A Historical Analysis of Cancer Control in Nigeria, 1980–2024

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Abstract

Cancer has evolved from a peripheral health concern into a significant non-communicable disease burden in Nigeria over the past four decades. This paper presents a historical account of cancer epidemiology in Nigeria, examining the connection between disease prevalence, risk factors, state policy responses, and persistent systemic barriers. The study analyses how infectious agents (such as Human Papillomavirus and hepatitis viruses), lifestyle change, environmental hazards, and genetic predispositions have influenced cancer trends. The study further explores Nigeria's evolving institutional responses including the National Cancer Control Programme (NCCP), Cancer Access Partnership (CAP), mobile screening initiatives, and school-based awareness programs while highlighting their achievements and limitations. The paper adopts the qualitative method of research to argue that despite remarkable progress, Nigeria's cancer control efforts remain hindered by late diagnoses, inadequate infrastructure, and limited insurance coverage. The paper underscores the need for stronger surveillance systems, equitable service delivery, and multisectoral collaboration to effectively address the cancer crisis in a developing health system context.

Keywords: Cancer Control, Nigeria, Health Policy, Epidemiology, Healthcare System

Introduction

Cancer is one of the Non-communicable Diseases (NCD) that has been marginalised in Nigeria's public health history. It has therefore today emerged as a formidable non-communicable disease challenge noting how in the 1980s, cancer was rarely diagnosed, poorly understood, and largely overshadowed by diseases like malaria and tuberculosis. Fast forward into the 2020s, it had become one of the leading causes of mortality in Nigeria, accounting for nearly 80,000 deaths annually.[1] This epidemiological transition is attributed to a multifactorial etiology, encompassing a range of determinants such as viral pathogens, environmental exposures, lifestyle modifications, and the consequences of increased urbanization.[2]

Cancer here is conceptualised as a group of diseases which are characterised by an uncontrolled cell division and holds the potential to invade or spread to other parts of the body. It is seen to be historically perceived as a spiritual affliction in many African societies, including Nigeria. No doubt therefore, cancer is observed medically to have grown in public understanding into a biomedical condition linked to cellular mutations and environmental exposures. The disease may originate in almost any organ and is typically classified based on the tissue or organ of origin and histological behavior.

Historically, Nigeria's approach to cancer has been a reflection of wider challenges in its national health system. These efforts were usually hampered by three main issues: inconsistent government commitment, inadequate funding for medical

[1]Okoroafor, Chinyere. "World Cancer Day 2024: Tackling Nigeria's Cancer Crisis – A Call to Action." *The Nation* (Nigeria), February 27, 2024. Accessed August, 2025. https://thenationonlineng.net/world-cancer-day-2024-tackling-nigerias-cancer-crisis-a-call-to-action/

[2] Sola Ogundipe, "Oncologist Bemoans Nigeria's Lack of Comprehensive Cancer Centre, as 79,542 Die in 1 Year," *Vanguard* (Nigeria), February 4, 2024, accessed August, 2025, https://www.vanguardngr.com/2024/02/oncologist-bemoans-nigerias-lack-of-comprehensive-cancer-centre-as-79542-die-in-1-year/

institutions, and undeveloped systems for collecting health data. In the earlier years, there was almost no formal system for tracking cancer cases across the country. Only a few major teaching hospitals, such as the University College Hospital (UCH) in Ibadan, maintained very basic records of cancer patients.[3] A more organised and structured effort to manage the disease only began in the 2000s, which eventually led to the creation of the National Cancer Control Programme in 2006.[4]

This study provides a historical analysis of Nigeria's cancer epidemic from 1980 to 2024, examining it within the context of the nation's evolving health policies. It investigates how the Nigerian government has responded to the rising cancer rates through various public health strategies and institutions. The paper argues that systemic challenges which includes weak infrastructure, limited access to early diagnosis, sociocultural stigmas, and inadequate financial protection for patients all continue to obstruct effective cancer control.

Classification of Cancer

Cancer study shows that in understanding it, it is simplified when classified. This made it important for the understanding that, cancer can be broadly classified into five primary types, these are:

1. Carcinomas – arise in epithelial tissues (e.g., breast, lung, prostate).
2. Sarcomas – originate in connective tissues like bone or muscle.
3. Leukemias – cancers of the blood-forming tissues.
4. Lymphomas – cancers of the immune system (e.g., Hodgkin and non-Hodgkin lymphoma).
5. Central Nervous System Cancers – include brain and spinal cord tumors.

Common Types of Cancer in Nigeria

Cancer case globally is a medical health condition that is regathered to be of high medical concern. Various kinds of cancer related cases are more common to some particular locations, discussing all in this article would not be convenient, this

[3] C. A. Adebamowo, A. O. Akinyemiju, and F. T. Odedina, "Cancer Registration in Nigeria: Challenges and Opportunities," *Nigerian Medical Journal* 41, no. 2 (2000): 89–94.
[4] Federal Ministry of Health, *National Cancer Control Policy* (Abuja, Nigeria: Federal Ministry of Health, 2006).

necessitate why it becomes important in limiting and observing those that are considered common to Nigeria which is the area of study. The table below therefore identified some common cancer cases that are most prevalent in Nigeria.

Type of Cancer	Affected Group	Key Risk Factors	Notes
Breast Cancer	Women (40–65 years)	Obesity, late childbearing, genetics	Most common cancer in Nigerian women
Cervical Cancer	Women (30–60 years)	HPV infection, early sexual activity	Preventable through HPV vaccination
Hepatocellular Carcinoma	Both sexes (40+)	Hepatitis B/C infections, aflatoxins	Common in rural and urban areas
Prostate Cancer	Men (50+ years)	Age, genetics, high-fat diet	Leading cancer among Nigerian men
Colorectal Cancer	Adults (30–60 years)	Diet, alcohol, genetics	Underdiagnosed due to limited screening

Period of Consideration: 1980–2020

The period between 1980 and 2020s captures the significant transformation in Nigeria's cancer profile—from a marginal disease with negligible attention in public health discourse to a prominent national health challenge requiring structured policy response. This 40-year span allows for an empirical and policy-oriented examination of key developments, including:

a. Pre-policy era (1980s–early 2000s), marked by weak data systems and low public awareness.
b. Initial policy interventions, such as the establishment of the National Cancer Control Programme (NCCP) in 2006.[5]

[5] Federal Ministry of Health. (2006). National Cancer Control Policy. Abuja, Nigeria.

c. Acceleration of institutional reforms following the 2018 revision of the NCCP and the launch of innovative access models such as the Cancer Access Partnership (CAP) in 2020.[6]
d. Recent (2019–date) decentralization efforts and expansion of screening programs, integration into primary healthcare, and improvements in cancer education and public engagement.

This timeline facilitates a historical and policy-focused interpretation of Nigeria's cancer control evolution within broader health systems and NCD control strategies.

History of Cancer in Nigeria, 1980–Early 2000s (Pre-Policy era)

The "Pre-Policy Era" period of cancer is defined by a public health agenda that was overwhelmingly focused on infectious diseases, a stark contrast to the burgeoning but largely unacknowledged threat of non-communicable diseases (NCDs) like cancer. The systemic factors of this period positioned cancer as a non-priority within Nigeria's public health framework. During the 1980s, Nigeria's public health agenda was overwhelmingly dominated by efforts to combat diseases such as malaria, tuberculosis, cerebrospinal meningitis, and yellow fever.[7] This strategic focus was a direct and rational response to the high morbidity and mortality rates associated with these communicable ailments. The National Health Policy and Strategy to Achieve Health for All Nigerians, promulgated in 1988, established primary healthcare (PHC) as the cornerstone of the nation's health system. The primary healthcare approach, inspired by the World Health Organization's "Health for All by the year 2000" initiative, aimed to provide basic and equitable access to medical services.[8]

[6] CHAI (Clinton Health Access Initiative). (2021). Cancer Access Partnership: Nigeria Progress Report. Abuja: CHAI.
[7] Helen Chapin Metz, ed., "Nigeria – Health", in *Nigeria: A Country Study* (Washington: GPO for the Library of Congress, 1991), accessed May 3, 2025, https://countrystudies.us/nigeria/50.htm
[8] Sholadoye Dada, "An Overview of the Primary Healthcare System in Nigeria," *International Journal of Academic Scientific Research* 1, no. 3 (November 2023), https://doi.org/10.59890/ijasr.v1i3.572

This policy, while a landmark achievement in its own right, was fundamentally unequipped to address the complexities of cancer. The primary healthcare framework's emphasis on preventive and curative services for common infectious diseases and maternal and child health meant that the long-term, specialised, and resource-intensive care required for cancer was relegated to the periphery of the national health agenda. The system was simply not designed to handle a chronic disease burden that would require significant investment in specialized personnel, advanced diagnostics, and expensive treatment modalities.

Furthermore, national economic conditions exacerbated this institutional neglect. Beginning in 1986, currency devaluation and structural adjustment programs led to severe government budget cuts that crippled the public health sector. These financial constraints resulted in widespread shortages of essential medical supplies, drugs, and equipment, rendering much of the expensive medical infrastructure inoperable.[9] The causal chain is clear: these economic policies directly led to the degradation of the public healthcare system, which in turn reinforced the government's focus on high-impact, low-cost interventions for infectious diseases, thereby ensuring the systemic neglect of complex, expensive non communicable diseases like cancer. The fact that a National Health Summit in 1995 identified the need for a review of the 1988 policy, but the revised version was not formally endorsed, further underscores the lack of political will or consensus to fundamentally shift the health paradigm to include a robust response to non communicable diseases.[10]

As the public healthcare system deteriorated, privately owned health facilities became increasingly important in the late 1980s. By the year 1985, these institutions accounted for 14% of hospital beds in the country. This growth was not a planned policy to address the emerging cancer burden but rather a direct consequence of a failing public system and a prevailing ideology that private healthcare was the

[9] Metz, "Nigeria – Health"

[10] Office of the Secretary to the Government of the Federation, "Health – OSGF", *Resources → Policies → Health*, Office of the Secretary to the Government of the Federation, accessed June 3, 2025, https://www.osgf.gov.ng/resources/policies/health/

solution to underfunded public services.[11] This development solidified a two-tiered healthcare system, where the public sector, with its limited funding, attempted to cater to the lowest-income members of society, while a more varied private sector served those with financial means.[12] The structure of this market-driven system was inherently misaligned with the requirements of a national cancer response. Private actors, driven by the profit motive, focused on providing curative services that guaranteed revenue through out-of-pocket payments, doing little to provide the preventive services and screenings that are essential for early cancer detection. The risks associated with this model as it included the exclusion of poorer populations and the catastrophic financial impact of illness are precisely the challenges that a comprehensive cancer strategy must overcome.[13] Consequently, the growing reliance on private healthcare during this era reinforced the fragmentation and inequity of the system, leaving the majority of the population without access to affordable, quality cancer care.

The profound absence of a national cancer surveillance system was a central feature of the pre-policy era. While the era was characterized by a data vacuum, this does not mean that all data was absent. A few isolated cancer registries existed for academic purposes. The Ibadan Cancer Registry (IBCR), established as early as 1960, was the first in Nigeria and was located within the Department of Pathology at the University College Hospital (UCH) in Ibadan.[14] The Calabar Cancer Registry began as a hospital-based registry in 1979, and the Enugu Cancer Registry was established in 1988.[15]

However, these registries were not part of a unified, national public health surveillance network. Instead, they operated as fragmented, academic units

[11] J. N. Chukwuma and F. A. Obi, "A Political Economy Analysis of Health Policymaking in Nigeria: The Genesis of the 2014 National Health Act", *Health Policy and Planning* 40, no. 4 (April 9, 2025): 459–70, https://doi.org/10.1093/heapol/czaf007

[12] Chukwuma and Obi, "A Political Economy Analysis of Health Policymaking in Nigeria," 464.

[13] Chukwuma and Obi, "A Political Economy Analysis of Health Policymaking in Nigeria", 464-67.

[14] Atlas of Longitudinal Datasets, "Ibadan Cancer Registry," *Atlas of Longitudinal Datasets*, accessed July, 2025.

[15] Nigerian National Cancer Registry / National Cancer Research and Treatment Institute (NICRAT), "Population-Based Cancer Registries," accessed July, 2025, https://ncr.nicrat.gov.ng/population-based-cancer-registries/

focused on research and publications.[16] The data they collected, though valuable for scholarly work on the changing epidemiology of cancers, was not systematically compiled or utilised to inform national health policy. This created a critical disconnect where a handful of researchers had some knowledge of the cancer burden, but this knowledge was never translated into a coordinated national response or public awareness campaign. The institutional infrastructure to harness this information for policymaking did not exist. The National System of Cancer Registries (NSCR), a centralized coordinating body designed to standardize and compile data from all registries, was not conceptualized until much later in 2009, a clear indication of the institutional gap of the earlier era.[17]

The fragmentation of data collection and the absence of a national surveillance system created a devastating, self-perpetuating cycle of neglect. Without a national system to compile and analyze data, the true incidence, prevalence, and mortality of cancer remained undocumented and largely unknown to policymakers. This lack of reliable information meant that cancer was not recognized as a significant public health problem, as infectious diseases, with their clearly measurable and devastating outbreaks, understandably commanded the attention of public health authorities and the government.[18] The lack of recognition and the minimal policy commitment that followed ensured that there was no significant investment in cancer control, specialized treatment facilities, or nationwide public education. This, in turn, perpetuated the absence of comprehensive surveillance, guaranteeing that the problem would remain hidden and unaddressed. The data vacuum thus became both the cause and the consequence of the era's policy of neglect, trapping the nation in a state of institutional blindness to its growing cancer burden.

In the absence of an effective institutional response, the cancer experience was shaped by non-institutional factors, particularly deeply ingrained cultural beliefs

[16] College of Medicine, University of Ibadan, "Department of Pathology," *College of Medicine, University of Ibadan*, accessed July, 2025, https://com.ui.edu.ng/index.php/pathology
[17] African Cancer Registry Network, "Nigeria – Ibadan Cancer Registry," *Current Membership List*, African Cancer Registry Network, accessed July, 2025, https://afcrn.org/index.php/membership/membership-list/88-ibcr
[18] Metz, "Nigeria – Health"

and the resulting health-seeking behaviors. These individual and community responses were a logical, and often desperate, consequence of a failing system. During this era, a pervasive culture of silence and shame surrounded cancer, which was often viewed as a "spiritual affliction", "punishment". or a "curse" from malevolent forces. This perception led many individuals to hide their diagnosis and seek help from "trado-spiritual healers" and traditional medicine rather than modern healthcare facilities.

These beliefs were not merely superstition but were a rational and culturally embedded response to a series of systemic failures. When modern healthcare was perceived as financially prohibitive and institutionally inadequate, traditional and spiritual healers represented a more accessible and economically pragmatic alternative.[19] The high out-of-pocket costs and the cultural shame associated with the diagnosis compounded the issue, driving patients further into secrecy and away from professional care. The high mortality rates from cancer in Nigeria were not just a result of a lack of treatment but also a direct consequence of the late-stage presentation driven by these socio-cultural barriers. The reliance on traditional medicine created a devastating feedback loop: cultural beliefs led to the avoidance of modern medicine, which resulted in late-stage presentation and poor prognosis, reinforcing the negative perception of modern medicine's inefficacy and perpetuating the reliance on traditional care.[20]

For a population facing significant financial and access barriers to modern healthcare, traditional and herbal medicine served as the primary alternative. The unavailability of specialized cancer treatment centers in most hospitals drove many to rely on natural products for management or treatment. This choice was at times based on the perception that herbal remedies were relatively affordable, readily available, and had fewer side effects compared to conventional synthetic

[19] Metz, “Nigeria – Health”
[20] Mary Ndu, MPH, “Cancer: Taking the Time to Converse”, *Global Health Equity (blog)*, Western University, February 3, 2022, accessed July, 2025, https://ghe.uwo.ca/blog/posts/cancer_taking_the_time_to_converse.html

drugs.[21] The use of plant extracts and other traditional methods was a logical, survival-oriented decision in a resource-constrained environment, as evidenced by a review of Nigerian medicinal plants that have been used to manage various cancers. While some of these plants may contain compounds with potential therapeutic properties, the reliance on them as a primary form of care highlights the profound inadequacy of the official healthcare system. This widespread use of traditional medicine further illustrates how the institutional and economic failures of the pre-policy era forced individuals to rely on non-conventional and largely unproven methods, directly contributing to the high rates of late-stage diagnosis and poor outcomes.

Prevalence of Common Cancers in Nigeria (1960–1995)

Site	Frequency % (1960–1980)	Frequency % (1981–1995)
Cervical	19.9	22.7
Breast	11.2	25.7
Colorectal	8.5	2.8
NHL	7.4	4.4
Ovary	6.1	4.0
Connective tissues	3.7	3.4

Source: Felicia and Ojikutu[22]

[21] Idayat Akinwumi and Owoola Azeezat Ambali, "Traditional Knowledge of Cancer Treatment in Southwestern Nigeria: An Ethnopharmacological Review" *Journal of the Chemical Society of Nigeria* 48, no. 5 (October 2023): 845–70, https://doi.org/10.46602/jcsn.v48i5.918

[22] Felicia A. Adetifa and Rasheed K. Ojikutu, "Prevalence and Trends in Breast Cancer in Lagos State, Nigeria," *African Research Review: An International Multi-Disciplinary Journal,* Vol 3, no. 5. 14.

As demonstrated in the table, between 1960 and 1980, cervical cancer had a higher prevalence rate than breast cancer. However, in the period from 1981 to 1995, breast cancer took the lead, with its prevalence more than doubling to 25.7%, surpassing cervical cancer which also saw an increase. This reversal is a critical indicator of an evolving disease landscape, potentially influenced by urbanization, lifestyle changes, and the aging of the population in Lagos and other urban centers.[23] This evidence provides a compelling case for the core thesis of this paper: the cancer burden was fundamentally changing, but the institutional and policy response remained static. The data, though fragmented, reveals a fundamental disconnect between the problem on the ground and the priorities of the government. The high rates of death from breast and cervical cancer despite lower incidence compared to Western countries are a direct consequence of this static response, as late diagnosis and poor survival became the tragic norm.

The high burden of primary hepatocellular carcinoma (HCC), or liver cancer, during this period serves as a devastating case study of the era's failures. A study from Ile-Ife found hepatocellular carcinoma to be a major cause of death among middle-aged Nigerians, with a significant proportion (61%) of patients testing positive for the Hepatitis B virus surface antigen (HBsAg).[24] This is consistent with a broader trend in sub-Saharan Africa, where HCC is a major cause of cancer deaths, particularly in rural populations.[25]

The scientific solution to this public health crisis existed: the Hepatitis B vaccine, which is recognized as the first anti-cancer vaccine because it can prevent liver cancer. Although the vaccine was introduced into Nigeria's National Program on Immunization in 1995, it only became "widely available" in 2004, and its uptake remained low. The national vaccination coverage in low-resource settings was

[23] Adetifa and Ojikutu, "Prevalence and Trends in Breast Cancer"
[24] Dennis Ndububa, Olusegun Ojo, Oluwagbemiga Adeodu, and Victor A. Adetiloye, "Primary Hepatocellular Carcinoma in Ile-Ife, Nigeria: A Prospective Study of 154 Cases" *Nigerian Journal of Medicine* 10, no. 2. 59–63.
[25] Michael Kew, "Epidemiology of Hepatocellular Carcinoma in Sub-Saharan Africa" *Annals of Hepatology* 12, no. 2 (March 2013): 173–82, https://doi.org/10.1016/S1665-2681(19)31354-7

reported to be as low as 41%.[26] The poor implementation and low uptake were a result of systemic and logistical challenges, including the cost of procurement and the difficulty of administering the vaccine in a strained healthcare system. This demonstrates a clear causal relationship between a policy failure and a specific, preventable cancer burden. The institutional and economic barriers of the time were so severe that even when the means for primary prevention existed, the system's capacity to deliver it did not.

The gross inadequacy of specialized cancer treatment infrastructure is perhaps the most tangible evidence of institutional neglect. In 2001, for a population of 120 million people, Nigeria had only five radiotherapy centers with a total of six megavoltage therapy machines. This translates to a ratio of one therapy machine for every 20 million people, an irony to the international recommendation of one machine per 250,000 people.[27]

These limited facilities were not only scarce but also largely non-functional due to a lack of maintenance and a "dearth of trained personnel" such as radiation oncologists and medical physicists. The absence of service contracts for repair meant that when expensive equipment broke down, it remained non-functional for extended periods, leading to long waiting times and treatment delays that had a direct impact on clinical outcomes.[28] The geographical disparity was also severe, with the majority of the few available centers concentrated in the Southwest geopolitical zone. This extreme scarcity and geographical imbalance meant that modern, curative cancer care was, for all practical purposes, non-existent for the vast majority of Nigerians during this era. The high death rates for cancers that have high survival rates in other countries are a direct consequence of this

[26] J. Ikobah, H. Okpara, I. Elemi, Y. Ogarepe, E. Udoh, and E. Ekanem, "The Prevalence of Hepatitis B Virus Infection in Nigerian Children Prior to Vaccine Introduction into the National Programme on Immunization Schedule" *Pan African Medical Journal* 23 (March 25, 2016): 128, https://doi.org/10.11604/pamj.2016.23.128.8756

[27] Simeon C. Aruah, Runcie C. W. Chidebe, Tochukwu C. Orjiakor, Fatima Uba, Uchechukwu N. Shagaya, Charles Ugwanyi, Aisha A. Umar, et al., "Status of Government-Funded Radiotherapy Services in Nigeria," *JCO Global Oncology* 9 (June 22, 2023): e2200406, https://doi.org/10.1200/GO.22.00406

[28] Aruah et al., "Status of Government-Funded Radiotherapy Services in Nigeria"

comprehensive systemic failure, with late diagnosis and a lack of access to care being the primary culprits.

Institutionalisation of Cancer Control (2006–2018)

The year 2006 marked a decisive moment in the history of cancer control in Nigeria, when the Federal Ministry of Health inaugurated the National Cancer Control Programme (NCCP). This development was not an isolated event but a direct response to international calls by the World Health Organization and allied bodies urging countries to articulate comprehensive strategies for the prevention and management of cancer.[29] With its launch, Nigeria shifted from decades of neglect and fragmented interventions to a more deliberate, policy-driven framework that sought to address cancer across the spectrum of education, prevention, early detection, treatment, and palliative care.

The National Cancer Control Programme (NCCP) was envisioned as an ambitious project that promised to place Nigeria on a progressive path in oncology care. Yet, as in many policy initiatives of the period, a profound gap soon emerged between formulation and execution. The lofty aspirations of the programme were repeatedly undermined by the structural weaknesses of the Nigerian health system. One emblematic case was that of a breast cancer patient at the National Hospital Abuja in 2014, who endured a four-month delay before accessing radiotherapy because of prolonged equipment malfunction. Such instances illustrated that the real challenge was not the absence of policy, but the chronic failure to translate it into reliable services.[30]

The centralised nature of the National Cancer Control Programme became one of its greatest liabilities. The exclusion of state governments from meaningful participation and failing to provide a costed, practical implementation framework, made the policy exist largely as a federal pronouncement rather than a lived reality

[29] Federal Ministry of Health. "National Cancer Control Programme". Abuja, Nigeria: Federal Ministry of Health. Accessed August 4, 2025. https://health.gov.ng/national-cancer-control-programme/

[30] Ogunniyi, T. J., B. S. Fatokun, K. O. Isah, A. Abdulbaki, A. R. Emiola, and K. Batisani. "Current Status of Cancer Diagnosis and Treatment in Nigeria". *Health Science Reports* 8, no. 6 (May 29, 2025): e70877. https://doi.org/10.1002/hsr2.70877

in the health facilities across Nigeria. The materials, financial resources, skilled personnel, and infrastructural support required to sustain its objectives were never fully mobilised. Consequently, patients remained trapped in a cycle where official proclamations of reform contrasted sharply with the harsh realities of inadequate facilities, frequent equipment breakdowns, and the absence of comprehensive support systems.[31]

The most recent phase of Nigeria's cancer control efforts reflects a crucial shift toward decentralisation, strategic innovation, and multi-sectoral collaboration. The revision of the National Cancer Control Programme in 2018 and its further update in 2023 marked a renewed emphasis on these principles. The establishment of the National Institute for Cancer Research and Treatment (NICRAT) in 2023 provides a dedicated national body to provide leadership in research, treatment, and control.[32] A key development has been the rollout of public-private partnerships (PPPs) such as the Cancer Access Partnership (CAP) in 2020. This collaboration has significantly improved the availability of essential oncology medications by reducing their cost through international procurement arrangements, making 27 life-saving drugs available at reduced prices in federal tertiary hospitals. However, the program's reach remains limited to major urban centers, highlighting a persistent access gap.[33]

Another development is the rise of mobile screening units like "PinkCruise" and school-based interventions such as the OCI Foundation's "Arm Our Youths" (ArOY) Health Campaign.[34] These initiatives represent a pragmatic response to the infrastructural and geographical barriers to care by delivering services directly to

[31] Federal Ministry of Health. "Nigeria National Cancer Control Plan (2018–2022)". *International Cancer Control Partnership*, 2018. Accessed July, 2025. https://www.iccp-portal.org/sites/default/files/plans/NCCP_Final%20%5B1%5D.pdf

[32] Federal Government of Nigeria. "NICRAT Overview". Accessed July, 2025. Federal Government of Nigeria. https://www.nicrat.gov.ng/nicrat-overview/

[33] Federal Ministry of Health. "National Cancer Control Programme". Accessed July, 2025. Federal Ministry of Health, Nigeria. https://health.gov.ng/Source/7/Cancer-Control-Programme

[34] mass medical mission (mmm). "About PinkCruise". Accessed July, 2025. mass medical mission (mmm), Nigeria. https://pinkcruise.org/about-pinkcruise/ https://thenationonlineng.net/minister-makinde-commissions-mobile-truck-clinic-hpv-molecular-laboratory-research-hub/

hard-to-reach rural communities and internally displaced persons (IDP) camps. The proliferation of these non-governmental and community-led initiatives, often filling gaps left by the formal health system, is not merely a sign of a robust civil society; it is evidence of a failing state-led service delivery model. These organisations, including Project Pink Blue and the First Ladies Against Cancer (FLAC) coalition, have become a vital parallel system, providing free screening, advocacy, and patient support where government-led programs have struggled to deliver. While commendable, this reliance on non-state actors raises questions about the long-term sustainability, scalability, and equitable distribution of cancer care.

Analysis of Primary Risk Factors

The etiology of cancer in Nigeria is multifactorial, shaped by a confluence of lifestyle changes, infectious agents, environmental exposures, and genetic predispositions. The rise in incidence has been closely linked to shifts in lifestyle, particularly in urban areas, where increased tobacco use, alcohol consumption, poor dietary habits, and physical inactivity contribute significantly to the prevalence of breast, colorectal, and lung cancers. A critical component of the cancer burden stems from infectious agents. Human Papillomavirus (HPV) is implicated in up to 90% of cervical cancer cases, yet awareness and vaccination coverage have historically been alarmingly low. The fact that Nigeria ranks seventh globally in cervical cancer deaths, despite the preventability of the disease, underscores a fundamental failure in previous public health messaging and resource allocation that allowed a preventable crisis to spiral. The recent national HPV vaccination program launched in 2023, which has already vaccinated 14 million girls, is a massive step forward and represents a direct attempt to address this historical failure.[35]

Furthermore, the environmental data reveals that cancer in Nigeria is a profound issue of socio-environmental injustice. Communities in the Niger Delta and artisanal mining zones bear a disproportionate burden of exposure to potent

[35] ICO/IARC Information Centre on HPV and Cancer. "Human Papillomavirus and Related Cancers, Fact Sheet 2023—Nigeria". March 10, 2023. Accessed July, 2025. ICO/IARC Information Centre on HPV and Cancer. https://hpvcentre.net/statistics/reports/NGA_FS.pdf

carcinogens. Studies have linked long-term exposure to pollutants from oil spills and gas flaring with elevated risks of leukemia, lung, and gastrointestinal cancers. Similarly, artisanal gold miners are routinely exposed to hazardous heavy metals such as lead, arsenic, and cadmium, which are strongly associated with cancers of the lung, bladder, and kidney.[36] This exposure is a direct result of a lack of environmental policy enforcement and corporate accountability. The presence of these socio-environmental determinants transforms the analysis from a simple health report into a critique of regulatory failure and its direct health consequences, highlighting the need for a multi-sectoral response that extends beyond the health ministry.

Interventions, Impact, Systemic Gaps and Persistent Challenges

The establishment of NICRAT in 2023 represents an important move away from the fragmented, ministry-led approach that characterized previous phases. The centralization of leadership, research, and policy coordination in a dedicated body has made the government to create a more coherent and accountable framework for cancer control. The most recent iteration of the NCCP (2023–2027) reflects this new, more integrated approach, prioritising the decentralisation of care to primary and secondary levels, the use of public-private partnerships, and the integration of palliative care.[37] The success of this new framework hinges on NICRAT's ability to effectively collaborate with state governments, which has been a perennial weakness and a major challenge to the implementation of previous plans.

A central challenge in Nigeria has been the catastrophic cost of cancer treatment. The Cancer Access Partnership (CAP) has been successful in making 27 essential oncology medicines available at reduced prices in federal tertiary hospitals. Building on this, the National Health Insurance Authority (NHIA) has partnered with Roche Pharmaceuticals on a cost-sharing model for select chemotherapy drugs. Under this model, Roche covers 50% of the cost, the NHIA contributes 30%, and the patient pays the remaining 20%. While this represents a critical step toward financial risk protection, its impact is severely limited by the fact that only

[36] Ordinioha, B., and S. Brisibe. "The Human Health Implications of Crude Oil Spills in the Niger Delta, Nigeria: An Interpretation of Published Studies". *Nigerian Medical Journal* 54, no. 1 (January 2013): 10–16. https://doi.org/10.4103/0300-1652.108887

[37] Federal Government of Nigeria, "NICRAT Overview".

about 5% of Nigerians are enrolled in any form of health insurance. For the overwhelming majority of the population, a cancer diagnosis still leads to a financial burden that can exceed ₦5 million, which is well beyond the means of most citizens and a key driver of treatment abandonment.[38] This creates a financial protection fallacy where a policy exists in theory, but in practice, it is inaccessible to the people who need it most.

The Nigerian cancer control ecosystem is defined by a functional duality: the government's state-led initiatives operate in parallel with a robust and critical network of non-governmental and community-led organizations. NGOs and community groups are on the front lines, providing direct services and advocacy. Project Pink Blue, for instance, has conducted over 14,000 free cervical cancer screenings and supported 78 patients through treatment, while FLAC has successfully mobilized resources and advocated for policy reform.[39] This reliance on non-state actors, while a testament to a vibrant civil society, is also evidence of a health system that has not yet achieved full functional capacity to serve all its citizens equitably.

A major challenge is the late presentation of cancer cases, with over 70% of diagnoses occurring at advanced stages. This is due to a combination of poor health literacy, cultural stigma, a pervasive reliance on traditional medicine, and a severe lack of accessible screening infrastructure.[40] Late-stage diagnosis drastically reduces survival rates and increases the cost and complexity of treatment, creating a vicious cycle of poor outcomes. Again, Nigeria's oncology infrastructure is critically underdeveloped. The country has fewer than 10 functioning radiotherapy machines for a population exceeding 200 million, a ratio that is significantly below the WHO recommendation. This is further compounded by a severe shortage of trained oncologists, pathologists, and oncology nurses. The recent commissioning of three new oncology centers in Katsina, Enugu, and Benin, equipped with cutting-edge technology such as TrueBeam Linear Accelerators,

[38] Health Digest. “NHIA, Roche Partner to Subsidise Cancer Treatment”. August 7, 2025. Health Digest. https://healthdigest.ng/nhia-roche-subsidise-cancer/
[39] TVC News, “Zamfara First Lady Emerges National Secretary of FLAC”, July 20, 2025, https://www.tvcnews.tv/zamfara-first-lady-emerges-national-secretary-of-flac/
[40] Ogunniyi et al., “Current Status of Cancer Diagnosis and Treatment in Nigeria”.

and the ongoing upgrade of others is a direct governmental response to this central, most visible failure of the last decade.[41] This action demonstrates a political will to address the infrastructure gap that has been a defining challenge since the NCCP's inception. Its success will be a key indicator for the future of cancer care in Nigeria.

For most Nigerians, cancer treatment remains financially catastrophic. A single cycle of chemotherapy can cost between ₦150,000 and ₦400,000, while a full treatment course may exceed ₦5 million, which is unaffordable for the majority of citizens. With less than 5% of the population covered by any form of health insurance, out-of-pocket expenditure continues to push families into poverty or force them to abandon care entirely.

The inadequacy of the data ecosystem remains a critical weakness. Population-based cancer registries are scarce and underfunded, and most available data is derived from hospital-based registries that do not provide representative national insights. The lack of comprehensive, reliable data impedes effective policy planning, funding allocation, and the evaluation of cancer control programs.

Conclusion

From a period of intense neglect in the 1980s, when cancer was a ghost in the national health discourse, Nigeria has embarked on a gradual, yet often disjointed journey toward institutionalised control and innovation. The establishment of the National Cancer Control Programme (NCCP) in 2006 marked a critical turning point, but its ambitious goals were frequently frustrated by a chronic disconnect between policy and on-the-ground implementation. The legacy of this policy-practice gap is evident in the current systemic challenges: an acute shortage of oncology infrastructure, substantial financial barriers to care, and a data vacuum that continues to obscure the true magnitude of the crisis.

[41] Ogunniyi et al., "Current Status of Cancer Diagnosis and Treatment in Nigeria".
Onyinye Nwachukwu, "FG Commissions Three Oncology Centres to Boost Cancer Care in Nigeria", *BusinessDay*, July 25, 2025, https://businessday.ng/news/article/fg-commissions-three-oncology-centres-to-boost-cancer-care-in-nigeria/

While the rise of decentralised initiatives, public-private partnerships, and a vibrant network of non-governmental organisations has begun to fill these gaps, this parallel system simultaneously underscores the persistent shortcomings of the formal state-led model. Nigeria's progress has been piecemeal, and its policies have mostly lacked the specific guidelines and financial commitment seen in comparable African nations like Ghana. To truly transition from a reactive to a proactive and effective cancer control framework, Nigeria must address these deep-seated systemic failures. The path forward requires a renewed focus on strengthening the national data ecosystem, expanding financial protection for patients, and investing in a sustained, long-term plan for oncology infrastructure and workforce development. Only by confronting the historical and ongoing challenges can Nigeria build a resilient and equitable system that can meet the growing burden of cancer head-on

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