Contextualizing the Cultural Factors Associated With Cancer Care in Nigeria: An Ethnonursing Study

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Abstract

Introduction: Culture and care are two important phenomena of particular concern to transcultural nursing. Cancer care is generally affected by certain cultural factors that influence how cancer patients experience diseases and seek and utilize care services. This study aimed to explore the cultural factors that affect cancer care in a Nigerian cancer care institution. Method: This study adopted an ethnonursing method involving participant observation and individual interviews. The study was conducted in the oncology unit of University College Hospital, Nigeria. Seven nurses and six patients were key participants, while four physicians, three ward assistants, and six patients’ relatives constituted the general participants. Result: Two themes and five patterns were identified. Participants described how the interplay of several cultural factors influenced or inhibited cancer care. Findings revealed significant influence of kinship, family, and social structure as well as the roles played by cultural beliefs, values, and practices in cancer care in Nigeria. Discussion: Cultural factors need to be considered broadly for the efforts toward prevention, early diagnosis, and treatment of cancer to be effective in Nigeria.

Keywords
cancer care, Nigerian culture, nursing, ethnonursing

Background of the Study

Cancer is a global critical health concern (Nwozichi et al., 2017). In Nigeria, the survival rate of people with cancer is much lower than the survival rate of those in high-income countries. This can be attributed to late presentation (Soyannwo et al., 2016), inadequate number of cancer care specialists, lack of functional equipment and resources (Adebamowo, 2013), and high level of poverty. There is also a rise in cancer cases in Nigeria, and aspects of the Nigerian culture contribute to this increase (Nwozichi, 2019; Nwozichi et al., 2017). Cancer patients are victims of a progressive disease and contend with cultural issues that, in some fashion, define their experiences before, during, and after hospitalization (Mulemi, 2010; Petri & Bethelsen, 2015). To adequately understand how culture affects responses to cancer, the patient and their caregivers must be seen as members of a social group (Black et al., 2018).

Cultural lenses determine how individuals perceive illnesses, outline their responses, and determine the expectations of caregivers. Specifically, culture influences how cancer patients experience the diseases and seek and utilize care services (Busolo & Woodgate, 2015). For example, Daher (2012) reported some myths about cancer such as beliefs that cancer is contagious and a form of punishment. These misconceptions can affect cancer patients’ expectations in the health care setting and can influence their responses to information about diagnosis and disease treatment (Graves et al., 2007). An ethnographic study conducted in India by Van Hollen (2018) showed how culture affected cancer diagnosis disclosure in India. The study iterated that in certain cultural circumstances, a patient’s knowledge of cancer diagnosis may induce psychological trauma. In Nigeria, health-related concerns are generally perceived to be private and can only be disclosed within the family circle. Therefore, this study explored the cultural factors that affect cancer care in a Nigerian cancer care institution using an ethnonursing approach. Studies on hospital cancer care nursing

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using the ethnonursing method are scarce as earlier studies were conducted among indigenous or minority groups in Western countries (Mulemi, 2010). Thus, there is currently less than an optimal understanding of the complexities of cultural considerations that are needed for effective and culturally harmonious cancer care in Nigeria.

**Method**

**Study Design**

This study adopted a qualitative ethnonursing methodology. This is an open discovery and naturalistic inquiry methodology developed by Madeline Leininger (2006) and revised by McFarland and Wehbe-Alamah (2018). This study is in compliance with the EQUATOR’s COREQ checklist for qualitative research (Tong et al., 2007).

**Study Setting**

This study was conducted in the oncology unit of University College Hospital, a federal government–owned hospital in Ibadan, Oyo State, Nigeria. Ibadan is the largest city in West Africa where the first university in Nigeria is situated.

**Selection of Participants**

Purposive sampling method was used to select the key and general participants. The key participants are those individuals who are generally most knowledgeable about the phenomenon of interest (emic view) and are interested in the domain of inquiry (McFarland & Wehbe-Alamah, 2018). The key participants in this study included seven nurses and six patients. The general participants have broad (etic) knowledge of the domain of inquiry and are witnesses to the key participants (McFarland & Wehbe-Alamah, 2018). In this study, the general participants included four physicians, three ward assistants, and six patients’ relatives. All the participants must have been in the unit for at least 4 months and be able to communicate in English Language. Participants were informed that the study is voluntary and that they have the full right to withdraw at any point without any consequences whatsoever.

**Data Collection Procedure**

Data for this study were collected through one-on-one interviews and participant observations. For data collection, the researchers adopted the stranger-to-trusted friend enabler, which allowed the researchers to establish a favorable relationship with participants in order to obtain authentic, credible, and dependable data. After revealing the purpose of the study to the participants, their written and signed informed consent was obtained. All participants were interviewed individually in an area and during a time they were most comfortable with. The interviews lasted between 40 minutes and 1 hour depending on the comfort of the participants and the amount of information they were willing to give. Participants were asked to describe what it was like to be a cancer care nurse, patient, physician, or relative as the case may be, in the cancer care setting. Participants were also asked to describe the factors that affected the care they received/provided on the ward. All interviews were carried out in English language as all participants preferred to respond in English. Separate interview guides were used to conduct the interview for each participant category. Interviews were audiotaped using a digital tape recorder. The participant observation for this present study took place in common areas over a period of 5 months of intensive data collection. The first author adopted the role of “observer as participant.” This role involved more observation than participation but allowed the researcher to engage actively with the key participants. Field notes were recorded during the participant observation. Data saturation determined the sample size for this study. Data collection took place between July and October, 2019. Prior to data collection, the researchers had been trained and were experienced in qualitative nursing research studies.

**Method of Data Analysis**

Transcripts from the interview and field note data were analyzed using NVivo 12. Data analysis followed the Leininger’s (2006) phases of ethnonursing data analysis enabler as described by Wehbe-Alamah (2018) and involved four phases. After transcription, the researchers reviewed the interview transcripts and field notes and coded the data. Descriptors from the interviews and field notes that described the phenomenon of interest were identified to initially generate codes. Codes with similar contents were grouped into meaningful categories or descriptive labels. Data categories were reviewed and sorted to discover recurrent patterns within the data, and categories were developed or reframed until major themes emerged (see Table 1).

**Ethical Considerations**

Ethical approval was sought and obtained from the Ethical Review Board of the Institute for Advanced Medical Research and Training, University of Ibadan, with application number UI/EC/0539, issued on February 19th, 2019. All participants voluntarily signed the consent form in agreement to participate in this study. All information and data collected in this study were treated with high confidentiality. Leininger’s (2006) six criteria for the systematic evaluation of ethnonursing research (credibility, confirmability, meaning in context, recurrent patterning, saturation, and transferability) were adopted to ensure rigor.
Results

Although a representative sample was not necessary for this study, the sociodemographic information of the nurse-participants represented the spectrum of nurses working in the oncology unit. All the nurses were female and Christians; their educational background ranged from only a diploma in nursing and midwifery to bachelor’s and graduate degrees. The sociodemographic profiles of the patient-participants revealed that the majority were female, graduates, and of Yoruba ethnicity. The patient-participants represented equal number of Christians and Muslims. The duration of illness ranged from 9 months to 4 years, while the duration on the ward ranged from 1 month to 7 months.

Significant Influence of Kinship, Family and Social Structure

Cancer care is an encompassing experience that affects the patient and significant others in the family, community, and health care environment. Nigeria has an unarguably robust family connectedness, which implies that caring for a sick person is considered a family duty.

Support From Family and Relatives and Their Involvement in Cancer Care. The significance of family support in this study cannot be overemphasized. Patients described how this helped them forge ahead in their cancer care journey. This support comes in the form of providing funds for treatment and other emotional benefits. Most patients were observed to have relatives around all the time. This indicates the close family ties. Nurse 1 explained that involving many family members helps them cope with the physical challenge associated with caring for cancer patients:

The role of the family is to support the patients emotionally, financially and otherwise. We also provide counseling for relatives to help them cope with the stress, because they may be really stressed out from running up and down to care for their patients. We encourage [them] to eat well so that they won’t break down while caring for the patients. (Nurse 1)

In spite of the benefit of having patients’ relatives involved in the care process, a nurse narrated that some relatives get frustrated and abandon their patients in the hospital. A physician equally described situations where some husbands abandoned their wives after undergoing mastectomy. This physician respondent opined that involving husbands in making the decision for their wives’ mastectomy would encourage them to play their roles of caring for their wives. The respondent buttressed the impact of cancer diagnosis on spouses by adding that some female patients kept their diagnosis and treatment a secret from their husbands to avoid abandonment.

Patients’ husbands should be involved in the decision about mastectomy because there are cases whereby some husbands abandon their wives because they had mastectomy done. We have some people who will request that their husbands should not be told about their cancer disease and some husbands will say “don’t tell my wife.” These are some of the issues that we face. (Physician 4)

Stigma Against Cancer Patients in the Community. Although cancer diagnosis no longer places an individual into a collectively understood stigmatized category globally, some patients in this study still experienced some form of stigmatization. Most forms of stigmatization found in this study were based on people’s assumption that an invalid who loses significant weight is most likely suffering from HIV/AIDS. Severe weight loss associated with cancer and cancer treatment fosters the association of cancer and HIV/AIDS. Some patients in this study actually wished that they had HIV instead of cancer:

People who saw me for the first time since I started this treatment thought I had AIDS. I wish I had HIV instead of cancer, at least HIV is treatable but this cancer is an unending struggle. (Field note)

Another important aspect is the culture of secrecy. Some caregiver participants expressed worry about the effect of keeping cancer diagnosis a secret. Even when a patient died of cancer, the cause of the patient’s death was kept secret from the public. This was done to “hide the secret of the dead” and to avoid the potential stigma on the family. Additionally, some patients would hide their family history of cancer even from health workers. This inevitably hampers the fight against cancer in Nigeria:

They want to hide the secret of the dead but a lot of people have medical conditions with genetic predisposition and they are hiding it, instead [of opening up] so that people can help. The worst is that [they] may face discrimination. (Physician 2)
Influences of Cultural Beliefs, Values, and Practices

Many participants in this study revealed how cultural beliefs and practices affected their cancer journey either as patients or as caregivers.

Folk Beliefs, Values, and Practices. Folk practices identified by participants related to the use of herbs and concoctions from spiritual healers:

Most of these patients that are hospitalized have relatives who come with herbal preparations for the patients to use. We do not know how these concoctions are prepared, they do not have specified dosage, and we don’t know the side effects. Most of the relatives sneak in these preparations. Some (relatives) will ask you for permission to allow them to bathe the patient themselves and after the bath you see the relatives rubbing some concoction on the patients and making some incantations. (Nurse 6)

The use of such herbs and concoctions is not entirely permissible within the formal hospital setting, and this reflects in the fact that the respondent (Nurse 6) said relatives “sneak in these preparations” and administer them without informing the professional health care giver. According to some nurse-participants, the use of these preparations may contraindicate with the treatment plan in use for such patients, but the consistency in which this situation presents in the treatment of cancer patients is an indication of the significance and extent of cultural beliefs in the management of cancer in Nigeria.

Another important aspect of the cultural beliefs and practices of participants observed was the culture of secrecy. Some participants expressed some worries about the effect of keeping cancer diagnosis a secret from relatives and family members. Even when a patient died of cancer, the cause of the patients’ death was kept secret. They believed that keeping the diagnosis of the dead person makes his or her spirit to be “at rest.” A physician noted,

There is this culture of concealing diagnoses in Nigeria. If you ask a patient “Is there any family history of cancer?” they will deny either intentionally or out of ignorance. The reason is that when a patient dies, relatives will say “je k’abo asiri oku” (let us keep the secret of the dead). We need that secret because these diseases run in the family. (Physician 2)

Cancer Is “an Attack From an Enemy”. Many patient-participants in this study attributed cancer diagnosis to a form of attack from an enemy. This is because of the folk belief that cancer is not an “ordinary illness.” One patient revealed that their cancer ordeal was caused by an enemy and was a punishment for “sins” committed:

I know this illness was sent from our village, my father has confirmed it, it was sent to destroy us many years ago but because I had three girlfriends some years ago, and I was having sex with many women, I derailed from God and that was why the devil had the chance to strike me with this illness. (Field note)

Patients who believed their conditions were some forms of attack tended to seek spiritual and supernatural solutions from native doctors. Even in the ward, it was observed that cancer patients would put a Bible or Qur’an under their pillows. A physician also confirmed the popular folk belief about the cause of cancer held by patients and relatives:

Yoruba people will say “won so lata” (they have thrown her a spiritual arrow). I have heard a patient say she was asleep when they threw her the arrow, which hit her on the chest, and since then she has been feeling the lump. (Physician 2)

Refusal of Treatment. In a physician’s conversation with a breast cancer patient on the importance of getting a mastectomy, it was observed that the patient was reluctant to accept the recommended treatment plan. The researcher’s follow-up interaction with the physician about the possible reasons why the patient was reluctant to accept mastectomy revealed that: “At times when we recommend a mastectomy, some women reject it claiming that they will lose their womanhood and pride as a woman.” A nurse also confirmed this mind-set about mastectomy.

Some patients also refused to undergo chemotherapy principally because they have been told by a friend or a relative not to take the treatment. A physician narrated an incident when he advised a patient to undergo chemotherapy, but the patient refused only to resurface months later with complications:

Breast lump 2 by 3 cm lump was removed on a patient; I advised the patients “you will need further treatment,” “you will need chemotherapy after removing the lump,” “you will need to do this test,” but the patient ran away and come back one and a half years later with cerebral metastasis . . . so the chemotherapy that she had refused earlier, she later took 10 courses of it. (Physician 2)

Discussion

Significant Influence of Family and Social Structure

Cancer patients and health care providers in this study emphasized the significant roles patients’ families play. The findings of this study showed that family involvement in cancer care is bidirectional. On one hand, family members served as a formidable source of support to the cancer patients during hospitalization, and on the other, the relatives themselves needed to be supported in order to cope with the strain associated with cancer caregiving. Evidence from the literature suggests that there is an increase in
patient satisfaction, decision making, and treatment adherence when family members are involved in cancer care (Al-Bahri et al., 2017; Hobbs et al., 2015).

In this present study, support from family and relatives was predominantly financial and emotional in nature, which corroborates the findings of Farrell and Kravits (2017). Despite being confined to bed due to the severity of their illnesses, some patients still preferred their relatives to provide their self-care activities. However, the findings of this study revealed that family involvement also necessitated giving attention to family caregivers. Farrell and Kravits (2017) addressed the plethora of sufferings encountered by family caregivers of cancer patients. Laryionava et al. (2018) regarded family members of cancer patients as “the second patient,” while Wozniak and Izyck (2014) called them a family at risk because when someone is diagnosed with cancer, the entire family is affected. Lee and Bell (2011) report that Chinese cancer patients revealed that their family is affected as much as they are. From the account of Berry et al. (2016), these family caregivers themselves require support for them to remain effective and maintain their well-being while caring for cancer patients.

Ironically, the findings of this study revealed some forms of abandonment of patients by their family members. Abandonment was principally caused by overwhelming frustration, a lack of resources to care for patients, personal values, and cultural prejudices. For example, physicians and nurses in this study alluded to situations where some husbands abandoned their wives after undergoing mastectomy because their wives were no longer attractive to them without one or both breast(s). A similar finding was reported by Olasehinde et al. (2019) and Mulemi (2010) in their study on cancer care in Nigeria and Kenya, respectively. Actively involving the husbands in decision making for their wives’ mastectomy would encourage them to give their wives the total support they deserve (Zahls & Lewis, 2010) and prevent spousal distress as also suggested by Olasehinde et al. (2019) and Mulemi (2010).

There is some evidence of stigma against patients with cancer in this study population, which was mostly associated with the belief that a person who is experiencing severe weight loss is probably suffering from HIV/AIDS. Some participants in this study reported that their families and friends withdrew from them because of their condition. Some patients were ignored by their friends and relatives because they were considered death candidates. A similar situation was reported in an ethnography study of cancer care in Kenya conducted by Mulemi (2010) and expounded by Knapp et al. (2014).

The effects of stigma and discrimination have also resulted in the concealment of cancer diagnosis, to the extent that when a person dies of cancer, the exact cause of death is not revealed by immediate family members. Additionally, cancers affecting visible body parts further predispose patients to more stigmatization. For example, while cervical cancer poses some form of stigma especially as the cervix is located in a part of the body that culturally Africans do not speak openly about, some patients count themselves stigma-free because the cervix is a hidden part.

Interestingly, Van Hollen (2018) found that diagnostic disclosure was affected by culture, and, at times, it was considered harmful to disclose cancer diagnosis to the patient because of the psychological harm that may ensue. Though the ethnographic study by Van Hollen (2018) on the effect of diagnostic disclosure to patients is presented as an example of how culture influences cancer care, disclosure of cancer diagnosis to Nigerian patients was not considered to be as psychologically harmful as the effect of disclosing “the secret of the dead” to the community. This in turn affected cancer patients’ disposition to reveal a family history of cancer to their health care providers and the family’s reluctance to reveal the cause of the patient’s death to the society as it could generate stigma on the family. Generally, participants in the present study had the fear that others will either avoid them or somehow regard them differently when they know about their cancer diagnosis.

**Influences of Cultural Beliefs, Values, and Practices**

Folk medicine existed in Nigeria before the advent of Western medicine, and its practices range from home remedies to spiritual healings. When these practices fail, patients make the hospital the last resort (Asuzu et al., 2015). Many Nigerians, regardless of ethnicity, use some form of ritual, herbs, and other similar practices to attend to their health concerns. Health care providers discourage this practice especially as they claim that it leads to late presentation in hospitals and the abandonment of ongoing medical treatment plans for religious and cultural alternatives. Similarly, cancer diagnosis and treatment have associated myths (Daher, 2012). In this present study, it was mostly seen as an attack from an enemy. This is similar to the belief in some Indian cultures recorded by Biswas (2014) in his article “Debunk the myth: Oncologic misconceptions.” These myths have led to a culture of treatment refusal. On several occasions, it was noted that some patients refused certain treatment measures due to certain taboos, personal reservations, and cultural restrictions. For example, some women with breast cancer refused to consent to mastectomy because of issues surrounding body image (Mulemi, 2010; Olasehinde et al., 2019).

The cultural implications of the amputation of a body part are significant in this study. Some participants refused amputations because they wanted to die and be buried in a complete form. A patient who required amputation for osteosarcoma commented, “I will be seen as a half-dead man because when I recover, a part of my body is already in the grave.” This finding is similar to that of Mulemi (2010) where Kenyan cancer patients preferred to die “complete” instead of having their body parts amputated. Unfortunately,
it has been established that patients who declined standard treatment had significantly worse survival chances than those who received standard treatments (Joseph et al., 2012).

There were perceptions among the patient population in this study that chemotherapy was the main cause of death among cancer patients. Consequently, many refused to accept chemotherapy as corroborated by Frankel’s (2013) study but is different from the findings of Huijer and Leeuwen (2000) who highlighted that refusing chemotherapy is not a common reaction on the part of cancer patients. According to some patients in Huijer and Leeuwen’s (2000) study at the Academic Hospital of the Vrije Universiteit in Amsterdam, the Netherlands, if the choice were totally theirs, they would likely opt for chemotherapy, even if there were only a small chance for improvement. The variations in peoples’ acceptance of chemotherapy in this present study could be culturally based.

Limitations
This ethnonursing study was limited to a specific geographic region in Nigeria, which may not reflect the exact situation in other regions of the country. The author is less concerned about the generalizability of the findings but more concerned about providing cultural and contextual information about cancer and cancer care in Nigeria that may help improve individual and collective efforts to fight disease in Nigeria.

Implications for Nursing Practice
Nurses should put into consideration the prevailing cultural factors while designing their care for patients and relatives with the ultimate goal of providing cancer care that is responsive, culturally appropriate, and therapeutic. Sufficient awareness should be created to educate members of the community on the importance of reducing stigma and discrimination on cancer patients and relatives. Furthermore, nurses must try to understand the various reasons why patients refuse treatment and devise evidence-based strategies to promote early diagnosis, care, and treatment compliance. Patients and their relatives should be educated on the need to comply with treatment regimen and not use alternative herbal treatment without the knowledge of health care providers. While some of the alternative and cultural interventions may be harmful, health care providers should adopt a nonjudgmental negotiation approach to foster treatment acceptance and adherence.

Conclusion
It was found that cultural beliefs, values, and practices had both beneficial and detrimental effects on the care for cancer patients in Nigeria. Beyond the physical and emotional complexities of cancer care, many cultural nuances and peculiarities can affect the care that oncology nurses give to their patients and relatives. Patient-centered cancer care requires culture-sensitive approaches to ensure patients’ well-being and satisfaction.

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