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Aspire Coronation Trust
Foundation

ADVANCING EQUITY, AWARENESS, AND ACTION IN NIGERIA'S CANCER RESPONSE

World Cancer Month

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Introduction

Nigeria is experiencing a clear epidemiological transition. For decades, national health priorities were shaped largely by infectious diseases such as malaria, tuberculosis, and HIV/AIDS. While these conditions remain important, improvements in child survival, urbanisation, changing diets, longer life expectancy, and environmental exposures have shifted the country toward a dual burden of disease, where communicable and non-communicable diseases coexist and increasingly compete for limited health resources. Within this transition, cancer has emerged as one of the most consequential threats to both population health and national productivity.

Unlike many infectious diseases, cancer carries long treatment timelines, high care costs, and significant disability burdens. The impact therefore extends beyond mortality: households face catastrophic expenditure, families lose income earners, and the health system absorbs prolonged demand for specialised care. Importantly, a large proportion of cancer deaths in Nigeria occur during economically productive years, amplifying the broader socioeconomic consequences.

Evidence from the International Agency for Research on Cancer's Global Cancer Observatory (GLOBOCAN 2022) underscores the magnitude of the challenge. Nigeria recorded 127,763 new cancer cases and 79,542 deaths in 2022, with more than 269,000 people living with cancer within a five-year prevalence window. The lifetime probability before age 75 now stands at approximately 12.1% risk of developing cancer and 8.0% risk of dying from it. In practical terms, this means cancer is no longer a rare or specialised condition encountered only in tertiary hospitals; it is a widespread national health issue affecting households across urban and rural communities and across income levels.

However, the most important insight from these figures is not incidence alone, but the relationship between incidence and mortality. Nigeria's mortality-to-incidence ratio remains high compared with countries that have functioning early detection systems. This indicates that many deaths are not inevitable outcomes of aggressive disease biology. Rather, they reflect delayed diagnosis, limited screening coverage, financial barriers to treatment, and fragmented referral pathways within the health system.

In other words, the growing cancer burden represents less a failure of medicine and more a failure of timely access. The transition Nigeria faces is therefore not only epidemiological but structural: a shift from treating visible illness to preventing advanced disease. Recognising cancer as a development and systems challenge, not solely a clinical one, is the first step toward reversing preventable mortality and protecting long-term population wellbeing.

The Pattern of Cancer in Nigeria

Cancer incidence and mortality in Nigeria follow a pattern that is both epidemiologically predictable and socially unequal. The country's burden is concentrated in a small number of high-impact cancers that disproportionately affect women and men in different ways, reflecting biological risk factors, gendered health-seeking behaviours, and structural access barriers within the health system.

Among women, breast cancer is the most diagnosed malignancy and the leading cause of cancer-related death. According to GLOBOCAN 2022 estimates, Nigeria recorded 32,278 new breast cancer cases in 2022, making it the single most prevalent cancer in the country. Breast cancer alone accounts for roughly one in four cancer cases among Nigerian women. Mortality remains high, largely because most patients present at advanced stages, when curative treatment options are limited.

Cervical cancer remains the second most common cancer among women and one of the most preventable. In 2022, Nigeria recorded 13,676 new cervical cancer cases, with approximately 8,000 deaths in the same year. Cervical cancer is primarily caused by persistent infection with high-risk human papillomavirus (HPV) strains, and globally it is one of the few cancers for which primary prevention (HPV vaccination) and secondary prevention (screening and early treatment of pre-cancerous lesions) are well-established and highly effective. The continued high mortality in Nigeria therefore signals gaps in vaccination coverage, screening access, and follow-up treatment pathways.

Among men, prostate cancer is the most common malignancy. In 2022, Nigeria recorded 18,019 new prostate cancer cases, with mortality rates that reflect late-stage detection in many instances. While prostate cancer incidence increases with age, limited awareness and low uptake of screening contribute to delayed diagnosis. Cultural norms around masculinity and preventive health-seeking behaviour also influence patterns of presentation.

Collectively, breast, cervical, and prostate cancers account for more than 40 percent of cancer-related deaths nationally. This concentration reveals a critical policy insight: Nigeria's cancer burden is not dominated by rare or untreatable malignancies. Instead, it is largely driven by cancers for which evidence-based early detection, vaccination, and screening interventions already exist and have been successfully implemented in other settings.

However, beneath this aggregate picture lies a profound inequity. Urban residents are more likely to access screening and diagnostic services than rural populations. Women in lower-income households often encounter financial and social barriers that delay care. Similarly, men frequently present at later stages due to limited preventive engagement.

These disparities shape survival outcomes and contribute to a higher mortality-to-incidence ratio compared to countries with established population-based screening programmes.

The pattern of cancer in Nigeria therefore reflects more than biological risk; it mirrors structural inequality in access to information, preventive services, and timely treatment. The fact that the dominant cancers are detectable and, in some cases, preventable underscores a central conclusion: reducing mortality in Nigeria is less about discovering new medical breakthroughs and more about scaling proven interventions equitably across the population.

Late Diagnosis: The Central Driver of Mortality

The most decisive factor shaping cancer outcomes in Nigeria is the timing of diagnosis. Evidence shows that approximately 72.81% of cancer patients present at late stage. By the time individuals enter the health system, treatment options are limited, survival probability declines sharply, and costs escalate dramatically.

Late presentation is often misinterpreted as poor health-seeking behaviour. It reflects structural barriers, limited awareness, financial constraints, weak referral systems, and insufficient screening services within primary healthcare. Many patients first encounter cancer care only after severe symptoms emerge, at which point curative treatment becomes difficult.

This dynamic explains why mortality rates in Nigeria remain disproportionately high relative to incidence. The health system is effectively treating advanced disease instead of preventing it.

Structural Constraints Within the Health System

Nigeria's health system faces profound structural challenges that directly impede effective cancer detection, diagnosis, and treatment. The country's diagnostic and treatment infrastructure is heavily concentrated in urban centres, leaving vast rural areas under-served. For a nation of over 220 million people, this urban-centric distribution creates critical geographic inequities: many patients must travel hundreds of kilometres to access basic diagnostic services, often delaying care until symptoms become severe.

Current national assessments reveal that Nigeria has only 218 mammography units nationwide, primarily located in tertiary hospitals and private facilities in major cities. Magnetic Resonance Imaging (MRI) machines are limited to 58 units, also mostly in urban hospitals. Furthermore, biopsy capacity, essential for confirming cancer diagnoses, is severely constrained, and only a small proportion of ultrasound centres are equipped to perform diagnostic biopsies. As roughly 50% of Nigeria's population lives in rural or semi-urban areas, most citizens face significant geographic barriers to timely diagnostic care (Jedy-Agba et al., 2024; NICRAT, 2023).

Infrastructure alone does not account for the delays; financial barriers are equally constraining. Nearly 90% of healthcare expenditure in Nigeria is out-of-pocket, meaning that families must pay directly for screening, diagnosis, and treatment. Studies indicate that only 5% to 32% of Nigerians can afford cancer treatment without catastrophic financial consequences, depending on location, cancer type, and socio-economic status (World Bank, 2022; Akinyemiju et al., 2022). For many, the cost of diagnostic imaging, pathology, and therapy, particularly chemotherapy or surgery, is prohibitively high. As a result, patients may postpone screening, delay hospital visits, or interrupt treatment due to affordability concerns, contributing directly to avoidable mortality.

These structural and financial constraints collectively invert the expected cancer care pathway in Nigeria. In a well-functioning system, early detection through screening triggers timely diagnosis and treatment, improving survival and reducing morbidity. In Nigeria, by contrast, the typical pathway is reactive: individuals present only when symptoms become acute or advanced, initiating crisis-driven interventions rather than preventive or curative care. This inversion increases both clinical complexity and economic burden, amplifying the human and societal cost of cancer.

The consequences of this structural misalignment are far-reaching. Rural populations, low-income households, and older adults are disproportionately affected, exacerbating existing inequities in health outcomes. The combination of geographic, infrastructural, and financial barriers underscores the urgent need for systemic reform, expanding diagnostic capacity, decentralizing services, and introducing financial protection mechanisms to enable timely access to cancer care across the population.

Screening and Prevention Gaps

Despite the well-documented burden of cancer in Nigeria, population-level screening and prevention remain severely limited. Unlike high-income countries where structured, routine screening is embedded within primary healthcare systems, in Nigeria most screening occurs on an episodic or campaign-based model, often led by tertiary hospitals, civil society organisations, or private clinics. This fragmented approach results in low coverage, uneven quality, and poor continuity of care.

Data from facility reviews and peer-reviewed studies consistently indicate that most patients first present with symptomatic disease rather than being detected through preventive screening (Akinyemiju et al., 2022; Jedy-Agba et al., 2024). For example, less than 10% of eligible women in Nigeria report having undergone cervical cancer screening in the past five years, and breast cancer screening rates are similarly low, concentrated primarily in urban populations with private insurance coverage. Rural populations, low-income households, and informal-sector workers face compounded barriers, including lack of facilities, long travel distances, and cultural misconceptions about screening.

The absence of organised screening programs is mirrored by gaps in primary prevention. HPV vaccination coverage is extremely low, and public awareness about risk factors, early warning signs, and preventive behaviours remains inadequate. Combined, these gaps contribute to a persistent cycle of late-stage presentation, high treatment costs, and poor survival outcomes.

Furthermore, the health system is largely reactive. Primary healthcare centres, the first point of contact for most Nigerians, rarely offer structured screening services. Where services exist, there is often insufficient integration with referral systems to tertiary care, leading to missed opportunities for early intervention. In many cases, patients who might have been diagnosed at a curable stage instead reach specialist hospitals only after advanced disease develops, requiring complex surgery, chemotherapy, or palliative care.

The consequences of these screening and prevention gaps are compounded by social and gender inequities. Women, particularly those in rural or low-income communities, face mobility restrictions and cultural stigma that discourage participation in screening programs. Men, on the other hand, frequently underutilise preventive health services, delaying detection of prostate or colorectal cancers until symptoms are severe. These inequities create a disproportionate burden of advanced disease in populations that already face systemic disadvantage.

In summary, Nigeria's cancer outcomes are shaped less by biology than by the structural and social context of health service delivery. The combination of low screening coverage, inadequate preventive services, and weak referral pathways ensures that most cancers are diagnosed late, driving high mortality. Closing these gaps will require systemic integration of screening into primary care, widespread public health education, expansion of vaccination programs, and removal of financial and cultural barriers, interventions that have proven effective in comparable low- and middle-income countries.

The Future Burden Without Reform

If current trends persist, Nigeria’s cancer burden is projected to increase sharply over the next decade, creating significant health, social, and economic challenges. National projections estimate that by 2030, Nigeria could experience approximately 166,379 new cancer cases and over 104,709 deaths annually (NICRAT imPACT Review, 2023). These projections assume no major systemic interventions in screening, diagnosis, or treatment access, highlighting the urgent need for structural reforms.

The anticipated increase in cases is driven by several interrelated factors. First, Nigeria’s population is both growing and aging, expanding the pool of individuals at risk for age-related cancers such as prostate and colorectal cancer. Second, lifestyle transitions associated with urbanisation, including dietary changes, physical inactivity, obesity, and increased tobacco and alcohol use, are elevating cancer risk across both urban and rural populations. Third, without improvements in early detection, the proportion of late-stage diagnoses is likely to remain high, sustaining mortality rates that are disproportionate to incidence.

Beyond individual health impacts, the projected rise in cancer cases carries profound economic consequences. Late-stage treatment is costly, often involving surgery, chemotherapy, radiotherapy, and prolonged hospitalisation. In a system where out-of-pocket payments account for nearly 90% of healthcare spending, this translates into catastrophic financial burdens for families, particularly among low-income households. The wider economy also suffers through reduced productivity as working-age adults face disability, illness, or premature death.

Critically, these projections also underscore the preventability of much of Nigeria’s cancer burden. The dominant cancers, breast, cervical, and prostate, are largely detectable at early stages through screening programs, and cervical cancer is largely preventable through HPV vaccination. The continued rise in mortality, therefore, reflects systemic failures in access to preventive care rather than unavoidable biological trends.

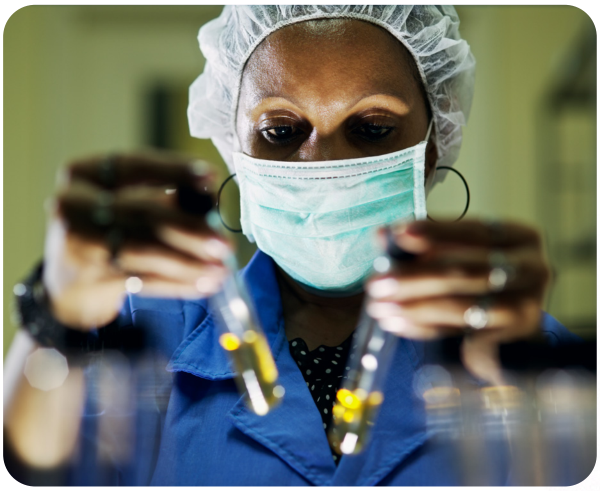
Without intervention, the health system is likely to become further overwhelmed, exacerbating inequities. Urban populations may continue to access limited tertiary services, while rural communities remain excluded, reinforcing disparities in survival outcomes. Moreover, the financial strain on households and health facilities will deepen, potentially crowding out resources for other essential health services.

The future burden projections make a compelling case for immediate action. Early investment in primary healthcare-based screening, financial protection mechanisms, and equitable expansion of diagnostic and treatment services could avert tens of thousands of preventable deaths and reduce long-term economic losses. In effect, the choice facing Nigeria is not whether cancer incidence will rise, but whether mortality and social impact can be mitigated through timely, systemic reform.

Policy Implications: What the Evidence Demands

The evidence on Nigeria's cancer burden points to a critical conclusion: the crisis is not an inevitable outcome of disease biology, but a predictable consequence of systemic weaknesses in prevention, early detection, and access to care. Addressing this challenge requires coordinated, multi-level policy interventions that strengthen the health system, protect households from financial catastrophe, and ensure equitable access to services across the country.

First, integration of cancer screening into primary healthcare is essential. Primary healthcare centres (PHCs) are the most accessible point of care for most Nigerians, particularly in rural and semi-urban areas. Embedding structured breast, cervical, and prostate cancer screening within PHC services would allow early identification of high-risk individuals, facilitate prompt referrals to diagnostic facilities, and reduce late-stage presentations. Evidence from comparable low- and middle-income countries demonstrates that decentralised, community-based screening can substantially reduce mortality, particularly when combined with effective referral networks.



Second, financial protection mechanisms must be expanded. With nearly 90% of healthcare expenditure in Nigeria paid out-of-pocket, many families are forced to delay or forego care. Implementing universal health coverage policies that include preventive services, diagnostics, treatment, and palliative care would mitigate catastrophic expenditures and enable patients to complete the full continuum of care. Financing models should prioritise high-burden cancers and be aligned with equitable access principles to reach low-income and rural populations.

Third, strengthening national and state cancer registries is critical for informed decision-making. Accurate, timely, and population-based data are indispensable for resource allocation, program evaluation, and policy planning. Nigeria currently faces gaps in cancer surveillance, with most registries limited to tertiary hospitals in urban centres. Expanding and standardising registries will allow policymakers to identify high-risk regions, monitor intervention impact, and track long-term trends in incidence and survival.

Fourth, diagnostic and treatment infrastructure must be decentralised and expanded. Investments should prioritise regional and rural centres to reduce geographic inequities. This includes not only equipment, such as mammography and MRI units, but also trained personnel capable of performing biopsies, interpreting imaging, and delivering safe oncology care. Equally important is ensuring that PHCs are linked to higher-level facilities through efficient referral systems.

Finally, cross-sectoral collaboration is indispensable. The government, civil society, and private sector must coordinate to deliver awareness campaigns, vaccination programs, and screening initiatives at scale. Evidence indicates that multi-stakeholder engagement, combining government oversight with non-state innovation and community-level mobilisation, accelerates uptake of preventive services and strengthens public trust in health systems.

The policy implications are clear: reducing cancer mortality in Nigeria requires a shift from reactive treatment to proactive, system-wide prevention and early detection. Prioritising these reforms will not only save lives but also reduce the economic burden of late-stage care and improve equity in health outcomes across socio-economic and geographic groups.

The Role of Non-State Actors

While government-led reforms are essential, addressing Nigeria's cancer burden requires the active participation of non-state actors, including philanthropic organisations, civil society groups, private sector entities, and community-based initiatives. These actors play a catalytic role in expanding access, innovating delivery models, and reaching populations that are traditionally underserved by formal health systems.

Philanthropic organisations can mobilise resources to pilot innovative screening, early detection, and treatment navigation programs, particularly in rural or low-income communities. Their flexibility allows rapid adaptation of interventions to local contexts, testing approaches that may later be scaled within public health systems. Civil society organisations complement these efforts by providing education, raising awareness, and challenging cultural and social barriers that impede timely health-seeking behaviour. For example, community groups can address stigma around cervical and prostate cancer, encourage participation in preventive services, and provide peer support to patients navigating complex treatment pathways.

The private sector also has an important role to play. Employers can implement workplace-based screening programs, fund health insurance coverage for employees, and contribute technological solutions for diagnostics and patient follow-up. Private diagnostic facilities and laboratories can augment government capacity, particularly in urban and peri-urban areas, helping reduce waiting times and improve the quality of care.

Critically, the effectiveness of non-state actors depends on coordination and alignment with national strategies. Independent efforts risk duplication, inequitable coverage, or gaps in continuity of care if they are not integrated into broader health system planning. Collaborative frameworks that link government oversight, civil society engagement, and private sector delivery ensure that interventions are evidence-based, sustainable, and scalable.

Ultimately, non-state actors extend the reach of cancer interventions, accelerate adoption of preventive strategies, and fill critical gaps in the health system. Their involvement is not supplementary but central to reducing late-stage diagnosis, improving survival outcomes, and achieving equity in access to care.

ACT Foundation's Role in Nigeria's Cancer Response

Within the landscape of Nigeria's cancer challenge, Aspire Coronation Trust (ACT) Foundation has emerged as a key philanthropic actor, strategically complementing government efforts and filling critical gaps in awareness, screening, early detection, and innovation. Over the past eight years, the Foundation has focused on evidence-driven, community-responsive interventions that address structural barriers and promote equity in cancer care.

ACT Foundation's approach supports community-based screening programs that bring breast and cervical cancer detection services directly to underserved populations, including rural women and low-income urban communities. By facilitating access to early diagnostic services, these programs address the geographic and infrastructural constraints that often delay early detection and treatment. The Foundation also invests in capacity strengthening, partnering with healthcare providers and local organisations to improve service delivery, train medical personnel, and integrate screening within primary healthcare centres.

In addition to service delivery, ACT Foundation has prioritised innovation and technology as tools for early detection. This includes supporting artificial intelligence driven risk assessment and diagnostic tools that enhance early identification of high-risk individuals, improve efficiency in screening programs, and reduce unnecessary repeat procedures. These technology-focused interventions aim to make cancer care data-driven, scalable, and sustainable within Nigeria's resource-constrained context.

ACT Foundation also plays a critical role in community engagement and awareness, particularly in populations that face cultural, gender, or economic barriers to care. Initiatives targeting men, for example, aim to improve knowledge of prostate cancer, encourage routine screening, and reduce stigma around preventive health-seeking behaviours. By fostering health literacy and promoting early action, the Foundation contributes to shifts in societal norms that have historically delayed diagnosis.

The Foundation's contributions demonstrate that strategic philanthropy can accelerate the adoption of preventive measures, strengthen the health system's responsiveness and enhance equity in cancer care delivery. While national policies and infrastructure form the backbone of the response, ACT Foundation exemplifies how targeted interventions, guided by data and local context, can complement systemic reforms to reduce preventable deaths and improve outcomes.

Conclusion: From Awareness to Systems Change

Nigeria stands at a pivotal moment in its public health trajectory. The evidence is unequivocal: cancer is no longer a rare or incidental disease but a major, preventable contributor to mortality and socio-economic loss. With over 127,000 new cases and nearly 80,000 deaths recorded in 2022, and projections indicating further increases by 2030, the country faces a dual challenge of rising incidence and persistently high mortality due to systemic weaknesses in prevention, screening, and treatment.

The pattern of cancer in Nigeria highlights that most cases, breast, cervical, and prostate, are detectable or preventable with early intervention. Yet structural constraints, including urban-centred diagnostics, limited primary healthcare integration, financial barriers, and social inequities, continue to drive late-stage presentation and high mortality. Screening coverage remains low, preventive services such as HPV vaccination are underutilized, and community awareness is insufficient to prompt early action. These gaps are compounded by inequities in access, leaving rural, low-income, and underserved populations disproportionately affected.

Addressing this challenge requires a comprehensive, system-wide response. Governments must integrate cancer prevention and screening into primary healthcare, expand financial protection mechanisms to cover preventive and curative services, decentralize diagnostic infrastructure, and strengthen cancer registries for evidence-based planning. Non-state actors, including civil society, the private sector, and philanthropic organisations such as the ACT Foundation, play a complementary and catalytic role in expanding access, fostering innovation, and promoting community engagement. Their interventions demonstrate that equity-driven, evidence-based programs can improve early detection, reduce stigma, and save lives even in resource-constrained settings.

The call to action is urgent and multi-level. Policymakers must move from planning to implementation, translating national cancer control strategies into tangible, measurable outcomes. Health institutions must shift from reactive, tertiary-focused treatment models to proactive, prevention-focused care pathways. Civil society and private sector partners must scale community-based awareness and screening programs to ensure no population is left behind. Citizens themselves must embrace routine screening and early health-seeking behaviours as a social norm.

The convergence of these actions can transform Nigeria's cancer landscape. Early detection, equitable access to care, and coordinated system-wide interventions are not abstract goals; they are achievable imperatives. With aligned policy, sustained investment, and strategic partnerships, Nigeria can reduce preventable cancer deaths, alleviate household financial burden, and move toward a future where a cancer diagnosis is no longer a near-certain death sentence.

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