ADDIS ABABA UNIVERSITY

SCHOOL OF GRADUATE STUDIES

COLLEGE OF EDUCATION & BEHAVIORAL STUDIES SCHOOL OF PSYCHOLOGY

Psychosocial experiences of kidney transplanted patients at St. Paul's Millennium Medical College

A THESIS SUBMITTED TO THE SCHOOL OF GRADUATE STUDIES ADDIS ABABA UNIVERSITY IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF ARTS IN SOCIAL PSYCHOLOGY

By

Aberehet Girmay

July, 2021

Addis Ababa

ADDIS ABABA UNIVERSITY

SCHOOL OF GRADUATE STUDIES

COLLEGE OF EDUCATION & BEHAVIORAL STUDIES SCHOOL OF PSYCHOLOGY

Psychosocial experiences of patients kidney transplant at St. Paul's Millennium Medical College

A THESIS SUBMITTED TO THE SCHOOL OF GRADUATE STUDIES ADDIS ABABA UNIVERSITY IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF ARTS IN SOCIAL PSYCHOLOGY

By

Aberehet Girmay

Advisor

Mulat Asnake (PhD)

Psychosocial experiences kidney transplant Patients at ST. PAULOS Millennium Medical College

By

Aberehet Girmay

School of Graduate studies

This is to certify that the thesis prepared by Aberehet Girmay entitled psychosocial experience of Kidney Transplant Patients at St. Paul Millennium Medical College and submitted in partial fulfillment of requirement for the Degree of Master of Art in Social Psychology with the regulation of the University and meet the accepted standard with respect of originality and quality

Approved by

__________________ __________ __________

Chairperson, school of Signature Date

Graduate Committee

Dr. Mulat Asnake __________ __________

Advisor Signature Date

Dr……… __________ __________

Examiner, External Signature Date

Dr. ……… __________ __________

Examiner, Internal Signature Date

Acknowledgements

First and foremost, I would like to extend my deepest gratitude to my advisor Dr. Mulat Asnake for his dedication, diligence, and discipline with which he guided me through the whole research process. I am also pleased to extend my heart-felt gratitude to the study participants for their time and responses about the rising problem in our country. I am indebted to my friends; particularly Sr. Lanchisil Amare and Mr. Dawit Assergidew for their persistent support. Last but definitely not least sincere gratitude goes to my sister Lielt G/Selasie for her priceless support.

Abstract

Dialysis is available as an alternative remedy for renal impairment, however, kidney transplantation is generally the preferred treatment as it tends to extend life-span and lead to an improved quality of life, in addition to being more cost-effective than dialysis. This is primarily due to the significant limitations caused by dialysis, many of which can be resolved by Kidney transplantation. The general objective of this study was to explore psychosocial experiences of kidney transplant patients before and after transplant at St. Paul's Millennium Medical College, Addis Ababa, Ethiopia. A total of ten participants were included using the purposive sampling method. Interviewer administered semi-structured data collection instrument made up of open and closed ended questions were used. Careful verbatim transcriptions of the gathered data were done. Data were analyzed with Interpretative Phenomenological Analysis. It's found that loss of freedom, uncertainty about timely transplant, social isolation, economic crisis, distracted self-image, and lowered elf-esteem emerged as psychosocial challenges during dialysis. Re-birth, thankfulness, social bond, liberty from dialysis, self-efficacy and social support were emerged as positive psychosocial experiences whereas dependency, fear of the future, adherence challenge, and regret emerged as negative psychosocial experiences. The researcher concluded that compared with dialysis, life after receiving a kidney is pleasant and enabling though it is not without challenges. While patients developed psychosocial crisis they become non-compliant with the treatment. The study recommends that every concerned stakeholder including government, hospitals and different concerned authorities should take part in supporting the dialysis and kidney transplant patients in order to address those individuals' psychosocial experiences.

Key Words: Kidney Transplantation, psychological experience, dialysis

Table of Contents

Acknowledgements i

Abstract ii

List of Table v

ACRONYMS vi

CHAPTER ONE—Introduction 1

1.1. Overview 1

1.1 Background of the Study 2

1.2 Statement of the Problem 4

1.3 Research Questions 6

1.5. Significance of the Study 7

1.4. Objective of the Study 8

1.4.1. General Objective 8

1.4.2. Specific Objectives 8

1.5 Motive of the Study 8

1.6 Delimitation of the Study 11

1.7 Definition of Terms 12

2. 1 Overview of Kidney Disease and Transplant 14

2.3. Social experiences of kidney transplanted patients 22

2.4. Negative Psychological Experience of Renal Transplant 24

2.5. Positive Psychological Experience of Kidney Transplant Patient 26

2.6. Factors Associated with Negative Psychological Experiences 27

2.7. Factors Associated With Positive Psychological Experience 28

3. Research Methodology 31

3.1 Research approach and design 31

3.2. Study Area and Target Population 32

3.2.1 Study participants 32

3.3. Sample and Sampling technique 32

3.5 Inclusion and exclusion criteria 34

3.5.1. Inclusion criteria 34

    - 3.5.2 Exclusion criteria 34
    - 3.5.3. Data quality management 34
    - 3.5.4 Data analysis 34
    - 3.5.5. Ethical Consideration 35
- CHAPTER FOUR—RESULTS AND DISCUSSION 36
  - 4.1. Demographic characteristics of participants 36
  - 4.2. *A*nalysis of semi-structured interviews 37
  - 4.3. Findings from semi-structured in-depth interviews 38
    - 4.3.1. Psychosocial experiences during dialysis 38
  - 4.3.2 Positive psychosocial experiences 42
    - 4.3.3. Negative psychosocial experiences after transplant 47
    - 4.3.4. Social support received by kidney transplant clients 48
    - 4.3.5. The impact of social support on kidney transplanted clients 50
- CHAPTERFIVE—DISCUSSION OF THE FINDINGS 52
  - 5.1. Positive psychosocial experiences during dialysis and after transplant 52
  - 5.2. Negative psychosocial experiences 53
- CHAPTER SIX—Conclusion and Recommendation 56
  - 6.1. Conclusion 56
  - 6.2. Recommendation 56
- *References* 58
- *APPEDECES* 65
    - *APPENDIX –I* 65
    - *APPENDIX –II* 66
    - *APPENDIX –III* 67
    - *APPENDIX –IV* 68
- Declaration 76
- Donor and Recipient Selection Process 77

List of Table

Table 1 Socio-demographic characteristics of in-depth interview participants, St. Paul Hospital, Addis Ababa, Ethiopia, ...36

ACRONYMS

CKD	Chronic Kidney Diseases
CKD-T	Chronic Kidney Diseases-Transplanted
ICU	Intensive Care Unit
IDI	In-Depth Interview
IPA	Interpretative Phenomenological Analysis
KT	Kidney Transplantation
ESRD	End Stage of Renal Disease
HD	Hemodialysis
SPMMC	St. Paulo's Millennium Medical College

CHAPTER ONE—INTRODUCTION

1.1. Overview

Chronic Kidney Diseases (CKD) is described as irregularities of kidney structure and function, persistent for greater than 3 months. This is the most common form of kidney disease, with a predicted occurrence throughout the world of approximately 10.4% among men and 11.8% among women (Naghavi, Wang, Lozano, Davis, Liang & Zhou, 2015). Chronic renal disease is increasingly identified as a worldwide public health burden and a key predictor of the impaired health outcomes. There is compelling evidence that disadvantaged communities, i.e., those from low-resource and economically disadvantaged backgrounds, suffer from noticeable increases in the problem of unidentified and untreated chronic renal disease. The total populations of low- income nation could be considered disadvantaged more from kidney disease (Crews, Charles, Evans, Zonderman & Powe, 2010). The economically disadvantaged peoples are more vulnerable to disease due to lack of access to goods and services, in particular clean water and sanitation, information about preventive behaviors (low adherence to exercise), sufficient nutrition, and reduced access to health care (Remuzzi, Perico, Macia & Ruggenenti, 2005).

Chronic renal disease can be defined by the requirement for life-saving dialysis or kidney transplantation. Between 5.3 and 10.5 million people need dialysis or transplantation, even though many die because they do not take these treatments due to lack of resources or economic problems (Liyanage, Ninomiya, Jha, Neal, Patrice Okpechi, & Rodgers, 2015; Wang, Naghavi, Allen, Barber, Bhutta, Carter & Coggeshall, 2016). It is also estimated that the number receiving kidney transplantation is growing by around 8% every year (Couser, Remuzzi, Mendis & Tonelli, 2011). The leading risk factors for this increment are population ageing, type 2 diabetes mellitus and hypertension. However, due to the expensive nature of kidney transplant, treatment for end-stage renal disease is largely performed in high-income countries. The burden of the end-stage renal problems is high in low- and middle-income countries (LMIC) due to impediments related with low access to renal replacement therapy (Tonelli & Riella, 2014).

Treatment with dialysis and transplantation is accompanied by not only somatic problems, but also different psychosocial burdens which have a significant impact on the patient's quality of life. Kimmel reported that during the course of dialysis, ESRD patients suffered from different stressors in addition to that of physiological pain, which include dietary and time constraints, functional limitations, loss of employment, changes in self-perception, alterations in sexual function, general and perceived effects of illness, medications used to treat the illness, and fear of death. The demands of ESRD treated with hemodialysis include potential changes in a patient's status in marital, familial, occupational, and societal contexts; the expenses and worries associated with the treatment and the illness, and the uncertainty, anxiety, and costs entailed while waiting for a transplant (Kimmel, 2010).

Renal transplantations are normally the ideal treatments as it tends to lengthen life-span and tends to a better worth of life, in addition to being more cost-effective than dialyses. This is especially because the significant problems caused by dialysis (e.g. decreased independence), a lot of which can be resolved via transplantation (Gordon, 2001). Switching from having dialysis to receiving a kidney transplant could have a positive effect on the emotional well-being of peoples with end- stage renal disease; however, there are still some problems that limit the number of transplants performed and the positive consequences of the interventions (Wainwright, Fallon & Gould, 1999).

1.1 Background of the Study

Organ transplantation not only gives ways of treating diseases, congenital defects, impairments, and injuries, it also affects processes of self-formation in different methods for the individual treated (Svenaeus, 2012). Moreover, having a kidney transplant can also result in long-term psycho-social effects, consisting of ongoing gratitude to the donor, experiencing medication as intrusive, and feeling different from others (Orr, Willis, Holmes, Britton & Orr, 2007).

Different previous studies showed that renal transplant conveys tremendous feelings like new hope to the future life, develops a feeling of independence (Lonargáin, Brannigan & Murray, 2017); Schulz & Kroencke,2015) ;(Wainwright, Fallon, & Gould, 1999). However, other studies claimed kidney transplant individuals also experience psychological and emotional impairments like depression, anxiety, fear, and sadness (Avramovic & Stefanovic,2012); (Brito, Paula, Grincenkov, Lucchetti & Sanders-Pinheiro , 2015); (O'Donnell, Chung, 1997); (Schulz & Thaiss, 2012).

Negative psychological experiences after kidney transplant has been specially related to the problem of accepting the new organ, experience feeling of guilt towards the donor, medication side effects and related comorbidities, uncertainty about the future life, worry of rejection and return to dialysis associated with lack of knowledge about the procedure. (Goetzmann, Irani, Moser, Schwegler, Stamm, Spindler, & Klaghofer, 2009); (Lee, Lee, Ahn, Kim, Lee & Suh, 2017); (Heinrich & Marcangelo, 2009. On the other hand, (Lonargáin, Brannigan & Murray, 2017); Schulz & Kroencke, 2015) revealed that; back to work, back to social roles, being free from dialysis, and becoming independent have significant impact on developing positive psychosocial experiences of kidney transplant individuals. Studying mental and behavioral health issues related to renal transplant has been recognized as vital since the former transplant in human patients when postoperative psychological problems and affective disorders commenced to appear and threaten what has been taken to consideration to be technically desirable outcomes (Olbrisch, 2012).

Further to the insufficient number of donated organs from deceased and living donors, major problems are the result of transplant course treatment often solely medical-surgical, ignoring the close interplay between mind and body. Organ transplantation could be very difficult for the affected person and acts as severe stress stimulus to which the patients reacts with neurotransmitter and endocrine-metabolic changes (De Pasquale, Veroux, Indelicato, Sinagra, Giaquinta, Fornaro, & Pistorio, 2014).

Although the kidney transplantation procedure in Ethiopia has short history, the country has developed donor and recipient selection process relevant to the society. According to the Ministry of Health of Ethiopia proclamation no. 691/2003 article 10, potential kidney recipients are selected from the pool of patients who came to the center with advanced chronic kidney disease or ESRD.

The most basic criterion of acceptance for kidney transplantation is a good probability of survival after kidney transplantation. The potential living donor shall also be examined and determined to have no contraindications and no identified risk factors for the procedure or for future health after kidney donation. According to our legislation the living donor shall also be related to the recipient and must come forward voluntarily, and give consent without coercion, financial or other incentives for the procedure.

All potential recipients and potential donors are evaluated by the physicians and other appropriate professionals associated with the program.The pre-transplant evaluation takes place in an outpatient setting; by a muliti-disciplinary team that will include nephrologists, surgeons, psychiatrist or social worker and transplant nurse coordinator. Once the transplant candidate and potential donor evaluation is completed, all the data and information are summarized and presented to the transplant selection committee, where a decision is made to accept or reject the patient and/or the donor for the procedure. Finally those cases accepted by the transplant selection committee will be sent to the National transplant committee, based in the MOH for final approval.

1.2 Statement of the Problem

Chronic kidney disease (CKD) is presently a worldwide public health issue (with the alarming increase in incidence (Zhangm & Rothenbacher, 2008). The lack of working registries in most of sub-Saharan Africa, including Ethiopia, has ended in an absence of reliable statistics, but there is a general impression that CKD is at least three to four times more common than in developed countries (Naicker, 2009); Mahmoud, 2014). Chronic illnesses like CKD are not only accompanied by somatic changes and functional difficulties but also by emotional, cognitive, and social modifications that need enormous adjustments and tremendous coping skills. These psychosocial changes should not be considered as secondary, since they are a greater part of the illness as pathological blood parameters and somatic symptoms (Schulz & Kroencke, 2015).

Psychological wellbeing positively influences healing from illness and medical interventions. Even though the interaction of physical, psychological, socio-economic, cultural, and spiritual determinates is highly complex in recovery processes, findings revealed that psychological expression enhances health and recovery from both illness and traumatic experiences (Amerena & Wallace, 2009). Moreover, Cabral, Cavadas, Ramos, Fraga, Martins, Rocha ... & Branco, 2015) claimed mental impairments within this complex are related with kidney function, medication, and treatment adherence.

Studies claimed that patients with ESRD receiving hemodialysis and transplant developed a new identity and sense of self. This new and evolving emotional/ psychological state indicated that patient's became aware of a new set of circumstances especially during the life of dialysis. ESRD patients diminished quality of life (QOL) is linked to limited personal freedom and control, for example, lengthy treatment time extended lives but contributed to these restrictions (Kimmel, 2010). Loss of freedom was also associated with prolonged preparations for dialysis which was a major source of frustration. Overall, the loss of freedom had wider implications altering marital, family, and social relationships during dialysis (Muringai et al, 2008). Depression is strongly recognized as a common psychological problem in hemodialysis patients (Kimmel, 2010).

Transplanted patients perceived their condition as less chronic, reported fewer symptoms compared to dialysis patients. The number of individuals getting renal transplants is increasing each year. Even though it is now a routine method less challenging than dialysis, patients are faced with numerous psychologically demanding situations (Schulz & Kroencke, 2015). Moreover, empirical findings reported that CKD individuals considered as a risk group for mental impairments even after KT.

De Pasquale et al, (2014); Schulz & Kroencke, 2015) revealed the acquisition of a new organ including kidney goes via psychological passage besides with the first experience as an object and only later does it merge silently with other self-representations, that takes on narcissistic energies and then, apart from times of uncommon stress, becomes a silent member of the self-system. It is at some stage in these instances of unusual stress (infection or a biopsy) that the new organ can once again be seen to be an 'object' - a stranger, a foreign body.

Chilcot et al, 2014); (Müller, Engelbrecht, Wiesener, Titze, Heller, Groemer... & Maler, 2015) found 25% of the mean prevalence of depressive problems for CKD, regardless of a functioning graft. Additionally, other studies reported a 70% prevalence of depression and anxiety related to transplanted CKD (Bromet, Andrade, Hwang, Sampson, Alonso, De Girolamo... & Karam, 2011); Resende, Guerra, Santana, Mil-Homens, Abreu & Da Costa, 2009); Palmer, Vecchio, Craig, Tonelli, Johnson, Nicolucci & Strippoli, 2013). These numbers are significantly increased compared with the general population, in which prevalence rates of 6.9% and even cancer patients with mean prevalence rates up to 17% (Chilcot et al, 2014; Krebber, Buffart, Kleijn, Riepma, De Bree, Leemans & Verdonck-de Leeuw, 2014).

Previous psychosocial studies have mainly centered on depressive disorders in non-transplanted CKD patients. Moreover, in Ethiopia despite the growing pieces of evidence about the prevalence of CKD and renal transplant patients are rising, to the best knowledge of the researcher, there was no single study conducted on the psychosocial experience of those patients'undergo dialysis and renal transplants. Thus, this study is designed to explore the psychosocial experiences of kidney transplant patients before and after transplant at St. Paulo's Millennium Medical College (SPMMC).

Furthermore, the actual experiences of the researcher who undergone in this path contributed to the initiation of this study. Although the procedure has conducted some three years back, the researcher has continued entertaining various psychosocial effectsthat requires multidisciplinary interventions. In the meantime as a socialpsychologist, it is our duty to recognize the problem and study its effects in our society to better understand the impact and device strategies to improve it.

1.3 Research Questions

1. What are the main psychosocial experiences of ESRD patients during dialysis?

2. What are the main positive and negative experiences of patients before, during and after Kidney transplantation?

3. What are the challenges Chronic Kidney patients go through?

4. How social support received from significant others affect the kidney transplanted individuals?

1.5. Significance of the Study

Chronic kidney disease is a major public health concern nowadays. Despite there are enough studies conducted on the prevalence of CKD and those undergone kidney dialysis and transplant, little is known about the psychosocial experience of ESRD individuals during dialysis and after transplant. Thus, the researcher aimed to improve the understanding of the psychosocial features of the experience, to support the interventions for the benefit of patients as there is lack of clarity about the availability and affordability of psychosocial counseling for transplant recipients.

Since the objective of the study is to explore the psychosocial experiences of patients during dialysis and after kidney transplant; the findings of the present study will have the following significance.

First, Health care providers and other stakeholders are in need of appropriate information on psychosocial experiences of end stage renal disease patients before and after transplant. So, the health professionals, psychologists, counselors and social workers will benefit from the acquired information regarding the psychosocial experiences of kidney transplant patients at St. Paul Millennium Medical College.

Second, as the finding from this study believed to provide appropriate information for health providers and other responsible bodies which have a key role in KT patients counseling and implementation of different intervention, which in turn, help them to do accordingly. Thus, ESRD patients will benefit from appropriate counseling and intervention.

Third, the findings of the present study will also benefit Policy Makers tostimulate their attention and have clear insightsabout the psychological and social experiences, available opportunities and the existing challenges of kidney transplant patients.

Finally, as there was no/very little previous study conducted that explore psychosocial experiences of kidney transplant recipients in Ethiopia, the current study will be used as a baseline for future researchers.

1.4. Objective of the Study

1.4.1. General Objective

The general objective of this study was to explore the psychosocial experiences of kidney transplanted clients during dialysis and after transplant at St. Paul's Millennium Medical College (SPMMC).

1.4.2. Specific Objectives

The specific objectives, this study intended to:

- Explore psychosocial experiences of kidney transplant patients during dialysis at St. Paulo's Millennium Medical College.
- Explore the positive psychological experiences of kidney transplant patients at SPMMC.
- Explore the negative psychological experiences of kidney transplant patients atSPMMC.
- Examine the social supports received from significant others among kidney transplant patients atSPMMC.
- Examine the impact of social support on psychological experiences of post-transplant patients atSPMMC.

1.5 Motive of the Study

I begin this feature with 'My Story' and then move onto how Chronic Kidney Disease (CKD) has changed my life and created a passion for me to contribute back to all those wonderful family, friends & medical staff that have cared for me over the years; which this thesis is for.

It was (September 2016), I was 40 years old, life was good, until I was faced losing of my twins to a pregnancy related complication. The complication did not stop at my loss, rather became life threatening. I had not felt really well then after. I just put this down to the problem that I have been passing through. I then lost my appetite, my feet and face started to swell, I had been feeling extreme fatigue for some time and suffered from frequent headaches. Anything that went down my throat (including medicine) would come back out again. My blood pressure registered at my pregnancy period was as high as 250/150, which led to increase in my creatinine hormone level that was between 2 – 9 /6.5 to be precise/, while a normal creatinine level is between 0.8 – 1.1. Finally, thinking that my creatinine level is gradually increasing despite the decrease in my blood pressure; I had to pay a visit to the hospital.

I saw a kidney specialist, Dr. Momina Mohammed (who is the pioneer introducing the first historic kidney transplant service in Ethiopia by 2015), she did a couple of further tests, and explained the problem; saying that the disease has gone undetected over the years and my kidneys had suffered. Only to be given the devastating news, that my kidneys were failing and I was told I would need a transplant. I felt shocked and devastated (I just cannot get enough words to describe how I felt even to this day), that day was the beginning of my worst nightmares. What I could say is, within a few days I'd gone from living a normal life to having it turned upside down. I sat opposite the doctor brokenhearted words were leaving her mouth but not reaching me. I was filled with anguish, depression … while thinking about the two unanswerable questions at the time: 'who would donate a kidney? And where would I get the amount of money required to undergo the treatment?' I felt hopeless & helpless.

It took me a long time to come to terms with the news, my family and friends were very supportive but at the same time worried and devastated. Around the same time, I was put on the transplant list and my sisters and brothers were going through compatibility tests to see if they were a match and well enough to donate. I had very mixed feelings about this and really did not want my family to go through any of it. Then, two of my best friends came forward for kidney donation. But we learned that Ethiopian law does not support such a donation outside close family ties.

After some discussion among my family, the fate falls on my younger brother. He was found to be compatible. He then has to get his wife's agreement for his kidney donation as per Federal Documents Authentication & Registration Agency. At first he refused saying that it's his own kidney, and his wife has no authority on. But that was the law. So, his wife, who was seven months into her pregnancy, was transported all the way from Tigray to give her consent. She was told that he might die on the process, and would be left to raise her children by herself, which she didn't hesitate to agree to. Saying "I don't want him to be alive & think that he could have saved his sister, if he loses her without trying to." That was another painful moment for me, but still one challenge was down. My worry on how & where the money would come from still persisted. It is then I decided to sell my house, so shared the idea with my friend who resides in the United States (Hamelmal Alemu). But she advised me against selling it, and created a VIBER group to raise the fund required. Lucky enough, USD 20,000.00 was raised in a week's time.

In (January 2018), I started the process at St. Paul Hospital Millennium Medical College. As my kidney function had deteriorated further down, I was advised to start dialyses. While attending dialysis, I requested when the transplant would be actualized. But the replay was discouraging; as the list was too long, I had to wait for another 9 months. The medical team performing kidney transplant was coming from aboard, and there were many on the list. At the time, I was so ill that I let alone 9 months, was unable to go on for another 9 weeks. Thus, I was obliged to seek for another option – India (New Delhi). With my doctor's advice, I reached Apollo Hospital with my younger brother (kidney donor) & my sister (our caretaker).

The very first challenge we faced in New Delhi was the food & its smell in the air; as a typical Ethiopian, it was difficult for us to get used to. Second challenge was document authentication; we were told that we need to take the document that we brought from Ethiopian Federal Documents Authentication & Registration Agency to the Ethiopian Embassy in Delhi. And so we did, but took a couple of days & I was to put on dialysis for those two days. After the paper work is done, my brother had to undergo some interviews. On the third day, my transplant went ahead.

Post-transplant – Although, I was so weak from the previous days' dialysis & pain of receiving a new organ, I was grateful & very thankful for the operation was successful. Next few days were not any easier, the dialysis line or 'life line' for the treatment (as the doctors call it) was on my neck, I have a catheter on, and glucose was put on both of my hands. On top of these, the sleepless nights, the nonstop headache and being unable to change my own clothes for days was a great challenge. However, because a have hope of a future life, I was so thankful of the second life that I am bestowed with &was not biter on the process.

A week after the transplant I started to walk around with the support from the nurses. Soon after was discharged from the hospital. But, I have to visit my doctor every week for blood works/test. In addition, I have to take a monitored immunity suppressant medicine; for otherwise the new kidney would be attacked as a foreign body. The side effect of the medicine lowered my body weight significantly. In the meantime, my brother got well and headed back home in 2 weeks, while I've to stay for 2 months.

In (March, 2018) I flew home, but I have to isolate myself for 6 more months in fear of getting sick from any disease, as less involvement means less chance of failing ill. I was advised against it, because getting any sickness will challenge my already suppressed immunity a lot. Gradually, my status improved, although I've to face the side effects of the medications (it should be taken for life time) I was taking, which now thinking back were as difficult as the kidney transplant itself.

It is my third year since the transplant; my precious gift of life is still going strong. There are no words that can express my gratitude how the precious gift and support from my loved ones have given me a second chance. I am now able to continue my education, and that is why I have dedicated the title of my research paper on Psychosocial Experience of Kidney Transplant Patients – an experience that generated from my own life.

Kidney failure made me realize that I should live for the moment and not take anything for granted. I try and live life to the fullest despite of the setbacks and adversities. I also live in the hope that, my country has more transplantation and dialysis equipment and that one day precious and invaluable transplanted Kidneys will be for life and change lives for the better.

1.6 Delimitation of the Study

While conducting researches covering every aspect may not be possible because different reasons of which one is directly associated with the accuracy of the findings. Therefore, for the sake of making it very focused, the scope of this particular study was presented into two dimensions: in terms of variable and study area. Positive and negative psychosocial experiences kidney transplantation was the focus of this paper. The study was conducted at St Paulo's Hospital Millennium Medical College in Addis Ababa, Ethiopia.

As there was no previous studies that explore psychosocial challenges related with kidney transplant recipients conducted in Ethiopia the current study was used only other country literature review

1.7 Definition of Terms

Operationally define technical terms; those terminologies would be used in this study as follows:

- **Psychosocial experiences**: Combination of psychological and social features in terms of experiences. For psychological aspect comprising Anxiety, Anger and depression, Social factors include general factors at the level of human society concerned with social structure and social processes that impinge on the individual
- **Anxiety**: when a renal transplant patient explains his/her mental status after a transplant by stating like "I suffer uncontrolled feelings of tension (uneasy), worried thoughts (worrying about the health of the donor, future life), irritability, restlessness, fear (unpleasant feeling (terrified) of something example, "Fear of not back to the workplace, fear of death, fear of graft rejection…) and anger related with loss of fulltime work, being dependent on others not return to their former social roles And physical changes like palpitation, sweating, dyspnea and sleeping difficulty of unknown origin or stimuli.

- **Psychosocial challenges**: The existing challenges faced by kidney transplant patients

- **Depression**: If post-transplant patients stated their experience like ' I have persistent sadness and loss of interest or pleasure in previously rewarding or enjoyable activities before transplant, feel tiredness and poor concentration, patients who had an attempt or idea of suicide, feeling of guilt, disturbed sleep or appetite.

- **Anger**: If a renal transplanted patient developed an emotion characterized with ill-feeling toward someone or something he/she feel has deliberately done you wrong.

- **Positive psychological experience**: The tremendous aspect of personal experience that makes life worth living in post-transplant patients like feeling of freedom, independence, and a sense of hope related to the transplant.

CHAPTER TWO—REVIEW OF RELATED LITERATURE

2. 1 Overview of Kidney Disease and Transplant

Different literatures/scholars have given a number of definitions on kidney disease and transplantation. The prevalence rate of kidney disease and transplantation, and its impacts at individual, family, societal, country and worldwide levels disclosed as follows.

Regardless of the causes, chronic kidney disease is explained as renal impairment or glomerular filtration rate (GFR) <60 mL/min/1.73 m^2 for 3 months or more. Renal damage in many renal diseases can be determined by the presence of albuminuria, defined as albumin-to-creatinine ratio >30 mg/g in two of three spot urine specimens (WHO, 2015).

Chronic kidney disease comprises conditions that impair the kidneys and decrease their ability to keep a person healthy by doing different functions. If kidney disease gets worse, wastes can build to high levels in the blood and make a person feel sick. CKD is accompanied by severe complications such as; hypertension, anemia (low blood count), weak bones, malnutrition, and nerve damage (Lee, Ahn, Kim, &Suh, 2017).

Chronic kidney disease is a situation in which the kidneys are impaired and cannot filter blood as expected. Due to this, excess fluid and waste from blood remain in the body and may result in different health impairments, such as heart disease and stroke; anemia or low number of red blood cells; increased occurrence of infections; low calcium levels; high potassium levels; high phosphorus levels in the blood;loss of appetite or eating less; and depression or lower quality of life (CDC, 2017).

The illness has different levels of seriousness. It usually gets worse from time- to- time though treatmenthas been shown to slow the development. If CKD remain untreated, it can develop to kidney failure and early cardiovascular disease. When the kidneys stop working, dialysis or kidney transplant is needed to extend life expectancy. Kidney impairment treated with dialysis or kidney transplant is called end-stage renal disease (ESRD) (CDC, 2017).

Renal disease has an indirect impact on global morbidity and mortality by increasing the risks related to at least five other major killers: cardiovascular diseases, diabetes, hypertension, infection with human immunodeficiency virus (HIV) and malaria. For example, the Global Burden of Disease (GBD) 2015 study estimated that 1.2 million deaths, 19 million disability-adjusted life-years (DALYs) and 18 million years of life lost from cardiovascular diseases were directly attributable to reduced Glomerular filtration rates (Naghavi, Wang, Lozano, Davis, Liang & Zhou, 2015).

The global burden of disease estimated that in 2010, around 2.3–7.1 million people with end-stage kidney disease died. Moreover, every year, approximately 1.7 million people are predicted to die from acute kidney impairment (Liyanage, Ninomiya, Jha, Neal, Patrice, Okpechi & Perkovic, 2015). Overall, an estimated 5–10 million people die annually from kidney disease. Given the scarce epidemiological data, the usual limitation of awareness and the frequently poor access to laboratory services, such numbers probably undermined the true load caused by kidney failure. It is therefore possible that, each year, at least as many deaths are attributable to kidney disease as to cancer, diabetes or respiratory diseases, three of the four main categories targeted by the 2013 action plan. In addition, the estimated number of disability adjusted life years (DALYS) related to kidney disease worldwide increased from 19 million in 1990 to 33 million in 2013 (Naghavi, Wang, Lozano, Davis, Liang & Zhou, 2015).

Kidney disease is associated with a tremendous economic burden. High-income countries typically spend more than 2–3% of their annual health-care budget on the treatment of end-stage kidney disease, even though those receiving such treatment represent under 0.03% of the total population. Globally, the total cost of the treatment of the milder forms of chronic kidney disease appears to be much greater than the total cost of treating end-stage kidney disease. Despite the disease is public health burden globally, approximately 80% of the total burden of CD mortality in developing countries like Ethiopia (Abegunde, & Stanciole, 2006).

The worldwide problem related to the diseases has tremendously miscalculated; most people are not aware about their altered kidney function. In general, kidney diseases are “silent diseases”, usually not accompanied without any apparent early symptoms (Hidden epidemic kidney disease, 2018).Several patients with kidney diseases are not aware that they have been living with high risks of kidney failure which might need dialysis or organ donation. Compared to therapies, renal transplantation is explained as the better therapy for patients with terminal Chronic Kidney Disease (CKD), as it promotes improved worth of life and decreased mortality, as well as being related with various benefits, such as reduction of healthcare costs (Neipp, Jackobs & Klempnauer, 2009).

Renal transplantation is recognized to be the best option of treatment for end-stage renal disease in terms of cost, quality of life, and survival. Data from 2018 reveal negative trends. The number of patients on the kidney transplant increases for the fourth year due to its peak at nearly 100,000 in 2018 (WHO, 2019). The increment was less than in the previous year, but this was largely because of much number of patients added to the list, nearly 3000 more than in the previous 2 years. Yet considerable global inequality exists in regards to renal transplantation provision. The inequality in transplantation activities identified to be largely not associated with the actual distribution of medical need; it was therefore related with the availability of resources for health care provision (CDC, 2015)..

Certainly, for many end-stages renal patients' successful transplant brings a new hire of life and free from dialysis, complicated medication regimes, and symptoms comprising nausea, pain, and fatigue. Despite transplant patients face different difficulties associated with the new physical and mental conditions (Brito, et al, 2015). The transplant recipient exists with a life of compromise influenced by uncertain health and immunosuppression.

End-stage renal disease (ESRD) follows a gradual decline in kidney functioning, often due to chronic medical conditions such as diabetes or hypertension. It is currently treated either by renal transplantation or dialysis (Christensen & Ehlers, 2002). Renal transplantation is generally the preferred treatment as it tends to prolong life-span and lead to an improved quality of life, in addition to being more cost-effective than dialysis (Gordon, 2001).

Transplantation is a very demanding and particularly stressful event that requires the patient to implement his bio-psycho-social skills in order to accept and integrate the new organ physically and mentally. This surgery, therefore, involves numerous psychological, existential, affective, relational, and social changes both for the patient candidate and for his family Front Psychiatry context. Switching from having dialysis to receiving a kidney transplant can have a positive impact on the emotional well-being of individuals with ESRD. This is mainly due to the significant constraints caused by dialysis (e.g. reduced independence), many of which can be resolved by transplantation (Wainwright, Fallon, & Gould, 1999)

2.2. **Psychosocial experience of patients with ESRD during dialysis/before transplant**

The course of the increasing awareness of being chronically ill is accompanied by emotional disasters and impairments. Depressiveness and hopelessness, anxiety, anger, hope, and confidence vary in an unpredictable pattern, representing the gradual process of adaptation. (Schulz & Kroencke, 2015). In chronic renal failure, the patient has to face his/her restrained life expectancy and the requirement for organ transplantation. Fear of death, inner conflicts, and the uncertainty of timely transplantation are the main emotional stressors in this stage of the illness.

In the case of renal impairment, dialysis is available as an alternative remedy. It is, however, related to different and severe difficulties, particularly regarding the quality of life (QOL) and life expectancy (Avramovic & Stefanovic, 2012; Schulz & Thaiss, 2012).Moreover, (O'Donnell & Chung, 1997) revealed that chronic kidney disease (CKD) patients are at excessive threat of depressive issues because of substantial psychological stress due to physical and social changes brought on by the disease. The most usual psychiatric complication happening as a consequence of renal failure is a depression in the patient and anxiety in the associated partner (De Sousa, 2008).

A qualitative study by Gregory et al. revealed that patients with ESRD receiving dialysis experienced a new sense of self and new identity that fluctuates with different circumstances. It also indicated that when patients confronted with this new way of existence, they become aware of an uncertain future, dependence on machinery, scarification of significant others demanded by the illness, medication, and health care providers (Gregory et al, 2011).

Perception of illness among hemodialysis patients was associated with poorer survival rates (Kimmel, 2010). Compared to other chronic illnesses, hemodialysis patients assessed their physical health as markedly diminished (Mittal et al, 2010). Illness representations anticipated non-adherence to fluid restrictions amongst dialysis patients and significant predictors of coping, adjustment, and outcome. Moreover, within a sample of UK renal patients, patients' perceptions of treatment control predicted survival independently of survival risk factors, including comorbidity, illustrating the negative impact of maladaptive illness perceptions on clinical outcomes (Chilcot, Wellsted, & Farrington, 2011). Griva et al. found that treatment and illness perceptions were formed as a function of different ESRD treatment (Griva et al, 2013).

Impaired self and body image are common psychological consequences of living with ESRD. Self-image and self-esteem have a bearing on aspects of quality of life, which encompasses the physical, social, and emotional elements of wellbeing (Griva et al, 2009). Patients may have to adjust to their changing appearance by changing the way of clothing and how they relate to others. Compared to transplant patients Griva et al. revealed that patients with ESRD during dialysis have lower quality of life as a consequence of lower control beliefs, more uncertainty, stronger chronic timeline beliefs, and more illness and treatment disruptiveness (Griva et al, 2009).

Dialysis treatment can have a significant impact upon body image, as patients might perceive themselves as ugly (Thomas, 2012). For example, procedures to create a point of access for dialysis via a fistula, neck line, or catheter can all change the appearance of the body. Immunosuppressant drugs taken to prevent organ rejection also contribute to obvious bodily changes impairing self-acceptance. Reflecting upon renal nursing practice, Muringai et al. discussed the need for a “holistic assessment tool” that allows for psychological considerations of body image (Muringai et al, 2008).

Patients with hemodialysis have also been shown to have higher hospitalization rates for depression and affective disorders (Kimmel, 2010). Distress in dialysis may be related to procedural aspects of treatment such as the need to travel to dialysis centers (DCs), transportation issues, spending considerable time in medical environments (ie, dialysis wards), the prolonged sitting time during dialysis, functional limitations, loss of employment, changes in self-perception, alterations in sexual function, general and perceived effects of illness, medications used to treat the illness, costs and expenses related to treatment, uncertainty, and fear of death. Distress may also be related to fear of infection, dialysis-related symptoms, and side effects, and distance to dialysis centers which are common concerns among patients on HD (Griva et al, 2013).Kimmel also revealed that

A qualitative study on the psychosocialexperience of patients with end-stage renal disease and its impact on quality of life revealed that ESRD during dialysis carries with it emotional, physical, psychological, social, and existential burdens. Transplanted patients perceived their condition as less chronic, reported fewer symptoms compared to dialysis patients and experienced lower psychosocial burdens (Finnegan & Thomas, 2013).

A qualitative study on the psychosocial and physical experiences of hemodialysis (HD) patients in Ghana claimed that HD patients experienced psychological; anxiety, depression, anger, worrying, and fear of death); social experiences (intentional isolation, inability to attend social functions, and effect of dialysis on marriage); economic encounters (difficulty in financing the treatment, loss of income, lowered productivity); and physical experiences (problems with sleeping, with fluid and diet restrictions, and with accessing the treatment site (Achempim & Donkor, 2012). Schulz & Kroencke claimed that occupational and financial burdens cause significant stress on dialysis patients. Moreover, fear of death, inner conflicts, and the uncertainty of a timely transplantation are prevailing emotional stressors (Schulz & Kroencke, 2015).

2.3. **Psychosocial experience ESRD patients after transplantation**

Kidney transplantation not only provides ways of treating diseases, congenital defects, impairments, and injuries, but also enhances the process of self-formation in many different ways for post-transplant patients. Kidney transplantation possibly leads to a change in person's identity. During the transplantation, the wholeness and unity of body images is broken. The process can develop emotional vulnerability with body image and self-representation disorders, or paranoid reactions to panic crises because of the presence of the new organ. This process is long and difficult which needs psychological integration of transplanted organ (Maurizio, 2014).

In kidney transplantation, if the treatment quickly restores the anatomical and physiological functions, cognitive and emotional integration is needed. The psychosocial impact of kidney transplantation is traumatic event that disrupts the sense of continuity and personal integrity which triggers strong emotional impairments (Abegunde, Stanciole, 2017). The existence of negative and disorganized psychological experience will lead the person to disability to cope with the stressors, including hospitalization, surgery, and invasive treatments, which can be determined in a distorted way and experienced as terrifying perceptions (Pasquale, Veroux, Indelicato, Sinagra, Giaquinta, Fornaro, & Pistorio, 2014).

Several international studies tried to reveal the physical functions and general post-transplant quality of life enhancement: uremic symptoms, sleep disturbances and appetite impairments vanished, and hematocrit and hemoglobin levels increased significantly, as well as improvements in cognitive function (Maurizio, 2014). However, these improvements and a reduction in total symptom distress, many studies also found a risk of psycho-social and psychosocial disorder (de Groot, Schipper, van Dijk, van der and Boog, 2013).

In the period immediately following surgery, the patient may present a psychological disturbance with anxiety, restlessness, confusion, agitation, hallucinations, confabulation and emotional liability. The frequency of this psychological differs (20%-40%) and the use of steroids may prolong the psychotic state resulting in “steroid psychosis” with the prevalence of paranoid and hallucination reactions (Waterman , Stanley, and Covelli, 2006).

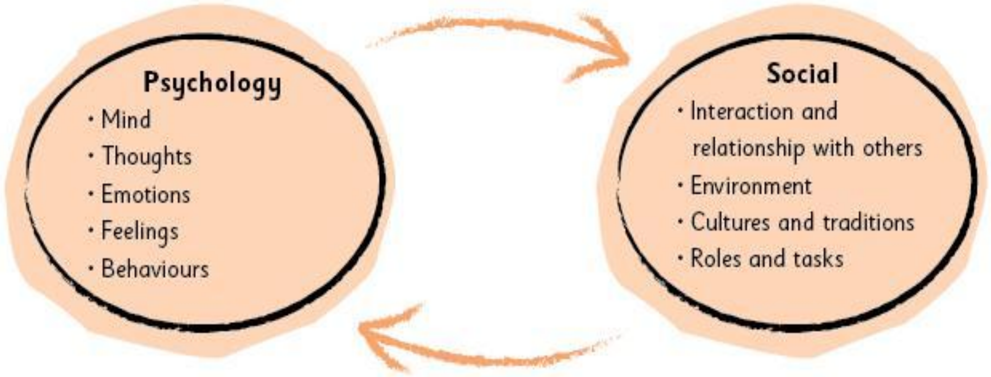
In the consequent post-transplant times feeling of freedom, powerful emotionalism, excessive excitement and a sense of rebirth may be prevalent. This phase, which is defined as the “honeymoon”, also presented with negative psychological experiences comprises fear of rejection, post-transplant difficulties, existential uncertainty and thankfulness feelings, but also regret feelings towards the donor. In the case where “healing” expectations are improved, both for limited information and for a state of post-operative excitement, anxious-depressive states are certainly present in the patients with post-transplant phase (Clemens, 2007).

The hospital discharge, back to the relatives and social background need an adaptation process lasting 6 months-to- a year, the “life by sick” and dependence for others sacrifice. The perception of loss of support from physicians can make modification to the outside world hard for post-transplant recipients. This is more obvious in people with a weak perception of their personal abilities and autonomy (Cavallero, Ferrar, Verbena and Mosca, 2007).

The psychosocial burden of post-transplantation is generally less intense than the burden during the preoperative time. The crucial part of making sense of this new life became immediately related to release from dialysis and patients feel free of unpleasantness on the treatment and restrictions associated with the dialysis. But patients should still be considered as chronically ill and ought to reveal substantial coping skills (Goetzmann, Lieberherr, Krombholz, Ambühl, Boehler, Noll, G … & Klaghofer, 2010; Lonargáin, 2017). Moreover, transplantation can result in a psychosomatic disaster that needs the affected person to mobilize all bio-psychosocial resources during the process of adaptation to the new foreign organ which might still result in an alteration in self-illustration and identity, with feasible psychopathologic repercussions. The emotional effect of transplantation can be a traumatic event that interrupts the sense of continuity and private integrity, eliciting strong feelings (De Pasquale, et al, 2014).

Studies have found depression and anxiety to be typical in kidney transplant patients (e.g. Cukor, Rosenthal, Jindal, Brown & Kimmel, 2009; Karaminia et al., 2007). Then again, another study revealed psychological difficulties like fear and anger are more apparent symptoms in kidney transplant patients than depression and anxiety (Pascazio, Nardone, Clarici, Enzmann, Grignetti, Panzetta &Vecchiet, 2010).

Psychosocial encounter is utilized the nearassociation between mentalangles of human encounters and the more extensive social encounters. Mentalimpacts are those that influencedistinctive levels of workingcounting cognitive (recognition and memory as a premise for thought and learning), full of feeling (feeling), and behavioral as well as social impacts concern relationship with family and community systems, socialconventions and financial status tallying life errand such as school or work (Bendasset pack, 2009).



Numerousindividualswithin the community accept that inability is somebody else's problem furthermore they don't acceptinability will touch their lives, and providesmall thought to the involvement of living with incapacity, or caring for somebody with a incapacity (Commonwealth of Australia 2009). The analyst of this ponder was endeavoring to uncover few psychosocial anglescountingfeeling /feeling, perception/attitude and behavior) and for social spacecentered on Interaction and Relationship with their Environment and others) as takes after.

2.3. Social experiences of kidney transplanted patients

The support and offer assistance from social network were cited as fundamental to the kidney transplanted patients on the physical, enthusiastic and social angles. There was accentuation on the solidarity of companions and other individuals at distinctive stages of the method, countingbudgetaryhelp for support, guaranteeing living conditions for when they are absent from their homes, since numerous families had to take off work to care for and screen the transplant handleabsent from their homes. The planning for the transplant was a generator of much pressure and inner conflict of sentiments. Brought aboutwithin the choice of the benefactor, and within thedevelopmenthandle for all included. A unconstrainedchoice to take an interest as a giver, given the nonattendance of other treatment alternatives, was an critical step towards realizing the transplant and anticipated with much uneasiness. Once the surgery was done, the transplant brought alleviation and sentiments of appreciation. In any case, the fear or the concern of confronting an obscurecircumstancemeasured to the plausibility of disappointment and return to the times of suffering. Once the transplant was performed, the re-adaptations were seen by most families as a time of alter, counting the care of the kidney unite, allowing all individualsincluded conditions to form plans.

The recipient in case of living donation experiences different social supports and difficulties specially related with relationship with the donor as well as the recipient's attitude toward living donation and possible associated expectations. The other social difficulty is related with social support in the work place of the recipients. Enabling patients to take up productive employment constitutes a main goal of transplantation(Engle, 2007) and is regarded as an indicator of societal participation. Prevalence rates of patients actually returning to work or finding new employment show a wide range between 18% and 86% (Rodrigue, Dimitri, Reed, Antonellis, Hanto and Curry, 2014).

The main difficulties faced by post-transplanted patients were associated with family understanding of the diseases process as well as the psychological burden of the recent related with the disability. Moreover, barriers keeping KT patients from returning to work comprises not only a fear of losing insurance coverage and financial support related with long duration of absenteeism but also lack of support from the employers and co-workers.

Social supportincorporates adirectingimpact on the relationship between main transplant-related stressors and anxiety (F alter $(1, 91) = 5.2$, $p < .05$, $\Delta R2 = 3\%$). The comes about are consistent with the theory that social supportincorporates a buffering part on the patients' troubletaking after renal transplantation and recommend that their mental well-being mayadvantage from upgrading the recognition of social back in post-operative care (Pisanti, Poli, Lombardo, Bennardi, Giordanengo, Berloco& Violani, 2014). .

Different literatures reported social experiences of kidney transplanted patients related with their conditions in their families, work areas and their respective society. Memberstoo commented on the critical impacts a transplant can have on family structure and parts. These reactions were regularlysaturated with feeling, and a fewcommunicated concerns almost how their future care would influence their families; such as, “I know my transplanted kidney will not final until the end of time. So I’m most concerned around getting debilitated once more and going through dialysis and another surgery and the impacts it'll have on my family presently that I have a child.” A number of mentioned the plausibility of getting to be a burden; e.g., “I do not wish to gotten to be a burden on my family,” and another said, “I’m beyond any doubt they [his/her developed children] would like to move out & have a typical life but feel very blame worthy attempting to offer assistance lookout of me &offer assistance with all the bills.” One detailed the concern “being taken care of.” Other patients were concerned about the inverse part - being able to back their families, e.g., “not being there for my family” and “not being able to require care of my family (Tucker, Smith, Daskin, Schapiro, Cottrell, Gendron & Maass, 2019).

A study conducted among transplanted patients on Kathmandu (Rachel, 2017) revealed uncovered that Seen social support as a composite develop risen as a major relate of both depression and uneasiness. Undoubtedly, those members announcing those with most noteworthy level of seen social bolster and controlee behavior of family were over five times less likely than those at the most reduced level sadness and four times less likely to support self-destructive ideation.

2.4. Negative Psychological Experience of Renal Transplant

Anxiety: An exploratory study with focus groups reported, the anxiety of KT are long-lasting and are associated with, being treated on the different way from others, pressure not to allow them to do things and the need to increase their knowledge about their conditions (Orr, et al, 2007). Another qualitative study conducted among 8 adults who undergone KT about their psychological experience of transplantation in the United Kingdom reported a variety of experiences for participants who incorporate psychological challenges, like anxiety related to the doubt of residing with a KT, and highlighted the increment of dependency on peoples through the transplant process (Lonargáin, Brannigan & Murray, 2017).

A qualitative research performed in Brazilian University revealed that renal transplantation induces fear along with loss for graft and the immunosuppressive medication was the main difficulties that were faced after transplant (Brito, et al, 2015). Similarly, an exploratory study undertaken following renal transplantation at different stages revealed that kidney transplant patients have many worries, of which fear for rejection was most frequently mentioned followed by stress generated by altered body image (product of immunosuppressive therapy (Fallen, Gould & Wainwright, 2007).

Moreover, the study conducted in the Erlangen Nuremberg University aimed at comparing depression, and anxiety incidence before/after renal transplant claimed that the incidence of anxiety in post-transplant patients was higher (21.6%) as compared general populace 6.9%, and even greater from patients with other illnesses like cancer with a mean incidence of 17% (Müller, et al, 2015).

Anger: The study conducted in London on the psychological experience of patients with transplanted kidney claimed that 'the burden facing by individuals pre- and post-transplant may be summarized as living with paradox and conflict. Accordingly, patients with KT may need to compare anger/sadness about losses with an adaptive attitude to making the most of a second chance at life and negotiate a positive relationship with an 'alien' organ"(Amerena & Wallace, 2009).

Depression: The study conducted at the University of Erlangen Nuremberg aimed at comparing depression prevalence among pre/post patients with KT kidney reported the prevalence of anxiety and depression in KT patients was more (21.6%) as compared general populace 6.9%, and even higher from patients with other disease like cancer with mean prevalence of 17% (Müller, et al, 2015).

Transplant patients and their families are often faced with emotional trials before, during, and after the transplant process. According to the American Psychological Association, an estimated 50% of transplant patients experience at least one episode of substantial anxiety or depression within the first 2 years of the post-transplant period. Symptoms of posttraumatic stress disorder (PSTD) are also prevalent, with one study reporting nearly 25% of transplant patients displaying PTSD symptoms.

Because organ transplantation is a serious and life-altering surgery, it is critical that the patient and the patient's family understand the long-term compliance necessary to improve patient outcomes, as well as the surgical risks involved. The United Network for Organ Sharing (UNOS) mandates a psychological assessment for transplant patients before they are added to the transplant list. The psychosocial evaluation is used to assess the patient's understanding of the procedure itself as well as the patient's acceptance of the requirements for maintaining a positive surgical outcome, such as compliance with immunosuppressive therapy, laboratory tests, and routine office visits to transplant healthcare providers.

In addition, the psychosocial evaluation usually includes an assessment of the support person who will be the primary caregiver for the transplant patient after the surgery. Since the primary caregiver role requires a considerable time commitment, the psychosocial evaluation enables the clinician to assess whether the primary caregiver is aware of and accepts the commitments essential for the care of the transplant patient.

Depression and anxiety disorders may manifest during the transplant process owing to psychosocial factors include general factors at the level of human society concerned with social structure and social processes that impinge on the individual. Psychosocial factors, medications, and physiological disturbances. Mood and anxiety disorders may occur in organ-transplant candidates—as many as 25% of patients with advanced pulmonary disease, 40% of patients with advanced hepatic disease, and 50% of patients with advanced cardiac disease—as well as in post-transplant patients, with up to 20% of kidney recipients, 30% of liver recipients, and 63% of heart recipients affected, especially in the first year. A systematic review and meta-analysis, conducted by Dew and colleagues, of studies that examined whether depression and anxiety impacted mortality risk after transplant concluded that there was a 65% increased risk of mortality with depression; however, anxiety did not show a significant association. Results of research examining whether depression or anxiety predicts transplant-related outcomes are mixed (Yvette C. Terrie, BS Pharm, RPh Nov 17, 2017**)**

2.5. Positive Psychological Experience of Kidney Transplant Patient

A qualitative study conducted among patients in Brazilian University medical college revealed KT results in positive change in the patient's routine such as the back to activities of daily living being the most important gain, in the participants' opinion (Brito, et al, 2015). Similarly, an exploratory study conducted after kidney transplant patients reported improved quality of life after transplantation, although the improvement was least marked in patients in the intermediate group (1-5) years after surgery (Fallen, Gould & Wainwright, 2007).

The qualitative study conducted among 8 adults who undergone KT about their psychological experience of transplantation in the United Kingdom reported a variety of psychological, social, and occupational experiences for participants which comprising patients tremendous emotions about receiving a transplant, particularly related to the new-found freedom that this includes, in addition to sturdy feelings of gratitude towards their donors (Lonargáin, Brannigan & Murray, 2017).

2.6. Factors Associated with Negative Psychological Experiences

The health of the donor: (Goetzmann, et al, 2009) stated negative experiences like stress and no adherence after a renal transplant is particularly related to the trouble of accepting the new organ and go through the feeling of guilt toward the donor. Moreover, (Lonargáin, Brannigan & Murray, 2017) again reported that feeling of guilt about the health of the donor became among the most principal reason for depression, anxiety, fear, and sadness in kidney transplant recipients.

Medication side effect: Medication side effects and related comorbidities become the main stressors disrupting recipient's quality of life (Lee, et al, 2017). Moreover, (Heinrich & Marcangelo, 2009) reported depression, anxiety, sadness, sleep disturbance, cognitive impairment, and delirium can arise as neurotoxic outcomes in peoples receiving immunosuppressive drugs.

Uncertainty about the future: Qualitative study conducted in national health service (NHS) in the United kingdom revealed negative psychological experiences like depression, anxiety, fear, and anger are mainly related to the uncertainty of living with transplanted kidney, increased vulnerability to various diseases like cancer and infection because of taking immunosuppressant, being worried about full-time job opportunity, others lack understanding about their difficulties after transplant (Lonargáin, Brannigan & Murray, 2017).

2.7. Factors Associated With Positive Psychological Experience

Free from dialysis: (Lonargáin, Brannigan & Murray, 2017) reported, after transplant patients develop positive feelings mainly related to release from dialysis. Furthermore, (Wainwright, Fallon & Gould, 1999) revealed receiving a kidney transplant can have a positive outcome on the emotional well-being of peoples with ESRD. This is mainly due to the substantial constraints caused by dialysis (e.g. reduced independence), a lot of which can be resolved through transplantation.

Return to work and social roles: (Schulz & Kroencke, 2015; Lonargáin, Brannigan & Murray, 2017) revealed positive feelings were related to living a better quality of life through transplant, back to work, and back to their social roles within the network they belong.

Theories of Psychological Experiences

Humanistic theories of psychological experience

Humanistic theory is based upon the idea that everyone has the potential to make a contribution to society and be a good and likeable person – if their needs are fulfilled. Abraham Maslow and Carl Rogers led the humanistic theory movement and it was Maslow who developed the “pyramid of needs”. Abraham Maslow has been considered the Father of Humanistic Psychology. Maslow’s theory is based on the notion that experience is the primary phenomenon in the study of human learning and behavior. Humanistic psychologists look at human behavior not only through the eyes of the observer, but through the eyes of the person doing the behaving. Humanistic psychologists believe that an individual’s behavior is connected to his inner feelings and self-image (De Carvalho, 1991). .

Humanistic psychologists study how people are influenced by their self-perceptions and the person meanings attached to their experiences. Carl Rogers felt that, in addition to Maslow’s hierarchical needs, in order for a person to develop fully he/she needed to exist in an environment which would provide them with genuineness, acceptance and empathy and that without such a nourishing environment healthy personalities and relationships would be unable to flourish. This theory gives more emphasis on conforming and contributing to, a slightly more conservative society.

Carl Roger a humanistic American psychologist developed new method of therapeutic relationship focused on the role of the client, rather than the therapist, as the key to the healing process. The therapist must promote the client's self-esteem as much as possible through three central concepts. These are a nonjudgmental caring for the client, genuineness and empathetic understanding (American Psychiatric Association, 2013).

Existential Theories of psychosocial experiences

Existential theorists believe that behavioral deviations result when the person is out of touch with himself or herself or the environment. Many existential therapists use cognitive therapy, which focuses on immediate, thought processing- how a person perceives or interprets his or her experience and determines how he or she feels and behaves. Many existential theorists use cognitive therapy to treat psychosocial disorders. Aaron Beck is credited with pioneering cognitive therapy in persons with depression. A cognitive therapy using confrontation of" irrational beliefs" that prevent the individual from accepting responsibility for self and behavior (Abedi, Monemian, & Naji, 2012).

Cognitive therapy is a "problem-focused" and "action-oriented" form of therapy, meaning it is used to treat specific problems related to a diagnosed mental disorder. The therapist's role is to assist the client in finding and practicing effective strategies to address the identified goals and decrease symptoms of the disorder (Leary & Gohar, 2014)

Phenomenology theory of psychological experience

Phenomenology emerged from philosophy (Smith, Flowers & Larkin, 2009). Phenomenological approaches to personality consider human experience or subjectivity as their primary focus. The phenomenological theorists assert that getting accurate information of another person needs understanding how that person experiences the world. Personal experience requires instant reality. A secondary center of phenomenological theories is the self. The self is a notion of as a cognitive-affective structure through which experience is filtered. The phenomenological theory involves understanding the essence of the phenomenon. This theory is interested in the individual experience of people and looking for the universal nature of the experience. It entails a rich and detailed definition of the human experience.

Phenomenological theorists focus on two kinds of subjective experience. The first is how individuals enjoy themselves with others. The 2nd form of experience is what is probably known as inner monitoring, or human beings' the intuitive feeling of their dispositions. According to phenomenological theory, experiences that reflect a person's true dispositions always exist in some form and can be recovered, leading to a more authentic sense of the self.

CHAPTER THREE

3. Research Methodology

This section provides an overview of the methodology used to study the psychosocial experiences of kidney transplanted patients. The research approach and design; study site and period; sources of information/research participants; sample and sampling technique; information collection instruments and procedures; and data analysis techniques are also incorporated in this part of the paper.

3.1 Research approach and design

As it was already indicated in the previous sections, the purpose of this study was to assess the psychosocial experiences of kidney transplant patients. The study is carried out with post-kidney transplant patients undergone through the procedure before 2019 in the transplantation program of St. Paul Millennium Medical College. At country level, this medical service is only provided at this hospital and the philanthropic service is rendered by Ministry of Health through the fund received from Michigan University (USA).

The researcher used qualitative research design with an assumption of qualitative design would properly and effectively address the psychosocial experiences, opportunities and challenges of kidney transplanted patients. Likewise, this research design helped to analyze the information collected from key informants especially their knowledge and experiences toward their health, donors, families and colleagues which have direct association with their psychological and social wellbeing.

In this research, semi-structured questionnaires are prepared to deeply investigate the psychosocial experiences of kidney transplanted patients. Interpretative Phenomenological Analysis (IPA) method is employed to analyze the outcome of the investigation results. IPA provides an excellent methodology if one wants to explore the experience as a way of generating information and insight. It highlights significance of the person and individual perceptions, as well as shared experiences, and goals to achieve an “insider’s view” of the study topic. It helps to dig out what, where, why, and how events are happening. IPA as an analytical approach provides ways to various trajectories of qualitative data interpretation and Analysis

3.2. Study Area and Target Population

The study was conducted at St. Paul's Millennium Medical College Addis Ababa, Ethiopia among KT clients before 2019. The hospital has 350 beds with a catchment population of 5 million the hospital is the first KT program launched in the country. The hospital is launched this treatment in September 2015 in collaboration with the University of Michigan. SPMMC KT center has three nephrologists, four KT surgeons, 20 nurses, and other supportive staff with 15 and 4 dialysis and ICU beds respectively and around the clock working pharmacy and laboratory. During this study period there were a total of 1800 CKD patients waiting for their turn of KT in this hospital. Of the total of 350 KT patients having follow-up in the SPMMC, 150 patients KT have done in this hospital.

3.2.1 Study participants

All patients diagnosed with CKD during the study period at St. Paulo's Millennium Medical College were the population of this study. The researcher picked this medical institution because it's the first and an only center for kidney transplantation and performs follow-ups after the procedure. Regardless of the type of their organ donors' sampled kidney transplanted patients were participated in this study.

The researcher made an utmost effort to maintain the gender balance of the study participants. Moreover, covering a wide range of socio-economic and demographic factors of the study participants has given high emphasis.

3.3. Sample and Sampling technique

In this study, one of the non-probability sampling techniques called purposive sampling technique is employed to obtain the medical center. As it was already mentioned St. Paul's Hospital is the only Hospital which is serving Kidney Transplant treatment institution for chronic kidney patients in our country. Hence, it's a plausible and an only place to pick research participants for this study.

As it is known purposive sampling is one of non-probability sampling technique; which is used in situations in which the researcher uses decision in selecting cases with a specific purpose in mind. According to Allen Rubben and Earle R. Babbie, (2014) if in some instances the researcher may wish to study a small subset of a larger population in which many members of the subset are easily identified however, enumerating all of them would be nearly impossible and it would also not be feasible to define and sample all of them. In such cases the researcher can represent those segments of the larger population with which they are familiar. Purposive sampling does not of course offer the guarantees provided by probability sampling, nor the simplicity of implementation seen in quota sampling. Nevertheless, it finds a convenient application in the case of very small samples. (Allen Rubben and Earle R. Babbie, 2014,)

Likewise, the researcher employed purposive sampling technique for the selection of research participants. The researcher purposely selected 10 kidney transplanted patients regardless of their donor type. All the participants were above the age of 18 and have follow-up at St. Paulo's Millennium Medical College. However, those patients who undergone re-transplantation and happened to be critically ill are excluded from this study.

3.4.1 Data Collection Procedure and Instrument

The research participants were selected during their routine follow up session at the hospital. The selected respondents were oriented about the study and their willingness to take part. Once their consent is guaranteed, in-depth interviews were conducted through the use of an electronic device i.e. Tape Recorder. All the interviews were carried out in private settings where the respondents were free to express their views and opinions as well as answers all the questions raised by the researcher.

As it was already indicated above Interpretative Phenomenological Analysis (IPA) is employed to analyze the data gathered through semi-structured interview. IPA requires a small sample because it involves a detailed picture of the perceptions and understandings of the individual respondents in the interview. The researcher administered both open and close ended questions. The tool had two sections. The first is referent to the patients' clinical and socio-demographic data, and the second was made up of three questions: 1) what does KT mean to you? 2) What are the main positive and negative psychological changes of post-transplantation? 3) What are the difficulties faced following KT? The tool initially was developed in English and later translated into Amharic by professional personnel who is an expert in English and Amharic. Then to guarantee the accuracy, clarity, relevance and consistency of the translation, the tool is re-translated to English by another person and positive result has gained.

3.5 Inclusion and exclusion criteria

3.5.1. Inclusion criteria

All KT patients regardless ofthe type of their donor and who are above the age of 18 years and have a follow-up at St. Paulo's Millennium medical college were included in this study.

3.5.2 Exclusion criteria

Patients with KT who undergonea re-transplantation and were critically ill or clinically unstable during the data collection period were not considered.

3.5.3. Data quality management

Careful verbatim transcription of the obtained data was done. To understand the key ideas, differences/similarities between participants' accounts the transcribed data were re-read several times. It was also listened through transcribed data several times without taking notes to get a sense of it.

3.5.4 Data analysis

Data was analyzed using Interpretative Phenomenological Analysis (IPA). The interviews were transcribed, analyzed, and audited by principal instigator (PI) with established guidelines for IPA methods. The analysis centered on recognizing what participants' experiences were and how they made sense of them. This process comprised identifying and suspending any assumptions about the topic under investigation. To start with, each transcript was read to recognize themes from a psychological perspective and with a focus on the phenomena being studied. After completing the transcription, for each transcript, a list of developing themes was collated so that commonalities and nuances within and between participants' data were investigated. Patterns across participants were then explored, including any areas of convergence and divergence across participants' data. Next, related themes were put together and the final theme titling was modified to reflect the depth and breadth within and across accounts. This stage of analysis concentrated on producing a parsimonious account of the study data which resulted in a theme narrative structure comprising the total of the data contained in the larger group of themes.

3.5.5. Ethical Consideration

Ethical clearance and approval of the study protocols was obtained from the Ethical Review Board of Addis Ababa University School of Psychology. In addition, permission was sought from the respective heads of Department of Kidney Transplant center. Prior to data collection, individuals were informed about the study and written consent was obtained from the study participants. Each patient was informed about the objective of the study, procedures of selection and assurance of confidentiality. No identifiers were used to minimize social desirability bias and enhance anonymity. Individuals were free to withdraw from the study at any time. Patients did not face any harm nor received any monetary incentive for participating and it was solely voluntary based. The collected data was handled and secured with the principal investigator in every data collection day and the data generated was used for the purpose of this research only.

CHAPTER FOUR—RESULTS AND DISCUSSION

One of the main intentions of this study was to inspect the psychosocial experiences of kidney transplant patients at St. Paulo's Millennium Medical College Addis Ababa Ethiopia. In the meantime the study answered the research questions through semi-structured interview associated with psychosocial experiences of kidney transplanted patients.

This chapter tried to analyze the responses of study participants and answered the research questions as stipulated in the first chapter. The results of the study were organized and presented under those major thematic areas of the study. The thematic areas were identified from each transcripts collected through semi-structured interviews. Therefore, this chapter presents the findings of the ten in-depth interviews of kidney transplanted patients thatalign with the objectives of the study.

4.1. Demographic characteristics of participants

The socio-demographic characteristics of study participants are organized under their gender, age, educational level, marital and economic status. Furthermore other features like type of relationship with their kidney donor and duration since transplantation is included in this part of the paper. Therefore, in table 1 the socio-demographic data of the study participants and their donors is presented as follows.

Table 1: Socio-demographic characteristics of participants

No	Age	Sex	Marital	Educational status	Relationship with the donor	Duration since transplantation	Salary
1	29	M	Married	Secondary	Wife	2 years	18000
2	38	M	Married	Secondary	Wife	3yrs.	5000
3	48	M	Married	Degree	Brother	2yrs.	15000

4	52	M	Married	M.A Degree	Brother	2yrs.	17000
5	28	F	Married	Primary	Uncle	2yrs.&4 month	Reserved to tell
6	30	F	Married	Degree	Father	2yrs.and1month	20000
7	56	M	Single	M.A Degree	Brother	3yrs.rs&6Month	16000
8	37	M	Single	Degree	Sister	2yrs&9month	Unemployed
9	38	F	Single	B.A Degree	Father	3yrs.	14000
10	28	F	Single	Degree	Brother	3yrs.	Unemployed

As indicated in table 1, the age of respondents is ranged from 28 to 56 years. Of the total of respondents, 6 (60 %) were males and the rest 4 (40%) were females. When we look into the participants' marital status 6 (60%) are married and 4 (40%) were singles during the study period. The gender composition of participants in regard to their marital status is the same to both genders. Likewise the educational level of participants revealed as 7 (70%) were reached at least tertiary education or above. A mean result of 2.8 years is obtained regarding duration since transplantation conducted. Eight (80%) of the study participants are received kidney from their blood related family members, the rest two (20%) are obtained from their wives. As it is shown in the table, 7 (70%) were revealed their employment along with their monthly earnings.

4.2. *A*nalysis of semi-structured interviews

A total of 40 pages of transcriptions from semi-structured interview with 300 concepts were drawn with redundancy from the entire responses and then extracted in order to minimize the redundancy and came up with the key concepts. With a major intention of addressing the research question, by transcription the responses from the study participant's responses through semi-structured interview the three major thematic areas were drawn. The current study revealed that the patients' everyday lives were affected in different ways through the transplantation process. It emerged that there were experiences of difficulties, hope and thankfulness after the process.

Under the three main themes of this study, the following sub-themes were emerged such as transplantation as a re-birth, thankfulness, social bond, liberty from dialysis, self-efficacy, and social support were emerged as positive psychosocial experiences whereas dependency, fear of the future, adherence challenge, and regret emerged as negative psychosocial experiences.

4.3. Findings from semi-structured in-depth interviews

4.3.1. Psychosocial experiences during dialysis

Economic crisis, self-image distraction, loss of freedom, uncertainty about timely transplant, and social isolation were the main stressors for kidney transplanted patients during dialysis.

Worrying about cost of dialysis

All the participants in semi-structured interview explained that the cost of dialysis was expensive and challenging. Interviewee [IDI1]-[IDI-10] shared the same feelings about the impact of the economic crisis on their need to survive.

A 52 years old male interviewee explained as…

> *I have had dialysis for two years. We used to save a few bucks, so we used it for a year. When it finished, nothing could be done, so we went out to beg. The money from the begging covered the cost of the dialysis. The government paid me only half of my salary …the expenses for house rent, children's education, and food was not even possible to cover with full of my salary. At the time, I was horrified when I thought of the cost beyond the pain of the disease process. While I think about the cost, I think about suicide but I have to live for my children.* [IDI 4]

> *I lost my job due to my illness. Despite, the money I got from begging on the street and from close families, relatives and friends used to cover my financial expenses*

> *for the dialysis, expenses for basic necessities, house rent and transportation were big challenges. There are also foods and medicines that the person who is undergone through dialysis must take but I was unable to get all these. More than the excruciating pain of the illness, thinking about how to get the money was very torturing. I usually unable to get enough sleep and even want to die quick because I couldn't resist all these. [IDI 7]*

All expressed that unable to cover the financial expenses during dialysis brought a feeling of shame, regret and identity crisis.

A 30 years old female participant explaining her feelings as,

"*I used to hate begging. I absolutely hate.... But I was unable to cover my expense for dialysis which was 4500 ETB per week, so I went out to beg. My heart breaks for unable to even cover the expenses for basic necessities. I always used to cry in secret and complaining God*". [IDI 6]

"*The economic crisis during the dialysis time was the worst scenario in my life. It was a time when the feelings of the shame and guilt went through my mind for asking my wife the food I needed".* [IDI 3]

Distracted self -image

Participants during semi-structured interview discussed about the uncomfortable feeling of the need to have a permanent internal fistula (in the arm) or peritoneal catheter to facilitate treatment, and taking immunosuppressant drugs which brought a change in their body appearance.

Interviewee coded [IDI2], [IDI 4], [IDI 5], [IDI 6], [IDI 9], and [IDI 10] shared similar feelings about self-image

A 30 years old female interviewee said "*The abyss created by the fistula in her arm is unattractive and always try to hide it from other people under clothing. Because of it I stopped wearing my favorite sleeveless shirt…that is depressive* [IDI 6].

"I feel discomfort and unattractive while I saw the disfigurement on my arm because of fistula. The worst thing is I'm aware of what other people think about it" [IDI 5].

Cumulative effects of taking immunosuppressant medication that changed bodily appearance of ESRD patients were another challenge which brought undermining self-image and lower self-esteem. Interviewee coded [IDI 5], [IDI6], [IDI 9], and [IDI 10] developed lowered self-esteem and feeling of unattractiveness due to changed bodily appearance (weight gain).

A 28 years old female interviewee explained her change as "*The facial shape I have acquired since I started dialysis is something ugly. It is puffy or moon face appearance. It is something that lowered my self-esteem". [*IDI 5]

> *That was the main challenge for me, because I pump-up like a balloon after I started taking immunosuppressant… I was always really thin, always fit, and healthy, I wore everything that was trendy, and fashionable, and then I put on tons of weight. And I am now walking around in clothes I cannot identify myself in…* [IDI 10]

Social isolation

Economic crisis, loss of income, back pain, loss of concentration, decreased self-confidence and time shortage on end stage renal disease patients during the course of dialysis have significant impact on the social interaction of participants.

A 30 years old female participant explained as

"*My confidence just goes down… I used to be whole person before dialysis but now I am not…I preferred being alone and isolated from the society to prevent my mind from being depressed by comparing myself with other healthy individuals. I feel like a bird with clipped wing "[IDI 6]*

"I went dialysis several times a week. However, I am not losing the whole day in dialysis, I have not got enough time in the morning to meet my friends and become tired and unwell at night (after dialysis). I totally become lonely because of dialysis" [IDI 7]

"The worst thing that makes me to be isolated from social roles is loss of memory and concentration, I easily fed up with things and my communication suddenly become bored for peoples who used to be in my surrounding…after transplant most of my friends explained 'you seems like you are not happy with us at the time of dialysis'. [IDI 10]

Uncertainty about timely transplant

All participants coded [IDI 1-IDI 10] shared similar feelings about waiting for the transplant. They explained that uncertainty about kidney donation was created an emotional toll on patients.

All participants discussed about how they have been afraid of uncertainty about timely transplant.

"I always wonder, am I live the rest of my life hooked in this machine, am I going to get the transplant, who will become volunteer to donate his kidney, It was troublesome. I was tired of living because of become hopeless of getting the transplant". [IDI 6]

A 52 years old male interviewee who received the kidney from his brother explained as,

> *After two years of dialysis my cousin becomes volunteer to donate. With full of hope and happiness we started the process. My joy and hopefulness escalated when the compatibility results were turned out to be positive. Finally we both are taken to the psychological counsellor to make sure about our readiness and his full willingness. Even after he heard the consequences after transplantation he was agreed to donate. However, on the date of operation my cousin has disappeared without telling anything to anyone. I feel hopeless, helpless and powerless to change the situation. Even after my brother become volunteer one year later, I didn't feel guaranteed until the actual date of operation. This creates a great challenge on my drug adherence. [IDI 4]*
>
> *After 6 years of dialysis my brother who lived in rural area becomes agree to donate his kidney, but he disappeared after the priest advised him not to donate his kidney as he may die. My mother also told me that "it is better to lose one than losing two sons'. I feel helpless and develop loss of interest to live [IDI 7]*

Loss of freedom

Participants coded [IDI2], [IDI 3],[IDI 5], and [IDI 6] explained that dialysis was restrained their life.

"It really ruined my freedom, it needs prolonged preparation for dialysis, I feel like my life is ruled by the dialysis" [IDI 2]

A 48 years old male participant explained as "I suddenly realized that am not like other people and I am machine dependent. I couldn't plan like I used to do before the dialysis. I feel like I am looked up in prison and punished for my sin" [IDI 3]

4.3.2 Positive psychosocial experiences

The positive psychosocial experiences of employees with kidney transplant patients was covered through the semi-structured interview with KT patients to capture the major points of their feeling of being a person with K.T their personal, emotional, and social interaction experiences associated with kidney transplant, the perception of significant others towards the kidney transplanted patients and perception of KT patients towards support from significant others.

Kidney Transplantation as a Re-Birth

Receiving a kidney transplant is a life-changing event. After kidney transplantation, most of patients in this study have assorted different encounters; they confront numerous changes within the physical and passionate perspectives of their life. Patients' understandings of the post-transplantation period impact their adjustment to the changes the new life. All patients detailed changes in their wellbeing. A few of these reactions were especially solid; e.g., "I feel awesome!!" and "having wellbeing reestablished is an extraordinary involvement.

All participants described the life after transplant as a rebirth/born again. Enjoying and looking forward to a new life following the kidney transplant. An important part of making sense of this new life was directly related to not having to undergo dialysis anymore. The two main difficulties with dialysis centred on its unpleasantness as a treatment and the major restrictions that it placed on participants' lives.

Even during a time of dialysis respondents reveal that their life was ended, they feel like they will die soon and they become losing interest in or not getting pleasure from most daily activities that they used to enjoy and feeling this way nearly every day since the whole time they know both their kidneys was failed. Those feelings of hopelessness and loss of interest in life were changed because of the transplant.

In the current study, all participants kidney transplant clients called transplantation is a process of new life and revival. This feeling was shared with all respondents. A 52 years old university professor explained that he felt that he restarted life again which have been resumed almost for five years and the life he lives now is an extra year of life which given for him as a gift from God. Respondents coded [IDI 1] and [IDI 3] explained the life after transplant as “enjoy even the small things, feel blessed after KT,” and another reported “every single day is a gift” respectively.

> *Kidney Transplant is a means to resume life; it is like restarting life…many people just passes away in their sleep. As for me, I am now living an extra life from the day kidney transplanted because while my kidney failed I was thinking as my last day to live on earth and now I am living extra years and very happy with it* [IDI 7]

Another 38 years old man repeated saying that his life is renewed after the transplantation

> *I am now as a child, like a new-born baby. I frankly tell you, I feel as if I did not transplant rather as a new-born. I’m leaving a very peaceful life. Even I feel that the God needs me to suffer from kidney disease for a long time to use it as a means to create me again.* [IDI 3]

Another 38 years old female shared the idea of other clients

> *The transplant process helped me to look at life differently, 'It makes you appreciate life a lot more…it sort of like changes the whole way that you look at life'. Simply reflecting on the fact that she had been given a new kidney was sufficient to fill her with happiness and gratitude, 'Only delight. Happiness, gratitude. Simple as that, you know'.*[IDI 8]

Thankfulness

All of the respondents in semi-structured interview expressed that they are so grateful and have endless gratitude to donors, health professionals, and to all kinds of support they received and receiving.

In regard to the perception of kidney transplant patients gratitude towards the donor who gives extra life, Interviewee Coded [IDI 1] – [IDI10] shared similar feeling towards the donor

A University lecturer explained saying

> *I had a lot of psychological support from all sides; people around me tried their best to make it as simple as possible. They said, "The current technology is implanting a heart from the dead so your kidney is very simple". I had tremendous support of all kinds like from my students, the community and from all staff [IDI 4]*

All expressed their gratitude to health professionals working at transplant unit of St. Paul Millennium Medical College during the in-depth interviewee said "*They [*health professionals*] are very helpful, they tried their best. They are the one who are available while you are in need and are amazing. I am grateful forever."*[IDI 10]

Another 29 years old interviewee said that she found that staff members were particularly good at supporting her during times of stress, *"Well they're very good at, you know…coping…like reassuring me and…it is nice to know that they are ther*e". ***[IDI 1]***

A 48 year's old male participant experienced staff as caring and efficient,

'The doctor…he explains everything […] He's a very caring gentleman […]

> *The nurses…as far as they can be…are very good…very hospitable He got the light-hearted attitude of staff to be very helpful to him in getting through a potentially traumatic experience. Just before the operation, they supported him to feel relaxed and calm by talking about a sporting event: I found I was in conversation with…even after transplant when I visit them for follow up they are asking me about my health and my donor*

Liberty from dialysis.

Dialysis was like a prison in which 'chains' were used to constrict and restrain resulting in participants being 'locked' at home. This sense of trap was likened to death and 'dying', not just regarding the fear of physical death but also the death of a way of life. Transplantation returned this way of life and brought 'freedom', 'delight' and 'gratitude'. Perhaps freedom from the shackles of having to undergo dialysis and also from the consequent restrictions of dialysis on participants' lives preventing them from leading the life they desired.

All participants referred to dialysis as a 'horrendous' treatment. Patients who undergone transplantation mentioned that they are freed from pain, suffering, financial burden caused by dialysis.

The interviewee coded [IDI 1] expressed his feeling by comparing the time during dialysis and after transplantation by

> *You lie in bed and rest within the morning and wake up and eat something and after that you rest once more and attempt to force yourself out of bed, but it's nearlyunusual to need up on your own, since it fixes up the wound. But, after transplant all this problems were eliminated and I feel no more confined in bed like a prisoner.*

A 28 years old young woman who received a kidney from her uncle said

"After the transplant it is so different now. I came back to life after transplantation but during the dialysis, I had countless problems like pain, income challenges, dependency, loss of interest, and many others but now I am living like any normal person".[IDI 2]

Another interviewee who received a kidney from his brother explained that life with a transplanted kidney is like resurrection from the life which have been harsh and horrible during dialysis.

> *….Immediately after KT, I saw a radical change in my life. I called it resurrection. During the dialysis time, whatever symptoms show up I used to feel like I am dying and suffered a lot but after that [transplantation] all my body functions came to normal. It has been now 3yrs and six months. I am very healthy and leading a normal life. I am a free man now* [IDI 7]

Another 56 years old man reaffirmed the above statement saying "*.....actually, I have never thought human beings can tolerate such painful times especially during dialysis. I had horrible nights at the dialysis centre which is history now....So I am grateful that there is transplantation which resolves all problems".* [after transplantation][IDI 9]

Self-Efficacy

Participants expressed that they have belief in themselves to do a task or reach a specific goal which was not the case before transplantation. An interviewee stated that he is can do what he has been doing before his ill-condition and doing same after the transplantation. He mentioned that

> *I've never felt or thought as if I am missing something or weaker than anyone else. For sure, I have been informed not to handle heavy materials and not to do home tasks which I am not doing however if I have to do I think I am able to do. As I told you, I am a lecturer and I'm giving lectures as before and as equal to other academic staffs...all those were excellent especially the time I went back to work has a lot meaning to me. Now I am competent enough to do what I used to do* [ID 4]

Other 38 years old woman mentioned how things changed for good after transplantation. "*Before KT, I was not able to do any type of work but post transplantation I can do and eat what I desired as per the recommendation. I was 51kg but now I am 61. I able to eat the foods I want*".[IDI 7].

Adherence

Participants explained that to maintain health status and quality of life taking prescribed drugs has paramount role in-turn to avoid possible failure. Interviewees claimed that it is difficult to follow but they try their best to adhere. One participant mentioned that "*...but I have some concerns with the medications I am taking as it is lifelong....I feel bored of all kinds of precautions I should take including medications to be taken on time. I don't know for how long I will carry on but I thank God and strictly adhere to it". [IDI 10]*

4.3.3. Negative psychosocial experiences after transplant

Fear of the Future

Almost all participants of the study expressed great concern and worry about the future than welcoming it. They explained that they have many questions unanswered about what will happen to them and to their donor in the future.

A recipient who received from his wife explained his concern particularly in the early times of post-transplantation saying

> *I was terrified after the transplantation thinking ….what if my wife and I die? What if the transplantation fails, or what if my wife dies who gave me her kidney? Who will raise my children? Those were questions I could not answer and scared me in the early weeks of post-transplant but as time goes things come to normal* [IDI 3].

Another female participant who received from her father explained how worried she is about any bad thing that could happen to her and potential consequences to her father "*I always fear that if I suddenly die; I imagine how my dad would feel. The other worry I have is about my father's health condition such as what if he gets any complications due to donation his kidney to me. I always fear about the future"*.[IDI 8]

Another participant who received from his wife expressed his worry saying we both have the same fate which he claims kidney failure

> *I got the kidney from my wife and always worry about her and what will happen to us. We both have the same fate which is kidney failure, which troubles me and I feel so stressed about it….On the other hand, when I hear that someone faced failure after few years of transplantation; I get scared saying will that pain get back to me. That causes fear and uncertainty about the future.* [IDI 1]

An uncertainty about the future was evident for all participants. This was primarily based on the knowledge that their new kidney would eventually fail and they would need to return to dialysis treatment, "*I would hate to go back on dialysis…undeniably hate it. I think I will get very depressed if I go back on dialysis (participant who had treated by dialysis for 4 years". [IDI7]*

Feeling of Peculiarity

The other negative experiences emerged from the data relate to the feeling of difference in ways. A participant explained his feeling of peculiarity that changed all ways of his life and felt that he is always on standby.

> *Before the transplantation, I used to lead a simple life but not no anymore I am different now….I have changed my way of life, so restricted in all ways. I don't entertain or chill outside as before, you cannot be as many others…My day to day life is like something set on alarm* [IDI 10]

Another informant explained saying "*As you know the Kidney I now have is not mine that forced me always to worry about it which is not the case before because we just have everything as it came. But thanks to God we can lead a life with extra carefulness".*[IDI 5]

Regret

The other sub-theme that emerged from the data were regret about their decision to receive a kidney from the family member. One participant who received from his wife explained how he feels sad and sorry about it saying, "*Sometimes I feel I should not have done [received the donation]. She could enjoy life like any healthy person without restriction if she would not donate her kidney to me. It has a lot of pressure".*[IDI 3].

4.3.4. Social support received by kidney transplant clients

Social support emphasizes relationship with whom that gives bolster and accessibility of support assets when are required. Social support creates shared commitments, in which, a person feels social troubles experienced by transplant recipients. These think about famous that beneficiaries may feel socially separated since of their constant physical condition. Life after transplant affects their self-image and relationships with others. After transplantation, patients need to adapt to a new lifestyle and social role.

A semi-structured interview indicated that there are a number of different social supports received by kidney transplanted clients from significant others (family, friends, colleagues…)

A 29 years old male who received the kidney from his wife explained saying

I had a tremendous support from all sides; especially from my wife and colleagues My wife was always around me to remind me to adhere to the medication, to see the life as simple, she always tries her best to make me feel happy, I have no words to express my gratitude to her, she is unacknowledged hero to me….and my colleagues also tried their best to support me financially as I am economically poor [IDI 1]

Another 38 years old married man who received kidney from his wife emphasized how his wife was delighted for him when he received the transplant*, 'My wife makes me to not regret for receiving the kidney from her. she always said" If I lose you because of loss of donor I also commit suicide because life is nothing for me without you, so I gave my kidney to live happy ending life that is just mutual benefit" [IDI 3]*

A 37 years old single man who received kidney from his sister explained saying "*My girlfriend was more than the life itself for me, she always attended in every hospital appointments with me and she always tried her best to make me feel worry less. It meant everything to me". [IDI 8]*

A university lecturer also saying

> *People around me tried their best to accept the transplant as simple. All people show sympathy for my status. Immediately after transplant I was thinking that things are not normal anymore and worried about my future. But the emotional encouragement and sympathy from health professionals and significant others help me to accept the transplant as such simple [IDI 9]*

Another 38 year old female recipient who received kidney from her father underlined "*I have definitely been supported a lot by…by my brother…and my mother, and my sister as well, and the whole family as well. I was also encouraged by health professionals to adhere the medications.*"

4.3.5. The impact of social support on kidney transplanted clients

The support which received from significant others was perceived differently by kidney transplant recipients. Participants explained that the social support they had from families, friends, and other people played a significant role in their self-image and recovery from the crisis.

A participant explained that

> *I have learned the vitality of one to another, it is because of the support in all ways such as financially, psychologically, and all ways I am alive today. People can build your morale and enable you…. I also got support from unexpected people which surprised me and changed me forever* [IDI 4]

Other participant explained the role of social support in healing process saying "*You know our communities care very much and try their best to support in time of need. After KT, there was a lot of support from friends, co-workers, and families that had a positive influence on my healing process".*[IDI 8]

37 years old female participant described the social support

> *What my families and friends, co-workers did to me is unforgettable. Before kidney transplant I was worried about the cost of dialysis and kidney transplant, because I lose my job. They collect money from the community and my organization to support me, without their support I couldn't be healthy in this way [IDI 10]*

On the other hand, some respondents have raised negative attitude towards the social support they received from significant others. Participants coded [IDI 1], [IDI 2] and [IDI 5] explained that they develop negative perception towards the social reaction and support received significant others

Loneliness

A participant explained saying

> *My colleagues wrongly/unfairly treat me like suck their lips, false sympathy because of these I feel sad, disappointed, and I develop depression as result of*

> *their reaction towards the transplant. Sometimes I am cognizant about my friend's loss of interest to spent time with me; I am not a person of their choice to enjoy because I can't drink alcohol anymore. Sometimes this makes me to feel lonely [IDI 2]*

Dependency

Another negative experience that emerged relates to the feeling of dependency created to them due to the way people treat them and how others think about them.

Respondent coded IDI 2 explains

> *Sometime it becomes mandatory to be helped by others, as I am not whole person, I become vulnerable think I am dependent on others because I cannot do things on my own like I used before. It makes me vulnerable to develop a wrong thought and belief about my performance like I am not competent enough, useless, and feels like I am dependent on others because of my physical impairment.*

A participant explained his experience and how his family view him *"Sometimes when my family members restrain me from doing anything at home, I feel as if I am not able to contribute but they are taking care of me that reassure me though* [IDI 5]

Another interviewee expressed that he no longer play a significant social role he used to that he explained his real experience saying *"I saw people fighting that make me feel responsible to stop them, then I wanted to mediate but I just restrained myself because I suddenly think that what about my donated kidney and the person who gave me his kidney. So I restrained myself [*IDI 1]

CHAPTERFIVE—DISCUSSION OF THE FINDINGS

In this chapter, an attempt was made to discuss and interpret the findings of the psychological and social experiences of kidney recipients. Also the chapter presents the general overview of this study results, the findings in relation with the existing different relevant literature in the light of main themes of study questions.

According to the demographic history of the study participants there were a range of responses shown how kidney failure affects people in different circumstances. Such difference has given better insight about the topic under the study.

5.1. Positive psychosocial experiences during dialysis and after transplant

Concerning the positive psychological experiences, participants did not mention any single experience related with dialysis. However, interviewees mentioned that transplantation is rebirth; this finding has been supported by a study (Lovera G, 2000) this similarity might be related to the fact that the person receiving kidney donation develops a feeling of hope and the desire for future life. Such statement might emanated from the respondents as transplantation is the last possible therapeutic solution for chronic kidney disease that might led them to think as coming back to life from once eminent death.

Another positive psychological experience noted in the current study was thankfulness that the respondents thanked several times to their God as well as their donor for helping them out in such time of need. This finding has been found to be expressed in other studies at which gratitude feeling has been most expressed toward the donor such as in Cardiac recipients too (LK, 1987; OS, 1989). Moreover, it is a fact that incidents of such time need a family member who is determined to help and never wants the survivor to lose his/her life hence the response given to such call deserves the highest honor and thanking from the recipient side.

In addition, liberation from the dialysis was also the most cited positive experience the recipients expressed. They mainly related the experience before renal transplant as worst as well as slavery and emancipated same day donated to them. This has been supported by other studies where they indicated transplantation as freedom from the restrictions imposed by the dialysis addiction (De Vito Dabbs A, 2003; Erim Y, 2006).

The fact that dialysis requires protracted preparation in terms of cost, transportation, and time. Moreover, being hooked at the machine for prolonged time and see your blood drown and returned back to your body during the course of dialysis may create a sense of being machine dependent and restrained.

Another positive experience seen during the interview was self-efficacy at which participants expressed as feeling of independency and enable to do what they used to do that they claimed to have pleasant life compared to the ill time. Participants explained that they were able to perform their daily tasks effectively in their workplace and elsewhere. According to affective event theory developed by (Shellen Barge, 2010) it has been clear that self-efficacy and mood are very crucial for our survival especially in our work lives because mood and what we have for ourselves influence performance and satisfaction in all ways and discuss saying that effective event theory was supported by many of the participants.

The other positive experience emerged was social support and bond at which participants explained that the social support they had from families, friends and other people played significant role in their self-image and recovery from the crisis. They reported that the way one supports the other is commendable and plays critical role in pre and post transplantation. They expressed that the support was all forms that ranges from financial to emotional support and also from prayer to expression of hope. According to Amerena and Wallace, 2009) it is not only the interaction of physical, psychological, socio-economic, cultural, and spiritual that determinates the recovery processes but also psychological expression enhances health and recovery from both illness and traumatic experiences (Amerena & Wallace, 2009). It can be further supported by the fact that poor social life or lack of support at individual, family and community level can lead to poorer health outcomes and self-stigmatization which worsens the lives of Kidney patients. Moreover, social support plays important role in such important life event and provides meaning to existence of social system unlike other structures made by governments.

5.2. Negative psychosocial experiences

In the current study stressors during the course of dialysis include economic crisis, uncertainty about getting timely transplant, distracted self-image, social isolation, and loss of freedom (dependency). All participants explained that the time before transplant /during dialysis was the worst time during their lifetime. All participants discussed that the psychosocial experiences during the course of dialysis was the challenging and stressful experience ever happened in their life.

Interviewees mentioned that the cost of treatment during dialysis make them vulnerable to existential stress and depression. This finding was supported by (Abegunde, & Stanciole, 2006) which stated the economic crisis during the course of dialysis is accompanied by emotional disaster. This is due to the fact that the cost of treatment during dialysis appears to be much greater than the total cost needed for treating end stage renal disease. This is specially a great burden for end stage renal disease patients in Ethiopia as most of them are economically disadvantaged. This economic crisis leads to emotional toll in patients.

Self-image distraction was another source of stress and depression for patients with end stage renal disease in the current study. This finding was in line with the finding of study conducted by (Gregory et al, 2011). It revealed that impaired self and body-image are common psychological consequences of peoples living with ESRD during their course dialysis. (Thomas, 20120) also uncovered the that dialysis treatment have as significant impact on body-image and patient perceived themselves as unattractive which finally vulnerable them to lowered self-esteem. This can be explained due to the fact that during the course of dialysis, the wholeness and unity of the body image is broken. This “Life-Extending” process can develop a kind of emotional vulnerability with body image and self-representation disorders.

Another source of stressor for ESRD patients during dialysis in the current study was social isolation. Participants explained that they find themselves lonely because of being isolated form the society. This is because of being prolonged locked up in dialysis, loss of time, loss of concentration and economic crisis. This finding was supported by (Kimmel, 2010). Patients with hem dialysis have higher hospitalization rates for depression related with being socially isolated.

Loss of freedom was also emerged negative psychosocial experience of end stage renal disease patients during dialysis. This is supported by (Kimmel, 2010; Gregory et al, 2011). This might be due to the fact that end stage renal disease patients spend almost three times a week and each session takes four hours during their course of dialysis. This makes patients to feel like their life is dependent on the machine. This feeling of dependency creates emotional toll in the patients during dialysis.

On the other hand, the existing renal recipients are not without negative psychological experience that this study explored. The finding of this study showed that respondents had fear of transplanted organ failure that has been explained by the doctors including the unpredictable nature of transplanted kidney. Several international studies revealed that one of the negative experiences rises from fear of organ failure after transplant that created worry and tension in living kidney recipients (De Vito Dabbs A, 2003; Griva K, 2002). Moreover, clients with transplanted kidney were commonly briefed shortly after transplantation that in their daily lives there is a possibility of infections, drug side effects and other conditions that could expose the patient to a state of physical discomfort leading to fear of possible transplanted organ failure. Hence, it is a possible scenario given the medical explanation that patients could expect organ failure despite all efforts and exceptional support that they received from donor.

As per the finding result almost all participants with transplanted kidney expressed that they developed feeling of dependency that appears to happen on how others view them. They explained that most people view them as incapable of taking full responsibility or play important role as others that participants claim to as able to do with no restriction. The finding has been found to be unsupported by other studies to my knowledge hence this might be related to the fact that our society has its own exceptional culture that shows extreme care to patients with such conditions while unknowingly introduce sense of dependency from the patient side.

On the other hand, regret is also found to be one of the negative experiences the patients developed. Few participants expressed that it was wrong to receive kidney and in danger the life of the donor. The claim that it was selfishness to late the donor risk his life to something that could possibly go wrong and lead two lives to death. Similar studies have supported this context (De Pasquale C, 2010; Fukunishi I, 2002).

CHAPTER SIX—Conclusion and Recommendation

6.1. Conclusion

Dialysis and kidney transplantation are a therapeutic method which, although, at the end of the day, enhances the quality of life of the patients, triggers numerous implications which are psychological in nature. For the patients the dialysis and kidney transplantation treatment are connected with long-term emotional tension, experiencing strong anxiety and with the need to confront and to deal with strong positive and negative experiences. During dialysis, transplantation, directly after the transplantation and throughout the functioning of the graft, in the patients there can appear psychological symptoms, most frequently anxiety and depressive disorders. The functioning of the patients is also often affected by social factor, thus frequent in dialyzed patients, which undergo regression after receiving kidney from another person while the donor feel some symptom of disease. Compared with dialysis, life after receiving a kidney is significantly more pleasant and enabling though it is not without challenges. The findings also concluded that despite there are tremendous psychosocial challenges during dialysis and transplantation, the psychosocial burdens during dialysis are more severe than after transplantation.

6.2. Recommendation

Based on the discussions of the major findings, the conclusions are drawn, based on the conclusion the researcher forwards the following suggestions.

It is important to provide integrated and multidisciplinary care and procedure for standard assessment, patient self-decision studies, new coping strategies and adoption of more appropriate lifestyles. It is important to provide programmed counseling during dialysis because the existential psychological burden suffered by patients during Dialysis and transplant not compliant with treatment recommendations. It also highlighted that the counseling process also needed for not only the donor and kidney transplant recipient but also for family friends and significant others as their perception and support affects the rehabilitation/adaptation process of the patient.

Hospital authorities and any charity organizations better to provide continues support and have to guidance for both recipients and donors. Some of the participants developed a feeling of guilt/regret after transplant for receiving a donation, so, psychologists and special need experts are better to continually monitor their psychological progress.

Ethiopia Federal democracy of Ethiopia Minster of Health proclamation 691 article 10 kidney Donors should be relative or marriage relation due to this proclamation many patients suffering of dialysis for long time

if one chronic kidney patient have not any relative to donate kidney he/she will continue dialysis throughout their life so Minster of Health should revise the proclamation for special patients.

References

Abegunde, D., & Stanciole, A. (2006). An estimation of the economic impact of chronic noncommunicable diseases in selected countries. *World Health Organization, Department of Chronic Diseases and Health Promotion*, *2006*.

Amerena, P & Wallace, P. (2009). Psychological experiences of renal transplant patients: A qualitative analysis. *Counselling and Psychotherapy research*, *9*(4), 273-279.

Avramovic, M&Stefanovic, V. (2012).Health- related quality of life in different stages of renal failure. *Artificial organs*, *36*(7), 581-589.

Brito, D. C. S. D., Paula, A. M. D., Grincenkov, F. R. D. S., Lucchetti, G., & Sanders-Pinheiro, H. (2015). Analysis of the changes and difficulties arising from kidney transplantation: a qualitative study. *Revistalatino-americana de enfermagem*, *23*(3), 419-426.

Bromet, E., Andrade, L. H., Hwang, I., Sampson, N. A., Alonso, J., De Girolamo, G., &Karam, A. N. (2011). Cross-national epidemiology of DSM-IV major depressive episode. *BMC medicine*, *9*(1), 90.

Cabral, J. F., Cavadas, V., Ramos, M. S., Fraga, A., Martins, M. L. S., Rocha, A.,& Branco, F. (2015, May). Female sexual function and depression after kidney transplantation: comparison between deceased-and living-donor recipients. In *Transplantation proceedings*, 47, 4, 989-999.

Costa-Requena, G., Cantarell, M. A., Rodriguez, A. U., &Seron, D. M. (2014). Health related quality of life and kidney transplantation: a comparison with population values at 6 months post-transplant. *Medicinaclinica*, *142*(9), 393-396.

Couser, W. G., Remuzzi, G., Mendis, S., & Tonelli, M. (2011). The contribution of chronic kidney disease to the global burden of major noncommunicable diseases. *Kidney international*, *80*(12), 1258-1270.

Crews, D. C., Charles, R. F., Evans, M. K., Zonderman, A. B., & Powe, N. R. (2010). Poverty, race, and CKD in a racially and socioeconomically diverse urban population. *American journal of kidney diseases*, *55*(6), 992-1000.

Cukor, D., Fruchter, Y., Ver Halen, N., Naidoo, S., Patel, A., &Saggi, S. J. (2012).A preliminary investigation of depression and kidney functioning in patients with chronic kidney disease. *Nephron Clinical Practice*, *122*(3-4), 139-145.

Cuker, D., Rosenthal, D. S., Jindal, R. M., Brown, C. D., & Kimmel, P. L. (2009). Depression is an important contributor to low medication adherence in hemodialysis patients and transplant recipients. Kidney International, 75(11), 1223-1229. doi: 10.1038/ki.2009.51.

De Pasquale, C., Veroux, M., Indelicato, L., Sinagra, N., Giaquinta, A., Fornaro, M. ...&Pistorio, M. L. (2014). Psychopathological aspects of kidney transplantation: Efficacy of a multidisciplinary team. *World journal of transplantation*, *4*(4), 267.

De Vito Dabbs A, D. M., Stilley CS, Manzetti J, Zullo T, McCurry KR, Kormos RL, Iacono A. (2003). Psychosocial vulnerability, physical symptoms and physical impairment after lung and heart-lung transplantation. J Heart Lung Transplant, 22(1268-1275).

De Sousa, A. (2008). Psychiatric issues in renal failure and dialysis. *Indian journal of nephrology*, *18*(2), 47.

Erim Y, B. M., Valentin-Gamazo C, Malago M, Frilling A, Schlaak JF, Gerken G …Senf W. (2006). Quality of life and psychiatric complications after adult living donor liver transplantation.Liver Transpl, 12:1782–1790

Fallen, M., Gould, D., & Wainwright, S. P. (1997). Stress and quality of life in the renal transplant patient: a preliminary investigation. *Journal of Advanced Nursing*, *25*(3), 562-570.

Fukunishi I, S. Y., Takayama T, Makuuchi M, Kawarasaki H, Kita Y, Aikawa A, Hasegawa A.(2002). Psychiatric problems in living-related transplantation (II): the association between paradoxical psychiatric syndrome and guilt feelings in adult recipients after living donor liver transplantation. Transplant Proc, 34(2632-2633).

Goetzmann, L., Irani, S., Moser, K. S., Schwegler, K., Stamm, M., Spindler, A. …&Klaghofer, R. (2009). Psychological processing of transplantation in lung recipients: A quantitative study of organ integration and the relationship to the donor. *British Journal of Health Psychology*, *14*(4), 667-680.

Goetzmann, L., Lieberherr, M., Krombholz, L., Ambühl, P., Boehler, A., Noll, G. …&Klaghofer, R. (2010). Subjektives Erlebennacheiner Organtransplantation-eine qualitative Studiemit 12, Herz-,Lungen-, Leber und Nierenem pfängern. *Zeitschriftfür Psychosomatische Medizin und Psychotherapie*, *56*(3), 268-282.

Gonzalez-Bedat, M., Rosa-Diez, G., Pecoits-Filho, R., Ferreiro, A., García-García, G., Cusumano, A., ... & Douthat, W. (2015). Burden of disease: prevalence and incidence of ESRD in Latin America. *Clin Nephrol*, *83*(7 Suppl 1), 3-6.

Gordon, E. J. (2001). Patients' decisions for treatment of end-stage renal disease and their implications for access to transplantation. *Social science & medicine*, *53*(8), 971-987.

Griva K, Z. J., Thompson D, Jayasena D, Davenport A, Harrison M, Newman SP. (2002). Quality of life and emotional responses in cadaver and living related renal transplant recipients. Nephrol Dial Transplant, 17, 2204-2211.

Heinrich, T. W., &Marcangelo, M. (2009). Psychiatric issues in solid organ transplantation.

Wang H, Naghavi M, Allen C, Barber RM, Bhutta ZA, Carter A, et al.; GBD 2015 Mortality and Causes of Death Collaborators. Global, regional, and national life expectancy, all-cause mortality, and cause-specific mortality for 249 causes of death, 1980-2015: a systematic analysis for the Global Burden of Disease Study 2015. Lancet. 2016 Oct 8;388(10053):1459–544. http://dx.doi.org/10.1016/S0140-6736(16)31012-1 pmid: 27733281

Karaminia,R.,Tavallaii,S.A.,Lorgard-Dezfuli-Nejad,M.,MoghaniLankarani,M.HadavandMirzaie, H., Einollahi, B., &Firoozan, A. (2007). Anxiety and depression: a comparison between renal transplant recipients and hemodialysis patients. Transplantation Proceedings, 39(4), 1082-1084. doi:10.1016/j.transproceed.2007. 03.088

Krebber, A. M. H., Buffart, L. M., Kleijn, G., Riepma, I. C., De Bree, R., Leemans, C. R., ... &Verdonck- de Leeuw, I. M. (2014). Prevalence of depression in cancer patients: a meta- analysis of diagnostic interviews and self- report instruments. *Psycho- Oncology*, *23*(2), 121-130.

Lee, D. H., Lee, H. W., Ahn, Y. J., Kim, H., Yi, N. J., Lee, K. W., &Suh, K. S. (2017). Initiating Liver Transplantation at a Public Hospital in Korea. *The Journal of the Korean Society for Transplantation*, *31*(4), 193-199.

Levey, A. S., Eckardt, K. U., Tsukamoto, Y., Levin, A., Coresh, J., Rossert, J., ... & Eknoyan, G. (2005). Definition and classification of chronic kidney disease: a position statement from Kidney Disease: Improving Global Outcomes (KDIGO). *Kidney international*, *67*(6), 2089-2100.

Liyanage, T., Ninomiya, T., Jha, V., Neal, B., Patrice, H. M., Okpechi, I. ...& Rodgers, A. (2015). Worldwide access to treatment for end-stage kidney disease: a systematic review. *The Lancet*, *385*(9981), 1975-1982.

LK, C. (1987). Cardiac transplantation: a psychological perspective. . Circulation, 75, 57–62.

Lonargáin, D. Ó.,Brannigan, D., & Murray, C. (2017). The experience of receiving a kidney transplant from a deceased donor: Implications for renal services. *Psychology & health*, *32*(2), 204-220.

Lovera G, B. A., Bertolotti M, Comazzi AM, Clerici CA, Gandione M, Mazzoldi M, Rupolo G, Feltrin A, Ponton P. . (2000). Psychological assistance in organ transplantation. . Ann Ist Super Sanità, ;36:225–246.

Mahmoud, S. A. A., Selim, M., &Raouf, H. A. (2014).Assessment of Self-Care Practice of Patients on Hemodialysis at Cairo University Hospitals. *Assessment*, *5*(39).

Müller, H. H., Englbrecht, M., Wiesener, M. S., Titze, S., Heller, K., Groemer, T. W., ...&Maler, J. M. (2015). Depression, anxiety, resilience and coping pre and post kidney transplantation–initial findings from the Psychiatric Impairments in Kidney Transplantation (PI-KT)-Study. *PloS one*, *10*(11).

Müller, H. H., Molnar, M. Z., Szeifert, L., Ambrus, C., Molnar-Varga, M., Szentkiralyi, A & Novak, M. (2011).Sleep disorders, depressive symptoms and health-related quality of life—a cross-sectional comparison between kidney transplant recipients and waitlisted patients on dialysis. *Nephrology Dialysis Transplantation*, *26*(3), 1058-1065.

Naghavi, M., Wang, H., Lozano, R., Davis, A., Liang, X., & Zhou, M. (2015).GBD 2013 Mortality and Causes of Death Collaborators. Global, regional, and national age-sex specific all-cause and cause-specific mortality for 240 causes of death, 1990-2013: a systematic analysis for the Global Burden of Disease Study 2013. *Lancet*, *385*(9963), 117-171.

Naicker S. End-stage renal disease in Sub-Saharan Africa.Ethn Dis. 2009; 19(1 Suppl 1):S13–S14.

Neipp, M., Jackobs, S., &Klempnauer, J. (2009). Renal transplantation today. *Langenbeck's archives of surgery*, *394*(1), 1.

O'Donnell K, Chung Y. (1997). The diagnosis of major depression in end stage renal disease. Psychother Psychosom. 66:38–43.

Olbrisch, M. E., Benedict, S. M., Ashe, K., &Levenson, J. L. (2002). Psychological assessment and care of organ transplant patients. *Journal of consulting and clinical psychology*, *70*(3), 771.

Orr, A Willis, S., Holmes, M., Britton, P., & Orr, D. (2007).Living with a kidney transplant: a qualitative investigation of quality of life. *Journal of health psychology*, *12*(4), 653-662.

OS, S. (1989). Psychiatric aspects of organ transplantation.Am J Psychiatry, 146, 972–982.

Palmer, S., Vecchio, M., Craig, J. C., Tonelli, M., Johnson, D. W., Nicolucci, A., ...&Strippoli, G. F. (2013). Prevalence of depression in chronic kidney disease: systematic review and meta-analysis of observational studies. *Kidney international*, *84*(1), 179-191.

Pascazio, L., Nardone, I. B., Clarici, A., Enzmann, G., Grignetti, M., Panzetta, G. O., &Vecchiet, C. (2010). Anxiety, depression and emotional profile in renal transplant recipients and healthy subjects: a comparative study. Transplantation Proceedings, 42(9), 3586-3590.Doi 10. 1016/j. transproceed.2010.08.056.

Pietkiewicz, I., & Smith, J. A. (2014). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Psychological journal*, *20*(1), 7-14.

Pisanti, R., Poli, L., Lombardo, C., Bennardi, L., Giordanengo, L., Berloco, P. B., & Violani, C. (2014). The role of transplant-related stressors and social support in the development of anxiety among renal transplant recipients: The direct and buffering effects. *Psychology, health & medicine*, *19*(6), 650-655.

Remuzzi, G., Perico, N., Macia, M., & Ruggenenti, P. (2005). The role of renin-angiotensin-aldosterone system in the progression of chronic kidney disease. *Kidney International*, *68*, S57-S65.

Revicki, D. A., Osoba, D., Fairclough, D., Barofsky, I., Berzon, R., Leidy, N. K., & Rothman, M. (2000). Recommendations on health-related quality of life research to support labeling and promotional claims in the United States. *Quality of Life Research*, *9*(8), 887-900.

Resende, L., Guerra, J., Santana, A., Mil-Homens, C., Abreu, F., & Da Costa, A. G. (2009, April).First year renal function as a predictor of kidney allograft outcome.In *Transplantation proceedings* (Vol. 41, No. 3, pp. 846-848).Elsevier.

Schulz, K. H., &Kroencke, S. (2015). Psychosocial challenges before and after organ transplantation. *Transplant Research and Risk Management*, *7*(1), 45-8.

Schulz, K. H., &Kroencke, S. (2015). Psychosocial challenges before and after organ transplantation. *Transplant Research and Risk Management*, *7*(1), 45-8.

Schulz,K.H.,&Thaiss,F.(2012).LangzeitüberlebenbeichronischerNiereninsuffizienz. *Bundesgesundheitsblatt-Gesundheitsforschung-Gesundheitsschutz*, *55*(4), 543-551.

Svenaeus, F. (2012). The Phenomenology of Organ Transplantation: How Does the Malfunction and Change of Organs Have Effects on Personal Identity?.The hidden epidemic: worldwide, over 850 million people suffer from kidney diseases.

Tonelli, M., & Riella, M. C. (2014). World Kidney Day 2014: CKD and the aging population. *American Journal of Kidney Diseases*, *63*(3), 349-353.

Tucker, E. L., Smith, A. R., Daskin, M. S., Schapiro, H., Cottrell, S. M., Gendron, E. S., ... & Maass, K. L. (2019). Life and expectations post-kidney transplant: a qualitative analysis of patient responses. *BMC nephrology*, *20*(1), 1-10.

Ver Halen, N., Cukor, D, Constantiner, M., & Kimmel, P. L (2012).Depression and mortality in end-stage renal disease. *Current psychiatry reports*, *14*(1), 36-44.

Wainwright, S. P., Fallon, M., & Gould, D. (1999). Psychosocial recovery from adult kidney transplantation: a literature review. *Journal of clinical nursing*, *8*(3), 233-245.

Wang, H., Naghavi, M., Allen, C., Barber, R. M., Bhutta, Z. A., Carter, A. ...&Coggeshall, M. (2016). Global, regional, and national life expectancy, all-cause mortality, and for the Global Burden of Disease Study 2015. *The lancet*, *388*(10053), 1459-1544.

Zhang, Q. L. &Rothenbacher, D. (2008). Prevalence of chronic kidney disease in population based studies: systematic review. BMC Public health, 8(1), 117. cause-specific mortality for 249 causes of death, 1980–2015: a systematic analysis

APPEDECES

APPENDIX –I

Personal information sheet

Title of research: Psychological experiences of kidney transplant patients in St. Paulo's Millennium Medical College (SPMMC) Addis Ababa, Ethiopia

Purpose of research: The aim of this study is explore psychological experiences of kidney transplant patients in St. Paulo's Millennium Medical College (SPMMC) Addis Ababa, Ethiopia 2020

Benefit of the study: - There is no direct benefit to you like payment. However, the result of the study will be helpful for all CKD patients who undergo transplant in the future by exploring psychological experience of kidney transplant patients which is important in making amendment psychological counseling.

Risk of the study: - by participating in this research you may feel some discomfort related to wasting time about 45 minutes during interview with data collection, but there is no other risk or harm

Rights of Participants: - You have full right to participate or to refuse and you can ask question if it is not clear for you. You have also a right not to respond some or the entire question if u doesn't want to respond.

Confidentiality: - Issue will be maintained, no identification will be recorded.

Name of sponsor: Addis Ababa University

Principal investigator: Aberehet Girmay (BSc)

APPENDIX –II

Written Informed Consent Form

Title of the project: Psychological experiences of kidney transplant patients in St. Paulo’s Millennium Medical College (SPMMC) Addis Ababa, Ethiopia

I have been well aware of that this research undertaking is for a partial fulfillment of MSc degree which is fully supported and coordinated by Addis Ababa University College of Education and Behavioral Studies school of Psychology, and the designate principal investigator. I have been fully informed in the language I understand about the research project an objective which is to explore psychological experiences of kidney transplant patients. I have been informed that all the information I shall provide to the interviewer will be kept confidential. I understood that the research has not any risk and no composition. I also knew that I have the right to withhold information, skip questions to answer or to withdraw from the study any time. I have acquainted nobody will impose me to explain the reason of withdrawal. It is also enlighten there would have no effect at all in my health benefit or other administrative effect that I get.

Principal investigator: Aberehet Girmay (B.Sc.)

I understand this form, or it has been read to me in the language I comprehend and understood the condition stated above, therefore, I am willing and confirm my participation by signing the consent.

Agreed to participate in the study: Yes No

Signature _____

Thank You.

APPENDIX –III

Introduction:

[Consent forms discussed and signed ahead of time]

Hello. Thank you for agreeing to take part in the interview. My name is ______________________. You have been asked here today since your point of view is important. I know you are very busy, and we appreciate your time.

INTRODUCTION: We are here today to talk about your psychological experience you have faced after kidney transplant

GROUND RULES: Please feel free to talk openly. There is no right or wrong answers. If you are uncomfortable talking about any aspect, or would rather not answer a particular question, that is fine.

The interview will take about 45 minutes.

Everything you say to us will be treated confidentially.

RECORDING: Do you mind if I record this interview? It is only in case we miss anything when taking notes. [Start recorder if agree. Will Take detailed notes whether the interview is recorded or not].

APPENDIX –IV

Part I: Socio-demographic characteristics of respondents

Questions	**Responses**
Age	
Sex	1. Male 2. Female
Marital status	1. Single 2. Married 3. Divorced 4. Widowed 5. Separated
Occupational status	1. House-wife 2. Self-employed 3. Government employed 4. Farmer 5. Merchant 6. Student **7.** Other
Educational status	1. No formal education 2. Primary education 3. Secondary education 4. Tertiary and above
Families monthly income	
Time when kidney transplant was done	D/M/Y

Part II: in-depth interview questions

1. What does having a kidney transplant mean to you?

   Probe: How do you explain the new life after transplant?

   How has having a kidney transplant affected your life?

   How did you feel during the build-up to the transplant?

   What have been the biggest changes over time your mind after transplant

2. What positive psychological experiences of life you have after transplantation?

   Probe: Have you experienced enhancing physical and social functioning/ return to work?

   What about develop hope/ Feeling of independence/enjoying in new life related to not having dialysis increased freedom?

3. What are the principal difficulties faced following kidney transplant?

   Probe: Have you experienced feeling different from others, Fear and anger concern for

   Health of the donor/uncertainty about the transplant/lack of understanding by people like treated you as normal/medication side effect?

4. What was your general experience of support from families/relatives/friends…?

   Probe: who was on your side through the process of transplantation?

   What social supported you have received from significant others?

   What was the role of support received from people on promoting your psychological wellbeing?

   Have you ever experience feeling of dependence while people supporting you?

Conclusion

We have come to the end of the specific questions we planned to discuss with you

Before we conclude, do you have any comments or things that we haven't discussed that you would like to share/mention, about your experience/general perception about kidney transplant?

Thank you so much for your time

በአዲስአበባዩኒቨርስቲ

የትምህርትናስነባህሪጥናትየስነልቦና

ት/ቤትድህረምረቃመርሃግብር

የግልመረጃወረቀት

የጥናትርዕስ-የቅዱስፓውሎሚሊኒየምሜዲካልኮሌጅ (SPMMC) ውስጥየኩላሊትንቅለተከላህመምተኞችየስነ-ልቦናልምዶችአዲስአበባ፣ኢትዮጵያ

የጥናትዓላማ-የዚህጥናትዓላማበቅዱስፓውሎሚሊኒየምሜዲካልኮሌጅ (SPMMC) አዲስአበባ፣ ኢትዮጵያ 2020 ውስጥየኩላሊትንቅለተከላህመምተኞችንሥነልቦናዊልምዶችንመመርመርነው፡፡

የጥናቱጥቅም-እንደክፍያለእርስዎቀጥተኛጥቅምየለም፡፡ ሆኖምየጥናቱውጤትለወደፊቱየስነልቦናምክክርማሻሻያለማድረግአስፈላጊየሆነውንየኩላሊትንቅለተከላህ መምተኞችንየስነልቦናተሞክሮበመዳሰስለወደፊቱንቅለተከላላደረጉለሁሉምየ CKD ህመምተኞችይረዳል፡፡

የጥናቱአደጋ-በዚህጥናትውስጥበመሳተፍከመረጃአሰባሰብጋርቃለ-መጠይቅበሚደረግበትጊዜለ 45 ደቂቃዎችያህልጊዜከማባከንጋርበተያያዘአንዳንድምቾትላይሰማዎትይችላል፣ ግንሌላአደጋወይምጉዳትየለም

የተሳታፊዎችመብቶች - - ለመሳተፍወይምላለመቀበልሙሉመብትአለዎትእናለእርስዎግልጽካልሆነጥያቄመጠየቅይችላሉ። እርስዎመልስለመስጠትየማይፈልጉከሆነእንዲሁምየተወሰነውንወይምሙሉውንጥያቄላለመመለስመብት አለዎት።

ሚስጥራዊነት-- ጉዳዩተጠብቆይቆያል፣መታወቂያአይመዘገብም፡፡

የስፖንሰርስም-አዲስአበባዩኒቨርሲቲ

ዋናመርማሪ-አብረኸትግርማይ (ቢ..ኤስ.ሲ)

በአዲስአበባዩኒቨርስቲ

የትምህርትናስነባህሪጥናትየስነልቦና

ት/ቤትድህረምረቃመርሃግብር

የቃለመጠይቅስምምነትቅፅ

በመቅድሚያለዚህመጠይቅጊዜዎንሰጥተዉፈቃደኛስለሆኑከልብአመሰግናለሁ፡፡

ስሜዳዊትአስረግደዉእባላለሁ፣ በአዲስአበባዩኒቨርስቲየትምህርትናስነባህሪጥናትየስነልቦናት/ቤትድህረምረቃመርሃግብርተመራቂተማሪ ነኝ፡፡

የኩላሊትንቅለተከላያደረጉሠዎችከንቅለተከላውበሐላያላቸውየስነልቦናእናማህበራዊልምዳቸዉን/ተሞክሯቸዉን፤ ምንአይነትአመቺሁኔታዎችእናተግዳሮቶችአሉበሚልጥናትማካሄድእችልዘንድከእርስዎጋርመወያየትእፈልጋለሁ፡፡

ይህቃለመጠይቅከአንድሰዓትያነሰጊዜየሚወስድሲሆን፤ የተጠየቁትጥያቄዎችምላሽ/ማንኛዉንምአስተያየትበፍጥነትመፃፍስለሚያስቸግርእናምንምነጥቦችንላለመሳት / ላለማጣት/ውይይታችንንበመቅረጸድምጽበመጠቀምእቀርፃለሁ፡፡ በተቻለመጠንማስታወሻለመያዝጥረትየማደርግቢሆንምፈቃድዎእንዲሆንእጠይቃለሁ፡፡

አንድላረጋግጥልዎትየምፈልገዉጉዳይቢኖርበቃለመጠይቅጊዜየሚገኘዉንምላሽ/መረጃእናማንነትዎበሚስጥርእንድሚያዝእና፤ለሌላምሶስተኛወገንየማይተላላፍመሆኑንበድጋሚአረጋግጥዎታለሁ፡፡

በተጨማሪምቃለመጠይቁበርሶመልካምፈቃድላይየተመሰረተስለሆነምንምአይነትምላሽአለመስጠት፤ ቃለመጠይቁንበማንኛዉምጊዜእናሁኔታየማቋረጥመብትዎየተጠበቀነዉ፡፡

ፍቃደኛመሆኖንዎንማረጋገጥእፈልጋለሁ

የተጠያቂዉመለያኮድ…………………

ፊርማ………………………………

ቀን…………………………………

1. የስነ-ማህበራዊእናስነ-ህዝባዊባህርያት

ተ.ቁ	መጠይቅ	መልሶች	
101.	እድሜሽ/ህስንትነው?		
102.	ፆታ		
103.	ከፍተኛያጠናቀቅሽው/ከውየት/ትደረጃምንድነው?	1. ያልተማረ/ች 2. የመጀመርያደረጃት/ት(1-8) 3. የሁለተኛደረጃት/ት(9-12) 4. ሶስተኛደረጃእናከዛበላይ(12^+)	
104.	ዋናስራሽ/ህምንድነው?	ስራየሌላት/ለው የግልድርጅትቅጥረኛ የመንግሰትቅጥረኛ ገበሬ ተማሪ ሌላካለይግለፁ…	
106.	በአሁኑሰአትየትዳርሁኔታሽ/ህምን ይመስላል?	ያገባ/ች ያላገባ/ች የተፋታ/ች የሞተባት/በት የተለያየ/ች	
107.	የቤተሰባቹወርሃዊገቢምንያህልነው		
108.	የኩላሊትንቅለተከላውመችነውየተሰራልሽ/ህ		

ክፍል 2፡የቃለመጠይቅጥያቄዎች

የኩላሊትንቅለተከላላንተ/ቿምንድነው?

አውጣጣ፡ከኩላሊትንቅለተከላበºላያለውህይወትእንዴት

ትገልፀዋለህ/ትገልጪዋለሽ?

የኩላሊትንቅለማድረግሽህይወትሽላይበምንመልኩተፅእኖአሳድራል?

የኩላሊትንቅለበሚደረግልሽግዜምንይሰማሽነበር?

ከኩላሊትንቅለተከላበºላከግዜጋርበአስተሳሰብሽላይየተቀየረነገርምንድነው?

በሌሎችላይጥገኛየመሆን/ራሰንበመቻልበኩልያለውሁኔታከድያልስስጋርስታነፃፅሪውምንይመስላል?

ከኩላሊትንቅለተከላበºላበህይወትሽምንምንፖዘቲቭየስነልቦናተፅእኖአለ?

አውጣጣ፡በአካልእናበማህበራዊህይወትሽየመጎልበት/ወደስራመመለስጋርያለውንእንዴትታዪዋለሽ/ህ?

በህይወትተስፋየማድረግ/ከጥገኝነትየመላቀቅ/ራስንየመቻልስሜትንከማዳበርእናከድያልስስነፃየሆነአዲስ ህይወትመኖርሽጋተያይዞየመጣፖዘቲቭየስነልቦናተፅእኖካለ

ከኩላሊትንቅለተከላጋርተያይዞበህይወትሽየመጣከባድነገርአለ?

አውጣጣ፡ከሌሎችየተለየሁነኝብሎማሰብ/ፍርሃት/ንዴት/ኩላሊትስልሰጠሽ/ህሰውጠናአብዝቶመጨነቅ/ በንቅለተከላውእርግጠኛአለመሆን/የመድሃኖቶችየጎንዮሽጉዳት/ በሌሎችሰዎችምንምህመምእንደማይሰማሽ/እርዳታበፍፁምእንደማያስፈልግሽማሰብ/

በአጠቃላይከማህበረሰቡ (ከ̀ህደኞችሽ/ህ፣ቤተሰቦችሽ/ህ፣ዘመዶችሽ/ህ) የምታገኚው/ኘውድጋፍ/እርዳታእንዴትነበር?

አውጣጣ፡የኩላሊትንቅለተከላውከተደረገጀምሮአጠገብሽ/ህየነበረሰውማንነበር?

የስነልቦናሽጠንነትከማጎለበትጋርተያይዞከማህበረሰቡ (ከ̀ህደኞችሽ/ህ፣ቤተሰቦችሽ/ህ፣ዘመዶችሽ/ህ) የምታገኚው/ኘውድጋፍ/እርዳታምንአስተዋፅኦነበረው?

ከማህበረሰቡ (ከጓደኞችሽ/ህ፣ቤተሰቦችሽ/ህ፣ዘመዶችሽ/ህ) በምታገኚው/ኘውድጋፍ/እርዳታደስተኛነበርሽ/ክ?

ከማህበረሰቡ (ከጓደኞችሽ/ህ፣ቤተሰቦችሽ/ህ፣ዘመዶችሽ/ህ) በምታገኚው/ኘውድጋፍ/እርዳታስታገኚየጥገኝነትስሜትይሰማሽ/ህነበር?

ከማህበረሰቡ (ከጓደኞችሽ/ህ፣ቤተሰቦችሽ/ህ፣ዘመዶችሽ/ህ) ምንአይነትድጋፍ/እርዳታታገኚ/ኙነበር?

ከራስሽልምድበመነሳትማህበረሰቡ (ጓደኞችሽ/ህ፣ቤተሰቦችሽ/ህ፣ዘመዶችሽ/ህ)፣ የስራባልደርቦችሽንጨምሮለኩላሊትንቅለተከላያላቸውአረዳድ/የመረዳትአቅምእንዴትታዩዋለሽ/ህ?

አውጣጣ፡

ሌሎችለኩላሊትንቅለተከላያላቸውአረዳድ/የመረዳትአቅም/አመለካከትየስነልቦናሽ/ህጠንነትላይተፅእኖነበረው?ከነበረውእንዴት/በምንመልኩ?

ከኩላሊትንቅለተከላበኋላበማህበረሰቡምንምየጠንነትእክልእንደሌለብሽ/ህወይምእንደማንኛውምሰውትታዩ/ይነበር/ከዚህበፊትይሰጡሽየነበረውድጋፍስየመቀነስሁኔታነበር

በአንቺ/ተአመለካከትማህበረሰቡለኩላሊትንቅለተከላያላቸውአረዳድ/የመረዳትአቅም/አመለካከትልክነው ወይምአይደለምየምትዪው/ለውአለ(ካለገለጪልኝ

የኩላሊትንቅለተከላውከማህበረሰቡ (ከጓደኞችሽ/ህ፣ቤተሰቦችሽ/ህ፣ዘመዶችሽ/ህ)፣ የስራባልደርቦችሽንጨምሮያለሽ/ህየመግባባት /የመቀራረብሁኔታላይተፅእኖ/ለውጥአሳድ…ል? እንዴት?

Declaration

The researcher undersigned, declare that this thesis is my original work, has never been presented in any other university including AAU before. All the sources and materials used here have been well acknowledged and stated in the reference list.

Name: Aberehet Girmay Mengesha

Signature: ____________________

Donor and Recipient Selection Process

Potential kidney recipients will be selected from the pool of patients who come to the center with advanced chronic kidney disease or ESRD. The most basic criterion of acceptance for kidney transplantation is a good probability of survival after kidney transplantation.

All potential recipients and potential donors will be evaluated by the physicians and other appropriate professionals associated with the program. The final decision on recipient and donor candidacy rests with the Kidney Transplant Selection Committee.

The recipient shall be examined and determined to have no contraindications or unacceptably increased risks for transplantation and fulfills the admission criteria for the center.

The potential living donor shall also be examined and determined to have no contraindications and no identified risk factors for the procedure or for future health after kidney donation.

The living donor shall be a related donor according to our legislation, must come forward voluntarily, and give consent without coercion, financial or other incentives for the procedure.

The pre-transplant evaluation takes place in an outpatient setting; by a muliti-disciplinary team that will include nephrologists, surgeons, psychiatrist or social worker and transplant nurse coordinator.

Physicians, psychiatrist and transplant nurse co coordinator who are taking care of the recipient, shall not be involved in the evaluation of the potential donor and vice versa (pre transplant care) A trained and dedicated transplant nurse coordinators (recipient and Donor coordinator nurses) coordinates the pre-transplant evaluation and post-transplant follow up process. The main function of the transplant coordinator nurse is, to serve as the first information source about transplant to both parties, facilitate the referral consultation process, will arrange for a series of tests that are needed to decide on the best treatment for you, oversee the evaluation, and follow through with the team's recommendations.

Once the transplant candidate and potential donor evaluation is completed, all the data and information are summarized and presented to the transplant selection committee, where a decision is made to accept or reject the patient and/or the donor for the procedure.

Finally cases accepted by the transplant selection committee will be sent to the National transplant committee, based in the MOH for final approval. The national committee comprises (Minster of Health proclamation article 10)