562 outreach events across 330 locations, the study provides a mixed-method analysis of how barbershops, beauty salons, and trusted community spaces can serve as critical nodes for health promotion, education, and equity. The research incorporates descriptive statistics, thematic narratives, and strategic policy analysis to assess the BBSI's impact on health behavior, community trust, and systemic engagement. Findings reveal that the BBSI model, which integrates trauma-informed care, arts-based engagement, youth leadership, and culturally responsive outreach, advances health equity not through clinical imposition, but through deep community partnership and empowerment. The research also identifies barriers and lessons learned, offering a replicable framework for other public health practitioners seeking to embed interventions in the social and cultural infrastructure of marginalized populations. The conclusion emphasizes the necessity of shifting from transactional outreach to transformational public health rooted in trust, creativity, and co-ownership.

Keywords: *health equity, community-based public health, barbershop interventions, culturally responsive outreach, trauma-informed care, African American health, arts in public health, youth engagement, public health innovation, participatory evaluation*

Introduction

Health equity, the notion that everyone should have a fair and just opportunity to attain their highest level of health, remains one of the most urgent and challenging goals in contemporary public health (Braveman et al., 2011). Across the United States, persistent disparities continue to affect historically marginalized communities, particularly African Americans, who face disproportionate burdens of chronic disease, inadequate access to care, and structural barriers to wellness. In response, public health leaders have increasingly turned toward culturally grounded, community-centered models as powerful tools to dismantle inequities (El-Amin et al., 2025). One such model is the Barbershop and Beauty Salon Initiative (BBSI), a flagship program of Project Ricochet, a nonprofit organization based in Central Kentucky, United States.

This research explores the strategies, implementation, and outcomes of Project Ricochet's Barbershop and Beauty Salon Initiative, drawing from a robust dataset of

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562 outreach reports spanning over three years, from 2023-2025. The BBSI exemplifies how culturally significant spaces, barbershops and beauty salons, can be mobilized as hubs for health education, screening, and engagement, especially within Black communities that often experience medical mistrust and underrepresentation in mainstream health systems (Fujii et al., 2024; Khanani & Haight, 2024; Khosla et al., 2024; Ruffin & Martin, 2024; Wade et al., 2024; Williams et al., 2024; Wippold et al., 2024; Tsai & McCann, 2025).

Project Ricochet launched the BBSI with a mission to reduce social drivers of health disparities by situating health promotion efforts within the trusted and familiar settings of African American barbershops and salons (El-Amin, 2025). This model was designed not only to deliver health interventions but also to honor and amplify the community leadership inherent in these spaces. Through a blend of grassroots outreach, trauma-informed care, peer mentorship, and creative arts engagement, BBSI offers a multifaceted approach to advancing health equity from the inside out (El-Amin et al., 2025).

Methodologically, this research draws from self-reported data collected through outreach forms completed by Project Ricochet staff, contractors, and community health workers (CHWs). These forms document the who, what, when, where, and how of each event, capturing both quantitative indicators (such as number of people served, event types, and locations) and qualitative narratives (including comments, reflections, and perceived pros and cons). Additionally, the research incorporates a strategic analysis of patterns in outreach geography, engagement modalities, and community responsiveness to derive actionable insights for replication and scaling.

The objectives of this research are threefold: (1) to document the scope and impact of the Barbershop and Beauty Salon Initiative; (2) to analyze the lessons learned through longitudinal data collection; and (3) to propose a strategic framework for integrating culturally responsive models like BBSI into broader health equity initiatives. As a living archive of grassroots public health in action, the BBSI dataset offers a unique lens into what community-centered health equity looks like in practice.

In an era when traditional healthcare systems struggle to reach vulnerable populations, the Barbershop and Beauty Salon Initiative reminds us that the most effective solutions often emerge not from institutional centers but from the margins, from the voices, spaces, and cultures of those most affected. This research contributes to a growing body of evidence supporting community empowerment, cultural resonance, and local leadership as the cornerstones of meaningful and sustainable public health transformation.

Literature Review: Community-Centered Health Equity and Culturally Grounded Outreach

Introduction to Health Equity Frameworks

Health equity refers to the attainment of the highest level of health for all people, emphasizing the need to reduce and ultimately eliminate disparities in health and its determinants. According to Braveman et al. (2011), health equity requires removing obstacles to health such as poverty, discrimination, and deep power imbalances, including their consequences: Lack of access to good jobs, quality education and housing, safe environments, and healthcare. The literature increasingly affirms that traditional healthcare systems alone cannot close these gaps. Instead, equity must be pursued through multisectoral, community-centered approaches that address social, economic, and cultural determinants of health (Solar & Irwin, 2010; Nass et al., 2024).

Project Ricochet's Barbershop and Beauty Salon Initiative (BBSI) aligns with contemporary health equity frameworks that call for culturally responsive, place-based strategies (Nass et al., 2024). Its embeddedness in community institutions exemplifies what the National Academies of Sciences, Engineering, and Medicine (2017) have advocated: local-level action is essential to advancing equity in health outcomes.

Culturally Responsive Public Health Models

An emerging body of scholarship highlights the effectiveness of culturally responsive models in public health promotion, particularly in racially and ethnically marginalized communities. The literature shows that culturally concordant health messaging, delivered by trusted messengers in familiar environments, can significantly increase community engagement, knowledge retention, and behavior change (Kreuter & McClure, 2004; Resnicow et al., 1999).

Barbershops and beauty salons, especially in Black communities, have long been acknowledged as culturally safe spaces where informal education, peer counseling, and resource exchange occur (Hart & Bowen, 2004). The "barbershop model" of health promotion was popularized by interventions targeting hypertension, obesity, and prostate cancer screening among African American men (Victor et al., 2018; Luque et al., 2010; Selvaraj & Sriram, 2024). These programs reported statistically significant improvements in health outcomes compared to control groups, largely attributed to the trusted status of barbers and their sustained relationships with clients. Similarly, beauty salons have been used to disseminate information about breast cancer, reproductive health, and domestic violence prevention, with salon staff trained to serve as lay health advisors (Linnan et al., 2014; Mackey, 2025). These interventions underscore the transformative potential of leveraging culturally embedded institutions as health promotion sites.

The Role of Trust and Trauma-Informed Care

Trust is an essential component of effective health communication. A substantial body of research indicates that medical mistrust, shaped by historical trauma, systemic racism, and personal experiences, remains a significant barrier to care in Black communities (Armstrong et al., 2007; Gamble, 1997). In this context, community-driven models that prioritize relational trust and emotional safety are especially valuable.

Trauma-informed care (TIC) has emerged as a key framework in addressing these challenges. Originally developed in mental health and social services, TIC principles are now being applied in community health initiatives to better understand and respond to the effects of trauma (Substance Abuse and Mental Health Services Administration, 2014). According to Harris and Fallot (2001), TIC is not about treating trauma directly, but about creating safe environments that reduce re-traumatization and promote empowerment. Moreover, programs like BBSI that integrate trauma-informed principles, such as promoting autonomy, building safe relationships, and engaging communities in decision-making, are positioned to have deeper and more sustained impacts. These approaches validate lived experiences and reduce the psychological barriers often associated with accessing care (El-Amin, 2025).

Creative Expression and Arts-Based Health Promotion

While the dominant literature on health promotion has focused on clinical interventions, there is growing recognition of the role that arts and culture play in shaping health outcomes. Arts-based health promotion harnesses creative mediums, such as visual arts, poetry, theater, and storytelling, to engage communities in conversations about health in more resonant, accessible, and emotionally expressive ways (Sonke et al., 2019). In particular, the use of participatory and community-driven art projects has been shown to foster social cohesion, reduce stigma, and elevate marginalized voices (Cohen et al., 2011). These outcomes are especially relevant in public health campaigns addressing sensitive topics such as mental health, substance use, or trauma recovery.

Project Ricochet's integration of the Urban Art Collective into BBSI illustrates this intersection of culture and health (El-Amin et al., 2025). By embedding arts programming into wellness outreach, such as poetry-based healing circles or mural projects, BBSI situates health equity within a broader framework of cultural affirmation and self-expression. These activities align with Freirean theories of critical consciousness, where individuals become aware of social injustices and are empowered to act through dialogic engagement and creative production (Freire, 1970).

Youth Engagement and Intergenerational Health Equity

Youth engagement is increasingly recognized as a key strategy for sustainable community health transformation. Scholars argue that involving young people in health advocacy fosters a sense of agency, builds leadership skills, and ensures that public health messaging is generationally relevant (Cargo et al., 2003; Zimmerman et al., 1992). Youth-led participatory action research (YPAR) and peer-to-peer education

models have been especially effective in tobacco prevention, sexual health, and mental health promotion.

Project Ricochet's Ricochet Squad Public Health Academy, an extension of BBSI that trains youth as peer health advocates, reflects this best practice. It mirrors broader trends in adolescent health engagement, such as the Truth Initiative's use of youth ambassadors in tobacco control. The involvement of young people in BBSI activities also fosters intergenerational dialogue, which has been linked to greater health knowledge transfer and strengthened community resilience (Ginwright, 2010).

Evaluation and Community-Based Participatory Research

A final thread in the literature concerns evaluation and accountability in community-based public health initiatives. Traditional research methods have often excluded the voices of community members or imposed rigid, top-down metrics of success. In response, community-based participatory research (CBPR) has emerged as an ethical and epistemologically grounded approach that centers lived experience and promotes shared ownership of data (Minkler & Wallerstein, 2008).

CBPR emphasizes iterative learning, co-design, and mutual benefit, all of which are evident in BBSI's data collection practices. While the outreach forms used in the initiative are not formal research instruments, they reflect a grassroots commitment to reflection, documentation, and continuous improvement. They serve as a tool for internal learning, community storytelling, and funder accountability, striking a balance that is increasingly advocated in equity-focused evaluation literature (Fetterman & Wandersman, 2005).

Summary

The literature reviewed affirms that Project Ricochet's Barbershop and Beauty Salon Initiative is firmly situated within a robust, interdisciplinary tradition of culturally grounded, community-led public health. Its alignment with trauma-informed care, creative engagement, intergenerational leadership, and participatory evaluation positions it as both an innovative local intervention and a model of national relevance.

In an era where health disparities are compounded by political, economic, and social upheaval, BBSI offers a pathway forward, one that is built not from the top down, but from the inside out, through culture, connection, and community power

Methodology

This research is grounded in a mixed-methods analysis of data collected from Project Ricochet's Barbershop and Beauty Salon Initiative (BBSI), with a specific focus on 562 outreach events documented through standardized reporting forms. These forms were completed by Project Ricochet staff, contractors, community health workers (CHWs), and peer mentors who conducted or supported events across Central Kentucky.

The data captures both quantitative and qualitative dimensions of community outreach. Quantitative fields included:

- Event date and location
- Event type (e.g., barbershop, beauty salon, outreach-on-the-go, virtual)
- Estimated number of participants
- Materials distributed (e.g., t-shirts, Quit Kits, health literature)

Qualitative components include open-ended questions that prompt respondents to describe what occurred, highlight perceived pros and cons, suggest improvements, and reflect on community reactions. These narrative entries provide rich contextual insights into community dynamics, outreach effectiveness, and personal interactions that would not be visible through numerical data alone. Data were collected between the years 2023 and 2025. The dataset was cleaned to correct formatting inconsistencies and anonymize any personally identifying information, ensuring compliance with ethical standards for public health documentation.

The analysis proceeded in two main phases:

1. Descriptive statistical review to determine program reach, frequency of event types, geographic distribution, and engagement levels.
2. Thematic coding of narrative responses to identify recurring patterns related to trust-building, participant outcomes, barriers to engagement, and the role of arts and culture.

While the dataset offers a powerful window into the scale and texture of the BBSI's work, it is not without limitations. Variability in how forms were completed, especially in narrative detail and numerical estimates, introduces a degree of subjectivity and inconsistency. Some outreach staff completed forms with detailed insight, while others left multiple fields blank or repeated phrasing. Additionally, participant demographic data (age, gender, socioeconomic background) was often omitted or generalized, limiting the granularity of subgroup analysis.

Nevertheless, the outreach forms represent a living archive of on-the-ground health equity work. They are not merely tools of accountability, but reflections of relationships, stories, and micro-interventions that collectively build toward systemic change. The methodology reflects Project Ricochet's commitment to community-centered learning and positions this research as a case study in embedded, participatory public health documentation.

The descriptive statistical review of the BBSI outreach dataset indicates:

- Total Events: 562
- Total Estimated Participants: 6,781
- Average Participants per Event: 14.34
- Number of Unique Event Types: 55
- Most Common Event Type: Barbershop
- Number of Unique Locations: 330
- Events with T-Shirts Distributed: 363

A descriptive statistical review of the BBSI outreach dataset reveals substantial program reach and diversity. The initiative conducted a total of 562 events across 330 unique locations, engaging an estimated 6,781 community members. The average attendance per event was approximately 14 participants, underscoring the initiative's ability to facilitate both intimate and large-scale engagements. Notably, barbershops were the most common setting for these events, aligning with BBSI's culturally grounded approach. Among 55 distinct event types logged, barbershops consistently served as trusted, high-traffic environments for health discourse. Furthermore, t-shirts, often used as culturally resonant health promotion tools, were distributed at 363 events. This data confirms not only the scope of BBSI's efforts but also its strategic alignment with place-based and peer-led health promotion models.

Historical and Cultural Foundations of the BBSI Model

To understand the significance of Project Ricochet's Barbershop and Beauty Salon Initiative (BBSI), it is essential to examine the rich historical and cultural contexts that make barbershops and salons such powerful conduits for public health work (El-Amin, 2025). These spaces are not simply places for grooming; they are deeply embedded in the social fabric of Black communities. Historically, Black barbershops and salons have served as safe havens for dialogue, cultural affirmation, political discourse, and informal mentorship. They are community anchors where intergenerational knowledge is exchanged, and where health and social concerns are often aired long before a doctor's visit is even considered.

In the African American experience, barbershops and beauty salons emerged not only as economic enterprises but as institutions of resilience and resistance (Ruffin et al., 2024). During eras of segregation and systemic exclusion from mainstream economic opportunities, these establishments offered rare avenues for Black entrepreneurship and self-determination. They provided more than jobs; they provided purpose, platforms, and power within neighborhoods that were often underserved or marginalized by public institutions. Their owners and operators were trusted leaders, advisors, counselors, and role models, whose influence extended far beyond the styling chair.

Public health advocates began to recognize this influence in the late 20th century, sparking a wave of community health interventions conducted within barbershops and salons (Victor et al., 2018). From hypertension screenings to HIV education to cancer awareness, these initiatives were early attempts to meet people where they were, both physically and culturally (Fujii et al., 2024; Mackey, 2025). Studies consistently found that health interventions delivered in barbershops and salons yielded higher engagement and retention rates than those conducted in clinical or government settings. This success is largely attributable to the atmosphere of trust and familiarity these spaces provide.

Project Ricochet's BBSI builds upon this legacy with a strategic and holistic model that integrates public health, arts, culture, and grassroots activism. Unlike temporary or pilot programs, BBSI is sustained through long-term partnerships with barbers and stylists who are trained not just as service providers but as community

health advocates. These partners are equipped with knowledge, tools, and resources to recognize public health risks, initiate sensitive conversations, and refer individuals to appropriate services.

The choice to root the initiative in cultural spaces also reflects a broader shift toward asset-based approaches to community development. Rather than viewing underserved communities through a deficit lens, BBSI acknowledges and leverages existing community strengths, like the cultural capital of barbershops and salons, as foundations for health promotion. This reframing transforms these spaces into proactive agents of change, rather than passive recipients of intervention. Furthermore, the BBSI model incorporates trauma-informed principles, recognizing that many community members have experienced adverse social conditions such as poverty, racism, violence, and discrimination within healthcare settings. By placing health outreach in environments that are culturally affirming and emotionally safe, BBSI mitigates barriers to trust and enhances the likelihood of long-term behavior change.

In summary, the historical and cultural foundations of the Barbershop and Beauty Salon Initiative are not just background context; they are integral to its design and success. The program draws its strength from the lineage of community resilience, cultural pride, and entrepreneurial spirit that barbershops and salons represent. By honoring this legacy, Project Ricochet ensures that its public health interventions are not only effective but also empowering and enduring.

Program Scope and Demographics

The reach of Project Ricochet's Barbershop and Beauty Salon Initiative (BBSI) reflects its expansive vision and deep-rooted commitment to community-centered health equity. According to outreach data collected through 562 documented events, the program has been implemented across 14 distinct geographic locations in Kentucky. These include both urban centers and smaller communities, reflecting a deliberate effort to reach Black populations in both densely populated and rural or semi-rural areas. From Lexington-Fayette County to Jefferson County, Kentucky, the BBSI has embedded itself in diverse contexts, responding to local needs with tailored outreach strategies.

The breadth of engagement is further evidenced by the sheer number of unique barbershops, beauty salons, and community venues involved: over 330 unique outreach locations were logged in the database. These included permanent partner sites, pop-up outreach stations, and virtual meetings, suggesting a flexible model that adapts to varied community rhythms. The initiative's ability to pivot between physical and virtual spaces demonstrates its agility in the face of logistical and public health challenges, particularly during and following the COVID-19 pandemic.

The human capital behind BBSI is equally compelling. With over 35 unique outreach staff and peer mentors recorded, the program benefits from a wide range of community voices and lived experiences. These individuals, many of whom are barbers, stylists, local leaders, or trained CHWs, represent the initiative's greatest asset: trusted messengers embedded in the cultural and emotional lives of the

communities they serve. Their presence lends authenticity to the outreach process and ensures that interventions are not only heard but embraced.

The timeline of engagement captured in the data spans over three years from 2023-2025. These data entries underscore the long-standing nature of Project Ricochet's presence in the region. The consistent reporting from 2023 onward shows concentrated and strategic scaling, particularly as public health systems grappled with pandemic-era disparities and systemic health failures. Likewise, one of the most illuminating aspects of the dataset is the diversity of event types. While the most common setting was the barbershop, events were also held at beauty salons, community-based organizations, faith-based organizations, recovery centers, re-entry programs, and educational spaces. This diversity reveals BBSI's intentional design to intersect with multiple social determinants of health, from economic opportunity and criminal justice to education and mental health (Khanani & Haight, 2024). Moreover, the program often partnered with other local initiatives, including youth programs, feeding programs, and recovery events, weaving itself into the broader fabric of community wellness.

In terms of community reach, engagement estimates varied across events, with some reporting interactions with 1-5 individuals and others engaging over 500 participants. This range indicates that BBSI is both high-touch and high-volume: Capable of creating intimate conversations in a single barbershop chair or convening large-scale outreach efforts in public parks and schools. The program's scalability is thus not just theoretical but evidenced in practice. Demographically, although the dataset does not always specify age, gender, or socioeconomic indicators, narrative comments frequently mention interactions with youth, seniors, returning citizens, and those experiencing food insecurity or homelessness. This suggests that the BBSI is not limited to a singular demographic profile but rather operates with an inclusive and intersectional lens. Its core focus on African American communities is preserved throughout, yet its adaptability allows for multi-dimensional impact.

Overall, the scope and demographic reach of the BBSI reflect a model that is both grounded and expansive. By meeting people in their everyday environments and empowering community leaders to be agents of health equity, Project Ricochet ensures that its interventions are not merely broadcast but rooted, embedded in the people, places, and histories that define local life. This section establishes the scale of the program and sets the stage for a closer look at how BBSI operates on the ground through its diverse and dynamic outreach activities.

Types of Outreach Activities and Community Engagement

The Barbershop and Beauty Salon Initiative (BBSI) thrives on its diverse repertoire of outreach activities that are designed to meet the community where it is, both literally and figuratively. Central to the success of BBSI is its dynamic engagement strategy, which encompasses formal events, informal conversations, educational workshops, pop-up services, and collaborative programs with external partners. Each activity is intentionally shaped to align with the needs of the community and the strengths of its cultural institutions.

A review of the 562 documented outreach events reveals a wide variety of engagement formats. At the core are in-shop health dialogues, interactions that occur organically during daily business within barbershops and salons. These conversations often center on topics like hypertension, cancer, diabetes, mental health, tobacco cessation, nutrition, and sexual health (Wade et al., 2024). Staff and peer mentors use toolkits, posters, and printed literature to facilitate these discussions, transforming casual encounters into moments of education and empowerment.

Beyond these conversations, BBSI also supports structured health screening events. These include blood pressure checks, glucose monitoring, body mass index assessments, and referrals to primary care providers. Many of these screenings are conducted in partnership with local clinics or public health departments, emphasizing BBSI's collaborative model. The presence of trusted community members at these events mitigates fear or skepticism, encouraging participants to engage with services they might otherwise avoid.

One notable innovation is the "Outreach-on-the-Go" model, mobile engagement sessions designed to serve individuals outside of shop settings, such as in parks, community fairs, apartment complexes, and street corners. These events often involve handing out Quit Kits, hygiene supplies, condoms, informational brochures, and culturally tailored promotional items like branded t-shirts (Cochran et al., 2025). The flexible and mobile nature of these engagements ensures BBSI can reach individuals who may not regularly visit salons or barbershops.

Educational sessions are another cornerstone of the initiative. Several outreach forms describe workshops focused on dietary health, stress reduction, parenting skills, and substance use prevention. These sessions often incorporate storytelling, peer sharing, and arts-based activities, such as spoken word poetry or painting, led by Project Ricochet's Urban Art Collective (El-Amin et al., 2025). The integration of creative expression into public health education not only sustains interest but also creates a non-judgmental space where complex and sensitive issues can be explored.

Youth engagement has become an increasingly central theme, especially through collaborations with the Ricochet Squad Public Health Academy and other youth-oriented programs. Events such as "Youth Healing Circles" and "Mentorship Mixers" foster intergenerational dialogue and build leadership skills among young people. These youth champions serve as liaisons between their peers and the broader health system, echoing the initiative's ethos of community empowerment from within.

The database also documents community listening sessions and family empowerment events, wherein facilitators solicit feedback from residents and co-design solutions with them. These participatory practices reinforce the idea that community engagement is not a one-way transmission of knowledge but a shared process of learning and transformation.

Additionally, across all outreach modalities, a consistent theme emerges: trust. Whether through one-on-one conversations or group events, the foundation of BBSI's success lies in the relationships built with community members over time. Many comments in the outreach forms underscore the importance of "being present," "showing up consistently," and "building rapport" as critical to fostering meaningful dialogue and behavior change. In sum, the types of outreach activities facilitated by the BBSI are as varied and vibrant as the communities they serve. By

utilizing a culturally competent, trauma-informed, and relationship-centered approach, Project Ricochet ensures that its outreach efforts are not only informative but also transformational (Armstrong et al., 2007; Gamble, 1997). The next section will explore how these engagement strategies translate into concrete impacts and community-level outcomes.

Impact Narratives and Outcomes

The true measure of the Barbershop and Beauty Salon Initiative's (BBSI) effectiveness lies not only in its scale but in the stories and tangible outcomes that emerge from its engagements. Through 562 recorded events, Project Ricochet has collected a wealth of qualitative reflections, community testimonials, staff insights, and anecdotal reports that reveal the deep and multifaceted impact of the initiative. These narratives offer a powerful counterpoint to purely statistical evaluations, capturing the lived experiences of individuals whose health trajectories and sense of community have been meaningfully altered by BBSI.

A recurring theme in these reflections is the restoration of trust. Many participants noted that they felt "seen," "heard," and "valued" during outreach events, particularly those who had previously experienced marginalization in healthcare settings. One report described a conversation in a Georgetown, Kentucky salon where a client, initially skeptical, contributed a personal experience about untreated hypertension after a stylist gently encouraged a screening. That moment, facilitated by a peer mentor and rooted in a familiar, culturally safe environment, led to a referral to a nearby clinic and follow-up care. Another account from a "Health Talk" in Fayette County, Kentucky, detailed a young man who had never spoken to a medical provider but was willing to discuss his anxiety and sleep problems with a barber he trusted. That barber, trained through BBSI, introduced the young man to a CHW who helped him access behavioral health services. In this and other stories, barbers and stylists are not passive participants but active agents of health transformation, gateways to healing.

Many outreach reports highlighted the ripple effects of youth involvement. At an event hosted in collaboration with a local youth empowerment program, teenagers led a presentation on vaping prevention (Wade et al., 2024; Cochran et al., 2025). A staff comment noted, "The youth were energized and took ownership. It made the adults pay more attention." These moments illustrate how intergenerational leadership is fostered through the program, with young people not only learning but teaching, challenging stereotypes about health engagement in Black communities.

The program's embeddedness in the community also fosters sustainability and long-term impact. A series of outreach events in Bourbon County, conducted in collaboration with a local feeding center, resulted in regular weekly check-ins between residents and Project Ricochet mentors. Over time, this consistent presence created a trusted support system for individuals facing food insecurity, housing instability, and chronic health issues. One mentor wrote, "They look forward to seeing us every week. It's not just outreach anymore, it's a relationship."

Beyond individual anecdotes, broader community outcomes have been observed. For example, after repeated BBSI presence in a particular salon, a local health department initiated a formal partnership with Project Ricochet to co-host wellness fairs. In another instance, a re-entry program for formerly incarcerated individuals integrated barbershop outreach into its core services, recognizing its value in bridging health and justice systems. These institutional responses show how grassroots initiatives can catalyze systemic change when given the time and support to flourish. Notably, the program does not ignore its limitations. Some reports acknowledged low turnout at certain events or difficulty engaging specific populations, such as older men who were hesitant to discuss mental health. These candid reflections are essential, as they inform ongoing adaptation and highlight the importance of continuous community feedback loops.

The initiative has also inspired a sense of pride and purpose among participating barbers and stylists. One participant reflected, "I used to think I just cut hair. Now I know I'm a healer too." This reframing of professional identity is a critical outcome of BBSI, one that elevates the cultural and emotional labor of these community leaders and positions them as integral to public health infrastructure. Ultimately, the impact of the Barbershop and Beauty Salon Initiative is not confined to health outcomes alone. It is about reweaving the social fabric, empowering everyday people to care for each other, and creating spaces where wellness is defined not by institutions but by communities themselves. These narratives are not just evidence; they are the heartbeat of a movement grounded in equity, dignity, and collective healing.

Barriers, Limitations, and Lessons Learned

While the Barbershop and Beauty Salon Initiative (BBSI) has demonstrated compelling successes in community engagement and public health promotion, it has also encountered a range of barriers and limitations that offer important lessons for future implementation and scaling. Acknowledging these challenges does not diminish the initiative's value; instead, it reveals the complexity of community-based work and underscores the need for adaptive, reflexive strategies.

One persistent challenge is outreach saturation. In some areas, especially those with smaller populations or limited numbers of barbershops and salons, community members reported seeing repeated messaging or feeling over-contacted (Williams et al., 2024). While consistency is key to relationship-building, these reports emphasize the importance of rotating engagement strategies and ensuring content remains relevant, timely, and responsive to evolving community needs. Logistical challenges also presented recurring obstacles. Some events were disrupted due to scheduling conflicts, transportation issues, or a lack of access to private space for health screenings. Others faced complications related to weather or poor communication with partner venues. These practical barriers reflect the necessity of robust event planning protocols and backup plans. Additionally, consistent training for outreach staff in communication and adaptability emerged as a critical success factor in overcoming such barriers.

Data collection inconsistencies were another limitation. Although the outreach forms provided rich qualitative insights, not all reports were completed with equal thoroughness. In some cases, demographic details, attendance figures, or follow-up actions were missing, making it more difficult to quantify outcomes across the full program timeline. This challenge suggests a need for ongoing training in data literacy and more standardized expectations for reporting. Engaging specific subpopulations also proved difficult in certain contexts. For instance, older men were sometimes hesitant to discuss mental health topics, while youth engagement fluctuated depending on school schedules and competing community events. Language barriers, digital divides, and cultural stigmas around certain health issues also influenced participation levels. Addressing these barriers requires intentionality, including multilingual resources, cross-sector collaborations, and culturally nuanced messaging.

Another lesson involved the emotional toll of outreach work on staff. Several comments reflected experiences of burnout, emotional fatigue, or frustration when efforts did not result in immediate change. This highlights the need for institutional support systems, including mental health resources, debriefing sessions, and regular recognition of outreach workers' contributions. The relational nature of BBSI's work is both its strength and its vulnerability, requiring sustained investment in staff well-being. Partnership management also presented mixed results. While many events featured prolific collaborations, others revealed tensions related to overlapping responsibilities, unclear expectations, or misalignment in organizational values. These challenges point to the importance of formalized partnership agreements, transparent communication, and shared leadership structures that respect the contributions of all parties involved.

Despite these barriers, the initiative generated several powerful lessons. First, flexibility is indispensable. The most successful outreach events were those where teams adapted to the moment, whether shifting a health talk outdoors due to space issues or engaging youth in an impromptu art activity when a scheduled facilitator canceled. This responsiveness is only possible when teams are empowered with autonomy and trust.

Second, authenticity is a non-negotiable asset. Community members can discern between performative outreach and genuine investment. The most impactful engagements were led by individuals who reflected the communities they served, spoke the language of the culture, and were committed to building long-term relationships rather than extracting data or delivering one-off interventions.

Third, evaluation must evolve alongside programming. Rather than relying solely on attendance counts or distribution metrics, BBSI benefited most from reflection-oriented feedback, questions about what shifted, what surprised, and what was learned. Embedding this kind of inquiry into outreach culture fosters a continuous improvement mindset that honors both successes and setbacks.

Ultimately, the BBSI model is not without its limitations, but it remains a testament to what is possible when health equity efforts are rooted in cultural relevance, community ownership, and deep listening. The lessons learned through its implementation serve as a roadmap for other initiatives seeking to move beyond transactional outreach toward transformational change. Next, the next session will explore how these lessons inform a strategic analysis of BBSI's contributions to the broader field of health equity.

Strategic Analysis for Health Equity Advancement

The Barbershop and Beauty Salon Initiative (BBSI) offers a replicable and scalable model for advancing health equity through culturally grounded, community-centered strategies. As a comprehensive outreach framework that integrates public health, the arts, grassroots mobilization, and trauma-informed principles, BBSI serves as both a practical intervention and a conceptual model. This section presents a strategic analysis of how the initiative contributes to the broader field of health equity and outlines the elements that make it effective, resilient, and adaptable.

At its core, BBSI exemplifies an asset-based approach to health promotion. Rather than framing Black communities as passive recipients of care, the initiative recognizes and mobilizes existing assets, trusted barbers and stylists, culturally significant spaces, intergenerational relationships, and local leadership. This framework shifts the narrative from deficits to strengths, making health promotion more relevant, empowering, and sustainable.

BBSI also operationalizes trauma-informed care in a way that is both subtle and powerful (Armstrong et al., 2007; Gamble, 1997). Outreach staff and peer mentors are trained to recognize the signs of trauma and approach conversations with empathy, patience, and respect for boundaries. By creating emotionally safe environments, BBSI enables participants to engage with health messages without feeling pathologized or judged. This approach is particularly vital in communities that have experienced historical trauma, medical racism, or social exclusion. Another key strategy is the initiative's integration of creative expression and public health. Through its collaboration with Project Ricochet's Urban Art Collective, BBSI leverages visual art, poetry, storytelling, and interactive installations to engage audiences in accessible and emotionally resonant ways (El-Amin et al., 2025). These creative elements are not ornamental; they are fundamental to BBSI's success in making health discourse inviting, participatory, and identity-affirming.

BBSI's cross-sector partnerships further enhance its strategic value. The program routinely collaborates with public health departments, recovery programs, youth organizations, faith institutions, and educational systems. These partnerships enable resource sharing, co-referral systems, and co-created programming that strengthen the public health infrastructure in under-resourced communities. Importantly, these collaborations are not extractive; they are built on mutual respect and reciprocity.

The initiative also models a distributed leadership structure. Rather than centralizing authority, BBSI empowers barbers, stylists, youth mentors, and community health workers to act as co-leaders and co-designers. This structure increases community buy-in, decentralizes expertise, and ensures cultural relevance at every stage of planning and implementation. It reflects a commitment to equity not only in outcomes but in process.

From a systems-level perspective, BBSI aligns with many of the key priorities identified by United States national health equity frameworks, including Healthy People 2030 and the CDC's Social Determinants of Health model. It addresses domains such as healthcare access, neighborhood and built environment, social and community context, and education. Yet it does so in a uniquely community-driven way, offering an on-the-ground complement to top-down policy initiatives.

The strategic adaptability of BBSI is another important asset. The program has demonstrated the capacity to evolve in response to emerging challenges, such as the COVID-19 pandemic, which necessitated shifts to virtual outreach, distribution of PPE, and conversations about vaccine access. This flexibility is a hallmark of resilient public health programming and one that positions BBSI for long-term sustainability. Crucially, BBSI is data-informed without being data-obsessed. The initiative collects both quantitative and qualitative data to guide decision-making, evaluate effectiveness, and report to funders. But it also honors the nuances and narratives that data alone cannot capture. This balanced approach fosters accountability while preserving the relational and cultural integrity of the work.

As other communities seek to replicate or adapt BBSI, several strategic pillars stand out:

1. **Cultural resonance**: Interventions should be grounded in the values, histories, and aesthetics of the communities they serve.
2. **Trusted messengers**: Health communication is most effective when delivered by individuals who have earned community trust.
3. **Flexibility and responsiveness**: Programs must be able to pivot quickly in response to feedback, crises, or changing needs.
4. **Creative integration**: The arts and culture are not side projects; they are central to holistic health and community engagement.
5. **Shared leadership**: Decision-making and program design should include diverse community voices at every level.

In conclusion, the Barbershop and Beauty Salon Initiative is not just a local innovation; it is a strategic framework with national relevance. It offers a blueprint for health equity work that is grounded, participatory, and profoundly human. As health systems across the country grapple with how to close equity gaps, BBSI provides a compelling case study in what is possible when community wisdom leads the way. The next section will explore how BBSI's data practices and reporting methods contribute to program evaluation, accountability, and continuous improvement.

Data-Informed Program Evaluation

An essential element of Project Ricochet's Barbershop and Beauty Salon Initiative (BBSI) is its intentional use of data to drive decision-making, assess impact, and refine strategy. While the initiative is deeply rooted in cultural responsiveness and relational outreach, it is equally committed to accountability and continuous improvement through evidence-based evaluation (Fetterman & Wandersman, 2005). This dual commitment ensures that the program not only feels right to the community but also proves effective to funders, stakeholders, and public health partners.

The primary data source for this research, the outreach forms, illustrates a robust and adaptable system for qualitative and quantitative program monitoring. These forms were completed by BBSI staff, peer mentors, and outreach coordinators following each event. They capture critical metrics such as event type, date, location,

estimated number of participants, staff involved, and distribution of educational or health promotion materials. More importantly, they include narrative responses that detail what occurred at the event, what went well, what could have gone better, and reflections on community feedback.

These open-text reflections offer insights not captured in standard evaluations. For example, while one event may report only five participants, the comments may indicate that one of those participants received a life-saving health referral or shared the information with ten others. This qualitative layer brings depth and nuance to the metrics, demonstrating that impact is not always a matter of volume but of connection and influence.

The structure of the outreach forms also enables pattern analysis across time, geography, and outreach modality. From a strategic standpoint, the dataset revealed high levels of engagement in certain neighborhoods, consistent participation by specific barbers and stylists, and noticeable upticks in community turnout when events were paired with arts or food distribution activities. These insights inform program planning by highlighting what works, where gaps exist, and which approaches are most resonant with different demographics.

BBSI's reporting also supports real-time adjustments. For instance, when multiple forms noted difficulty engaging older male participants in health discussions, the team responded by introducing barbershop-centered storytelling sessions that addressed masculinity and vulnerability. Similarly, when data showed youth turnout dropping in summer months, the program added seasonal activities that incorporated art, games, and wellness challenges. This level of responsiveness reflects an agile evaluation culture that values learning as much as it values outcomes. Importantly, the outreach forms also function as documentation for grant reporting and stakeholder communication. The ability to quantify impact while also providing compelling stories strengthens the initiative's funding case and appeals to a wide range of partners, from traditional public health funders to culturally specific arts organizations. The integration of evaluation into day-to-day programming, not just as a bureaucratic necessity but as a learning tool, sets BBSI apart from many initiatives where evaluation is viewed as an external burden.

Challenges remain, of course. Inconsistent completion of forms, variability in data detail, and lack of standardized participant demographics occasionally limit the analytic potential of the dataset. Project Ricochet has responded to this by piloting digital reporting tools, offering ongoing training to staff and contractors, and refining form questions to enhance clarity and utility. These iterative improvements underscore the program's commitment to not just doing the work but documenting it in a way that facilitates growth.

As BBSI continues to evolve, there is increasing potential to integrate even more robust evaluative practices. This includes pre- and post-engagement assessments for participants, longitudinal tracking of community outcomes, and greater integration with local health data systems. However, any expansion must maintain the core ethic of the program: Honoring the community's voice, preserving cultural integrity, and valuing lived experience as a legitimate and powerful source of evidence.

In sum, BBSI's evaluation framework reflects a balance of rigor and relevance. By embedding data practices within a relational model of care, Project Ricochet ensures that its outreach is not only measurable but meaningful. This evidence-based approach allows the program to adapt, grow, and advocate for broader systemic change with credibility and confidence. The following section will address how this model informs policy, funding strategies, and equity-centered sustainability efforts.

Policy Implications and Funding Strategies

Project Ricochet's Barbershop and Beauty Salon Initiative (BBSI) is not only a model for effective health equity programming at the grassroots level, but also a beacon for informing broader public health policy and sustainable funding strategies. The lessons derived from the initiative's community-driven framework offer critical insights into how policy and philanthropy can support, replicate, and scale culturally resonant public health models.

One of the clearest policy implications of BBSI is the value of integrating community-based organizations and culturally specific institutions into the formal public health ecosystem. Barbershops and beauty salons are often excluded from conversations about health infrastructure, yet BBSI demonstrates that these spaces function as informal health access points for communities historically marginalized by mainstream institutions. Policymakers at local, state, and federal levels should recognize these institutions as legitimate health partners and design funding mechanisms that support their engagement in prevention, screening, and education efforts.

To that end, public health departments can adopt more inclusive funding strategies by embedding line items for community partner stipends, training, and technical assistance. BBSI's success relies heavily on the sustained involvement of barbers, stylists, and peer mentors who are compensated for their time, labor, and expertise (Ruffin & Martin, 2024). Institutionalizing these roles through policy would not only validate their contributions but also create pathways for workforce development in underserved communities. Another key policy recommendation involves the integration of trauma-informed care into public health practice (Armstrong et al., 2007; Gamble, 1997). While often framed as a clinical concern, BBSI reveals the broader applicability of trauma-informed principles in community outreach. Policies that require or incentivize trauma-informed training for public health workers and community-based contractors would support more ethical and effective engagement with populations experiencing cumulative disadvantage.

BBSI also provides a compelling argument for the inclusion of arts and culture within public health funding streams. The initiative's use of creative expression to communicate health messages and foster healing is not an auxiliary feature; it is central to its impact. Policymakers and funders alike must recognize that health equity is not achieved solely through medical intervention, but through holistic approaches that address emotional, spiritual, and cultural well-being (Nass et al., 2024). From a funding strategy perspective, BBSI has thrived through a blend of private philanthropy, local government support, and in-kind contributions. However, reliance on short-term or restricted grants poses sustainability risks. Multi-year, unrestricted funding is essential

for allowing programs like BBSI to innovate, adapt, and respond to emergent community needs. Funders must shift from metrics-driven, output-based models toward more trust-based philanthropy that prioritizes community-defined success and long-term relationship-building. Additionally, funders should consider the replicability of the BBSI model and invest in infrastructure to support its expansion. This includes training toolkits, technical assistance for new sites, and seed funding for pilot programs in other regions. Project Ricochet has already demonstrated a capacity for adaptation across geographic and demographic contexts; targeted investment could amplify its reach while preserving its locally grounded ethos.

Another significant opportunity lies in aligning BBSI with broader public health priorities such as tobacco cessation, chronic disease prevention, and mental health promotion. By framing BBSI within these national and state-level agendas, Project Ricochet can position the initiative as a key implementation partner for health departments and managed care organizations. This alignment opens pathways for Medicaid reimbursement, contract-based service delivery, and interwoven funding models that leverage multiple sources to sustain operations. Importantly, any policy or funding strategy must respect the autonomy and leadership of the community. The power of BBSI lies in its authenticity and its rootedness in cultural identity. Scaling or institutionalizing the model must not dilute its essence. Policymakers and funders must engage in genuine co-design processes, center community voices, and maintain accountability to those most impacted. As a result, the Barbershop and Beauty Salon Initiative offers a strategic roadmap for integrating equity into policy and funding frameworks. It challenges institutions to rethink where health happens, who leads it, and how it is funded. By supporting initiatives like BBSI, Project Ricochet invests not just in better health outcomes but in stronger, more connected, and more resilient communities. The final section will synthesize these insights into a unified call to action.

Conclusion: A Call to Action

The Barbershop and Beauty Salon Initiative (BBSI) is more than a public health program; it is a model of transformative engagement rooted in cultural relevance, relational trust, and grassroots empowerment. Through its work in barbershops, beauty salons, and other community-centered spaces, Project Ricochet has demonstrated how health equity can be advanced not through institutional imposition, but through collaborative, creative, and locally informed practices. As the nation grapples with ongoing health disparities, systemic racism, and underinvestment in marginalized communities, BBSI stands as a beacon of what is possible when communities are not just served but centered.

This research has traced the origins, implementation, outcomes, and strategic implications of the BBSI model. Drawing from over 562 outreach events and hundreds of qualitative reflections, the Project Ricochet team has seen how barbers, stylists, peer mentors, and youth leaders have emerged as credible messengers and agents of healing. These individuals are not merely service conduits; they are cultural custodians whose influence extends into the homes, hearts, and health decisions of the communities they serve.

This research has also examined the diverse activities facilitated by BBSI, from screenings and health talks to arts-based healing circles and youth empowerment events. These engagements reflect a holistic view of health that transcends medical checklists and embraces identity, history, and belonging as determinants of wellness. The initiative's flexible, trauma-informed, and creative approach makes it not only effective but deeply resonant and sustainable. Importantly, the research has also illuminated the barriers BBSI has faced, logistical hurdles, data inconsistencies, staff fatigue, and occasional gaps in engagement. These challenges are not failings but features of community work. They remind us that authentic engagement requires humility, adaptability, and a commitment to learning from the very people we aim to support.

This strategic analysis has affirmed that BBSI is aligned with key health equity frameworks and has the potential to inform regional and national policy. Whether through trauma-informed training requirements, culturally anchored outreach models, or inclusive funding structures, BBSI can serve as a replicable and scalable solution. But any such replication must preserve its heart: the deep listening, shared leadership, and cultural affirmation that define the program.

For funders, this is a call to invest not only in services but in relationships. For policymakers, it is an invitation to broaden the definition of health infrastructure to include the everyday places where people gather, laugh, reflect, and care. For public health professionals, it is a challenge to co-create rather than prescribe. And for communities, it is a reminder that power, wisdom, and wellness already reside within. Finally, Project Ricochet's Barbershop and Beauty Salon Initiative does not offer easy answers, but it does offer a powerful example. It shows that when we honor culture, empower community leaders, and build from within, we can move from outreach to transformation.

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An Intervention to Support the Health and Work Ability of Unemployed People with Long-term Conditions – Clients' Experiences

*By Mari Salminen-Tuomaala**

A 3-year multiprofessional intervention was carried out in Finland with 155 long-term unemployed people living with prolonged illness to support their health and work ability. The study aims at producing information that could be used to develop further interventions to support the unemployed individuals with long-term illness. Triangulation was used to collect data about how the participants experienced the intervention. According to the quantitative results of this study, the intervention increased participants' experience of inclusion, and improved their emotional wellbeing and coping with daily activities. It had no immediate or extensive effect on the aspects of general life satisfaction and experienced health, functioning and work ability. The qualitative findings portrayed a positive image of the participant experiences; many of the participants had positive experiences concerning client-centredness, multiprofessional support, the flow of information between professionals and their involvement and agency in the intervention. They especially appreciated the individualized services and being treated with respect. The intervention forms a useful foundation for similar projects, especially if attention is paid to recruiting individuals with a realistic prospect of being employed. Collaboration between employment services and health services is required at the recruitment stage.

Keywords*: client, experience, intervention, unemployed, work ability*

Introduction

Multimorbidity, or living with more than one long-term illness, is a significant health challenge among the adult population of the world (Chowdbury et al. 2023, WHO 2016), commonly leading to temporary or prolonged loss of employment (Finnish Institute for Health and Welfare 2019). Better coordinated efforts are required to support the health and work ability of unemployed people with long-term conditions (Džakula et al. 2023, Hujala and Lammintakanen 2018).

This article first introduces concepts relevant to the topic, including work ability, and discusses long-term illness and its association with unemployment. Secondly, the article describes a 3-year multiprofessional intervention, carried out in Finland in order to support the health and work ability of people with long-term illness. Last, the article reports and discusses participant experiences of the intervention using triangulation.

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Literature Review

Long-term illness is a chronic health condition or disease requiring ongoing management over six months or longer (Statistics Finland 2021). It is seen as resulting from a combination of genetic, physiological, environmental and behavioural factors. Common types of chronic diseases worldwide include cardiovascular diseases, cancers, chronic respiratory diseases and diabetes (WHO 2024). It has also been estimated that 1 in every 8 people in the world live with mental disorders, part of which are long-term conditions. Anxiety and depression are the most common mental disorders globally (WHO 2022). In addition, multimorbidity or the coexistence of two or more chronic conditions in the same individual has been rising in prevalence worldwide (WHO 2016). According to an extensive systematic review covering 5.4 million people with the mean age of approximately 57 in 54 countries (Chowdbury et al. 2023), multimorbidity was more common in women, compared to men, and more prevalent in South America (45.7%) and North America (43.1%), compared to Europe (39.2) and Asia (35%) (Chowdbury et al. 2023). In Finland, 1.9 million individuals of the working-aged population (total population 5.6 million), live with one or more long-term diseases or disabilities (Statistics Finland 2021). In the working age group (18-64), the multimorbidity rates are 31% for men and 44% of women (Duodecim 2021). The two leading conditions underlying retirement on disability pension were musculoskeletal conditions (32%) and mental health and behavioural disorders (32%) in 2023 (Finnish Centre for Pensions 2023).

There is a strong reciprocal association between long-term illness and prolonged unemployment (Finnish Institute for Health and Welfare 2019). Long-term unemployment refers to people who have been unemployed for 12 months or more. (OECD 2025) At the end of 2024, the long-term unemployment rate was 0.92 in the United States, 1.8 in the European Union and 1.7% in Finland (Trading Economics 2025). Long-term unemployment has been shown to increase mortality and the risk of mental disorders (Herbig et al. 2013). It can also undermine an individual's sense of coherence or ability to see life as comprehensible, meaningful, and manageable (Fitzgerald Miller 2000). However, unemployed people with long-term illness are a heterogenous group. For example in Finland, they were found to fall into three groups: one third presented a stable career history, another third had lived unemployed for several years, and the last third had alternated between unemployment and temporary jobs (Oivo and Kerätär 2018).

The concept of work ability has been used extensively in occupational health research and practice in Finland for decades. This study uses a broad definition of work ability, based on a construct developed by the Finnish Institute of Occupational Health. The construct, the Abilitator® self-report questionnaire, is a result of the Social Inclusion and Change in Work Ability and Functioning project funded by the European Social Fund from 2014 to 2023 (Finnish Institute of Occupational Health 2023). The questionnaire combines the multidimensional and biopsychosocial models of work ability and functioning, including aspects of social inclusion and employability. The questionnaire can be used to assess individuals' social, psychological, cognitive and physical functioning, and their ability to cope with everyday life. The Abilitator® has been found to cover relevant aspects needed to

assess the overall work ability and function of the population in a weak labour market position (Wikström et al. 2020) and to have acceptable to excellent intrarater test-retest reliability and internal consistency, apart from an item on life satisfaction (Wikström et al. 2021).

Summarizing earlier research, Selander et al. (2023) note that perceived work ability is affected by a wide variety of factors, including poor health and unhealthy lifestyle; personal competence, values, attitudes and motivation, and the work environment. Work ability decreases with age and with the length of unemployment (Savinainen et al. 2020, Hult and Lappalainen 2018, Szlachta et al. 2012). Recurrent failure in finding employment, deteriorating well-being, and lowered self-esteem have been found to be associated with longer periods of unemployment (Szlachta et al. 2012) The role of the individual's physical condition with respect to work ability has been found to be essential, along with good general health, functioning and maintenance of personal relationships (Savinainen et al. 2020, Hult and Lappalainen 2018). More effective care and treatment, combined with adjustments at work might result in a significant number of unemployed people with a long-term illness being employed (Hult and Lappalainen 2018). There are calls for the dominant medical model and compartmentalization to be replaced by a more comprehensive model (Džakula et al. 2023), including effective multiprofessional collaboration between primary health care, specialized medical care and social services (Hujala and Lammintakanen 2018, Männikkö and Martikka 2017).

Further important concepts related to perceived work ability in this study include agency and inclusion as defined in Bandura's social cognitive theory. Agency is "the power to originate action" (Bandura 2001, p. 3), related to individuals' ability to regulate their thinking, motivation, and behavior through self-efficacy, or subjective judgments about the competence to perform actions in order to reach established goals (Bandura 1986, 2006), Self-efficacy refers to a person's subjective judgments about the competence to perform actions in order to achieve the initially established goals. Individuals with higher self-efficacy invest more effort and persist longer than those with low self-efficacy. Self-efficacy can affect work ability positively (Wallin et al. 2021, Xanthopoulou et al. 2013, Larsson et al. 2012).

The Intervention

The 3-year intervention described in this article involved 155 participants in Finland from early February 2021 until the end of 2023. The project aim was to improve participants' health, work ability and employability by supporting their functioning and preventing work-limiting health problems. A further aim was to improve participants' daily coping. The project was called Pitkospuut in Finnish, meaning "Duckboards" or slatted flooring on a wet or muddy surface.

The intervention primarily targeted individuals over 50 years, who lived with multiple long-term health conditions and individuals with an immigrant background, but younger people with work-limiting conditions were also included. The project was undertaken by Seinäjoki University of Applied Sciences in the west of Finland

and funded by the European Social Fund. The interventions took place in the participants' own domicile.

Most participants were enlisted from employment and social services offices and from local government trials designed to boost employment and education. A few individuals participated out of their own initiative. Eight professionals representing employment and career counselling, occupational health nursing, public health nursing, physiotherapy, project management, information and communications technology, as well as nursing, physiotherapy and social work education were engaged in the project, working with the 155 participants. The number of contacts with the various professionals depended on the participants' individual needs and wishes.

Important elements of the intervention involved the following: (1) Comprehensive assessment of the participants' situation, including work ability and functioning, using the Abilitator® self-report questionnaire as a basis for individual counselling; (2) Physiotherapeutic assessment of participants' physical activity and functioning using Alpha Fit and Firstbeat analytics as a basis for individual counselling; (3) The Future Workshop concept developed during the intervention.

(1) The Abilitator® self-report questionnaire was an important tool in this project. The participants completed it twice; once for an initial assessment of their work ability and functioning at the beginning of the intervention and another time, for an evaluation of change at the end of the project. The questionnaire has the following sections: (a) Personal Details (age and gender); (b) Wellbeing, including general life satisfaction and experienced health, functioning and work ability; (c) Inclusion, covering participation and social relationships; (d) Mind, or emotional wellbeing; (e) Everyday Life, or coping with daily activities; (f) Skills, including cognitive functioning and various skills, (g) Body, or issues related to physical fitness; (h) Background information (life situation and education) and (i)Work and the Future. The last section deals with the person's employment situation, barriers to employment and wishes for change. The questionnaire can be completed online or on paper and it is available in nine languages, including English (Finnish Institute of Occupational Health 2023).

In this intervention, the results from the Abilitator® self-report questionnaire formed a basis for further planning and work with a physiotherapist, teacher of social work, digital expert and worklife coach. The results were also used for monitoring change both at individual and general level to evaluate the effectiveness of the project. The professionals found that the instrument provided them with a coherent approach. It helped them take up relevant topics, define needs for services and set realistic goals together with the project participants. Besides employment opportunities, a healthy diet, exercise, mental wellbeing and addictions (e.g. tobacco, alcohol or gambling) were discussed. When required, the participants were referred to further counselling.

(2) Other important tools in the project involved parts of the Alpha Fit test battery for adults and Firstbeat analytics, used in an extensive physiotherapeutic assessment of each participant's physical activity, fitness and functional capacity. The Alpha Fit test battery was planned as a part the project ALPHA (Instruments for Assessing Levels of Physical Activity and Fitness), funded by the European Commission. It is based on two systematic literature reviews presenting evidence of physical fitness as a predictor for future health and of the retest repeatability and criterion-validity of field based health-related fitness tests. (Suni et al. 2010). The Alpha tests are considered reliable, valid and

feasible in assessing health-related fitness in both adults and children (Tejero-Gonzalez et al. 2013). Firstbeat has been found to be a feasible method with sufficient validity in measuring sleep stage variation (Kuula and Pesonen 2021) and its TeamBelt is suitable for real-time monitoring and the Body Guard 2 system for long term monitoring of heart rate and respiration (Bogdány et al. 2016).

In this intervention, the assessment covered participants' health, resources and goals, as well as barriers to functioning. Examination methods were selected individually for each participant based on an initial interview. Depending on the participant, the Alpha Fit test battery was used, for example, to measure body composition (BMI), motor fitness (one-leg stand) and musculoskeletal fitness (hand grip, modified push-up and abdominal muscle testing). In addition, shoulder-neck mobility, posture and general mobility were assessed. The Firstbeat analytics used heart rate variability to analyse participants' physical and psychological stress- recovery balance, resources and sleep quality. The method helped identify both work and leisure related stress factors (Firstbeat 2022, Suni et al. 2010).

The participants were prescribed individual exercises and advised how to perform them. They were taught how to increase physical activity, aerobic fitness, mobility and muscle strength and endurance. The physiotherapist also helped them find suitable forms of exercise and sports groups close to their homes. Many of the participants living with pain, tension and sleeping problems benefited from psychophysical exercises.

(3) The Future Workshop is a concept developed and piloted during the intervention. It involved participants and two project workers working in small groups to discuss participants' health, education and work history and to seek individual strengths, employment perspectives and means of coping. The approach was based on peer support and positive psychology. Both in-person and online meetings were arranged. A number of participatory and dialogic methods were used: (a) the Futures Triangle; (b) the Resource Analysis developed by the project workers; (c) the Management Group of Your Mind; (d) the Anatomy of Success and (e) in-person and virtual simulations to practise job-seeking skills.

(a) The Futures Triangle (Inayatullah 2023) helped participants identify three types of factors that affected them: the push of the present, the weight of the past and the pull of the future. The aim of the sessions was a more positive but realistic image of the future and each participant's strengths and resources.

(b) The Resource Analysis was developed by the project workers. In this work, the focus was on participants' resources and agency; on discovering and writing down one's unforeseen strengths and resources. The work also involved resilience training on one hand, and adaptation to those aspects of one's life that could not be changed on the other hand.

(c) The Management Group of Your Mind (Ruutu and Putkisaari 2022) method was used to help participants deal with negative thoughts, beliefs and "life-traps" while looking at them with help of an assignment from the outside and from a wider perspective. Illustrations portraying a compassionate encouraging management group and a balanced mind management group were used to examine participants' situation.

(d) The Anatomy of Success (Ruutu and Putkisaari 2022) was continuation to the Management Group of Your Mind method. The participants were asked to give an account of something they had managed to reach and considered a success. They were

asked, for example, what things had given them joy and pleasure, what they had done to accomplish it and what else had been needed to reach the success. Secondly, the participants reflected on what the success revealed of their hidden talents, strengths and skills. Third, empowering visualization was practised to work on participants' dreams and wishes. They were also asked to remember the future, looking at their improved situation from a point of time in future.

(e) Last, in-person and virtual simulations were performed to practise job-seeking skills and to prepare for job interviews. Each participant assumed both roles; that of an interviewer and interviewee. In some simulations the project workers took the role of an interviewer. The simulations were preceded by a discussion on what questions might emerge during a job interview, what aspects employers were likely to pay attention to and how applicants could make their strengths known. The simulations were followed by a feedback discussion, in which the participants reported their experiences and the observers shared their impressions. Ethical discretion and constructive feedback were emphasized.

In quantitative terms, the project results at the end of the intervention involved 95 individuals still unemployed, 14 employed, 10 retired, 6 in training/education, 5 actively seeking employment and 4 undergoing a trial work period. The original aim of 10% of the participants finding employment was almost reached, whereas the other aim of having 20% of the participants in training or education was not achieved. A quantitative survey with 45 participants revealed that the intervention had had a greater positive effect on the participants' experienced physical and social health and daily coping, compared to job-seeking skills or career planning (Salminen-Tuomaala 2024). Further information about the participants' experiences is presented in this study.

The Study

Study Design

Triangulation or a mixed methods design was adopted to reach comprehensive information about how the participants in the Duckboards project (2021-2023) had experienced the intervention. The data involved a) quantitative data based on the Abilitator® self-report questionnaire; b) qualitative data collected through semi-structured interviews; and c) qualitative data gathered through the Method of Empathy-Based Stories. Inductive content analysis and typification were used to analyse qualitative data.

The Aim of the Study

The study purpose was to collect data about how the unemployed participants in the project "Duckboards" experienced the intervention and to explore meanings they attached to their participation. The study aimed at producing information that could be used to develop further interventions to support the health, work ability, functioning and coping of unemployed individuals with long-term illness. Another aim was to evaluate the usefulness of the intervention based on participant feedback.

The research questions were:

1. How did the intervention affect the various aspects of participants' work ability?
2. What kind of experiences did participants have concerning client-centredness and their involvement and agency during the intervention?
3. What kind of narratives did participants produce to describe their client pathway?

Data Collection

a) The first research question was addressed by collecting quantitative data by the Abilitator® self-report questionnaire (Finnish Institute of Occupational Health 2023). At the beginning of the intervention, all project participants were asked to complete the self-administered questionnaire to collect baseline data on the participants' emotional, cognitive and physical wellbeing and functioning, inclusion, coping and employment situation. Further self-assessments were requested from participants at later stages of the intervention for an evaluation of change. Out of the 146 participants at the end of 2023, 142 had completed the questionnaire. Out of this group, 66 responded only once, while the 76 individuals who were the most active ones throughout the intervention, completed the questionnaire 2-3 times. The total number of completed questionnaires was 227.

b) Secondly, semi-structured interviews were conducted with eight project participants in June 2022 (n=3), August 2023 (n=2) and October 2023 (n=3). The interviewees were selected using purposive sampling among those individuals, who had participated in all stages of the intervention. Participation was voluntary. The main themes of the interviews were, in harmony with research question 2, a) the interviewee's involvement in the project process from planning until evaluation; b) Client-centredness and multiprofessional support and c) the interviewee's agency in the current life situation, including enablers and barriers to agency and the family's role in promoting agency.

The interviews were recorded with prior consent from the interviewees. Semi-structured interviews were chosen, because they allowed interviewees freedom in expressing meaningful opinions in their own words, while the interviewer concentrated on maintaining focus on the topic, changing the order of questions if appropriate and asking additional questions based on interviewee responses (Naz et al. 2022; Orr et al. 2020).

c) The Method of Empathy-Based Stories (MEBS) was used in the third data collection stage in this study (research question 3). It involved five volunteers, who were not the same individuals as those interviewed. They received a short frame story of a few sentences on paper and were asked to continue the story by writing about their own client pathway. They were instructed to use their own words and any format they found appropriate. MEBS can be traced back by to the United States and the 1970's, and its basic idea is to have participants picture themselves in a situation and write about how the situation will proceed or what

must have preceded it. The material can be analysed using thematic analysis, typification or discourse analysis. (Särkelä and Suoranta 2020).

Data Analysis

(a) The quantitative data collected through the Abilitator® self-report questionnaire was handled according to the instructions in the Abilitator Handbook (Finnish Institute of Occupational Health 2023). Respondents who completed all sections were provided with an overall situation percentage, which is the combined average of the section-specific percentages. Baseline data and data from the post-intervention period were compared to detect potential change, both at individual level and group level.

(b) The qualitative data from the semi-structured interviews was transcribed into 36 pages of text in Times New Roman, font 12, and analysed using inductive content analysis (Polit and Beck, 2017, Elo et al. 2022). After reading through all the data to become very familiar with it, the investigator identified text sections relevant to the research questions. These units of meaning were reduced into 96 expressions, which were organized into 10 sub-categories. They were combined by content to form five higher order categories. The last step was to form two main categories. Original data was consulted from time to time.

(c) The qualitative data from the empathy-based stories consisted of 14 pages in Times New Roman, font 12. The typification involved searching for essential, typical features in the material through exploring participants' similarities and differences (KvaliMOTV Research Methods Guidebook 2025). The patterns discovered were coded in different colours. The findings were presented in the form of various types. The descriptions of types represent summaries of essential elements that emerged from the material.

Research Ethics and Rigour

The project followed the guidelines of the Finnish National Board on Research Integrity (2023), observing the basic principles of reliability, honesty, respect and accountability. Special attention was paid to the privacy policy and data protection under the supervision of the Data Protection Officer of Seinäjoki University of Applied Sciences. Written consent was obtained from all participants before entering their personal family, health and employment data onto the project's client register. Details concerning data protection and data security were explained in the Data Protection Description and Client Factsheet. A Data Processing Impact Analysis was also conducted to assess potential risks. Codes were used when completing and analyzing Abilitator® self-report questionnaires to ensure that participants remained anonymous. The data was destroyed after the results had been reported. Participants to semi-structured interviews and empathy-based stories received a cover letter containing information about the method, stressing the voluntary and anonymous nature of participation. Participants were treated with respect and dignity. The counselling and support was individual, based on participants' needs, wishes and values.

To increase reliability and credibility, the research team made an effort to ensure that the planning, methods and analysis proceeded according to high quality research standards, openly and as objectively as possible. The transferability of the results was increased by a detailed description of the data collection and analysis. The results are transferable to the national context and provide important insights to international readers.

The Results

Demographic Participant Data

The participants were 155 unemployed jobseekers from the west of Finland, living with one or several long-term illnesses. Four of them were of immigrant background. There were 85 women and 70 men. The majority (75 individuals) were 55 or older. The under 30-year-olds formed the minority (15 individuals). Most participants, 92 individuals, had been unemployed for more than a year, whereas 25 individuals had been out of work for less than 6 months and 22 persons 6-12 months. The mean age of the participants who completed the Abilitator® Self-Report questionnaire was 57 years.

Changes in Various Aspects of Participants' Work Ability Based on the Abilitator® Self-Report

The quantitative results showed that the overall situation of the 76 project participants, who had completed the Abilitator® Self-Report questionnaire at least twice, had improved to some extent, from 67% in the baseline data to 72% in the post-intervention data. Significant changes or changes considered "good" according to the Abilitator Handbook (Finnish Institute of Occupational Health 2023) had occurred in the following sections of the questionnaire:

1) Inclusion. In this section, the score improved from 70% to 88%. The intervention can be claimed to have increased respondents' experience of inclusion.
2) The Mind. The intervention can also be said to have improved the emotional wellbeing of the respondents; the change was from 63% to 96%.
3) Everyday Life or coping with daily activities. In this section, the positive change was from 82% to 96%.

Desirable changes did not occur, however, in the Wellbeing section, which covered the important aspects of general life satisfaction and experienced health, functioning and work ability. The participants in this project lived with serious health challenges. On a scale of 1 (lowest) to 5 (highest), the mean for their experienced health was 2.33 in the final stage self-assessment. The mean for their self-reported work ability and functioning was 5.2 on a scale from 0 to 10. In addition, the participants were still far from the employment threshold; their mean was 3 on a scale from 0 to 10.

Participants' Experiences of Involvement, Agency and Client-Centredness Based on Semi-Structured Interviews

According to the eight interviewees, their involvement in the intervention was characterized by the experience of being well informed. The interviewees found that starting from the very beginning of the project, they had learnt a great deal about the content of the intervention and about their possibility to be involved in planning and decision-making to improve their coping and employment situation. One of the participants said, "I was nicely involved at least in the planning stage, when I registered to the Duckboards project". The assessment of physical condition, recovery and sleep quality had been very informative. To quote two of the participants, "There were these FirstBeat measurements and you could see a little bit where you stand and that was a sort of motivator"; "I appreciate the information about my recovery". The interviewees recognized the worth of their involvement in the assessment of work ability using the self-report questionnaire. On the other hand, they also appreciated their freedom to decline participation; "You got free hands to participate, there was no obligation."

The interviews also revealed that the participants had found the intervention to be based on a client-centred approach. They had been heard, their individual wishes had been taken into account and they had been able to influence various aspects of the project. They especially appreciated the fact that their work history had been carefully discussed during the group meetings and that their wishes for training and employment had been heard in the work and career coaching. According to the interviewees, there had been "no pressure" from the project workers, but they had been respected as humans. They said, for example, "At least here they listen to the client and give some thought to their problems" and, "They appreciate the past work history".

Multiprofessional support was also appreciated as part of the client-centred approach. The project provided a single point of contact, combining expertise from different fields and ensuring a good flow of information between the professionals. To quote the interviewees, "I got various tips and advice from the experts, for example for the sleep issue"; "It's good that you didn't have to repeat the same things to different people", and "Seeing the project workers has been smooth, like a seamless continuation".

According to the interviewees, the individualized counselling had strengthened their agency and self-efficacy both during the intervention and in their life in general. Secondly, they appreciated the non-judgmental and encouraging atmosphere of the Future Workshop. It had provided a low threshold place to examine one's work and medical history and future prospects confidentially together with peers and project workers. The encounters had been "between humans", without any limiting bureaucracy. The interviewees said, for example, "I felt I got my human dignity back, I was not just the unemployed one" and, "We have been looking at the past, present and future, that Futures Triangle was a great help in looking at your life".

Last, the interviewees revealed what factors outside the intervention had affected their situation either negatively or positively. Their experience of agency had been undermined by lack of self-confidence, social anxiety and negative life

experiences. Impaired physical health, pain, poor mobility and sleeping problems were also mentioned as obstacles to independent coping and agency. Some individuals reported cognitive or learning disabilities. To quote some participants, "Agency is really a challenge to me, all this bureaucracy and filling in papers is a huge challenge...I have this learning disability"; "I have felt like an outsider in my life", and "My self-management skills are lacking, I can't get anything done".

On the other hand, many interviewees' independent agency, inclusion and coping was enhanced by their families, who provided emotional, social and financial support. The family represented inclusion, sharing and community. At home, the interviewees could be who they really were; the family also provided them with the space and independence they needed. They said, for example, "I have been able to live here, they didn't kick me out"; "Positive, you can share your feelings and get support if you feel bad", and "I don't necessarily want my family to interfere, I can stay independent when I want to, and sociable when I feel like that. That's how I would explain the role of the family, I don't want it to be too strong". Some interviewees explained that having experienced psychological and financial insecurity or alcoholism in their childhood, they wanted to be better parents to their own children. A few interviewees said they felt shame and guilt due to their own alcoholism and dysfunctional relationships. For example, "I didn't have a real father, there was just some brawling alcoholic who visited us sometimes. I want to be a father to my own children", and "It's this guilt that bothers me, when you should be the head of the family and the breadwinner, but you are out of work and don't have enough money."

Participants' Narratives on their Client Pathway

The last set of results in this study involved positive narratives on the client process in the project Duckboards, written by five participants. The descriptions were named to describe their essential contents as follows: a) Consolidation of one's strengths and skills on the road towards self-efficacy in the labour market; b) Better physical fitness and health in promoting the career pathway; c) Peer support as a means to increase faith in better coping; d) Self-care of long-term illness as a pathway to rehabilitation and employment and e) Initiative and support from professionals in the journey towards employment.

Discussion

This mixed methods study presents participant feedback for a 3-year multiprofessional intervention, designed to improve the health and work ability of long-term unemployed individuals living with prolonged illness. According to the quantitative results, the intervention increased participants' experience of inclusion, and improved their emotional wellbeing and coping with daily activities. The results confirm the earlier quantitative survey results that the intervention had a greater positive effect on the participants' experienced physical and social health and daily coping, compared to job-seeking skills or career planning (Salminen-Tuomaala

2024). The qualitative findings revealed that many of the participants had positive experiences concerning client-centredness, multiprofessional support, the flow of information between professionals and their personal involvement and agency in the intervention. They especially appreciated the individualized services and being treated with respect. It can be hoped that this experience of involvement and client-centredness leads to greater inclusion and agency in society in general. Narratives written by participants brought out what they considered as important tools in improving their work ability and employment prospects: physical fitness and health, self-care, peer and professional support, and cultivation of their strengths. To sum up the essential observations, according to the quantitative results of this study, the intervention was not found to directly or extensively improve the aspects of general life satisfaction and experienced health, functioning and work ability. The qualitative findings portrayed a more positive image of the participant experiences, probably due to the selected individuals representing the healthier group among the participants.

The study highlights the importance of the recruitment process, or enrolling participants, who have a realistic prospect of being employed, part-time or full-time. This intervention involved some people, who could already have retired, could hardly cope at home with help of the family, or urgently required mental health services. The participants had not had adequate access to occupational health nursing services. Seeing the project public health nurse helped them identify and prevent health risks related to hypertension and overweight. The project would have benefited from the services of a psychiatric nurse or psychologist as well. Earlier research has suggested that many unemployed people with a long-term illness would be fit for work if proper care for their illness and adjustments at work were provided (Hult and Lappalainen 2018). The health services are frequently fragmented (Džakula et al. 2023). The poor work ability among the long-term unemployed is not always detected by health services, which indicates weakness at the point of contact to the service system and possibly aims to cut down care costs (Nurmela et al. 2018). Consequently, the assessment and care of long-term unemployed people should be a team effort between employment services and health services (Savinainen et al. 2020). As with any clients, collaboration between primary health care, specialized medical care and social services is also essential (Hujala and Lammintakanen 2018, Männikkö and Martikka 2017).

The relatively limited number of participants to the intervention (155) and study (76+8+5) may be considered a limitation to this study. However, geographically the participants represented an extensive area in the west of Finland. The results are likely to be relevant at least in Finland and other Nordic countries, and can provide important insights in the European context.

Conclusions

The intervention described in this study forms a useful foundation for similar projects, especially if attention is paid to recruiting individuals with a realistic prospect of being employed. Collaboration between employment services and health services is therefore required at the recruitment stage.

In the future, it will be important to develop flexible pathway models that promote education and employment for young long-term unemployed individuals, in order to prevent their social exclusion. Youth engagement in working life is needed, as the population in Finland is aging and there will soon be a shortage of workers in many different occupational sectors. It is important to support young people's strengths and resources and to encourage them to pursue education and enter working life. Later, it will be possible to study whether the employment-promoting tools developed and used in this project are suitable for supporting the employment pathways and work ability of younger unemployed individuals.

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Athens Journal of Health & Medical Sciences – Volume 13, Issue 1, March 2026 – Pages 47-66

Grief and Coping Strategies Among Hematology-Oncology Nurses: An Integrative Review

*By Swapna Jacob Binoy**

Hematology-oncology nurses (HONs) face repeated patient deaths, resulting in a significant emotional burden. This integrative review synthesizes current evidence on grief experiences and coping mechanisms among HONs, highlighting specialty-specific challenges and evidence gaps. A systematic search of CINAHL, PubMed, and Google Scholar (2017–2023) identified 156 studies, with 48 meeting inclusion criteria. Results indicate that HONs experience high levels of grief, secondary traumatic stress, and burnout. Adaptive coping strategies—such as peer support, reflective practices, and spiritual engagement—are associated with reduced stress, whereas maladaptive strategies—including emotional suppression and avoidance— correlate with increased burnout. Organizational support, mentorship, and palliative communication training are critical moderators of grief outcomes. Despite consistent findings, methodological limitations (e.g., small sample sizes, convenience sampling, lack of cultural diversity) limit generalizability. The review underscores the need for evidence-based, institutionally supported interventions and further research integrating longitudinal, cross-cultural, and quantitative analyses.

Keywords: *nurses, hematology, oncology, emotional burden, coping mechanisms*

Introduction

Hematological malignancies, including over sixty subtypes such as myeloma, acute myeloid leukemia, and chronic lymphocytic leukemia, are associated with complex treatment regimens and often poor prognoses (Batista et al. 2017). In the United States, these malignancies account for approximately 10% of all cancer diagnoses (Kaye & Isidori 2021). Characterized by the abnormal proliferation of bone marrow cells, these diseases frequently lead to high mortality rates, particularly in advanced stages.

Nurses working in hematology-oncology settings, particularly hematology-oncology nurses (HONs), develop close relationships with patients and their families, making the emotional impact of patient loss significant. HONs commonly experience grief, emotional exhaustion, and psychological stress, yet research on how they cope with repeated patient death remains limited (Oates & Fogelman 2021).

While prior studies have described the emotional toll of patient loss, few have situated these experiences within established theoretical frameworks. Incorporating models such as Kübler-Ross's stages of grief, which outline the progression of emotional responses to loss, and Lazarus and Folkman's stress-coping theory, which emphasizes the interaction between stressors, appraisal, and coping strategies, would

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provide a structured lens to understand HONs' experiences. The application of these frameworks can enhance conceptual depth, guide the interpretation of findings, and inform the development of targeted interventions to support nurses' emotional well-being in high-mortality clinical environments.

This literature review, therefore, aims to explore the lived experiences of HONs regarding grief and their coping mechanisms, framed within these theoretical perspectives, to inform support strategies and professional practice in hematology-oncology settings.

Background

Over the past decade, healthcare professionals, particularly those in oncology, have reported rising levels of burnout and compassion fatigue (Khalaf et al. 2018). Hematology-oncology nurses (HONs) are uniquely exposed to frequent patient deaths, particularly among individuals with advanced or terminal hematologic malignancies. Repeated encounters with suffering and loss place HONs at heightened risk of emotional distress, including secondary traumatic stress and professional burnout (Oates & Fogelman 2021). Despite the critical need to support nurses in these emotionally demanding roles, research specifically examining how HONs experience grief and employ coping strategies remains limited. This integrative review seeks to address this gap by synthesizing existing evidence on the emotional experiences and coping mechanisms of HONs caring for terminally ill patients.

Methods

Design

This literature review employed an integrative approach guided by Whittemore and Knafl's (2015) framework, encompassing problem identification, literature search, data evaluation, data analysis, and presentation of findings. The review explicitly incorporated theoretical frameworks—Kübler-Ross's stages of grief and Lazarus & Folkman's stress-coping model—to enhance conceptual depth in understanding hematology-oncology nurses' (HONs) experiences of grief.

Search Methods

A comprehensive literature search was conducted across PubMed, CINAHL Complete, and Google Scholar using keywords including "hematology oncology nurses," "grief in oncology nurses," "coping mechanisms," "patient death," "bereavement," and "emotional impact." Studies published between 2017 and 2023 were considered.

PRISMA Reporting

The review followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines. The PRISMA flow diagram documented the identification, screening, eligibility, and inclusion of studies. The initial search yielded 156 records, which were screened for duplicates and relevance, resulting in 38 studies meeting the inclusion criteria.

Inclusion and Exclusion Criteria

Inclusion criteria: peer-reviewed primary studies in English examining grief and coping in HONs. Exclusion criteria: dissertations, editorials, literature reviews, and studies not addressing nurses' grief. Limiting to English introduces cultural bias, which is acknowledged.

Screening and Data Extraction

Two independent reviewers conducted screening and data extraction. Inter-rater reliability was calculated using Cohen's kappa ($\kappa = 0.82$), indicating strong agreement. Discrepancies were resolved via discussion. Extracted data included study aims, sample characteristics, methodology, findings, and alignment with grief/coping theories.

Quality Appraisal

The Johns Hopkins Nursing Evidence-Based Practice (JHNEBP) Evidence Rating Scale assessed study quality. While most studies were Level II or III evidence, detailed risk-of-bias considerations—such as small sample sizes, convenience sampling, and heterogeneity—were noted.

Data Synthesis

A narrative thematic synthesis aligned with grief and coping models was employed. Quantitative data were summarized descriptively; where possible, effect sizes were extracted. A formal meta-analysis was not feasible due to heterogeneity in design, populations, and outcomes.

Results

This integrative review revealed that the lived experiences of hematology-oncology nurses (HONs) caring for terminally ill patients are multifaceted, emotionally demanding, and influenced by individual, organizational, and relational factors. Five major themes emerged: (1) emotional toll following patient death, (2) nurse grief response, (3) coping mechanisms, (4) organizational support, and (5) the therapeutic nurse-patient relationship.

Emotional Toll Following Patient Death

Across studies, nurses reported a wide spectrum of psychological and physiological responses following patient deaths, highlighting the profound emotional impact of oncology care. Goris et al. (2023) noted existential distress, fear of death, and a deep sense of personal loss. Lima et al. (2021) found that unexpected pediatric deaths triggered secondary traumatic stress (STS), including intrusive thoughts, emotional avoidance, and hyperarousal. Factors such as patient age, manner of death, and family reactions intensified the burden.

First encounters with patient death often left nurses unprepared, overwhelmed, and physically symptomatic (nervousness, tachycardia, fear of error) (Ma et al. 2020). Prolonged interactions, particularly with pediatric patients, fostered deeper attachments, amplifying grief. Omran and Browning Callis (2022) and Kostka et al. (2021) reported burnout, compassion fatigue, and emotional numbness, alongside sadness, helplessness, anger, despair, and anxiety.

Compassion Fatigue and Burnout

Compassion fatigue and burnout were recurring outcomes. Recurrent patient deaths reactivated previous grief, creating cyclical emotional stress (Wilkes 2022). Structured interventions, such as a six-month compassion fatigue program providing organizational, educational, and self-care resources, reduced fatigue (Pesut et al. 2020). While debriefing sessions did not statistically reduce burnout or STS, they increased compassion satisfaction. Guilt over unmet psychosocial needs, and interprofessional conflicts—particularly dehumanizing language from physicians—exacerbated emotional strain. A significant inverse correlation between compassion satisfaction and compassion fatigue ($r = -0.294$, $p = .003$) underscored the protective role of meaningful human connections (Kostka et al. 2021).

Nurse Grief Response

Grief was rooted in relational bonds with patients and families. Repeated exposure to patient death intensified mourning (Goris et al. 2023, Font-Jimenez et al. 2020). Initial grief was often intense, but nurses gradually transitioned toward acceptance (Khalaf et al. 2021). Witnessing patient suffering, particularly intractable pain, heightened grief reactions. Communicating patient death to families was emotionally taxing, especially without adequate training, and grief correlated with depressive symptoms and burnout (Ma et al. 2020, Kostka et al. 2021, Omran & Browning Callis, 2022).

Coping Mechanisms

Coping strategies were diverse. Adaptive mechanisms included problem-solving, humor, seeking support, spiritual practices, and acceptance (Kostka et al. 2021, Yi 2021). Informal rituals—journaling, peer discussions—helped process grief (Khalaf et al. 2021). Maladaptive strategies—denial, avoidance, emotional suppression, and overworking—were linked to burnout and STS (Ma et al. 2020, Pesut et al. 2020). Poor

self-care behaviors such as sleep deprivation, binge eating, and alcohol use were counterproductive (Font-Jimenez et al. 2020). Reflective writing, peer dialogue, and mindfulness were effective for emotional processing (Khalaf et al. 2021).

Organizational Support and Constraints

Organizational factors significantly shaped nurses' experiences. Lack of formal training in palliative care and ethical guidance intensified emotional strain (Goris et al. 2023, Cao et al. 2021). Leadership support was protective, correlating with lower burnout and higher job satisfaction (Anderson et al. 2020). Teamwork, communication, and staff debriefings were valued but inconsistently available. Nurses recognized the need for boundaries in nurse-patient relationships, balancing grief management with professional fulfillment (Font-Jimenez et al. 2020, Khalaf et al. 2021).

Therapeutic Nurse-Patient Relationships

Close relationships were emotionally enriching but increased vulnerability to grief (Ma et al. 2020, Chew et al. 2022). Caring for patients without familial support was less emotionally taxing but also less rewarding (Omran & Browning Callis 2022). Nurses struggled to detach emotionally while maintaining compassionate care, highlighting the dual role of the therapeutic relationship in oncology nursing (Font-Jimenez et al. 2020, Kostka et al. 2021).

Discussion

Caring for dying patients presents profound emotional challenges for HONs. Nurses form deep therapeutic bonds, making repeated patient deaths impactful on emotional, physical, and professional well-being (Font-Jimenez et al. 2020, Kostka et al. 2021). This review underscores the need for structured, sustainable support systems to manage grief in oncology care.

Adaptive and Maladaptive Coping

Adaptive strategies—including peer support, spirituality, and reflective practice—buffered the psychological burden of repeated patient deaths. Maladaptive behaviors, such as emotional detachment, avoidance, and overwork, were prevalent, reflecting gaps in formal education and institutional support (Font-Jimenez et al. 2020, Pesut et al. 2020). These findings align with stress-coping models (Lazarus & Folkman 1984), emphasizing the need for interventions that promote problem-focused and emotion-focused coping.

Need for Grief Education and Theoretical Integration

Despite regular exposure to patient death, formal grief education is lacking in pre-licensure and graduate nursing programs. Nurses largely rely on informal learning, trial-and-error approaches, and personal coping strategies (Foster et al., 2020). Integrating grief and bereavement frameworks, such as Kübler-Ross' stages of grief and Lazarus & Folkman's stress-coping theory, can provide conceptual scaffolding to guide educational programs and interventions.

Structured Support Programs

Evidence suggests that structured interventions—mentorship programs, reflective writing, facilitated debriefings, and mental health resources—enhance resilience and emotional regulation (Pesut et al. 2020, Wilkes 2022). Interventions should be tailored to institutional realities, with attention to staffing constraints, resource availability, and cultural considerations. Interventions could be prioritized based on empirical support, feasibility, and potential impact.

Therapeutic Relationships

The dual role of nurse-patient relationships—as both a source of grief and professional fulfillment—highlights the need for institutional support in managing emotional labor. Leadership engagement and psychologically safe environments can empower nurses to balance empathy with self-protection (Anderson et al. 2020).

Critical Appraisal

Included studies were limited by small sample sizes, convenience sampling, heterogeneous designs, and inconsistent reporting of effect sizes or reliability measures. Lack of longitudinal data and potential publication bias further constrain the strength of conclusions. The absence of quantitative synthesis reduces the precision of effect estimates, underscoring the need for future meta-analytic research.

Limitations

This review has several notable limitations that should be considered when interpreting the findings. First, the literature search was confined primarily to English-language studies, which may exclude culturally specific perspectives on grief and coping from non-English-speaking regions, limiting the generalizability of the results to global nursing populations. Second, the majority of included studies focused broadly on oncology nurses rather than exclusively on hematology-oncology nurses, potentially underrepresenting the unique stressors and grief experiences inherent to this specialty. Third, most studies were qualitative with small sample sizes, convenience sampling, and heterogeneous designs, reducing the methodological robustness and limiting the ability to draw strong causal inferences. Furthermore, reporting of inter-rater reliability, risk-of-

bias assessments, and quantitative effect sizes was minimal, and no meta-analytic synthesis was conducted. The absence of longitudinal research limits understanding of the long-term impacts of repeated patient deaths on nurse well-being, resilience, and retention. Additionally, some studies were preprints that had not undergone formal peer review, raising concerns regarding the validity and reliability of their findings. Finally, potential publication bias was not formally assessed, which may have influenced the selection of studies and skewed the overall conclusions.

Recommendations

The findings underscore an urgent need for structured, evidence-based interventions to support hematology-oncology nurses in managing professional grief. Educational curricula at both undergraduate and graduate levels should integrate content on grief, bereavement, coping strategies, and emotional resilience, supplemented by nurse residency programs and ongoing professional development initiatives. Healthcare institutions should implement comprehensive wellness programs, including structured grief debriefings, peer support networks, mentorship opportunities, and accessible psychological counseling services. Interventions should be prioritized based on empirical evidence, feasibility, and potential impact, with attention to cultural relevance and inclusivity. Nurse leaders, managers, and educators must advocate for holistic, staff-centered approaches that normalize emotional expression and support adaptive coping. Reflective practices, such as journaling, simulation-based scenarios, and facilitated group discussions, should be embedded into routine practice to help nurses process grief constructively. Additionally, future research should adopt methodologically rigorous designs, including quantitative measures, inter-rater reliability reporting, risk-of-bias assessment, and longitudinal follow-up, as well as meta-analytic synthesis where possible, to strengthen the evidence base and inform scalable interventions.

Conclusion

Hematology-oncology nurses experience complex, recurring grief in response to patient deaths, encompassing a spectrum of emotional responses including sadness, guilt, anger, and diminished sense of purpose. Without adequate institutional support, these experiences may contribute to burnout, compassion fatigue, emotional detachment, and reduced job satisfaction. Nurses employ a variety of coping strategies, both adaptive—such as peer support, reflective practice, and spirituality—and maladaptive, including avoidance and emotional suppression. Organizational factors, including the availability of grief education, leadership support, and structured debriefing opportunities, play a critical role in moderating these responses. Evidence indicates that institutionally supported interventions that integrate education, reflective practice, and wellness programs can enhance nurse resilience, improve emotional well-being, and support retention. Future research should focus on culturally sensitive, longitudinal studies to examine the long-term effects of grief, evaluate intervention effectiveness, and provide robust evidence to guide practice.

Implications for Practice

The findings of this review highlight the critical importance of proactively addressing professional grief among hematology-oncology nurses. Healthcare organizations must prioritize emotionally safe environments where nurses feel empowered to express vulnerability and seek support. Comprehensive grief support programs—including mentorship, structured debriefings, psychological counseling, and palliative communication training—can mitigate emotional exhaustion, compassion fatigue, and cumulative grief. Embedding reflective practices into daily routines enables nurses to process grief constructively and sustain engagement in patient care. By integrating grief and coping education into nursing curricula, residency programs, and ongoing professional development, institutions can equip nurses with practical skills to navigate the emotional demands of their work. Leadership commitment is essential to cultivate a culture that values emotional well-being alongside clinical competence. Ultimately, implementing evidence-based, contextually relevant interventions can enhance nurse resilience, improve job satisfaction, support retention, and ensure the delivery of compassionate, high-quality care to patients throughout the end-of-life process.

Future Directions

Future research should employ longitudinal and methodologically rigorous designs to examine the cumulative impact of repeated patient deaths on hematology-oncology nurses' well-being and retention. Meta-analytic approaches could clarify intervention effectiveness, while inter-rater reliability and risk-of-bias assessments would enhance transparency. Cultural diversity should be addressed by including non-English studies and exploring culturally specific grief responses. Integrating grief and coping frameworks, such as Kübler-Ross and Lazarus & Folkman, can guide intervention design and evaluation. Evaluating the feasibility and sustainability of institutional support programs will inform evidence-based strategies to reduce burnout, promote resilience, and optimize patient care in high-mortality settings.

Table 1. *Summary Table*

Author & Publication Year	Aim/Question	Sample /Setting	Study Design	Key Findings	Critique Strength/ limitations
Murphy et al. 2021	Investigate, describe, and comprehend how pediatric hematology/oncology nurses (PHONs) caring for chronically ill or dying patients utilize their spirituality to manage job stress, sustain well-being, and persist in this field.	N=130 nurses Pediatric /oncological setting	Mixed-method	Types of stress: Work environment Emotional/psychological Coping mechanisms: Self-care and spirituality	Large sample size. The use of mixed methods provided in-depth findings. The non-random sampling method was used, which increased the risks of selection bias.
Ma et al. 2021	Examine the cognitive, emotional, and behavioral aspects of the experiences of pediatric oncology nurses when their patients die.	N=22 pediatric oncology nurses Jiangsu province, China	Descriptive Qualitative	Emotional solid reactions included anxiety and concern, grief, and reluctance to accept the situation, The feeling of loss and powerlessness. Grief coping strategies included putting in extra effort and being conscientious; Releasing emotions; Reflection and work quality improvement; Empathy; avoiding information. Inadequate support system: Insufficient emotional and psychological support; Inadequate knowledge.	Limitations Selection Bias Convenience sampling Level of Evidence II
Goris et al. 2017	To assess the influence of training on end-of-life care on nurses' perceptions of death in an oncology hospital in Turkey.	N=41 Oncology unit of a hospital in Turkey	Qualitative study	The study found that fear of death and losing a significant other influenced nurses' perception of death. Nurses described death as demise, rebirth, and death as an ordinary event that separates one from one's beloved ones.	It was experimental research with both control and experimental groups. A small sample size could affect the generalizability of the findings. Level of Evidence II
Lima et al. 2018	To investigate the effects of unexpected deaths in pediatric care on nurses working in pediatric critical care units.	N=62 Pediatric critical care unit.	A mixed-methods design	Secondary traumatic symptoms that were reported in the study included intrusion, avoidance, and hyperarousal.	They used mixed methods, which provided in-depth and more

					elaborate findings. Unexplained dropping off of participants from the study Level of Evidence II
Finley & Sheppard 2017	Explore early-career oncology nurses' experiences of compassion fatigue.	N=5 A level 1 hospital facility in Nevada	Qualitative Study Phenomenology, secondary analysis of parent study	Early-career oncology nurses like to connect with patients and families. Prolonged hospitalization and high patient mortality rates lead to compassion fatigue.	With a small sample size, newer oncology nurses expressing CF symptoms support CF education and intervention. The population is solely female, with seven or fewer years of oncology experience in the nurse profession. Level of evidence II
Chew et al. 2021	To investigate and understand the experiences, difficulties, and methods of coping used by novice nurses when facing pediatric death in a medical setting	N=12 new pediatric nurses Tertiary public hospital in Singapore	Qualitative study	A spectrum of emotions was reported, including being emotionally scarred, overwhelmed, and at a loss, avoidance, self-blame, and blaming unpredictability. Resources to cope with grief included collegial support, spirituality, and providing personal growth opportunities. New nurses identified the need for the implementation of training and community-sharing platforms.	The study investigated a wide range of themes related to grief exhaustively The research was largely homogenous because it involved nurses from the same clinical setting. Level of Evidence III
Font-Jimenez et al. 2020	To investigate the experiences of nurses regarding the care relationship established with medical-surgical patients in acute hospitalization units and its relationship to their clinical practice	N=23 Surgical unit caring for oncological patients	Qualitative study	Nurses' emotions included Fulfilling experiences Feeling the pain of others Emotional distress Nurses' coping strategies: Stepping back Seeking professional support Evolution of emotions	The main strength was the in-depth and descriptive findings since it was a qualitative study. The main limitation was the small sample size and homogeneity of the participants.

					Level of Evidence III
Guoa & Zheng 2019	This research aims to evaluate burnout among Chinese oncology nurses and examine the association with their attitudes toward death.	N=279 Oncology unit in a Chinese healthcare organization	Quantitative Study	Burnout; Emotional exhaustion; Depersonalization	Large sample size The main weakness was the lack of randomizatio n, increasing the bias risks. Level of Evidence II
Cao et al. 2022	To explore the thought process and experiences of Chinese oncology nurses when confronted with a patient's request for hastening death, to identify the barriers that impede their response, and to offer recommendations for addressing such requests.	N=18 Oncological setting in a Chinese hospital	Qualitative study	The nurses' cognition of the patients' death wish: Patient's language, Expression, Behavior The coping style adopted by the nurses when the patients made their death request; Comfort the patient. Divert their thoughts Get Help from Psychologists Obstacles that prevented the nurses' response to the death request: Subjective reasons (dilemma, ambiguous feelings, insufficient coping ability) Objective reasons (No Relevant Policy Support) Suggestions on how to deal with the death request: To Receive Relevant Training Getting support from patients' family members. Promote multidisciplinary cooperation	Provided comprehensiv e findings as a qualitative study The main limitation was the small number of participants. Level of Evidence III
Gribben & Semple 2021	Examine the prevalence and predictors of burnout and work-life balance amongst Ireland's hematology cancer nursing workforce.	N=78 Hematology oncology Nurse conference	Quantitative Study	Nurses with dependent children had significantly poorer work-life balance scores. In addition, one-third reported they did not receive adequate support or reasonable adjustments from their organization, with inpatient nurses finding this particularly challenging.	Possibility of a twofold response. slighted underpowere d unable to determine whether the associations observed are causally related and the potential directions of

					the effect. Level of Evidence II
Khalaf et al. 2018	To examine the personal experiences of nurses regarding their emotions, grief reactions, and coping strategies in the aftermath of their patient's death	N= 21 Oncology unit in a hospital in Jordan	Qualitative study	Processing Grief Experience: Initial intense grief Patient death acceptance with time. Patients' conditions can impact nurses' grief. Managing Grief: Writing topics based on patient death; Talking with colleagues and families; Reflecting on the care provided Faith and spirituality. Dealing with Death: Nurses may struggle with informing families of a patient's death Struggle to prepare the body; Nurses may also perform religious and spiritual rituals; Offering support to families.	The main strength was the comprehensive findings detailing the participants' grief and coping mechanisms. Selection bias Non-randomized sample. Level of Evidence III
Jarrad & Hammad 2020	Explore the compassion fatigue, burnout, and compassion satisfaction among specialized oncology nurses.	N=100 Cancer Centers in Jordan	Descriptive correlation design	There are significant negative relationships between compassion satisfaction and the number of dependents. The correlation between compassion satisfaction and the nurses' sleep, rest, and leisure hours yielded statistical significance. A strong positive relationship exists between compassion fatigue and burnout.	Small sample size Convenience sampling, non-generalizability Level of Evidence II
Soheili et al. 2021	This research aims to investigate oncology nurses' views on stressors related to their work.	N= 52 Oncology department.	Qualitative study	Personal abilities: Being job fit Psychological abilities Physical environment arrangements: Work/Life balance; Physical conditions, equipment, and facilities Workplace psychosocial safety. Addressing the challenges of caring for cancer patients Promoting a balance between work and personal life.	The main strength is that the research design provides an in-depth and broad insight into the issue of nurse stressors. The sample was drawn from university teaching hospitals, which means an inadequate

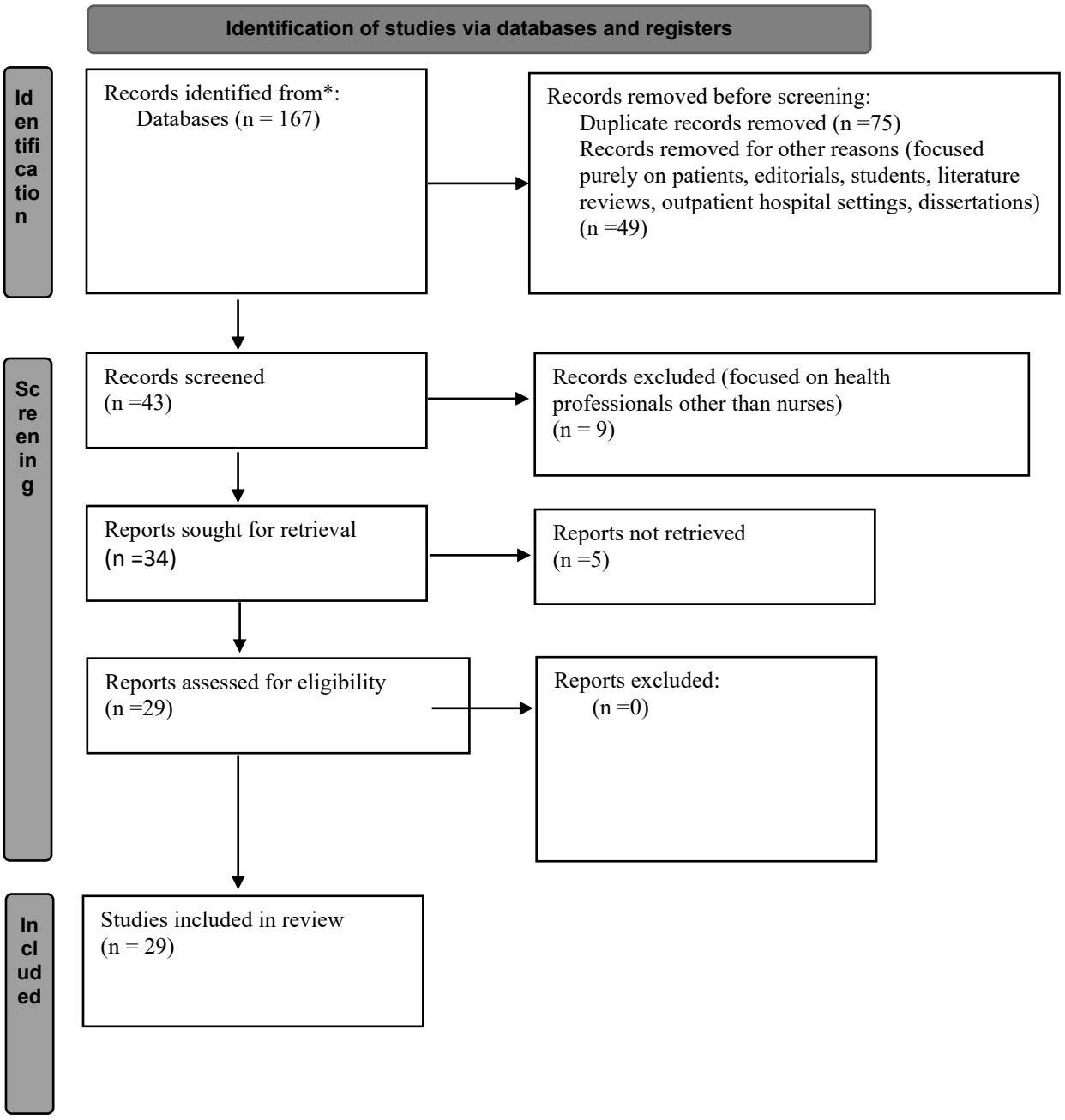
				Nursing professional recognition within society. Organizational context: Support from the organization Interpersonal relationships Fairness in the workplace Human resources management	representation of the nursing population. Level of Evidence III
Kostka et al. 2021	To evaluate and analyze the emotions experienced by nurses when caring for dying patients in selected inpatient units. The goal was to understand the feelings that accompany nurses during their work in such circumstances.	N=160 Palliative care setting	Qualitative study	The emotions experienced by nurses included compassion, sadness, helplessness, anger, sorrow, anxiety, calmness, despair, indifference, depression, and discouragement.	Large heterogeneous sample size There is no randomization of the participants, which could increase bias. Level of Evidence III
Pesut et al. 2020	To gain insight into the effects of a legal framework for assisted death on the experiences and practices of nurses. The study aimed to investigate how legislated assisted death impacts nurses.	N=60 Palliative care settings	A qualitative study	Three themes: Influential person's leadership within the system. The presence or the nature of the influential persons within systems, (2) The presence and personality of the multidisciplinary team (3) The systems' complexity and capacity in supporting the MAiD.	Qualitative design. Inadequately addressed the research question. Level of Evidence III
Omran & Browning Callis 2021	To examine the grief support needs of critical care nurses following a patient's death, whether expected or unexpected.	N=10 Critical care units	A qualitative study	Burnout Secondary traumatic stress Compassion satisfaction	Deeper meanings were relevant to the phenomena under investigation. small sample size Level of Evidence III
Sullivan et al. 2019	Develop an evidence-based compassion fatigue program and evaluate its impact on nurse-reported burnout, secondary traumatic stress, and compassion satisfaction, as well as correlated factors of resilience and coping behaviors,	N=59 pediatric oncology unit	Quantitative Pre-test/post-test	Interventions to foster tailored, individualized self-care. Encourage adaptive coping styles to facilitate compassion satisfaction Support in combating compassion fatigue during the holidays because of patient acuity, staffing schedules,	Level of Evidence II

Zajac et al. 2017	Assess direct care providers' compassion fatigue (CF) level in the inpatient oncology setting. Determine if the level of CF differed from baseline to the completion of the intervention.	N=117 Medical-surgical units in an NCI-designated comprehensive cancer center	A mixed-methods sequential design	The preintervention results revealed average compassion satisfaction, secondary traumatic stress scores, and low burnout scores. A significant difference was noted between pre- and postintervention CF scores.	Seven facilitators provided the intervention, causing variation in the delivery and duration of the debriefing sessions, and staff reported that the units were busy, which may have prevented others from participating in the debriefings. The current study also had a small sample size. Level of evidence III
Anderson et al. 2020	To explore the role of leadership in addressing emotional labor and burnout among oncology nurses.	Oncology nurses (n = 150) in 5 hospitals.	Cross-sectional survey.	Leadership support was significantly correlated with lower burnout and higher job satisfaction.	Strength: Clear evidence of leadership's role in preventing burnout. Limitation: Survey-based design limits depth of qualitative insights.
Baker et al. 2024	To evaluate the effectiveness of grief support programs for oncology nurses.	Oncology nurses (n = 75) in a large cancer center.	Pre/post-test evaluation.	Nurses who participated in grief support programs reported reduced grief symptoms and increased emotional resilience.	Strength: Strong evaluation of program effectiveness. Limitation: Limited sample size; not generalizable to all oncology settings.
Brown et al. 2023	To examine the emotional toll of long-term care in hematology oncology nursing.	Hematology oncology nurses (n = 50) at a university hospital.	Qualitative interviews.	Nurses experienced significant grief due to the long-term nature of patient care and frequent deaths.	Strength: In-depth qualitative exploration of nurse emotions. Limitation: Small sample size may not reflect broader oncology settings.

Carter et al. 2022	To explore anticipatory grief among hematology oncology nurses in the context of terminal diagnoses.	Hematology oncology nurses (n = 60) across multiple hospitals.	Mixed-methods (survey & interviews).	Anticipatory grief was common, especially in patients with unpredictable relapses, leading to emotional strain on nurses.	Strength: Comprehensive mixed-methods design allows for both quantitative and qualitative insights. Limitation: Self-report data may have bias.
Foster et al. 2020	To explore the prevalence and impact of compassion fatigue among oncology nurses.	Oncology nurses (n = 100) in a regional cancer care center.	Cross-sectional survey.	High levels of compassion fatigue were reported, with grief being a significant contributing factor.	Strength: Provides quantitative data on compassion fatigue. Limitation: Cross-sectional design limits causal conclusions.
Lopez et al. (2024)	To examine the relationship between burnout and grief in oncology nurses.	Oncology nurses (n = 200) in hospital oncology units.	Longitudinal study.	Chronic exposure to patient death was a significant predictor of burnout and emotional exhaustion.	Strength: Large sample size enhances generalizability. Limitation: Longitudinal design requires long-term follow-up, which was challenging.
Nelson et al. 2022	To evaluate coping strategies for emotional distress in oncology nurses.	Oncology nurses (n = 40) in a community hospital.	Qualitative case study.	Nurses who practiced mindfulness and engaged in regular self-care experienced lower levels of distress.	Strength: Provides practical coping strategies for nurses. Limitation: Case study approach limits broader applicability.
Roberts et al. 2021	To assess the role of peer support as a coping strategy for grief in oncology nurses.	Oncology nurses (n = 120) in a cancer center.	Mixed-methods (survey & interviews).	Peer support was crucial in managing grief and emotional stress, with nurses reporting less isolation and higher resilience.	Strength: Strong integration of quantitative and qualitative methods. Limitation: Limited by reliance on self-report data.
Smith et al. 2021	To systematically review the impact of grief and burnout in oncology nursing.	Review of 15 studies (n = 1,200 nurses).	Systematic review.	Repeated exposure to patient loss leads to significant grief and burnout in oncology nurses.	Strength: Comprehensive review of existing studies. Limitation: No primary data

					collection, limited to existing studies.
Sullivan et al. 2023	To investigate the effectiveness of grief management training for oncology nurses.	Oncology nurses (n = 85) from various hospitals.	Randomized controlled trial.	Grief management training reduced symptoms of burnout and increased coping effectiveness.	Strength: Randomized controlled trial provides strong evidence of effectiveness. Limitation: Short duration of intervention and follow-up.
Taylor et al. 2023	To explore depression and anxiety in oncology nurses and their connection to grief.	Oncology nurses (n = 150) in urban hospital oncology units.	Cross-sectional survey.	Depression and anxiety were higher among nurses who reported experiencing grief and emotional exhaustion.	Strength: Provides clear links between grief, depression, and anxiety in oncology nurses. Limitation: Cross-sectional design limits understanding of causal relationships.

Figure 1. *PRISMA Flow Diagram*



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Athens Journal of Health & Medical Sciences – Volume 13, Issue 1, March 2026 – Pages 67-78

Mental Health Outcomes among Women with Cervical Cancer in Africa: A Scoping Review

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Background: Cervical cancer is one of the major contributors to cancer-related morbidity and mortality in women in Africa. Even though there is conclusive evidence regarding the physical toll of this condition, there is little known about mental health outcomes in women who suffer from this condition. Objective: The aim of this scoping review was to map existing findings on mental health outcomes for women suffering from cervical cancer in Africa. Methods: The scoping review was carried out using the PRISMA-ScR. Electronic databases (PubMed, Scopus, African Index Medicus, and Google Scholar) were utilized for searching through peer-reviewed literature in English up until 2025. The inclusion criteria comprised literature studying the mental health outcomes of women with cervical cancer in Africa. The literature was examined for features and outcomes relating to mental health, alongside the key findings. Results: A total of 15 studies satisfied the inclusion criteria. The most reported outcome was depression, anxiety, psychological distress, and a compromised quality of life. Prevalence of depression was reported between 25% and 50% and anxiety was up to 38% in some studies. Factors that escalated psychological distress include stigma, fear of death, a lack of certainty regarding the treatment, a concern regarding infertile partners, and isolation. Quality of life, especially emotional and social aspects, was severely affected. Only a few studies assessed structured interventions. There was a lack of available mental health care. Conclusion: Mental health issues are found at a high level of prevalence among women with cervical cancer in Africa, but there is little treatment provided for mental health issues in cervical cancer treatment systems. There is a pressing need for cervical cancer treatment systems that include systematic mental health screening and culturally compatible mental health counselling components.

Keywords: *cervical cancer, mental health, depression, anxiety, psychological distress, Africa*

Introduction

Cervical cancer is a major public health concern in Africa, with almost 90% of cervical cancer-related deaths reported among low and middle-income countries (LMICs) worldwide (Ginsburg et al. 2018). Infection with human papillomavirus (HPV), a viral disease, is considered the main causal factor, but lack of screening, vaccination, and treatment contributes to increased cervical cancer morbidity (Abate et al. 2020). Late stages are often encountered, and most affected females are found with cervical cancer after those symptoms started manifesting, hence

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increasing chances of death due to treatment difficulties and challenges (Mwaka et al. 2019). Overall physical suffering brought by cervical cancer is also accompanied by social stigma, financial burdens, and various sociocultural attitudes toward personal and global health care and treatment adherence among affected females (Chidyaonga-Maseko et al. 2017, Maree & Wright 2010).

Problems in mental health are common among patients with cancer, where depression and anxiety are identified as the frequently encountered psychiatric comorbidities in these patients (Derbew et al. 2024). The patients encounter powerful emotions, including shock, fear, loss, and uncertainty, which can remain throughout the period of treatments (Ginsburg et al. 2018). Lack of good mental health has been found to result in decreased compliance, late presentation, and poor quality of life (Abate et al. 2020, Mwaka et al. 2019).

Literature Review

Globally, the estimated proportion of women with cancer suffering from depression is around 30 to 40%, with even higher rates found in LMICs because of added socioeconomic stressors (Derbew et al. 2024). Even so, the need for psychosocial support seems to be overlooked in cancer care in Africa, with the integration of mental health for cancer services being limited as stated in Maree et al. 2025).

Depression is consistently cited as having the highest prevalence as a psychological consequence for African women suffering from cervical cancer. Major studies conducted in both Ethiopia and Uganda have shown that half of all women suffering from cervical cancer are prone to depression (Dagne et al. 2019, Okello et al. 2018, Mengistu et al. 2020). Depression contributes to lower adherence and poorer quality of life related to treatment, and this makes it essential to identify and treat it on a constant basis (Lubuzo et al. 2021). Systematic reviews undertaken in Africa-related settings further affirm that prevalence of this psychological disorder is higher than that of other women, and this makes them psychologically more vulnerable (Derbew et al. 2024).

Anxieties, even if less extensively researched, are a serious issue. In Morocco, for example, 38% of the cervical cancer-diagnosed women had symptoms of anxiety (Khalfi et al. 2025). Anxieties are commonly associated with ambiguous diagnoses, the fear of death, the sequelae of treatment, and issues of reproduction (Ginsburg et al. 2018). Structured programs for anxiety in the case of cervical cancer are limited and even less represented in the African environment.

In addition to depression and anxiety, the psychological toll of mental distress further covers emotional suffering, fear, stigma, and loneliness. Qualitative research conducted in Nigeria, Zimbabwe, Malawi, and South Africa indicates that women experience fear of diagnosis, fear of infertility, strains in relationships, and stigma, thus increasing the emotional toll (Ojo et al. 2020, Mutambara et al. 2021, Chidyaonga-Maseko et al. 2017, Maree & Wright 2010). The onset of treatment, compliance, and quality of life have been negatively influenced by psychological distress, thus making this area a vital intervention point (Mwaka et al. 2019).

Cervical cancer has been shown to have a significant impact on QoL, especially regarding emotional, social, and functional aspects of QoL. Emotional well-being, fatigue, and participation in society have been reported to be decreased by women undergoing radiotherapy in South Africa (Lubuzo et al. 2021). Depression and distress have been shown to have a large relationship to decreased overall QoL, indicating that mental issues have a direct effect on functional findings and satisfaction with life (Mengistu et al. 2020, Ginsburg et al. 2018). Mental health outcomes in African women with cervical cancer are influenced by the sociocultural environment. The sociocultural environment creates barriers such as a lack of availability of psychosocial support services, financial struggles, and a shortage of mental health practitioners (Ginsburg et al. 2018, Mwaka et al. 2019). Additionally, the stigma associated with cervical cancer because of sexual practices results in social discrimination, relationship conflicts, and the patient withholding information, hence exacerbating mental health problems (Maree et al. 2025, Chidyaonga-Maseko et al. 2017).

Cervical cancer is a major cause of cancer-related death among women in Africa, but its impact on mental health is not sufficiently characterized (Ginsburg et al. 2018). Women with cervical cancer often experience depression, anxiety, mental distress, and poor QOL due to factors of late presentation of cervical cancer, societal stigma, and lack of access to mental health and psychosocial resources (Dagne et al. 2019, Mengistu et al. 2020). However, there is clearly a lack of mental health-related resources in cancer care in Africa (Mwaka et al. 2019, Lubuzo et al. 2021). An integration of evidence on mental health outcomes is therefore urgently required for informing mental health-related interventions in Africa.

Research Question

> What mental health outcomes have been reported in women with cervical cancer in Africa, and what factors have been identified as influencing these outcomes?

Materials and Methods

A scoping review is considered to be a form of knowledge synthesis, which is used to explore the scope, extent, and nature of the available research evidence on a particular issue or topic. Unlike the systematic review, which is generally conducted to answer a particular question or issue, the scoping review is conducted to obtain an overview of the available evidence, key concepts, evidence types, and the existing gaps on the particular issue or topic.

In the present study, the scoping review method was used to collect all the available research evidence on the mental health outcomes in African women with cervical cancer. This is considered to be the best method to understand the available research on the issue, the methods adopted to collect the data, the mental health outcomes, and the gaps in the existing evidence on the particular issue.

It is therefore clear that the scoping review provides a platform for establishing the knowledge that is already in existence regarding mental health outcomes in women suffering from cervical cancer in Africa.

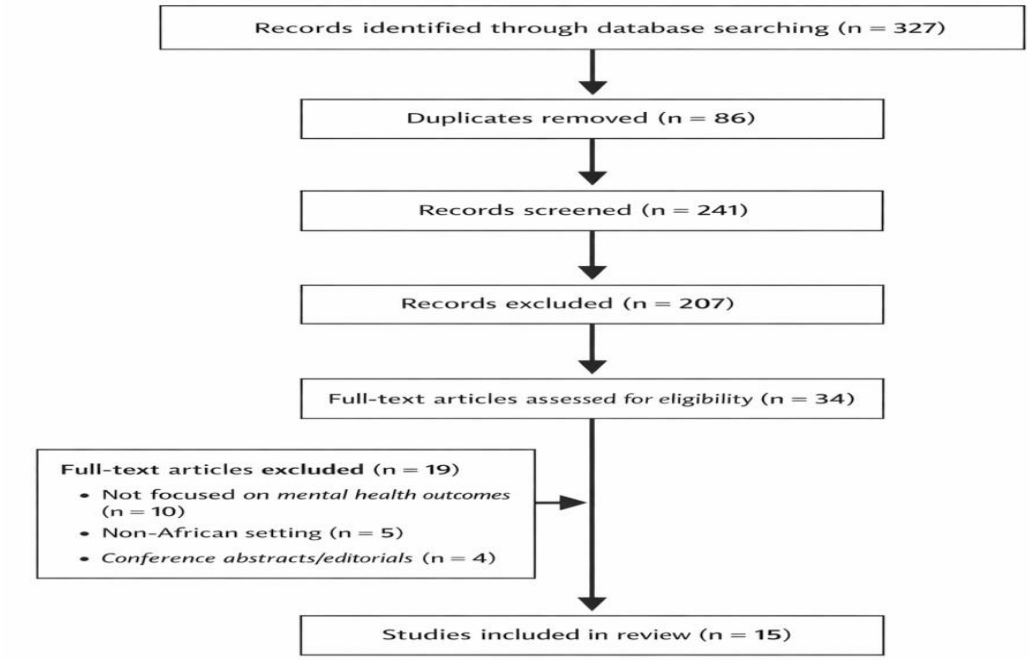
The study made use of a Scoping Review approach in order to map out systematically available data on mental health outcomes in women with cervical cancer in Africa. Scoping reviews are extremely useful in research that is broad in nature and aims at filling research gaps (Peters et al. 2020). The study adhered strictly to the guidelines outlined in the extension of PRISMA for Scoping Reviews (PRISMA-ScR) (Tricco et al. 2018).

Eligibility criteria included studies with participants composed of women with cervical cancer, regardless of age and disease progression. Studies had to include mental health outcomes, such as depression, anxiety, psychological distress, emotional functioning, or quality of life. There was a restriction that only studies done within African countries would be included. Acceptable research designs included primary quantitative, qualitative, mixed-methods studies, as well as systematic/scoping reviews, provided they included mental health outcomes. Articles published in English that included peer reviews up to the end of 2025 were only included. Exclusion of articles included studies that only revolved around cervical cancer prevention, HPV vaccination, as well as studies that included general oncology populations that did not relate to cervical cancer. Conference abstracts, editorials, as well as grey literature, would also be excluded.

A comprehensive search was carried out on various electronic databases, such as PubMed/MEDLINE, Scopus, African Index Medicus, and Google Scholar. The search strategy consisted of a combination of keywords related to cervical cancer, mental health outcomes, and Africa, using MeSH terms as well as free-text terms. An example of a PubMed search strategy would be: ("Cervical Neoplasms" [MeSH] OR AND ("Mental Health" [MeSH] OR "psychological distress" OR depression OR anxiety OR "quality of life") AND ("Africa"[MeSH Terms] OR "Ethiopia" OR "Uganda" OR "Nigeria" OR "South Africa" OR "Kenya".

For a more comprehensive approach, a search of the databases was followed by a review of the reference lists of relevant articles for further potential studies to include. All identified records were further imported into the reference management software, EndNote, after which the removal of duplicates was done before the screening process. The procedure of selecting the studies adopted a two-stage process. In the first stage, two authors assessed the titles and abstracts of the identified records by comparing them to the selected criteria. Studies that fit the criteria were considered in the second stage, which involved the evaluation of the full texts of the articles to establish if they fit the selection criteria. Any discrepancies in the process of selection of the articles were resolved by seeking the input of a third party. The process of selection of the articles was tracked and represented in a PRISMA-ScR flow diagram (Figure 1).

Figure 1. *PRISMA-ScR Flow Diagram of Study Selection for Scoping Review on Mental Health Outcomes among Women with Cervical Cancer in Africa*



The data extraction form was developed and pilot-tested to ensure that there are uniformity and a systematic approach. The following information was extracted from each included paper: the authors and year of publication, country and setting, design and size of the sample, mental health outcome measured, methods employed, and major mental health findings. The two authors independently extracted the data. Any discrepancies that arose were settled through discussion.

The extracted data were integrated in a descriptive manner. Results are presented in three main themes: characteristics of studies (which include country of studies, design, and sample size), the outcomes of mental health (such as depression, anxiety, psychological distress, and quality of life), and the contextual factors that include the socio-cultural, economic, and healthcare system aspects. Since there are variations in the study design, outcome measures, and the tools used in the studies cited in the literature, a meta-analysis was not conducted.

Although scoping reviews are intended for the purpose of evidence mapping and not effect size estimation, a risk of bias assessment was not formally carried out, in accordance with the PRISMA-ScR statement (Tricco et al. 2018). However, the designs of the studies, sample sizes, and methodological constraints considered.

Since the research conducted was a literature analysis, obtaining ethical approval was not required. All the information procured was from publications accessible to the public.

Results

In Table 1, the features of the included studies are presented. The 15 articles range in publication date from 2010 to 2025 and in geographical distribution cover a range of regions in Africa including Ethiopia, Uganda, South Africa, Nigeria, Zimbabwe, Malawi, Kenya, Morocco, and other parts of Africa (Table 1).

Based on the method and design of the studies, there were six cross-sectional quantitative studies, five qualitative studies, two mixed-design studies, and two systematic=scoping reviews. The sample size for the primary studies ranged from 15 to 422 participants. The primary studies were conducted in the oncology department of the hospital.

Table 1. *Characteristics of Included Studies on Mental Health Outcomes among Women with Cervical Cancer in Africa (n = 15)*

Author(s), Year	Country	Study Design	Sample Size	Mental Health Outcomes Assessed	Key Findings
Mengistu et al. 2020	Ethiopia	Cross-sectional	254	Depression, Quality of Life	Depression significantly associated with poorer overall and emotional QoL
Dagne et al. 2019	Ethiopia	Cross-sectional	422 (mixed cancers)	Depression	High prevalence of depressive symptoms; cancer severity associated with depression
Abate et al. 2020	Multiple (incl. Africa)	Systematic review & meta-analysis	–	Depression	High pooled prevalence of depression among cancer patients in LMICs
Mwaka et al. 2019	Uganda	Mixed methods	134	Psychological distress, Depression	Emotional distress, fear, and social disruption common
Okello et al. 2018	Uganda	Cross-sectional	149	Depression	45% of participants reported depressive symptoms
Lubuzo et al. 2021	South Africa	Cross-sectional	227	Emotional functioning, QoL	Poor emotional wellbeing during radiotherapy
Maree & Wright 2010	South Africa	Qualitative	15	Psychological distress	Fear, uncertainty, and emotional suffering following diagnosis
Balogun et al. 2021	Nigeria	Cross-sectional	120	Psychological distress, QoL	Financial hardship significantly worsened distress
Ojo et al. 2020	Nigeria	Qualitative	28	Emotional distress	Stigma, social isolation, and marital strain reported
Mutambara et al. 2021	Zimbabwe	Qualitative	20	Psychological distress	Fear of death, infertility concerns, and emotional trauma
Chidyaonga-Maseko et al. 2017	Malawi	Qualitative	32	Psychological distress	Diagnosis shock, fear, and unmet psychosocial needs
Ginsburg et al.	Kenya	Mixed	94	Psychological	Limited psychosocial

2018		methods		distress, Psychosocial needs	support within cancer care services
Khalfi et al. 2025	Morocco	Cross-sectional	100	Anxiety, Depression	38% anxiety; 25% depression prevalence
Derbew et al. 2024	Multiple African countries	Systematic review & meta-analysis	–	Anxiety, Depression	High pooled prevalence across African cancer patients
Maree et al. 2025	Sub-Saharan Africa	Scoping review	–	Psychosocial outcomes	Identified widespread distress and lack of interventions

Mental Health Outcomes Assessed

The outcomes for mental health showed differences in the studies that were considered. The primary outcomes measured in the studies that appeared in the research included the assessment of depression and psychological distress. Other notable outcomes in terms of their prominence in the studies conducted included the evaluation of anxiety and the quality of life. Some studies undertaken for their qualitative insights involved in-depth interviews with the subjects to determine their experience. The instruments applied in the studies showed considerable variability.

Depression and Anxiety

Depressive symptoms had a high prevalence in women diagnosed with cervical cancer. Cross-sectional studies done in Ethiopia and Uganda showed 45% to 50% of the participants showed clear symptoms of depression. Overall, in the cited studies, symptoms of depression had a definite link to the stage of the illness, the intensity of pain experienced by the patients, and the quality of life.

Anxiety was assessed to a lower extent, but it still remained a serious issue. Based on a Moroccan study, it has been seen that the prevalence of anxiety symptoms in women was 38%, while the symptoms of depression in patients were 25%. Systematic reviews supported the high prevalence rate of anxiety and depression in African cancer patients, including women with cervical cancer.

Psychological Distress and Emotional Experiences

Psychological distress was revealed as a theme that cut across qualitative studies, as well as mixed-methods studies. These studies revealed that female participants experienced a fear of death, emotional distress after receipt of a positive diagnosis, concerns regarding treatment outcome, and other sources of distress related to female infertility and body image. Studies were carried out among South African, Nigerian, Zimbabwean, and Malawian participants.

Women in numerous studies spoke about insufficient preparation for diagnosis, treatment, as well as lack of access to counselling or mental health services. Problems caused by lack of finances, as well as caregiving obligations, added to the psychological risks.

Quality of Life and Emotional Functioning

Four studies directly examined quality of life issues related to health. For women undergoing radiotherapy, there were subjective experiences of problems with emotional functioning, fatigue, and reduced social participation. Depression and psychological distress were strongly related to lower quality of life scores. Emotional well-being stood out as a domain seriously impacted for women with cervical cancer.

Mental Health Services and Support

There has been a pervasive absence of organized mental health/psychosocial support services integrated into cervical cancer programs. Even among the settings that support a range of oncology services, the provision of psychosocial support sometimes was unorganized, irregular, or absent. Several multi-country reviews, qualitative research, and a qualitative examination have identified unmet psychosocial needs. There has also been a pervasive absence of mental health screening.

Evidence Gaps

Although the prevalence of mental health issues is a significant problem, few studies have measured anxiety. Additionally, no studies have explored mental health intervention programs designed specifically for women with cervical cancer. There is a need for longitudinal research that focuses on mental health changes at various points along the continuum of cancer care.

Discussion

This scoping review brings together the current body of evidence of the mental health issues affecting women with cervical cancer in Africa and shows the significant level of mental health issues present. The evidence suggests that depression, anxiety, mental distress, and poor quality of life impact women significantly in Africa, but these issues are not being adequately addressed in cancer care systems.

High Burden of Depression and Anxiety

As found in the results of the present study, the common observed mental health problem in the female cervical cancer patients was depression. The prevalence of depression was found to range from 45% to 60%, which was higher compared to the general female population in Africa, as the prevalence of mental health problems, including depression, among the general female population of Africa was 25% (Okello et al. 2018, Dagne et al. 2019). The study found agreement with the previously conducted studies in the field of African oncology, which stated that the prevalence of cancer was associated with higher occurrences of depression and anxiety (Derbew et al. 2024).

Anxiety, although to a lower extent than distress, continued to be a critical issue, especially regarding diagnoses and treatment uncertainty. The Moroccan study that found a prevalence of anxiety of 38% corresponds to others carried out in low- and middle-income countries, where the anxiety caused by having a malign disease is related to death and to treatment and prognostic uncertainties (Khalfi et al. 2025, Ginsburg et al. 2018). This lack of studies on anxiety might be indicative of a gap in measurement and not a lack of importance.

Psychological Distress, Stigma, and Sociocultural Context

Research on qualitative and mixed methods has found that living with psychological distress is a common experience associated with fear, shock at the time of diagnosis, emotional suffering, and withdrawal. This may be exacerbated by stigma and sociocultural perceptions associated with cervical cancer and their connections with sexuality, infertility, and conjugal instability (Maree & Wright 2010, Ojo et al. 2020).

Distress associated with stigma has been found to result in delayed help-seeking, decreased social support, and worsening mental health symptomatology in women with cervical cancer in sub-Saharan Africa (Chidyaonga-Maseko et al. 2017, Mutambara et al. 2021). Thus, the results of the present review confirm the pressing need to view mental health results in the broader context of social and cultural milieus, rather than in isolation.

Quality of Life and Emotional Functioning

Poor quality of life, especially related to emotional and social functioning, has appeared as a significant result. Studies carried out among populations from Ethiopia and South Africa have shown a significant correlation between depressive symptoms and poor quality of life. These effects tend to be most significant among female patients with depressive symptoms undergoing radiotherapy (Mengistu et al. 2020, Lubuzo et al. 2021). Of course, it has already been established that left untreated, mental disturbances tend to increase symptoms and impede treatment among cancer patients (Ginsburg et al. 2018). Interestingly, emotional well-being has suffered the most among various quality-of-life indicators, suggesting that mental health programs could have a profoundly positive impact even under resource-constricted conditions.

Lack of Integrated Mental Health Services

Despite the established prevalence of mental health issues, the literature review has established the absence of organized mental health services in cervical cancer management. The psychosocial support that existed was unstructured and dependent on individual practitioners (Mwaka et al. 2019, Maree et al. 2025). This is similar to the current challenges in the integration of mental health at non-communicable diseases in Africa despite the WHO guidelines that champion a comprehensive and patient-centered approach to cancer management. The lack of intervention studies in the mental well-being of women with cervical cancer is an unexplored area with immense potential to be effective in-patient outcomes.

Further Study

This review points to areas of further research since some of the issues were either under-researched or not well dealt with in the existing studies. Such areas include the conduct of longitudinal studies to ascertain the mental health outcomes of women with cervical cancer as they progress through the various stages of the disease. There also seems to be a need for more intervention-based studies to be carried out to determine the efficacy of the various forms of psychological support, counseling services, and support programs for women with cervical cancer in Africa. In addition, the existing studies seem to be few in the area of the mental health of women with cervical cancer in rural areas where access to health services for women with cervical cancer may be a challenge.

Further studies are also needed to determine the effect of socioeconomic factors, stigma, cultural factors, and support from the family on the mental health of the women with cervical cancer. There also seems to be a scarcity of studies carried out to determine the integration of mental health services with the services of the oncology and primary health departments in Africa. Such studies will be important in the development of a comprehensive health program to address the health needs of women with cervical cancer in Africa.

Practical Implications

Among the findings contained in this systematic review are the following directions that should receive a high level of priority. First, the screening for both depression and anxiety should therefore be included in the cervical cancer services using simple and valid tools. The second direction would involve the development of psychosocial programs using appropriate strategies for the cultures found in Africa. The final research direction would therefore involve the conduct of further studies using different methodologies.

Strengths and Limitations

The scoping study presents a thorough mapping of the current state of the literature. Nevertheless, it is important to interpret the results in the context of a number of issues. Firstly, outcome measures varied between studies, the studies concentrated on hospital-based samples, and there was a restriction to studies published in English. Despite the above, the consistency and generalizability of the results strengthen the validity of the inferences.

Conclusion

This literature review reflects the large problem of mental morbidity in women suffering from cervical cancer in Africa, as a result of clinical, social, as well as structural issues. For the problem to be properly addressed, mental health support must be strategically incorporated into the cancer services they offer.

Acknowledgments

The authors would like to thank the three research assistants who helped identify the articles for the study.

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