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THE CHURCH'S RESPONSE TO THE RISING CANCER BURDEN IN NIGERIA: A THEOLOGICAL APPRAISAL OF PREVENTION, EARLY DETECTION AND SUPPORTIVE CARE

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ABSTRACT
The rising cancer burden in Nigeria constitutes a critical health, social, and pastoral challenge, compounded by inadequate awareness, misconceptions, late diagnosis, and limited access to screening and treatment. In several communities, cancer is interpreted primarily through spiritual explanations, a tendency that can delay medical intervention. This study examines the Church's response to Nigeria's rising cancer burden, focusing on prevention, early detection, and supportive care. Its objectives are to examine the Church's contribution to cancer prevention and health education, assess its role in promoting early detection and timely medical intervention, and evaluate its pastoral, psychosocial, and advocacy responsibilities toward cancer patients and their families. The study is anchored on the Social Gospel Theory, which emphasises the Church's responsibility to respond practically to human suffering. Methodologically, it adopts a qualitative documentary research design, drawing on scholarly, theological, and policy documents published between 2009 and 2026, identified through Google Scholar, PubMed, and African Journals Online and selected using defined inclusion and exclusion criteria. Findings indicate that the Church holds considerable potential to promote cancer awareness, healthy lifestyles, screening, referral, counselling, and psychosocial support, but that inadequate health knowledge among religious leaders, persistent misconceptions, weak collaboration with health professionals, and over-reliance on spiritual remedies currently limit this contribution. The study concludes that the Church should complement, rather than replace, professional healthcare through informed and compassionate ministry, and recommends sustained cancer education, screening advocacy, clergy training, stronger partnerships with health institutions, and structured pastoral and psychosocial support for affected individuals and families.

Keywords: Cancer Burden, Church Response, Theological Appraisal, Cancer Prevention, Supportive Care

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Introduction

Cancer has emerged as one of the most significant public-health challenges confronting societies worldwide, generating profound psychological, social, economic, and spiritual difficulties alongside its medical consequences. Global estimates place the annual burden at approximately 20 million new cases and close to 10 million cancer-related deaths (Bray et al., 2024; WHO, 2026). Nigeria is not exempt from this challenge: the International Agency for Research on Cancer estimated 127,763 new cancer cases and 79,542 cancer deaths in Nigeria in 2022, with breast, prostate, and cervical cancers among the leading types (IARC, 2024). These figures demonstrate that cancer is a broader societal challenge requiring coordinated responses from governmental, medical, civil-society, and religious institutions.

The Nigerian cancer situation is intensified by inadequate awareness, misconceptions, delayed presentation, limited screening opportunities, and financial difficulty. Some cultural and religious interpretations associate cancer with divine punishment or spiritual attack, which can discourage timely medical care (Salami, Kanmodi, & Amzat, 2023). Cancer control in Nigeria therefore requires not only biomedical intervention but also culturally and religiously sensitive engagement with the beliefs that shape health-seeking behaviour.

Within this context, the Church occupies an important position in Nigerian society. As a centre of worship, moral formation, and community mobilisation, the Church has established platforms — sermons, fellowships, counselling units, and health ministries — through which health information can reach large populations. Existing scholarship acknowledges the Church's potential to contribute to cancer education, myth correction, and psychosocial support (Salami, Kanmodi, & Amzat, 2023), but this contribution remains under-examined theologically and has not yet been systematically linked to prevention, early detection, and supportive care within a single framework.

It is against this gap that the present study, titled "The Church's Response to the Rising Cancer Burden in Nigeria: A Theological Appraisal of Prevention, Early Detection and Supportive Care," is undertaken. The study argues that a more informed, medically responsible, and theologically grounded Church response could complement national cancer-control efforts while strengthening the Church's social witness. Specifically, the study aims to: (i) examine the Church's contribution to cancer prevention and health education; (ii) assess its role in promoting early detection and timely medical intervention; and (iii) evaluate its pastoral, psychosocial, and advocacy responsibilities toward cancer patients and their families.

Conceptual Clarification

The conceptual clarification of this study focuses on the concepts embedded in its title, organised here into four clusters to avoid unnecessary fragmentation and repetition of material already introduced above.

Cancer and the Rising Cancer Burden

Cancer refers to a broad group of diseases characterised by the uncontrolled growth of abnormal cells, which may invade surrounding tissue and spread to other parts of the body (WHO, 2026). It is not a single disease but a collection of diseases with different causes, risk factors, and outcomes; the WHO (2026) notes that a substantial proportion of cancers are preventable through modification of factors such as tobacco use, alcohol consumption, and physical inactivity (Islami et al., 2018), and that many are treatable when detected early. This study therefore conceptualises cancer not simply as a biomedical condition but as a health issue with physical, psychological, social, and spiritual consequences.

The expression "rising cancer burden" denotes the increasing scale of these consequences — reflected in incidence, mortality, treatment costs, caregiving demands, and pressure on health systems — as already indicated in the Introduction. Salami, Kanmodi, and Amzat (2023) note that Nigeria's cancer burden is compounded by myths, misconceptions, and socioeconomic factors that discourage timely prevention and care, meaning that addressing it requires community-level educational intervention alongside clinical capacity.

The Church, Its Response, and a Theological Appraisal

The Church, in this study, refers to Christian institutions, congregations, clergy, chaplains, and organised Christian communities exercising religious, moral, and social influence in Nigeria. Its mission is traditionally understood in terms of worship, proclamation, and pastoral care, but the contemporary Nigerian context requires this mission to be exercised holistically, encompassing a compassionate response to human suffering.

The Church's response accordingly refers to the deliberate theological, pastoral, educational, and practical actions Christian institutions may undertake in addressing the cancer burden: awareness campaigns, health education, promotion of screening, referral, counselling, prayer, advocacy, and collaboration with health institutions. Salami et al. (2023) identify education, advocacy, counselling, and psychosocial support as areas in which chaplains can contribute, while also noting limitations such as inadequate training and unclear boundaries between spiritual and medical care. This study advances that submission by arguing that the Church's response should be structured and theologically responsible rather than sporadic.

A theological appraisal, correspondingly, means critically examining this response through Christian principles of compassion, human dignity, healing, and justice — not to substitute theology for medical evidence, but to determine why and how the Church should engage cancer as a moral and pastoral concern.

Prevention, Early Detection, Supportive Care, and Religious Misconceptions

Cancer prevention refers to measures that reduce the risk of developing cancer, including avoidance of modifiable risk factors, promotion of healthy lifestyles, and vaccination where appropriate (WHO, 2026). Early detection refers to identifying cancer at a stage when treatment is more likely to succeed; the WHO (2026) distinguishes early diagnosis (recognising symptoms and obtaining prompt clinical evaluation) from screening (identifying disease before symptoms appear). Supportive care denotes the physical, psychological, social, and spiritual assistance provided to patients and families alongside treatment, encompassing pastoral counselling, visitation, and bereavement support (Peteet & Balboni, 2013).

Across all three dimensions, cancer-related myths and misconceptions — inaccurate beliefs regarding the causes or treatment of cancer, including interpretations of cancer as witchcraft or divine punishment — pose a recurring obstacle, since they may lead patients to postpone medical consultation in favour of exclusively spiritual intervention (Salami et al., 2023; Eli et al., 2020). The Church is not responsible for diagnosis or treatment; its distinctive contribution lies in health education, encouragement of screening and prompt consultation, correction of misinformation, and compassionate accompaniment throughout the illness.

Conceptual Position of the Study

These concepts are interconnected: the rising cancer burden generates the need for a Church response that can be organised around prevention, early detection, and supportive care, and evaluated theologically according to Christian principles of compassion, service, and human dignity. This study understands the Church's response to cancer as a holistic Christian engagement

with cancer-related suffering, combining health education, preventive advocacy, encouragement of early medical attention, and psychosocial support.

While Salami et al. (2023) establish the relevance of chaplains to cancer education and support, and Ahmed (2024) and Lawal et al. (2025) demonstrate persistent gaps in cancer knowledge among religious scholars in Ile-Ife, this study extends these contributions by situating the discussion explicitly within Christian theology and the Nigerian Church, and by integrating prevention, early detection, and supportive care within a single theological framework. Consequently, the Church's obligation is understood as neither to medicalise its ministry nor to spiritualise cancer at the expense of medicine, but to combine responsible compassion with evidence-based education, timely referral, and sustained pastoral care.

Theoretical Framework

Social Gospel Theory

This study is anchored primarily on the Social Gospel Theory, which provides an appropriate theological framework for examining the Church's response to the rising cancer burden in Nigeria. The theory understands Christian faith not merely as a matter of personal salvation but also as a mandate to confront human suffering and conditions that undermine human flourishing. Walter Rauschenbusch, one of its most influential proponents, argued in A Theology for the Social Gospel that Christian ethics must be expressed through efforts to transform society and promote the common good (Rauschenbusch, 1917). Although his work predates contemporary cancer discourse, its theological principle remains applicable to present health challenges.

Contemporary scholarship has developed the Social Gospel beyond its historical context. Dorrien (2015) argues that it represents a Christian commitment to social justice, human dignity, and the transformation of structures that contribute to human suffering, and that Christianity possesses an ethical responsibility to engage concrete social realities rather than retreat into purely private concerns. This provides a foundation for understanding cancer as not merely an individual medical problem but also a social issue requiring community-based responses.

Relevance of the Theoretical Framework

The Social Gospel Theory is relevant to the study in four respects. First, it justifies interpreting cancer prevention as part of the Church's social responsibility: prevention requires public education and reduction of risk factors, and the Church has congregational networks through which reliable health information can be communicated (Salami et al., 2023). Second, it supports the Church's role in early detection, since religious leaders can use their moral authority to encourage members to seek qualified medical attention and participate in screening (Salami et al., 2023). Third, it grounds the Church's involvement in supportive care, given its emphasis on compassion and practical service toward those experiencing fear, anxiety, and spiritual distress. Fourth, it clarifies the relationship between faith and medical care: the Social Gospel does not require the Church to replace professional healthcare but encourages practical cooperation with it, addressing the training and integration gaps that Salami et al. (2023) identify as barriers to effective religious involvement in cancer care.

Other frameworks could have been applied to this study. The Health Belief Model, for instance, explains individual health behaviour in terms of perceived susceptibility, severity, benefits, and barriers, and has informed research on cancer-screening uptake in Nigeria (Abugu & Nwagu, 2021). Its focus, however, is individual and cognitive, making it less suited to appraising the institutional and theological responsibilities of the Church as a collective actor. An African theology of suffering, which interprets illness within communal and ancestral frameworks of meaning, offers valuable insight into how Nigerian congregants interpret cancer, but does not, on

its own, provide a normative basis for prescribing institutional action. The Social Gospel Theory was preferred because it directly links theological conviction to organised social action, making it better suited to appraising what the Church, as an institution, ought to do in response to a public-health crisis.

The framework is not without limitation for this topic. Because it emerged from early twentieth-century Western Protestantism responding to industrial poverty, it does not directly address biomedical realities such as screening technology or the specific theological tensions raised by African beliefs in spiritual causation of illness. Its emphasis on structural social transformation can also, if applied uncritically, understate the Church's more modest, complementary role alongside professional healthcare. The framework is therefore applied here as a general theological orientation toward practical compassion, supplemented by the broader religion-and-health literature, which associates religious involvement with more positive health behaviours and coping (Koenig, 2012), and by the empirical literature on cancer, religion, and health-seeking behaviour in Nigeria discussed below.

Methodology

Research Design

This study adopts a qualitative research design, specifically a documentary research approach, to examine the Church's response to the rising cancer burden in Nigeria. A qualitative approach is appropriate because the study interprets theological perspectives, social realities, and existing scholarly arguments rather than measuring variables statistically (Creswell & Poth, 2018). Documentary research is particularly suitable because it allows systematic examination of existing scholarly and institutional materials relating to cancer, Christian theology, healthcare, and pastoral care.

Documentary Research Method

The study relies exclusively on secondary sources: peer-reviewed journal articles, books, theological publications, government and health-policy documents, and reports of recognised health organisations published in English. Bowen (2009) explains that documentary analysis enables researchers to examine and interpret documents systematically to develop understanding of a phenomenon, and Salami, Kanmodi, and Amzat (2023) similarly demonstrate the suitability of secondary-source research for examining cancer, religious belief, and the role of chaplains in Nigeria.

Search Strategy and Source Selection

To make the documentary process transparent, sources were identified through structured searches of Google Scholar, PubMed, and African Journals Online (AJOL), using combinations of the terms "cancer," "church," "chaplain," "religion," "faith-based," "Nigeria," "prevention," "screening," and "pastoral care." The search covered publications from 2009 to 2026, with priority given to Nigerian and African sources published from 2018 onward, alongside foundational theological texts on the Social Gospel selected for their direct relevance to the study's theoretical framework irrespective of publication date. Documents were included where they addressed cancer epidemiology, religion and health-seeking behaviour, chaplaincy or pastoral care, or Nigerian cancer policy; they were excluded where they addressed cancer biology or clinical management with no social, religious, or policy dimension, or where they were not available in English. After removing duplicate and near-duplicate reports and applying these criteria, twenty-six sources were retained and are listed in the References.

Literature Review

The rising cancer burden in Nigeria has become an important public-health and theological concern because cancer affects not only physical health but also families, livelihoods, and spiritual life. The WHO (2026) identifies cancer as a major cause of global mortality and emphasises that a substantial proportion of cancers can be prevented through modification of risk factors and vaccination, while early diagnosis significantly improves survival outcomes. The Nigerian National Cancer Screening Guidelines similarly place prevention and early detection within a continuum of cancer control that recognises the importance of timely referral (Federal Ministry of Health and Social Welfare, 2024).

A foundational contribution to the theological and pastoral dimension of this literature is Salami, Kanmodi, and Amzat's (2023) narrative review of the roles of chaplains in dispelling cancer myths in Nigeria. They argue that religious leaders possess considerable influence over health behaviour as trusted community figures, and that cancer misconceptions are frequently reinforced by beliefs that cancer is a divine punishment or spiritual affliction. Complementing this, Eli, Kalio, Aaron, Okagua, Briggs, and Wichendu (2020), in a study of 176 antenatal-clinic attendees at the Rivers State University Teaching Hospital, found that although awareness of breast cancer was high, religious institutions contributed to only a small proportion of that awareness, and preventive practices such as self-examination and mammography remained uncommon. This suggests that Nigerian churches currently under-utilise their potential as health-education platforms.

Empirical evidence from church-based interventions supports the feasibility of a more active role. Mbachu, Dim, and Ezeoke (2017) found that peer health education delivered through women's meetings in Anglican churches in Enugu State significantly improved participants' risk perception and screening uptake for cervical cancer, illustrating that church platforms can be mobilised effectively for cancer-prevention messaging. However, Abugu and Nwagu (2021), studying a Catholic parish in Nsukka, found generally poor knowledge of cervical cancer among churchgoing women despite relatively high awareness, with the great majority never having been screened — evidence that awareness generated within congregations does not automatically translate into preventive action without sustained education and referral support. A comparative Lagos study similarly found only marginal differences in screening knowledge and uptake between faith-based and non-faith-based women, underscoring the need for structured, rather than incidental, health promotion within congregations (Odeyemi & Ajogwu, 2014).

The persistence of spiritual causal beliefs as a barrier to timely care is well documented. Asuzu, Akin-Odanye, Asuzu, and Holland (2019) found that many Nigerian cancer patients consulted traditional or faith healers before presenting for biomedical treatment, often delaying diagnosis until curative treatment was no longer possible. Recent research among Islamic scholars in Ile-Ife similarly found substantial gaps in cancer knowledge and documented persistent myths concerning cancer among religious leaders, leading the researchers to recommend targeted educational interventions (Ahmed, 2024; Lawal et al., 2025). Although this evidence concerns Muslim rather than Christian clergy, it has wider implications: religious authority without adequate health knowledge can unintentionally reinforce misinformation, reinforcing Salami et al.'s (2023) argument that chaplains and religious leaders are well placed to correct such misconceptions, provided they receive adequate training.

International evidence indicates that church-based cancer interventions can be effective when properly structured. A recent scoping review of cancer interventions delivered through faith-based organisations found that the majority of the studies reviewed reported significant

improvements in cancer-related outcomes, particularly screening uptake, with breast, prostate, and colorectal cancer the most common targets (Yeary et al., 2025). Although this evidence originates largely outside Nigeria, it demonstrates that church platforms can produce measurable public-health results when interventions are deliberately designed rather than left to informal preaching.

The Nigerian policy environment also supports the involvement of religious organisations. The National Cancer Control Strategy identifies religious bodies as important partners in cancer advocacy and social mobilisation (Federal Ministry of Health/National Cancer Control Programme, 2023), and Nigeria's cervical-cancer prevention strategy similarly recognises faith-based organisations as part of the wider cancer-control ecosystem (National Institute for Cancer Research and Treatment, 2023). The WHO (2024) reported that cervical-cancer prevention interventions in five Nigerian states enabled more than 21,000 women to receive screening, with women testing positive for HPV treated to prevent progression to cervical cancer.

Taken together, the literature indicates that Nigerian churches possess considerable latent capacity to contribute to cancer prevention and early detection, but that this capacity is presently under-utilised, and that even where health messaging occurs it is not always effective without structured design and referral pathways. Comparatively less attention has been given to the Church as a proactive institution integrating prevention, screening advocacy, referral, and psychosocial support within an explicit theological framework — a gap this study addresses by building on existing scholarship, particularly Salami et al. (2023), while extending the discussion into a Nigerian Christian theological register.

Findings

The seven themes below were developed through a thematic analysis of the documents reviewed — familiarisation with the material, coding of recurring ideas, and generation of themes (Braun & Clarke, 2006) — organised around the study's three objectives of prevention, early detection, and supportive care.

1. Cancer awareness remains inadequate, making health education an important area of Church intervention.

Inadequate knowledge of cancer, its risk factors, and available screening options contributes to delayed presentation and poor outcomes in Nigeria. Salami, Kanmodi, and Amzat (2023) observe that cancer myths and misconceptions remain significant obstacles to prevention and treatment, and Eli et al. (2020) similarly found that religious institutions contributed only marginally to breast-cancer awareness among the women they studied, despite the Church's established communication structures through sermons, Bible studies, and fellowship groups. The implication is that preaching and Christian education should incorporate responsible health education rather than treating cancer exclusively as a spiritual problem.

2. Religious and cultural misconceptions can delay cancer detection.

Some Nigerians interpret cancer through spiritual categories such as divine punishment, witchcraft, or spiritual attack. Salami et al. (2023) and Asuzu et al. (2019) both show that such misconceptions discourage individuals from utilising appropriate screening and orthodox medical treatment, with the latter finding that many patients consult traditional or faith healers before biomedical treatment, often until curative options are foreclosed. The theological significance is that Christian faith should provide meaning, hope, and spiritual support without becoming a substitute for medical diagnosis and treatment.

3. The Church has considerable, but currently under-realised, potential to promote early detection.

Early detection is one of the most important opportunities for reducing cancer mortality, yet awareness alone does not guarantee screening uptake: Abugu and Nwagu (2021) found that most of the churchgoing women in their study had never been screened for cervical cancer despite relatively high awareness. By contrast, Mbachu, Dim, and Ezeoke (2017) found that structured, sustained peer health education within Anglican women's meetings measurably increased screening uptake. Together, these findings suggest that the Church can function as a bridge between communities and health services, but only where health messaging is deliberately structured rather than incidental.

4. The Church's response should be preventive rather than merely curative.

Effective cancer control must address modifiable risk factors alongside treatment. Islami et al. (2018) identify tobacco use, harmful alcohol consumption, and lifestyle-related factors among the leading preventable contributors to cancer globally, while Salami et al. (2023) identify similar risks as relevant in Nigeria. This challenges churches that become involved only after a member has developed cancer; theologically, prevention can be understood as an expression of stewardship of life, and congregations can promote healthy lifestyles, discourage tobacco and harmful alcohol use, and support HPV vaccination and appropriate screening.

5. Pastoral care remains essential after cancer diagnosis.

Cancer produces psychological, social, and spiritual distress alongside physical suffering. Salami et al. (2023) identify counselling, advocacy, and psychosocial support as important functions of chaplains, and the broader literature on spiritually integrated care similarly emphasises the value of addressing patients' sacred concerns alongside medical treatment (Pargament, 2011). This finding reinforces a holistic Christian theology of care in which pastoral ministry accompanies patients through diagnosis, treatment, survivorship, and, where necessary, end-of-life care, without spiritualising cancer or reducing the patient to a medical diagnosis.

6. Effective Church intervention requires collaboration with health professionals.

Religious leaders possess influence but may lack specialised medical knowledge. Salami et al. (2023) recommend better training and integration of chaplaincy within healthcare systems, and international evidence indicates that faith-based cancer interventions are most effective when explicitly structured and coordinated with health providers rather than left informal (Yeary et al., 2025). The Church's comparative advantage lies in trust, communication, mobilisation, and pastoral counselling; collaboration with medical professionals can ensure that theological convictions translate into medically responsible practice.

7. Cancer prevention and detection constitute an expression of Christian social responsibility.

Nigeria's cancer-control efforts increasingly emphasise prevention, screening, HPV vaccination, and treatment, and the National Cancer Control Strategy identifies religious bodies as partners in this agenda (Federal Ministry of Health/National Cancer Control Programme, 2023). The Church's theological responsibility therefore extends beyond individual prayer to public advocacy and community health promotion, grounded in Christian teachings on love of neighbour, care for the vulnerable, and stewardship of life.

Limitations of the Study

This study is limited in several respects. It relies exclusively on secondary, published sources rather than primary data collected from Nigerian congregations, clergy, or cancer patients, so its findings should be read as an interpretive synthesis rather than direct empirical evidence of

what Nigerian churches currently do. The literature reviewed remains dominated by a small number of studies explicitly linking religion, chaplaincy, and cancer in Nigeria — particularly Salami, Kanmodi, and Amzat (2023) — and although this revision incorporates additional empirical studies on faith-based cervical- and breast-cancer screening, dedicated research on Christian-specific, as opposed to interfaith or Islamic, responses to cancer in Nigeria remains scarce. Finally, because the study is confined to English-language, publicly accessible documents, it may not capture unpublished denominational reports, sermons, or informal church health programmes that could offer further insight.

Conclusion

The rising cancer burden in Nigeria is simultaneously a medical, social, and theological challenge. This study has argued, through the lens of the Social Gospel Theory, that the Nigerian Church currently possesses more capacity than it exercises: its congregational networks, moral authority, and pastoral structures are well suited to cancer prevention, early detection, and supportive care, yet the evidence reviewed suggests that this potential remains only partially realised, constrained by inadequate health knowledge among religious leaders, persistent spiritual explanations for illness, and weak formal linkage to the health system. Repositioning the Church from a source of consolation after diagnosis to a proactive partner in cancer control does not require it to relinquish its spiritual identity; rather, as the Social Gospel tradition suggests, it asks the Church to treat bodily wellbeing as inseparable from its ministry to the whole person. The theological and practical case made here is that such repositioning is both doctrinally defensible and practically achievable within existing church structures, provided it is pursued deliberately rather than left to individual initiative.

Recommendations

1. The leadership of Christian denominations in Nigeria — including the Christian Association of Nigeria, denominational headquarters, and individual congregations — should incorporate accurate, evidence-based cancer education into sermons, Sunday-school curricula, and fellowship programmes, actively correcting misconceptions that associate cancer with witchcraft, curses, or divine punishment.

2. Theological colleges and seminaries should include basic cancer awareness and health-communication training in ministerial formation, equipping clergy to discuss cancer responsibly without unintentionally reinforcing myths.

3. Local churches should establish structured screening-and-referral partnerships with nearby hospitals, primary health centres, and cancer-screening outreach programmes, actively directing members toward timely diagnosis rather than relying on prayer alone.

4. Churches should integrate HPV-vaccination advocacy and messaging on other modifiable risk factors — tobacco, alcohol, diet, and physical activity — into existing health and family ministries.

5. Denominational and parachurch bodies should establish or strengthen pastoral-care and psychosocial-support structures, including trained lay counsellors, visitation teams, and bereavement ministries, for cancer patients and their families.

6. Umbrella Christian bodies should formally engage the Federal Ministry of Health and the National Cancer Control Programme as partners in implementing the National Cancer Control Strategy 2023–2027, particularly in community mobilisation and advocacy for accessible, affordable screening and treatment.

7. Future Nigerian research should evaluate the actual effectiveness of church-based cancer-education interventions, rather than relying primarily on general literature about religious influence, to build the local evidence base this study identifies as lacking.

References

Abugu, L. I., & Nwagu, E. N. (2021). Awareness, knowledge and screening for cervical cancer among women of a faith-based organization in Nigeria. Pan African Medical Journal, 39, 200. https://doi.org/10.11604/pamj.2021.39.200.23761

Ahmed, A. T. (2024). Knowledge, attitude, and practices of Islamic scholars on cancer care and preventive measures in Ile-Ife, Nigeria: Islamic scholars cancer awareness study. The Indonesian Journal of Cancer Control, 4(1), 6–14.

Asuzu, C. C., Akin-Odanye, E. O., Asuzu, M. C., & Holland, J. (2019). A socio-cultural study of the traditional healers' role in African health care. Infectious Agents and Cancer, 14, 1–5. https://doi.org/10.1186/s13027-019-0232-y

Bowen, G. A. (2009). Document analysis as a qualitative research method. Qualitative Research Journal, 9(2), 27–40.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3(2), 77–101.

Bray, F., Laversanne, M., Sung, H., Ferlay, J., Siegel, R. L., Soerjomataram, I., & Jemal, A. (2024). Global cancer statistics 2022: GLOBOCAN estimates of incidence and mortality worldwide for 36 cancers in 185 countries. CA: A Cancer Journal for Clinicians, 74(3), 229–263.

Creswell, J. W., & Poth, C. N. (2018). Qualitative inquiry and research design: Choosing among five approaches (4th ed.). SAGE Publications.

Dorrien, G. (2015). The new abolition: W. E. B. Du Bois and the Black social gospel. Yale University Press.

Eli, S., Kalio, D. G. B., Aaron, F., Okagua, K., Briggs, N. C. T., & Wichendu, P. (2020). The role of pastors in the prevention of breast cancer: Analysis of 176 ante-natal clinic attendees at the Rivers State University Teaching Hospital. Journal of Advances in Medicine and Medical Research, 32(16), 49–50.

Federal Ministry of Health/National Cancer Control Programme. (2023). National cancer control strategy 2023–2027. Federal Ministry of Health.

Federal Ministry of Health and Social Welfare. (2024). National cancer screening guidelines. Federal Ministry of Health and Social Welfare.

International Agency for Research on Cancer. (2024). Global cancer observatory: Cancer today – Nigeria fact sheet (GLOBOCAN 2022). World Health Organization.

Islami, F., Goding Sauer, A., Miller, K. D., Siegel, R. L., Fedewa, S. A., Jacobs, E. J., McCullough, M. L., Patel, A. V., Ma, J., Flanders, W. D., Brawley, O. W., Gapstur, S. M., & Jemal, A. (2018). Proportion and number of cancer cases and deaths attributable to potentially modifiable risk factors in the United States. CA: A Cancer Journal for Clinicians, 68(1), 31–54.

Koenig, H. G. (2012). Religion, spirituality, and health: The research and clinical implications. ISRN Psychiatry, 2012, Article 278730.

Lawal, K. Y., Olowookere, S. A., Makinde, A. K., Ahmed, A. A., Sonibare, O. O., Idowu, A., Folami, E., Afolabi, B. A., Azeez, I. A., & Olaniyan, F. (2025). Knowledge, attitude and practices of Islamic scholars and clerics on cancer care and preventive measures in Ile-Ife, Nigeria: Implications for policy action. Nigerian Journal of Family Practice.

Mbachu, C., Dim, C., & Ezeoke, U. (2017). Effects of peer health education on perception and practice of screening for cervical cancer among urban residential women in south-east Nigeria: A before and after study. BMC Women's Health, 17, 1–8.

National Institute for Cancer Research and Treatment. (2023). National strategic plan for prevention and control of cancer of the uterine cervix, 2023–2027.

Odeyemi, N., & Ajogwu, A. (2014). Comparative assessment of knowledge, attitude and practice of cervical cancer screening among faith-based and non-faith-based women in Surulere LGA, Lagos. Nigerian Medical Practitioner, 65(5–6), 63–68.

Olumodeji, A. M., et al. (2024). Attitude to cervical cancer screening and human papillomavirus testing experience in self-sampled Nigerian women. African Health Sciences, 24(1), 127–134.

Pargament, K. I. (2011). Spiritually integrated psychotherapy: Understanding and addressing the sacred. Guilford Press.

Peteet, J. R., & Balboni, M. J. (Eds.). (2013). Spirituality and religion within the culture of medicine: From evidence to practice. Oxford University Press.

Rauschenbusch, W. (1917). A theology for the social gospel. Macmillan.

Salami, A. A., Kanmodi, K. K., & Amzat, J. (2023). The roles of chaplains in dispelling cancer myths in Nigeria: A narrative review. Health Science Reports, 6(8), e1502.

World Health Organization. (2024). Enhancing cervical cancer prevention in Nigeria. WHO Regional Office for Africa.

World Health Organization. (2026). Cancer. WHO.

Yeary, K. H. K., Allen, J. D., Arredondo, E., Atemnkeng, J., Buzcu-Guven, B., Day, K. R., Dicarlo, E., Formagini, T., Kwon, S. C., McElfish, P., McNeill, L. H., Newton, R. L., Park, C. L., Wilcox, S., Williams, L. B., Yusuf, Y., & Zoellner, J. (2025). Cancer interventions with faith-based organizations: A scoping review. Supportive Care in Cancer.