

## BUILDING COMMUNITY IN THE SHADOWS OF STIGMA

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### The Weight of Silence

**D**uring my years of service as a clinical nurse at *Tikur Anbessa Specialized Hospital*—Ethiopia’s primary governmental referral center and largest oncology hub—I witnessed firsthand the intersection of medical complexity and human suffering. As families traveled from every remote corner of the country to reach us, I came to understand the deep social burdens they carried. This perspective helped me to address the psychological *shadows* of cancer and treat the patient as a whole person.

Working in this context, I witnessed a kind of suffering that medicine alone could not heal. Patients faced a crushing weight of financial crisis and cultural stigma. For women with cervical cancer, the struggle was particularly difficult. They often faced an offensive discharge—a persistent, foul-smelling vaginal leakage caused by the necrosis of the tumor—which, coupled with deep-seated shame, often led to total isolation. In the quiet hallways of the ward, I saw women who would not look me in the eye, their shoulders hunched as if trying to disappear into the hospital walls, especially for those from rural areas where cancer is sometimes whispered about as a “curse” or a divine punishment. At first, I felt entirely alone in my frustration, helpless against the sorrow of patients who were not just fighting for their lives, but for their dignity.

## The Sanitary Pad: A Turning Point

My perspective changed because of a 47-year-old woman from a rural area who came to our procedure room. She was in distress, suffering from heavy discharge, and had no sanitary pads. I remember the way her hands shook as she tried to adjust her clothes and felt heavy with embarrassment. I gave her my own products, and this small, human gesture broke her silence. She wept—not the loud weeping of a sudden injury, but the slow, heavy tears of someone who had been holding a mountain inside. She told me that her husband and family had isolated her, forcing her to use separate utensils and refusing to eat with her because they feared she was "contagious."

I realized then that her anxiety was more painful than her physical tumor. With her quiet consent, I invited her husband into the room. I did not want him to feel accused; I wanted him to feel informed. I provided health education on the medical realities of her condition and the importance of emotional support. I stayed with them until I saw the tension leave his shoulders, waiting for that moment of realization when he understood that his wife was not a danger to the family, but a woman in need of his love. The moment he finally reached out to touch her hand was the moment the 'community' of their marriage began to be restored.

Seeing them leave the hospital together—not as a patient and a fearful stranger, but as a couple reunited in understanding—was a profound victory. The smile she offered me was evidence of a "prescription" more powerful than any medicine I could provide; it was the smile of someone brought back into the *warmth of her community*.

## Restoring Dignity and Health

When I shared this experience with my colleagues during lunch time—sitting over shared plates of "*injera*"—the isolation I had been feeling vanished. We realized we all shared a collective "moral injury" from seeing our patients suffer in ways medicine alone could not reach. We realized that we, the nurses, were also a community that needed to heal itself by helping others. At that moment we all reached the conclusion that this scenario can be a powerful reminder that a simple, human intervention can be more curative than the most complex clinical procedure. Therefore, together, we began to grow our own quiet community of care, rooted in the principles of Whole Person Care—treating not just the disease, but the human being in their specific cultural and financial context. Thus, we turned two things into action.

**1. The Sisterhood of Care:** We recognized that many patients, especially those arriving from remote rural areas, were completely unprepared for the physical realities of their condition. Many did not know about sanitary pads and relied on a single piece of traditional textile like "*Netela*". This was not only a matter of dignity but a serious health risk, as it exposed their already vulnerable bodies to infection. For this reason,

we began a small, quiet practice of saving one or two sanitary pads from our own personal supplies to give to these women. We were not only providing a resource, we were providing a lesson in self-care and safety. Moreover, it was our way of telling these women that their health and their honor mattered to us.

**2. Bridging the Awareness Gap:** We expanded our morning health education sessions to integrate psychological support alongside clinical information. We transformed our waiting areas into *classrooms of compassion*. We achieved this by rearranging the seating to encourage dialogue and using our morning health education sessions to openly discuss the emotional needs of oncology patients. Our goal was to target the specific cultural misconceptions that fuel social stigma. By educating caregivers on the emotional needs of oncology patients and correcting the misconceptions about the disease being “contagious”, we fostered a community of informed and compassionate support around every patient.

## Restoring the Spirit

To treat the disease effectively, we must first stabilize the patient’s psychological state. A body cannot heal if the mind is in a state of stress. While many of my peers chose to specialize further in clinical oncology nursing, I realized that my greatest impact would come from stepping into the *shadows* that medicine often ignores—the space where physical care meets mental health.

Consequently, I decided to upgrade my career by pursuing a Master’s in Counseling Psychology. This was not a move away from nursing, but an expansion of it. Today, working in a large private hospital, I integrate these two worlds. My nursing background provides the clinical foundation, while my psychological training allows me to address the deeper, invisible battles that oncology patients face.

I have learned that a cancer diagnosis often triggers a total collapse of identity and a loss of self-confidence. Beyond the physical trauma, many patients enter a profound spiritual struggle, wrestling with feelings of unworthiness or engaging in a ‘fight with God’ to find meaning in their suffering. My role now is to hold space for these existential crises, helping patients rebuild their sense of self and find peace amidst the storm. I have realized that Whole Person Care is about more than clinical recovery; it is about restoring the spirit of the human being behind the patient. When we foster community, we prove to the patient that we are one and the same. ■

## Biographical Note

Selamawit Kinfu Alemayehu is a clinical nurse and counseling psychologist based in Addis Ababa, Ethiopia. During her years of service at Tikur Anbessa Specialized Hospital, she witnessed the deep social burdens and profound isolation carried by oncology patients—shadows that medicine alone could not heal. Having completed her Master’s in Counseling Psychology, she now integrates clinical nursing expertise with

psychological training to address the invisible battles her patients face. Currently, she practices in a large private hospital where her work focuses on "Whole Person Care". She helps oncology patients rebuild their self-confidence, and bridge the gap between clinical treatment and the life they cherish with their loved ones.