



Health-Seeking Behavior and Patterns of Traditional Medicine Patronage Among Breast Cancer Patients in Oyo State, Nigeria

Abstract

Globally, breast cancer accounted for an estimated 2.30 million new cases and 764,000 deaths in 2023, with Nigeria recording the highest incidence in West Africa at 50.5 per 100,000 women. Incidence figures alone conceal a quieter crisis: across Nigeria's underfunded, urban-centred healthcare system, where nearly 90% of treatment costs are paid out-of-pocket and a complete biomedical protocol can cost between ₦5 million and ₦40 million. Thus, a substantial number of patients abandon hospital oncology altogether in favour of Traditional Medicine Practitioners (TMPs). This study investigated the sociocultural, economic and psychological drivers behind this pattern of care-seeking among breast cancer patients in Ibadan and Iseyin, Oyo State. Drawing on Critical Medical Anthropology, Cultural Relativism and the Health Belief Model, the study adopted a qualitative ethnographic design involving twenty-five key informants with five purposively selected TMPs and twenty patients recruited through snowball sampling. Data were gathered through semi-structured interviews and participant observation conducted in the Yoruba language and analysed thematically. Five interlocking drivers emerged and they are: catastrophic treatment costs precipitating financial defection; psychological resistance to mastectomy as a threat to bodily wholeness and womanhood; the visible toxicity of chemotherapy, including hair loss, and its social consequences; a cosmological understanding of the illness as *Afowofa*, an affliction of spiritual origin requiring ritual redress through practices such as *Ifa* divination and *ebo* alongside herbal treatment; and lay referral networks that circulate testimonies of recovery. These findings suggested that patronage of TMPs is not a failure of awareness but a structured, rational response to systemic constraint.

Keywords: Breast Cancer; Ethnomedicine; Health-Seeking Behavior; Traditional Medicine Practitioners; Cultural Relativism

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Introduction

Breast cancer remains one of the most prevalent cancers worldwide, with significant variation in incidence and

mortality across regions and socioeconomic groups (GBD 2023 Breast Cancer Collaborators, 2026). In 2023, there were an estimated 2.30 million new

cases globally and approximately 764,000 deaths among females, with higher-income countries benefiting from advanced screening while low- and middle-income nations face rising incidence amid limited resources (Sun *et al.*, 2017; Newman, 2022). Nigeria, the most populous country in Sub-Saharan Africa, reports an incidence rate of 50.5 per 100,000 women, the highest in West Africa (Azubuike *et al.*, 2018; Agodirin *et al.*, 2025) a burden further complicated by cultural attitudes toward health that shape prevention and treatment adherence across diverse populations (Wypych-Ślusarska *et al.*, 2025; ecancer, 2026).

Nigeria's healthcare infrastructure is characterized by significant underfunding, centralized care in urban tertiary hospitals, and high treatment costs, producing considerable disparities in access and outcomes, particularly for rural patients. Approximately 90% of healthcare expenses are borne out-of-pocket, forcing many to delay or abandon necessary care (Ogunniyi *et al.*, 2025; Wuraola *et al.*, 2024). As a result, an overwhelming majority of Nigerian breast cancer patients delay clinical presentation or default entirely to alternative therapies, a pattern worsened by fear of invasive interventions such as mastectomy and the visible side effects of chemotherapy, which systematically push vulnerable individuals toward indigenous practitioners.

To date, public health literature lacks granular, ethnographically grounded

insight into how these structural constraints manifest as alternative health choices. This study addresses that gap by investigating the sociocultural, economic, and psychological drivers that lead breast cancer patients to patronize Traditional Medicine Practitioners (TMPs) across Ibadan and Iseyin, Oyo State.

Theoretical Framework

This study draws on three complementary models, Critical Medical Anthropology, Cultural Relativism, and the Health Belief Model, to explain how money, culture, and personal belief jointly shape a patient's care-seeking journey.

Critical Medical Anthropology depicts how large-scale political and economic systems directly shape a person's health choices, framing such choices not as poor decisions but as responses to societal unfairness, or structural violence (Vukićević, 2024). In Nigeria, centralized orthodox cancer care and the absence of widespread health insurance force patients to pay nearly 90% of treatment costs out of pocket (Ogunniyi *et al.*, 2025). CMA helps us see that walking away from hospital care is rarely simple preference; it is an act of economic survival forced by a system that makes modern healthcare unaffordable.

Cultural Relativism examines behavior through the lens of a person's own culture rather than outside standards (Renteln, 1988). While skipping hospital treatment might read as ignorance to a Western observer, within the traditional

Yoruba worldview illness such as breast cancer is rarely just a physical malfunction, it is often a spiritual or social issue, making traditional treatment a reasonable, internally logical response.

The Health Belief Model maps how a person's decision to seek care depends on perceived severity, expected benefits, and perceived barriers (Alyafei and Easton-Carr, 2024). In Nigeria's dual medical system, patients weigh the hospital's overwhelming costs, fear of mastectomy, and aggressive chemotherapy side effects against the flexible payments, non-invasive methods, and familiar cultural environment offered by traditional practitioners.

Methodology

Research Design and Sampling

This study used a qualitative ethnographic approach (Reeves *et al.*, 2013), relying on immersive fieldwork rather than statistical measurement to capture the lived experiences and cultural perspectives of patients and healers. Fieldwork spanned two historic Oyo State cities: Ibadan, a major urban and peri-urban area where centralized biomedical cancer centers exist alongside longstanding traditional healing practitioners and herb markets; and Iseyin, a semi-urban and rural setting known for its preservation of ancestral Yoruba belief systems and generational healing families (Borokini and Lawal, 2014). Comparing the two allowed the study to examine how health choices vary

with geographic location and proximity to modern hospitals.

Twenty-five key informants were recruited using two non-probability methods (Zrineh *et al.*, 2026): purposive sampling selected five highly experienced TMPs specializing in breast tumors and severe inflammation, while snowball sampling, necessary given the private nature of cancer diagnoses and traditional treatment, identified twenty breast cancer patients through referrals from existing patients within the healing compounds.

Data Collection and Analysis

Data were collected through in-depth, semi-structured interviews and direct participant observation (Jamshed, 2014), including extended time inside the healing clinics observing herbal preparation and healer-patient interaction. Interviews focused on how patients discovered their illness, the financial challenges faced at modern hospitals, and their reasons for choosing traditional care. All interviews and observations were conducted in the Yoruba language to properly capture local expressions and spiritual concepts without loss of meaning. Recordings were transcribed verbatim in Yoruba, translated into English, and analyzed using thematic analysis (Jowsey *et al.*, 2021), with key patient statements retained as direct quotes to preserve their voices.

Ethical Considerations

Institutional approval was obtained before fieldwork began, and every participant gave informed consent, in writing or verbally, in their preferred Yoruba dialect. All real names were removed and replaced with anonymous labels (Informant I through Informant XXIV) throughout the paper.

Results

Theme 1: Structural Healthcare Expenses and Financial Defection

The gathered data show that direct healthcare expenses are the primary barrier forcing breast cancer patients to default from conventional cancer centers, with a complete biomedical protocol; screenings, biopsy, scans, chemotherapy cycles, surgery, and post-operative medication; costing between ₦5 million and ₦40 million.

Because roughly 90% of these costs are borne out-of-pocket, preliminary diagnostics alone often depleted patients' reserves before treatment began, encouraging defection to TMPs, who adjusted to community economic constraints by offering flexible pricing, including installment plans, post-recovery negotiation, or non-monetary trades.

The immediate financial constraints driving clinical default were recorded across patient accounts:

"It was actually the money involved that made me to turn to herbal medicine. I went to the hospital but was driven away by the money that I was charged.

Even the test to confirm it drained my finance seriously."

Informant X (Ibadan, Oyo State)

Traditional practitioners confirmed that their pricing structures intentionally captured the populations economically abandoned by formal oncology centers:

"The money paid was never as high as Western... sometimes a token of fifty thousand Naira were collected... the financial aspects of herbal medicines was so low and encouraging compared to the exorbitant and heavy financial aspects of Orthodox modern therapies."

Informant I (Egbeda, Oyo State)

Theme 2: Psychological and Identity Resistance to Surgical Mastectomies

The data showed an acute psychological aversion to invasive hospital protocols, specifically surgical mastectomies. In the study areas, a woman's breast is tied directly to social identity, bodily completeness, and maternal role expectations. Consequently, clinical recommendations for surgical breast removal were experienced as an act of physical disfigurement and a loss of womanhood, creating intense social anxieties and causing individuals to leave conventional treatment pathways.

This resistance was heavily reinforced by circulating communal accounts claiming that surgical incisions destabilize latent tumors and accelerate immediate mortality. Healers actively utilized this

fear by promising that their phytotherapeutic recipes possessed the specific capacity to safely dissolve or “melt away” internal malignant lumps without breaking or violating the skin surface.

This surgical aversion and subsequent clinical default are documented in the field interviews:

“I went for a series of tests and eventually was told it was breast cancer and that I should come for surgery to get it removed, but I fear being cut... What made me go for herbal cancer treatment was because of the news I heard about the people who did cancer operations and still died, and I don't want to die.”

Informant VII (Ibadan, Oyo State)

Practitioners detailed how this specific fear directly redirected the flow of patients into traditional therapeutic compounds:

“Many are afraid to go through the rigor of surgery, coupled with what the patients have seen and heard about those that made use of orthodox modern therapies.”

Informant I (Egbeda, Oyo State)

Theme 3: Clinical Toxicity and Visible Bodily Disfigurement

Patronage was also driven by the physical and social impact of chemotherapy toxicity: patients reported constant pain, exhaustion, gastrointestinal distress, and

compromised fertility, while visible effects such as weight loss, skin darkening, and hair loss (*alopecia*) exposed their illness publicly and led to social isolation. TMPs addressed this by offering natural “blood builders” and “immune boosters” that let patients manage their condition privately, without losing their hair or communal routines.

The toll of clinical chemotherapy toxicity on a patient's physical appearance and social capital is illustrated in this account:

“I went for the screen and it was discovered. So I submitted to chemotherapy straight. During this, the experience was not interesting at all and I could not endure it for my look was disfigured, I had pain regularly. The most painful aspect to me was the fact that I lost my beautiful hair and my social life was really impaired.”

Informant IX (Ibadan, Oyo State)

Theme 4: Cosmological Sickness Etiology and Ritual Requirements

A major cultural driver is the dual model of disease causation in the Yoruba worldview. Where biomedicine sees breast cancer strictly as a physical cellular growth (*kokoro*), the indigenous framework treats chronic or unresponsive illness as potentially originating in the metaphysical realm diagnosed as *Afowofa*, an ailment artificially sent via spiritual means (*owo aye*). Because the cause is seen as metaphysical, biomedical drugs are believed structurally unequipped to

resolve it, making traditional care; combining herbs with *Ifa* divination, *Ofo* (incantations), *Ebo* (cleansing sacrifices), and *Ipese* (appeasement offerings); a rational necessity.

This direct choice to follow internal religious convictions over biomedical explanations was explicitly documented:

"Igbagbo mi ko gba awon oogun oyinbo, nitori idi eyi nko ni gba iwosan nibe. (Translated: "My faith does not rest on western medicine, so I will not receive their treatment.")"

Informant VI (Atiba, Oyo State)

Theme 5: Lay Referral Networks and Experiential Social Capital

The final key driver is the influence of informal lay referral networks. Healthcare decisions in the study areas are rarely made in isolation; they are heavily guided by peer groups, family, faith communities, and workplace networks. When conventional treatment showed no improvement or hospital expenses became unmanageable, these networks presented peer survival testimonies that dismantled skepticism and catalyzed a shift toward traditional care.

The role of peer motivation and word-of-mouth validation, including within religious prayer houses and workplace networks, is detailed in this field transcript:

"Actually, a friend of mine at my workplace equally encouraged

me to embrace trado-medical and precisely this place, because she was once treated here. Her sporadic recovery motivated and made me give it a trial."

Informant XIV (Ojoo, Oyo State)

Discussion and Conclusion

Discussion

Together, these findings indicate that patronizing alternative healing spaces is a structured, strategic negotiation shaped by economic, cultural, and psychological variables rather than an arbitrary departure from medical orthodoxy. The high rate of clinical default across the urban-rural axes of Ibadan and Iseyin reveals how macro-level political and economic imbalances manifest as structural violence at the individual level: with baseline biomedical costs of five to forty million Naira and nearly 90% of expenses borne out-of-pocket, households face capital exhaustion before treatment even begins (Iragorri *et al.*, 2021; Ajala *et al.*, 2026). Defaulting from hospital care is therefore not an uneducated choice but a calculated act of economic survival, one that TMPs actively absorb through flexible pricing frameworks that resolve the structural exclusion created by a market-driven formal healthcare sector (Patuzzo and Ciliberti, 2017; Chali *et al.*, 2021).

Cultural Relativism, in turn, illuminates the internal rationality of these choices within Yoruba worldviews. Where biomedicine frames breast cancer as a

localized physical growth (*kokoro*), the indigenous etiologically framework categorizes chronic or unresponsive illness as a multi-dimensional, often spiritual phenomenon (Uchendu and Eboreime, 2022; Nwozichi *et al.*, 2025). A diagnosis of *Afowofa*; an ailment transmitted via malevolent spiritual forces (*owo aye*); renders biomedical intervention structurally unequipped to reach the disease's perceived origin, so engaging traditional protocols such as *ofo*, *ebo*, and *ipese* becomes a coherent effort to restore holistic balance (Asiimwe *et al.*, 2023).

This cultural logic is reinforced by the lived toll of iatrogenic suffering and by lay referral capital. Because a woman's breast is tied to physical wholeness, identity, and maternal role expectations in Southwest Nigeria, mastectomy is experienced as bodily disfigurement that triggers resistance around marital security and stigma, an anxiety compounded by chemotherapy's visible effects such as hair loss and skin hyperpigmentation (Adaranijo *et al.*, 2024; Mnisi *et al.*, 2026). When public clinical environments fail to address these anxieties, informal networks; family, workplace, and faith communities; step in, and a trusted peer's recovery within a traditional healing compound becomes more persuasive than clinical direction, making the familiar, non-invasive traditional practitioner more appealing than an intimidating biomedical clinic (Berhe *et al.*, 2024; Wollie *et al.*, 2025).

Conclusion and Recommendations

This study shows that ethnomedicinal patronage among breast cancer patients is driven by a logical convergence of financial barriers, body-integrity anxieties, and cosmological belief systems. Traditional healing persists not merely as a fallback for the poor but as a culturally synchronized institution addressing social, psychological, and spiritual dimensions of illness that overcrowded, resource-constrained hospitals often cannot. To improve early-stage oncology outcomes within this dual medical system, three interventions are recommended: establishing formal training and referral pathways so TMPs can recognize early signs of malignancy and route patients to biomedical centers early; partnering academic and government laboratories with generational healers to validate and standardize the dosages and safety of indigenous remedies; and expanding national health insurance to reduce the out-of-pocket burden, paired with culturally competent public health campaigns that destigmatize early conventional interventions such as mastectomy and chemotherapy.

References

- Adaranijo, A. A., Amzat, J., Abdulrahman, D., and Kanmodi, K. K. (2024). Living with a new normal: Self-identities of women with breast cancer in Nigeria. *Cancer Reports*, 7(9), Article e2148. <https://doi.org/10.1002/cnr.2.2148>
- Agodirin, O., Chijioke, C., Mustapha, F., Rahman, G., Olatoke, S., Olaogun, J.,

- and Akande, H. (2025). Nigeria's 6-year (2018–2023) stage distribution of breast cancer at diagnosis: A systematic review and meta-analysis. *ecancermedicalscience*, 19, Article 1899. <https://doi.org/10.3332/ecancer.2025.1899>
- Ajala, D. E., Ogunmodede, E. O., and Ishola, R. O. (2026). Strengthening public policy to address the financial burden of breast cancer care in Nigeria: A critical imperative. *Cancer Control*, 33, Article 10732748251414203. <https://doi.org/10.1177/10732748251414203>
- Alyafei, A., and Easton-Carr, R. (2024). The Health Belief Model of behavior change. In StatPearls. StatPearls Publishing. <https://www.ncbi.nlm.nih.gov/books/NBK606120/>
- Asiimwe, J. B., Nagendrappa, P. B., Atukunda, E. C., Nambozi, G., Tolo, C. U., Ogwang, P. E., and Kamatenesi, M. M. (2023). The meaning of caring for patients with cancer among traditional medicine practitioners in Uganda: A grounded theory approach. *PLOS Global Public Health*, 3(7), Article e0001764. <https://doi.org/10.1371/journal.pgph.0001764>
- Azubuikwe, S. O., Muirhead, C., Hayes, L., and McNally, R. (2018). Rising global burden of breast cancer: The case of sub-Saharan Africa (with emphasis on Nigeria) and implications for regional development: A review. *World Journal of Surgical Oncology*, 16(1), Article 63. <https://doi.org/10.1186/s12957-018-1345-2>
- Berhe, K. T., Gesesew, H. A., and Ward, P. R. (2024). Traditional healing practices, factors influencing access to the practices and its complementary effect on mental health in sub-Saharan Africa: A systematic review. *BMJ Open*, 14(9), Article e083004. <https://doi.org/10.1136/bmjopen-2023-083004>
- Borokini, T. I., and Lawal, I. O. (2014). Traditional medicine practices among the Yoruba people of Nigeria: A historical perspective. *Journal of Medicinal Plants Studies*, 2(6), 20–33.
- Chali, B. U., Hasho, A., and Koricha, N. B. (2021). Preference and practice of traditional medicine and associated factors in Jimma Town, Southwest Ethiopia. *Evidence-Based Complementary and Alternative Medicine*, 2021, Article 9962892. <https://doi.org/10.1155/2021/9962892>
- ecancer (2026, March 2). Breast cancer remains the most common cancer among women worldwide, with annual cases expected to reach over 3.5 million by 2050. *ecancer News*. <https://ecancer.org/en/news/27867-breast-cancer-remains-the-most-common-cancer-among-women-worldwide-with-annual-cases-expected-to-reach-over-3-5-million-by-2050>
- GBD 2023 Breast Cancer Collaborators (2026). Global, regional, and

- national burden of breast cancer among females, 1990–2023, with forecasts to 2050: A systematic analysis for the Global Burden of Disease Study 2023. *The Lancet Oncology*, 27(3), 302–326. [https://doi.org/10.1016/S1470-2045\(25\)00730-2](https://doi.org/10.1016/S1470-2045(25)00730-2)
- Iragorri, N., de Oliveira, C., Fitzgerald, N., and Essue, B. (2021). The out-of-pocket cost burden of cancer care: A systematic literature review. *Current Oncology*, 28(2), 1216–1248. <https://doi.org/10.3390/curroncol28020117>
- Jamshed, S. (2014). Qualitative research method Interviewing and observation. *Journal of Basic and Clinical Pharmacy*, 5(4), 87–88. <https://doi.org/10.4103/0976-0105.141942>
- Jowsey, T., Deng, C., and Weller, J. (2021). General-purpose thematic analysis: A useful qualitative method for anaesthesia research. *BJA Education*, 21(12), 472–478. <https://doi.org/10.1016/j.bjae.2021.07.006>
- Mnisi, D., Sumbane, G. O., Mothiba, T. M., and Mokhelepa, L. W. (2026). Redefining self after mastectomy: Exploring the psychological and emotional adaptation of women during the post-mastectomy period at Mankweng Tertiary Hospital in Limpopo Province, South Africa. *Women*, 6(1), Article 5. <https://doi.org/10.3390/women6010005>
- Newman, L. A. (2022). Breast cancer screening in low and middle-income countries. *Best Practice and Research Clinical Obstetrics and Gynaecology*, 83, 15–23. <https://doi.org/10.1016/j.bpobgyn.2022.03.018>
- Nwozichi, C. U., Ojewale, M. O., Salako, O., Brotohor, D., and Olaogun, E. (2025). The lived experience of suffering by Nigerian female breast cancer survivors: A phenomenological perspective. *Journal of Patient Experience*, 12, Article 23743735251314858. <https://doi.org/10.1177/23743735251314858>
- Ogunniyi, T. J., Fatokun, B. S., Isah, K. O., Abdulkaki, A., Emiola, A. R., and Batisani, K. (2025). Current status of cancer diagnosis and treatment in Nigeria. *Health Science Reports*, 8(6), Article e70877. <https://doi.org/10.1002/hsr2.70877>
- Patuzzo, S., and Ciliberti, R. (2017). Non-conventional practice versus evidence-based medicine: A scientific and ethical analysis of the Italian regulation. *Acta Bio-Medica: Atenei Parmensis*, 88(2), 143–150. <https://doi.org/10.23750/abm.v88i2.5863>
- Reeves, S., Peller, J., Goldman, J., and Kitto, S. (2013). Ethnography in qualitative educational research: AMEE Guide No. 80. *Medical Teacher*, 35(8), e1365–e1379. <https://doi.org/10.3109/0142159X.2013.804977>
- Renteln, A. D. (1988). Relativism and the search for human rights. *American Anthropologist*, 90(1), 56–72.

- <https://doi.org/10.1525/aa.1988.90.1.02a00040>
- Sun, Y. S., Zhao, Z., Yang, Z. N., Xu, F., Lu, H. J., Zhu, Z. Y., Shi, W., Jiang, J., Yao, P. P., and Zhu, H. P. (2017). Risk factors and preventions of breast cancer. *International Journal of Biological Sciences*, 13(11), 1387–1397. <https://doi.org/10.7150/ijbs.21635>
- Uchendu, O. J., and Eboime, O. O. (2022). Clinico-pathological evaluation of breast cancer in a Nigerian tertiary care center. *Journal of the Medical Women's Association of Nigeria*, 7(1), 1–7. <https://doi.org/10.60787/jmwan-v7i1-32>
- Vukićević, J. (2024). Critical medical anthropology – Development, theses, concepts. *Papers in Ethnology and Anthropology*, 35(24), 11–36. <https://easveske.com/index.php/pea/article/view/437>
- Wollie, A. M., Usher, K., Rice, K., and Islam, M. S. (2025). Challenges and opportunities for integrating traditional healing approaches with biomedical care for mental illness: A scoping review from healers' perspectives. *PLoS ONE*, 20(6), Article e0325353. <https://doi.org/10.1371/journal.pone.0325353>
- Wuraola, F. O., Blackman, C., Olasehinde, O., Aderounmu, A. A., Adeleye, A., Omoyiola, O. Z., Kingham, T. P., Fodero, R. F., Adisa, A. O., Lumati, J., Dare, A., Alatise, O. I., and Knapp, G. (2024). The out-of-pocket cost of breast cancer care in Nigeria: A prospective analysis. *Journal of Cancer Policy*, 42, Article 100518. <https://doi.org/10.1016/j.jcpo.2024.100518>
- Wypych-Ślusarska, A., Ociepka, S., Krupa-Kotara, K., Głogowska-Ligus, J., Oleksiuk, K., Słowiński, J., and Yanakieva, A. (2025). Ways of coping with stress in women diagnosed with breast cancer: A preliminary study. *Healthcare*, 13(6), Article 609. <https://doi.org/10.3390/healthcare13060609>
- Zrineh, A., Al-Usta, M., and Alwawi, A. (2026). Sampling methods and sample size determination in clinical research: An educational review. *Journal of General and Family Medicine*, 27(1), Article e70096. <https://doi.org/10.1002/jgf2.70096>