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The Multidimensional Social Burdens of Informal Caregivers of Cancer Patients in Ibadan, Southwest Nigeria: A Qualitative Study Using the Health Belief Model

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ABSTRACT

Background: Cancer is an emerging public health crisis in low- and middle-income countries and places an immense strain not only on patients but also on the informal caregivers who provide essential support to them. Despite their critical role, there is limited evidence on the social burden experienced by informal caregivers in Nigeria. This paper identifies the social burdens experienced by informal caregivers of cancer patients in Ibadan, Southwestern Nigeria.

Methods: A qualitative study design was employed using in-depth interviews to explore caregivers' experiences. Eighteen informal caregivers (14 females and 4 males) were recruited through purposive and convenience sampling at a tertiary healthcare facility in Ibadan. Moreover, interviews were conducted exclusively in English, which may have limited participants' ability to express nuanced experiences, as many were Yoruba speakers. Data was analysed using thematic analysis to identify recurring patterns and themes.

Results: Findings revealed that caregiving responsibilities were predominantly assumed by women, particularly spouses and family members. Informal caregivers experienced multi-faceted social burdens, including physical strain and financial hardship. Caregivers also navigated complex emotional dynamics, balancing their own distress while supporting patients.

Conclusion: Social inequalities, cultural expectations, and personal responsibilities increase the burden faced by informal caregivers of cancer patients in Ibadan. Informal caregiving roles disrupt the personal and professional lives of the caregivers. Therefore, there is a need for targeted policy and interventions, including structured caregiver support and improved healthcare infrastructure, to reduce caregiver burden and improve cancer care.

Keywords: Cancer, Informal caregivers, Social burden, Caregiving, Qualitative study, Health belief model

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Introduction

Cancer is a silent pandemic that remains a global public health concern (Hopewood, 2022), disproportionately affecting low- and middle-income countries, including Nigeria. In 2020, cancer claimed more lives worldwide than the COVID-19 pandemic (Eurostat, 2023). The rising incidence in Nigeria underscores the essential role of informal caregivers—family members, friends, and unpaid individuals who provide physical, emotional, and logistical support across the care continuum (National Cancer Institute, 2019; Adebayo et al., 2024). These caregivers perform tasks ranging from personal hygiene and medication administration to navigating complex hospital procedures, filling critical gaps left by an overstretched healthcare system (Gambe et al., 2023). Cancer care in Nigeria thus depends heavily on informal caregivers (Fayehun et al., 2025), yet their welfare remains largely overlooked (Adelman et al., 2014; Inogbo et al., 2017).

Although informal caregiving is rooted in cultural norms of kinship obligation and communal responsibility (Chigozie et al., 2024), it has gained public health visibility only recently, driven by the epidemiological transition toward non-communicable diseases and increasing strain on health facilities.

This study adopts the Health Belief Model (HBM) to examine caregivers' experiences. The HBM posits that health-related behaviours are shaped by perceived severity, susceptibility, benefits, barriers, cues to action, and self-efficacy (Glanz, 2022). Within this framework, caregivers' sustained involvement reflects their belief in the benefits of care for patient outcomes, despite significant physical and emotional burdens. Perceived duty and emotional rewards function as psychological reinforcers of caregiving (Akpan-Idiok et al., 2020). Thus, caregivers' appraisal of caregiving demands (perceived threat) and their confidence in accessing support or engaging in self-care (self-efficacy) shape their coping strategies and overall well-being.

Social burden is operationalised here as the physical, emotional, financial, and structural challenges that arise when care demands exceed caregivers' resources (Utz & Warner, 2022). This burden manifests as strain on caregivers' time, social roles, health, and finances, compounded by the absence of formal support. Consequences include exhaustion from coordinating clinic visits, home care, and insurance logistics (Liu et al., 2020), as well as anticipatory grief and end-of-life decisions, such as discontinuing life support, in advanced cancer (Oboh & Adayonfo, 2017).

Informal caregivers in Southwestern Nigeria face additional burdens from poor hospital conditions—inadequate sleeping arrangements and limited sanitation—that intensify their strain (Adebayo et al., 2024). Formal support systems for caregivers are virtually non-existent, leaving them to shoulder these responsibilities alone. Evidence on the social burden of cancer caregiving in such low-resource settings remains limited. To address this gap, this study aimed to (1) characterise the social burdens experienced by informal caregivers of cancer patients in Southwestern Nigeria; (2) identify factors shaping these burdens; and (3) explore caregivers' coping mechanisms through the lens of the HBM.

Methods

Study Design and Theoretical Framework:

This study employed a cross-sectional qualitative design, collecting data at a single point in time to examine informal caregivers' lived experiences and burdens within a real-world oncology care context. Unlike phenomenology, which focuses on exploring the essence of human experiences (Ho & Limpaecher, 2022), or grounded theory, which aims to generate theory from analysed data (Khan, 2014), this study aimed to identify and thematically categorise types of social burden. The HBM provided the micro-level theoretical lens (Glanz, 2022), and reporting followed the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist (Tong et al., 2007).

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Setting:

The study was conducted at University College Hospital (UCH), Ibadan North Local Government Area, Oyo State, Nigeria, a premier teaching hospital and regional cancer referral centre. UCH houses the Alanu House for Cancer Patients and the Hostel for Patients' Relatives, both on-site accommodations for patients and their informal caregivers. Ibadan North's mix of urban and peri-urban communities provided a diverse pool of participants.

Sampling and Recruitment :

Participants were selected using stratified purposive sampling, followed by convenience sampling. Caregivers were first stratified by setting: (1) those residing in hospital-provided accommodation and (2) those commuting from outside. Within each stratum, purposive sampling identified individuals directly involved in the daily care of a cancer patient, aged ≥18 years, and willing to provide informed consent. Convenience sampling was applied to enrol available and willing participants, ensuring diversity in gender, relationship to patient, and caregiving setting. Eighteen (18) caregivers were recruited, and data saturation—where no new themes emerged—was confirmed after 16 interviews, with two additional interviews conducted to verify consistency (Saunders et al., 2018).

Interview Guide Development:

Data were collected using a semi-structured interview guide developed from HBM constructs and existing literature on caregiver burden. The guide comprised two sections: (1) socio-demographic characteristics and (2) open-ended questions exploring physical, emotional, financial, and social burdens. Key prompts included: "Can you describe a typical day caring for your relative?" and "How has caregiving affected your health, finances, or relationships?" The guide was reviewed for clarity and cultural relevance by the co-author and pretested with two caregivers who were excluded from the final sample. Pre-test findings informed minor revisions to wording and question sequencing. The guide remained flexible to allow probing and narrative expansion.

Language and Cultural Considerations:

Researcher was not fluent in Yoruba, the predominant local language. To mitigate language barriers and avoid interpreter-induced bias, all interviews were conducted in English. Participants were screened during recruitment for sufficient conversational English proficiency. In cases where participants spontaneously used Yoruba terms for culturally specific concepts, the researcher sought English explanations to ensure accurate understanding. The exclusion of non-English-speaking caregivers is acknowledged as a limitation.

Data Collection:

Face-to-face, audio-recorded in-depth interviews were conducted between 1 September and 30 November 2024. Interviews took place in private locations within UCH—including caregiver accommodations and quiet clinical areas—scheduled according to participants' availability and lasted 15–45 minutes. Written informed consent was obtained prior to each interview following explanation of study objectives, voluntary participation, and confidentiality. Reflexive field notes were maintained throughout to capture contextual and observational insights.

Trustworthiness:

Trustworthiness was established using Lincoln and Guba's criteria (Schwandt, 2007). Credibility was enhanced through prolonged engagement in the field, iterative questioning, and member checking via summary confirmation during interviews. Dependability was ensured through an audit trail of transcripts, raw data, and coding decisions, periodically reviewed with the co-author. Confirmability was strengthened through reflexive journaling, peer debriefing, and grounding interpretations in verbatim quotations. Transferability was supported by a thick description of the study context, participant characteristics, and sampling procedures.

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Data Analysis:

All interviews were transcribed verbatim, anonymised, and analysed using manual inductive thematic analysis. Given the manageable sample size (n=18), manual coding facilitated close engagement with the data and preservation of narrative nuances. Analysis followed Bingham's (2023) five phases: (1) repeated reading for familiarisation; (2) inductive coding from participants' narratives; (3) clustering of codes into categories (e.g., "back pain," "fatigue," "lack of sleep" → physical burden); (4) development of themes and sub-themes; and (5) reviewing, defining, and naming themes to ensure internal coherence. Manual coding using highlighters and sticky notes enabled close engagement with the data. HBM-informed interpretation linked caregiver experiences to perceived barriers and coping responses. Peer debriefing with the co-author supported refinement of themes and reduced interpretive bias. Findings are presented with illustrative verbatim quotes.

Reflexivity Statement:

The researcher's background in medical sociology and familiarity with the Ibadan healthcare environment facilitated access and contextual understanding but also risked introducing assumptions about caregiving. To mitigate this, the researcher maintained a reflexive journal documenting personal reactions, used an open-ended interview style, and repeatedly challenged emerging interpretations against raw data. The researcher's positionality is acknowledged as part of the interpretative process.

Results

Participant Characteristics:

Participants ranged in age from 18 to 64 years (Table 1). Most were employed (16/18), indicating that caregiving was frequently undertaken alongside professional and family obligations. Women constituted the majority (14/18), reflecting cultural norms in Nigeria and comparable low- and middle-income settings where caregiving is constructed as a feminine responsibility—a pattern that suggests significant personal, educational, and occupational sacrifice.

Patients' diagnoses included head and neck cancers (n = 6), breast cancer (n = 2), acute lymphoblastic leukaemia (ALL; n = 1), and other malignancies (n = 9), many at advanced stages. Caregiving duration ranged from three months to over a year. The overlap between employment and caregiving created a dual burden characterised by disrupted work lives, reduced productivity, and income instability (P11, P17). From an HBM perspective, caregivers' perceptions of the severity and demands of their role —and the consequences of inadequate care—may compel them to prioritise caregiving over paid work, manifesting in reduced hours or full withdrawal from employment and thereby deepening economic strain (P4 and P7). Table 1 summarises participants' socio-demographic and caregiving characteristics (Table1).

Table 1. Socio-Demographic and Caregiving Characteristics of Participants

Participant ID	Gender	Age	Relationship to the Patient	Marital Status	Employment Status	Cancer Type
P1	Female	57	Spouse	Married	Employed	Head and neck
P2	Female	28	Daughter	Single	Employed	Breast
P3	Female	39	Mother	Married	Employed	Acute Lymphoblastic Leukaemia (ALL)
P4	Female	59	Spouse	Married	Employed	Head and neck
P5	Female	57	Spouse	Married	Employed	Unknown
P6	Female	18	Daughter	Single	Unemployed	Unknown
P7	Female	42	Mother	Married	Employed	Unknown
P8	Male	30	Son	Married	Employed	Head and neck
P9	Female	50	Daughter	Married	Employed	Unknown

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Table 1. Socio-Demographic and Caregiving Characteristics of Participants

Participant ID	Gender	Age	Relationship to the Patient	Marital Status	Employment Status	Cancer Type
P10	Male	35	Brother-in-law	Married	Employed	Unknown
P11	Female	37	Spouse	Married	Unemployed	Head and neck
P12	Female	40	Spouse	Married	Employed	Unknown
P13	Female	27	Sister	Married	Employed	Unknown
P14	Female	55	Spouse	Married	Employed	Unknown
P15	Female	50	Mother	Married	Employed	Head and neck
P16	Male	62	Spouse	Married	Employed	Breast
P17	Male	64	Spouse	Married	Employed	Head and neck
P18	Female	40	Spouse	Married	Employed	Unknown

Table 2 summarises the characteristics of the 18 caregivers who participated in the study. Participants had a mean age of 43.9 years and a median age of 41years, with ages ranging from 18 to 64 years. The sample was predominantly female (14), with males accounting for just over a fifth of participants (4) (Table2).

Table 2. Descriptive Statistics of Participant Characteristics (n = 18)

Variable	Category	Statistic
Age (years)	Mean	43.9
	Median	41.0
	Range	18 – 64
Gender	Male	4 (22.2%)
	Female	14 (77.8%)
Relationship to Patient	Spouse	9 (50.0%)
	Daughter	3 (16.7%)
	Mother	3 (16.7%)
	Son	1 (5.6%)
	Sister	1 (5.6%)
	Brother-in-law	1 (5.6%)
Marital Status	Married	16 (88.9%)
	Single	2 (11.1%)
Employment Status	Employed	16 (88.9%)
	Unemployed	2 (11.1%)

Daily Routine of Informal Cancer Caregivers:

Caregiving was intensive and immersive, typically beginning abruptly after diagnosis and evolving into a full-time role encompassing hospital-based care, treatment coordination, and multifaceted support. This necessitated a fundamental restructuring of daily life around competing work and family demands. Table 3 details the daily routines of participants, illustrating the breadth of activities undertaken throughout the caregiving process (Table3).

Theme 1: Multidimensional Social Burdens

Caregivers experienced interconnected physical, emotional, financial, and structural burdens, interpretable through the HBM as the product of perceived threats, barriers, and diminished self-efficacy. One spouse caregiver of a husband with head and neck cancer captured this multidimensionality:

"The financial part is not easy. So, emotionally, you will be disturbed. Physically, you will not be okay because moving from one end to the other in the hospital is not an easy thing." (P1/Female/Spouse caregiver)

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Table 3. Daily Routine of Informal Cancer Caregivers in Ibadan North LGA

Physical routine	Personal care of the cancer patient (bathing, dressing, fetching water, changing personal effects, washing clothes, and bedsheets). Running errands related to the care of hospitalised cancer patients (buying food and drugs). Self-care (bathing, fetching water, changing personal effects). Travel routines for caregivers residing outside Ibadan and those who had to travel to hospitals in other states for Radiotherapy.
Spiritual routine	Personal prayer (e.g., reading the Bible or the Quran) Engagement in prayer sessions at the Chapel or in the Mosque Singing songs or chants Meditation
Financial routine	Sourcing funds to pay for hospital bills Collecting bank loans Borrowing from friends and family
Disruptions from their routine	Getting another family member to fill in if they need to leave the hospital to attend to other pressing issues or source funds for the patient.

Physical Burden:

Physical burden, reflecting perceived severity, stemmed from prolonged hospital stays and physically demanding tasks (Table 3). Caregivers reported considerable physical strain associated with prolonged hospital stays and demanding caregiving tasks. These included fatigue, musculoskeletal pain, and stress-related conditions, exacerbated by inadequate hospital facilities, such as a lack of sleeping arrangements. A mother caring for her child with leukaemia described:

"Physically, I developed a form of oedema, I had swollen feet... I developed severe lower back pain from sitting because I was not privileged to have a bed space in the hospital, so I was sleeping on a chair... Eventually, I got a mat, which I used on the floor." (P3/Female/Mother caregiver)

The conditions described in the findings suggest that caregiving may affect not only patients but also give rise to secondary health risks for caregivers, particularly in hospital environments with limited resources.

Emotional and Psychological Burden:

Similarly, the emotional and psychological burden reported by participants is linked to perceived severity and perceived susceptibility. Caregivers managed their own distress while supporting patients through pain and treatment uncertainty. A husband caring for his wife with breast cancer illustrated this dual struggle:

"I am trying to be strong… the kind of pain she is passing through, definitely one will not feel okay. Moreover, there are a lot of things going through your mind." (P16/Male/Spouse caregiver)

Proximity to the patient's illness increased their sense of vulnerability to psychological strain and burnout. The responsibility of providing emotional support while managing their own fears created a significant psychological burden, particularly with limited formal psychosocial support services.

Financial Burden:

The substantial economic hardship reported by participants exemplifies the HBM construct of perceived barriers. High treatment costs, transportation expenses, income loss, and debt accumulation created significant obstacles to sustained caregiving:

"We have borrowed more money from my family, even borrowed from bank. I have collected money. I have got a loan. I have seen so many things just for him to survive." (P8/Male/Son caregiver)

Economic strain was compounded by reduced work participation, reinforcing a cycle of caregiving and financial vulnerability.

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Health System and Infrastructural Challenges:

Systemic deficiencies within the healthcare environment constituted a further set of perceived barriers. Unreliable electricity, inadequate water supply, and non-functional equipment were pervasive.

"For three days now there has been no light here. There is no water. We carry a keg to go and fetch." (P18/Female/Spouse caregiver)

During data collection (September–November 2024), a two-week strike by resident doctors over poor power supply led to cancelled and rescheduled clinic appointments and surgical procedures, delaying treatment and compounding caregiver burden:

"The important thing is this light issue, and then the strike. That's what delayed us till now. It has really affected a lot of things. If not, I'm sure that by now we would have done all the things..." (P16/Male/Spouse caregiver)

Furthermore, some of the cancer treatment facilities at the hospital were not functional, so this led to long-distance referrals for specialised treatment, after which they returned to Ibadan for follow-up appointments. Some of the caregivers recounted:

"The cancerous treatment is not easy. It did not just start from here. First, we went to Kaduna, and then from Kaduna, we did another operation in Abuja. We went for radiotherapy in Lagos." (P4/Female/Spouse caregiver)

"We were referred from here to Maiduguri for radiotherapy, then came back for chemotherapy…" (P17/Male/Spouse caregiver)

These referral trajectories illustrate how structural inadequacies shift additional logistical burdens onto caregivers, extending their role to compensating for health system deficiencies.

Changes in Patient-Caregiver Dynamics:

Caregivers also reported relational strain arising from patients' psychological responses to illness progression, including hostility and treatment refusal. These shifts reinforced perceived barriers, adding a further layer of complexity to caregiving:

"The patient became hostile. Because at some point… psychologically, the patient did not want to continue treatment" (P3/Female/Mother caregiver)

Theme 2: Factors Intensifying Caregiver Burden

Disease Progression:

As patients' conditions worsened, caregiving demands intensified—consistent with the construct of perceived severity. Physical dependency increased, transforming caregiving into a more time-intensive role:

"He does not have much strength to do things by himself, so I have to be around him to assist him" (P12/Female/Spouse caregiver)

In advanced head and neck cancers, progressive dysphagia required constant feeding assistance. For the leukaemia caregiver, repeated hospital admissions and treatment consent processes, including life-or-death decisions:

"Because there are different phases of treatment. So, for each phase of treatment, we were required to sign some documents showing that we had given consent in the event of anything going wrong." (P3/Female/Mother caregiver)

Employment and Personal Life Disruption :

Balancing caregiving with employment emerged as a major challenge due to the overwhelming routine which most of them adopted (Table 3). The disruption of employment and personal life demonstrates the interaction between perceived barriers and perceived benefits. Despite income loss and social withdrawal, caregivers consistently prioritised patient care, perceiving their continued presence as essential to positive health outcomes. Many reduced working hours or withdrew from employment entirely:

"I had to stop... 2 years now. Though I tried to manage it, it wasn't easy taking excuses from work every day, going late to school. Of course, I have to take care of him before going… so I just had to stop working" (P11/Female/Spouse caregiver)

Caregiving significantly disrupted participants' livelihoods, particularly women engaged in informal economic activities withdrawing from work.

"I am not going to the market again. I have left it to care for my husband... My neighbour in the shop helps me to sell, so from there I can make some money to take care of our needs" (P14/Female/Spouse caregiver)

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Limited Preparedness for Caregiving Roles:

The theme of limited preparedness for caregiving roles is particularly relevant to the HBM construct of self-efficacy. Most caregivers had little or no prior experience, formal training, or adequate guidance from healthcare professionals, resulting in a steep learning curve. Of the 18 participants, only two (P13 and P15) had prior experience caring for patients:

"I am a caregiver for small children in the hospital, so I know how important it is to care for my brother here" (P13/Female/Sister caregiver)

"Before I got married, when I was young, I worked in a hospital at Ile-Ife" (P15/Female/Mother caregiver)

The remaining caregivers relied on informal observation and trial and error to manage complex treatment regimens, underscoring a critical institutional gap in caregiver training and support. Reduced self-efficacy heightened stress and diminished confidence in performing caregiving tasks.

Across both themes, cancer diagnosis, worsening symptoms, treatment schedules, and referrals functioned as cues to action that motivated caregivers to sustain their roles despite mounting burden. The interplay of HBM constructs—perceived severity, susceptibility, barriers, benefits, and low self-efficacy—explains their persistence.

Table 4 illustrates the thematic analysis process to identify the social burdens experienced by informal caregivers.

Table 4. Thematic Analysis of Social Burdens Experienced by Informal Cancer Caregivers

Verbatim Quote	Initial Code	Sub-theme	Main Theme
"That's my major stress. Finding what she will eat… Yesterday, my leg was on fire. So many walking up and down, up and down." (P2/Female/Daughter caregiver)	Physical strain	Health Impact	Theme 1: Multidimensional Social Burdens
"Those who are running errands, around, up and down, they are feeling it too much." (P15/Female/Mother caregiver)	Physical strain	Health Impact	Theme 1: Multidimensional Social Burdens
"There was also the emotional side of being able to self-comfort and then comfort the patient as well." (P3/Female/Mother caregiver)	Psychological strain	Mental Health Impact	Theme 1: Multidimensional Social Burdens
"I experienced the death of a patient in the hospital, and it was traumatising." (P3/Female/Mother caregiver)	Psychological strain	Mental Health Impact	Theme 1: Multidimensional Social Burdens
"It is financial. Yes, the burden is much on my husband." (P15/Female/Mother caregiver)	Financial constraints	Economic Hardship	Theme 1: Multidimensional Social Burdens
"There were challenges in the hospital, no light, no water… became a stress to me as well." (P11/Female/Spouse caregiver)	Infrastructural challenges	Health System Impact	Theme 1: Multidimensional Social Burdens
"I am the closest person to her. She is my wife, so every other thing is on hold." (P16/Male/Spouse caregiver)	Personal life disruption	Employment & Life Disruption	Theme 2: Factors Intensifying Caregiver Burden
"It's only my job, the thing is affecting… we're trying to manage both, and my employer is trying." (P17/Male/Spouse caregiver)	Employment disruption	Employment & Life Disruption	Theme 2: Factors Intensifying Caregiver Burden
"It has affected me because I'm kind of restricted to just some things. Sometimes, some things I want to do are very important, but her issue comes up, so I have to let it go." (P7/Female/Mother caregiver)	Personal life disruption	Employment & Life Disruption	Theme 2: Factors Intensifying Caregiver Burden
"I'm still working. I took permission to stay with him because he cannot stay alone." (P1/Female/Spouse caregiver)	Employment disruption	Employment & Life Disruption	Theme 2: Factors Intensifying Caregiver Burden
"I did not really know much about it. I was not the one that stayed with her… so I don't know." (P6/Female/Daughter caregiver)	Limited preparedness	Limited Preparedness for Caregiving	Theme 2: Factors Intensifying Caregiver Burden

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Discussion

Informal caregivers in this Nigerian setting experienced intersecting physical, psychological, and financial burdens (Table 4). Physical strain—including oedema, musculoskeletal pain, and sleep deprivation—arose from prolonged hospital stays compounded by overcrowding and deficient amenities. These findings echo evidence from Ghana, where poor hospital infrastructure similarly produced musculoskeletal discomfort among caregivers (Bekui et al., 2022), suggesting that caregiver burden is shaped not only by caregiving tasks but by broader health system deficiencies.

Emotional and psychological burden emerged pervasively. Caregivers managed their own distress while supporting patients through pain and treatment uncertainty reflecting a dual responsibility consistent with findings by Salifu et al. (2025) and Chukwu et al. (2022). Within the HBM framework, caregivers' recognition of cancer's severity and their loved ones' vulnerability appeared to sustain caregiving commitment despite considerable emotional exhaustion.

Financial burden emerged as among the most significant challenges, with caregivers borrowing, taking loans, and depleting savings to finance treatment while caregiving simultaneously curtailed income generation. This combination of direct costs and indirect productivity losses mirrors patterns of catastrophic health expenditure documented in comparable low-resource settings (Brimblecombe & Cartagena Farias, 2022; Legese et al., 2020). The findings suggest that caregivers perceived the potential benefits of treatment and recovery as outweighing economic barriers, even when doing so threatened long-term household financial security.

Employment disruption compounded financial strain. Participants left jobs, reduced working hours, or delegated business responsibilities—experiences consistent with evidence from Ethiopia linking caregiving to career interruption and long-term economic disadvantage (Kasahun et al., 2020). However, unlike Ethiopian caregivers who frequently relied on asset sales or community-based health insurance, participants in this study relied largely on kinship networks and informal borrowing, highlighting the continued importance of family-based support systems in Nigeria.

Caregiving also altered family relationships and social participation. Participants withdrew from social activities and assumed dual roles as caregivers and providers, consistent with documented declines in social engagement among cancer caregivers (Okikiade Oyegbile, 2024). These findings illustrate how caregiving responsibilities may require individuals to prioritise patients' needs over their comfort and well-being, thereby increasing vulnerability to adverse physical and psychological outcomes (Adejoh et al., 2020).

The gendered nature of caregiving burden was pronounced. Female caregivers—daughters, wives, and mothers—disproportionately assumed primary caregiving roles at the expense of education, careers, and personal well-being. This parallels findings from Ghana (Kusi et al., 2020) and Kenya (Githaiga, 2015), where traditional gender roles perpetuate economic inequality. Additionally, over time, some patients exhibited resentment toward caregivers, as their condition deteriorated—a relational shift plausibly attributable to helplessness and depression, which intensified emotional strain on both parties.

Across all domains, HBM provides a coherent interpretive lens. Physical burdens were closely tied to structural barriers—inadequate sleeping facilities, unreliable water and electricity—that both increased strain and undermined caregivers' confidence in sustaining their role. Emotional burdens reflected heightened perceptions of severity and the anxiety of feeling ill-equipped to manage complex patient needs. Financial burdens illustrate the HBM's cost–benefit dimension: despite catastrophic expenditure, caregivers persisted because the perceived benefits of recovery outweighed economic costs, even as the absence of institutional support eroded self-efficacy. Structural and gendered barriers—healthcare infrastructure deficiencies, employment disruption, and the disproportionate concentration of caregiving

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among women—reinforced caregivers' perception that systemic support was inadequate, compelling self-sacrificing practices at considerable personal cost.

Limitations of the Study:

The small sample size (n = 18) limits generalisability and was not determined using quantitative criteria. Moreover, the cross-sectional design captured experiences at a single point in time. Findings were context-specific to Ibadan North LGA and may not reflect other regions. Conducting interviews exclusively in English may have constrained expression of nuanced experiences among participants more comfortable in Yoruba. While this facilitated consistency in data collection and analysis, it may have limited the participation of caregivers more fluent in Yoruba. The hospital-based setting may also have influenced responses. Although interviews were conducted in quiet locations where possible, proximity to patients and caregiving responsibilities may have inhibited open discussion of sensitive experiences—including emotional exhaustion, resentment, and relationship strain—leading to consciously or unconsciously underreporting of psychological strain.

Future Research Directions:

Several avenues for future research emerged from these findings. Longitudinal studies are needed to track how caregiver burden evolves across the cancer care trajectory from diagnosis through potential bereavement. Comparative research across Nigerian regions and sub-Saharan African countries would clarify whether the burdens identified here reflect local contextual factors or shared structural challenges. Future studies should employ mixed-methods designs that combine qualitative exploration with validated quantitative burden scales to enable broader generalisation while preserving the depth of caregivers' lived experiences. Finally, given the language limitation identified in this study, future studies should conduct interviews in local languages to capture more nuanced accounts and ensure inclusive participation.

Conclusion

Cancer care often involves prolonged, intensive, and resource-demanding treatment processes, and the informal caregivers play a critical role in supporting patients throughout the care continuum. Findings demonstrate that informal cancer caregiving is a highly demanding and immersive role, characterised by intersecting physical, emotional, financial, and structural burdens. These burdens are intensified by disease progression, health system limitations, and competing socio-economic responsibilities, resulting in significant disruptions to caregivers' health, livelihoods, and social relationships. Collectively, the results highlight the cumulative and dynamic nature of caregiver burden within resource-constrained settings. To address these burdens, practical interventions such as hospitals establishing mandatory basic amenities and embedding trained psychosocial support personnel within oncology units can mitigate the emotional strain of managing dual distress. At the policy level, expanding national health insurance schemes to cover outpatient cancer costs would directly alleviate the catastrophic out-of-pocket payments documented in this study. Future research should employ longitudinal designs to track how caregiver burden, perceived severity, and self-efficacy evolve across the disease trajectory, and rigorously test multi-component interventions to identify which packages most effectively sustain informal caregiving capacity.

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Conflict of Interests

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Ethical considerations

Ethics approval was obtained from the University of Ibadan Social Sciences and Humanities Research Ethics Committee (Ref: UI/SSHREC/2024/0153). Participants received a full explanation of the study before providing verbal and written informed consent. Participation was voluntary, and the study was conducted in accordance with the Declaration of Helsinki.

Code of Ethics

Ref: UI/SSHREC/2024/0153

Authors' Contributions

U.N. conceived and designed the study, revised the interview guide, conducted data collection, and led analysis, interpretation, and manuscript drafting. K.S. contributed to study design, provided methodological oversight, supported data interpretation, and critically revised the manuscript for intellectual content. Both authors approved the final version. U.N. is the guarantor of this work and assumes responsibility for the overall content, data integrity, and accuracy of the analysis.

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