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EVALUATING NURSE-LED SPIRITUAL CARE AND COPING STRATEGIES AMONG CANCER PATIENTS AT ASI-UKPO CANCER CENTER: ACROSS SECTIONAL STUDY

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ABSTRACT

Background: In Sub-Saharan Africa, spirituality is deeply embedded in the lived experience of illness and nurse-led spiritual care holds particular relevance. Despite growing international evidence, site-specific data from Nigerian oncology centres on the impact of spirituality on patient coping remain scarce.
Objective: To assess the prevalence of nurse-led spiritual care and faith-based coping strategies of cancer patients at the Asi-Ukpo Cancer Centre, Nigeria.

Methods: A descriptive cross-sectional study of 73 cancer patients recruited by consecutive sampling. Data were collected using a structured self-administered questionnaire and analysed using Microsoft Excel 2021 and IBM SPSS Statistics version 27. Descriptive statistics and univariable logistic regression were performed. Statistical significance was set at $p < 0.05$.

Results: Mean age was 48.5 ± 13.5 years. Most respondents were female (65.3%), Christian (93.8%), and undergoing active treatment (84.1%), with breast cancer predominating (52.5%). Nurse-led spiritual care was reported by 84.9%, most commonly through prayer (56.9%), encouragement of hope and meaning (52.3%), and listening to spiritual concerns (40.0%). Prayer or meditation was the most received (76.9%) and most preferred (75.8%) coping strategy. A total of 91.1% agreed that spiritual care helped them cope better, and 92.4% reported improved psychological well-being. Ninety percent recommended formal integration into nursing practice. Disease stage significantly predicted preference for prayer-based support, with advanced stage patients more likely to prefer prayer (OR = 4.67; 95% CI: 1.34–16.24; p = 0.015). Age showed a borderline association (OR = 2.60; 95% CI: 0.93–7.29; p = 0.069). Gender and religion were not significant predictors.

Conclusion: Nurse-led spiritual care is highly prevalent and strongly valued at the Asi Ukpo Cancer Centre. Advanced stage patients were significantly more likely to prefer prayer-based support, suggesting spiritual needs intensify with disease progression.

Keywords: Spiritual care, cancer, coping strategies, oncology nursing, Nigeria.

INTRODUCTION

Beyond its biological dimensions, a cancer diagnosis fundamentally disrupts a patient's sense of identity, purpose, and meaning (domains that are intrinsically spiritual in nature). The clinical management of cancer has historically focused on physical interventions, including chemotherapy, surgical resection, and radiotherapy. Modern oncology frameworks increasingly emphasise holistic care models, which integrate physical treatments with interventions designed to support the psychological and spiritual dimensions of the patient.[1] Spiritual well-being has been increasingly recognised as a core component of holistic cancer care, with evidence demonstrating its association with improved quality of life and better outcomes.[2,3] Patients living with advanced cancer frequently turn to religious and spiritual resources to make sense of their illness, sustain hope, and negotiate the difficult questions that arise as their condition progresses.[4] In a multicentre study of 230 patients with advanced cancer in the United States, Balboni et al. (2007) found that 88% of patients identified religion as at least somewhat important to their lives, and that patients who received spiritual support were more likely to report better quality of life and less likely to receive aggressive medical interventions at the end of life.[5] This is similar to a study of 179 Australian oncology patients by Whitford & Olver (2012), which demonstrated that spiritual well-being, particularly the dimensions of peace and meaning, was significantly associated with positive coping and reduced psychological distress.[3]

A qualitative study of 68 patients with advanced cancer in the United States, by Alcorn et al. (2010) found that patients drew extensively on religious and spiritual themes to interpret their illness, with many describing their survival as a sign of divine purpose.[4] Statements such as 'if God wanted me yesterday, I would not be here today' in this study reflected how patients actively used faith to construct meaning in the face of a life-threatening diagnosis. In their study of 135 advanced cancer patients, Winkelman et al. (2011) also reported that spiritual concerns, including loss of faith, feeling abandoned by God, and unresolved existential questions, were significantly associated with poorer quality of life scores, further affirming that spiritual distress carries real clinical consequences that cannot be addressed by medical management alone.[6]

Nurses occupy a uniquely privileged position in the delivery of cancer care, maintaining the most sustained and intimate contact with patients throughout their treatment journey. Spiritual care in nursing encompasses a broad repertoire of practices that aim to address patients' deepest needs for meaning, peace and connection. These include offering prayer, encouraging hope, listening attentively to existential concerns, sharing words of affirmation, and facilitating referrals to chaplains or faith leaders where appropriate.[1,7] In a quasi-experimental study among 84 oncology nurses in China, Hu et al. (2019) found that nurses who received a structured spiritual care training programme demonstrated significant improvements in spiritual health and spiritual care competency scores compared to the control group.[8] The intervention also led to measurable

improvements in the spiritual health of the patients under their care. From the patient perspective, spiritual care needs in the cancer setting are both significant and varied. A cross-sectional study of 213 patients with advanced cancer in China found that the majority of patients reported unmet spiritual needs, with the greatest deficits observed in areas related to the search for meaning, hope, and transcendence.[9] The study further found that patients with higher levels of education, those with more advanced disease, and those undergoing active treatment reported greater spiritual care needs. Wang et al. (2024), using the Kano model[11] to study 186 Chinese in-patients with advanced breast cancer, identified prayer-based support, emotional encouragement, and engagement with existential concerns as high-priority spiritual care needs that patients regarded as non-negotiable expectations rather than optional extras.

Nigeria carries a disproportionate cancer burden, with over 100,000 new cases and approximately 70,000 cancer-related deaths recorded annually. In a descriptive study assessing spiritual care practices among nurses caring for cancer patients at a tertiary hospital in Nigeria, Bolarinwa et al. (2023) found that while the majority of nurses acknowledged the importance of spiritual care, fewer than half consistently incorporated it into their clinical practice.[12] The most common barriers cited were inadequate training, lack of time, and the absence of institutional policies on spiritual care provision.

Asi-Ukpo Cancer Centre, a privately owned specialist oncology centre, serves as a hub for cancer diagnosis and treatment, managing patients across all disease stages from newly diagnosed individuals to those receiving palliative support. Within this setting, the majority of patients are deeply religious and predominantly Christian, with faith serving as a primary coping resource in the face of life-threatening illness. The nursing workforce at this centre, therefore, interfaces daily with patients whose spiritual needs are both immediate and profound. A rigorous assessment of whether these practices translate into improved coping outcomes is therefore both timely and necessary. The present study addresses this evidence gap directly, and its findings are intended to inform nursing education, clinical guidelines, and the design of spiritually sensitive cancer care models as well as to provide contextualised evidence for the integration of spiritual care into oncology nursing practice in Nigeria.

General Objective

The objective of this study was to evaluate nurse-led spiritual care and the coping strategies of cancer patients receiving care at the Asi-Ukpo Cancer Centre.

Specific Objectives

Specifically, the study sought to:

1. Determine the prevalence and forms of nurse-led spiritual care practices received by cancer patients at the Asi-Ukpo Cancer Centre
2. Assess and identify the most preferred spiritually inclined coping strategies by cancer patients
3. Evaluate the perceived impact of nurse-led spiritual care on a patient's ability to cope with their illness and on their emotional and psychological wellbeing, and examine patients' attitudes towards the formal

integration of spiritual care into routine oncology nursing practice at the Asi-Ukpo Cancer Centre.

MATERIALS AND METHODS

Study Design

This was a descriptive cross-sectional study to describe the prevalence of practices and the associations between care received and patient-reported outcomes.[9,12]

Study Setting

The study was conducted at the Asi-Ukpo Cancer Centre, a private oncology facility in Calabar, South-South zone of Nigeria.

Study Population

The study population comprised adult cancer patients receiving care between June 2025 and March 2026. Patients were eligible if they were aged 18 years and above, had a confirmed cancer diagnosis, were undergoing active treatment, in remission, or attending follow-up visits at the oncology clinic, and were able to read and respond to a self-administered questionnaire in English. Patients who were too ill to participate and those who declined consent were excluded from the study.

Sampling Technique and Sample Size

A consecutive sampling technique was employed; all eligible patients who attended the oncology clinic during the data collection period and met the inclusion criteria were invited to participate until the desired sample was reached. The final sample size of 73 respondents was calculated using a prevalence estimate of 86% for nurse-led spiritual care based on available literature from comparable African settings.[12]

Data Collection Instrument and Procedure

Data were collected using a structured, self-administered questionnaire developed by the research team, informed by existing instruments used in comparable studies on spiritual care in oncology settings.[7,9,12] The instrument was designed to capture key domains relevant to the study objectives and was organised into five sections. The sections captured sociodemographic information, clinical patient data, assessed patients' experiences of nurse-led spiritual care, coping strategies, patients' perceptions of the impact of spiritual care on their coping ability and psychological wellbeing and their attitudes towards the formal integration of spiritual care into oncology nursing practice.

Content validity was ensured through expert review by oncology nursing and palliative care specialists.

Ethical Considerations

Ethical approval for the study was obtained from the relevant institutional authority at the Asi-Ukpo Cancer Centre prior to the commencement of data collection, with approval number. Written informed consent was obtained from all participants before questionnaire administration. Participation was voluntary, and the right to withdraw from the study at any point without consequence to their care was explained to participants. Provision for psychological support was made readily available when needed by participants during the study. All questionnaires were anonymised at the point of collection, and no identifying information was recorded on any study document. Data was stored securely and accessed only by members of the research

team. The study was conducted in accordance with the ethical principles governing research involving human participants as outlined in the Declaration of Helsinki.

Data Analysis

Data were analysed using Microsoft Excel 2021. Descriptive statistics were used to summarise all study variables. The mean and standard deviation were calculated for continuous variables. Results are presented in tables and as narrative summaries. Univariable logistic regression was used to identify sociodemographic and clinical predictors, setting significance at $p < 0.05$.

RESULTS

A total of 73 cancer patients were recruited during the data collection. Results are presented in line with the study objectives, featuring the sociodemographic and clinical characteristics of respondents, the prevalence and forms of nurse-led spiritual care received, the frequency of spiritual support, patients' preferred coping strategies, the perceived impact of spiritual care on coping and psychological wellbeing, and patients' attitudes towards the formal integration of spiritual care into routine oncology nursing practice.

Table 1: Sociodemographic Characteristics of Respondents

Variable	Category	Frequency (n)	Percentage (%)
Age Range	20 - 30 years	7	**10.3**
	30 - 40 years	16	**23.5**
	40 - 50 years	18	**26.5**
	50 - 60 years	12	**17.6**
	60 - 70 years	11	**16.2**
	70 - 80 years	4	**5.9**
	Total	68*	**100.0**
Gender	Female	47	**65.3**
	Male	25	**34.7**
	Total	72*	**100.0**
Religion	Christian	61	**93.8**
	Muslim	3	**4.6**
	Traditional	1	**1.5**
	Total	65*	**100.0**

*Totals reflect the number of valid responses per variable, as some participants did not respond to all items

Table 2: Clinical Characteristics of Respondents

Variable	Category	Frequency (n)	Percentage (%)
Type of Cancer	Breast	32	**52.5**
	Head and Neck	13	**21.3**
	Gynaecological	6	**9.8**
	Prostate	4	**6.6**
	Gastrointestinal	2	**3.3**
	Colorectal	1	**1.6**
	Others	3	**4.9**
	Total	61*	**100.0**
Stage of Cancer	Stage 1	7	**14.9**
	Stage 2	23	**48.9**
	Stage 3	11	**23.4**
	Stage 4	6	**12.8**
	Total	47*	**100.0**
Stage of Care	Active Treatment	58	**84.1**
	Remission	4	**5.8**
	Palliative Care	3	**4.3**
	Newly Diagnosed	3	**4.3**
	Follow up	1	**1.4**
	Total	69*	**100.0**

*Totals reflect valid responses per variable

Table 3: Prevalence and Forms of Nurse-led Spiritual Care Received

Statement	Response	Frequency (n)	Percentage (%)
Have nurses provided you with any form of spiritual care?	Yes	62	84.9
	No	7	9.6
	Not Sure	4	5.5
	Total	73	100.0
Form of Spiritual Support Received (multiple responses permitted)	Offering prayer	39	58.4
	Providing Spiritual hope and meaning	34	52.3
	Listening to spiritual concerns	26	40.0
	Singing and dancing to spiritual songs	21	32.3

	Referral to a chaplain or faith leader	7	10.8
	Not applicable	1	1.5

Percentages for forms of spiritual support are based on 65 respondents who answered this item; multiple responses were permitted.

Table 4: Frequency of Spiritual Support Currently Received and Desired

Variable	Frequency	Percentage (%)
Frequently	46	68.7
Occasionally	16	23.9
Rarely	2	3.0
Never	3	4.5
Total	67*	100

*Totals reflect valid responses per item.

Table 5: Coping Strategies Preferred by Patients

Coping Strategy	Patients' Preferences (Frequency)	Percentage (%)
Prayer or meditation	50	75.8
Talking with others	30	45.5
Sharing words of affirmation	34	51.5
Reading spiritual texts	23	34.8
Positive reframing	19	28.8
Other	1	1.5

Multiple responses were permitted. Percentages for received strategies are based on n = 65; percentages for preferred strategies are based on n = 66.

Table 6a: Perceived Impact of Spiritual Care on Coping and Psychological Well-Being

Statement	Response	Frequency (n)	Percentage (%)
Spiritual care helped me cope better with my illness	Strongly Agree	41	61.2
	Agree	20	29.9
	Neutral	3	4.5
	Disagree	1	1.5
	Strongly Disagree	2	3.0
	Total	67*	100.0
Spiritual care improved my emotional and psychological well-being	Yes	61	92.4
	No	2	3.0
	Not Sure	3	4.5
	Total	66*	100.0

*Totals reflect valid responses per variable

Table 6b: Classification of Respondents by Perceived Impact of Nurse-Led Spiritual Care on Coping

Perceived Impact Level	**Frequency (n)**	**Percentage (%)**
Positive Impact, Agree or Strongly Agree (score ≥3.5)	61	91.1
Negative Impact, Neutral, Disagree, or Strongly Disagree (score <3.5)	6	8.9
Total	67	100.0

Mean score = 4.45. Scoring: Strongly Agree = 5, Agree = 4, Neutral = 3, Disagree = 2, Strongly Disagree = 1. Respondents scoring ≥3.5 were classified as perceiving positive impact; those scoring <3.5 were classified as perceiving negative impact

Table 7: Preferred Type of Spiritual Support and Attitudes towards Integration of Spiritual Care into Nursing Practice

Statement	**Response**	**Frequency (n)**	**Percentage (%)**
Type of spiritual support most helpful in care journey (multiple responses permitted)	Prayer-based support	45	75.0
	Encouragement or words of affirmation	9	15.0
	Meditation	5	8.3
	Talking or counselling	4	6.7
	Reading spiritual texts	3	5.0
	Singing or worship	3	5.0
	Referral to a faith leader or ordained clergy	2	3.3
	Other	2	3.3
Would you recommend spiritual care as part of nursing care for cancer patients?	Yes	63	90.0
	Maybe	6	8.6
	No	1	1.4
	Total	70*	100.0

*Total for recommendation item reflects valid responses. Percentages for preferred spiritual support type are based on n = 60; multiple responses were permitted

Table 8: Univariable Logistic Regression of Sociodemographic and Clinical Predictors of Perceived Coping Benefit and Preferred Spiritual Care (N = 72)

Predictor	Outcome	OR	95% CI	P-value
Age (40–50 years vs others)	Perceived coping benefit of spiritual care	1.25	0.49 – 3.17	.638
Gender (Female vs Male)	Perceived coping benefit of spiritual care	1.42	0.79 – 2.56	.241
Religion (Christian vs others)	Perceived coping benefit of spiritual care	1.22	0.73 – 2.03	.439
Religion (Christian vs others)	Prayer as preferred care	1.40	0.84 – 2.34	.199
Gender (Female vs Male)	Prayer as preferred care	1.56	0.86 – 2.81	.144
Age (40–50 yrs vs others)	Prayer as preferred care	2.60	0.93 – 7.29	.069†
Disease stage (Advanced vs Early)	Prayer as preferred care	4.67	1.34 – 16.24	.015*

OR = Odds Ratio. CI = Confidence Interval. *Statistically significant at $p < 0.05$. †Borderline significance ($p < 0.10$). Each predictor was entered separately in a univariable model.

DISCUSSION

The majority of participants were female (65.3%), which is consistent with findings from Bolarinwa et al. (2023), who reported a female predominance in a Nigerian oncology sample, and with the broader epidemiological pattern in which breast and gynaecological cancers, which disproportionately affect women, account for a significant share of cancer diagnoses on the continent.

The largest proportion of respondents are between 40 and 50 years, approximately 50% were aged between 30 and 50 years and majority of respondents identified as Christian (93.8%), a finding that mirrors the religious composition of the Cross River State region where the Asi-Ukpo Cancer Centre is located, and which has direct implications for the types of spiritual care likely to be acceptable and meaningful to patients in this setting.

The most commonly documented clinical stages were stages 2 (48.9%) and 3 (23.4%).

About 84% of respondents were actively undergoing treatment at the time of the study, which shows that the majority of participants were at a stage in their cancer journey where spiritual support is particularly needed, similar to findings by Balboni et al. (2007) where 230 advanced cancer patients undergoing active treatment reported receiving spiritual support and were more likely to have a better quality of life and to make care decisions consistent with their values.[5]

Over three-quarters (84.9%) of respondents reported having received some form of spiritual care from nurses during the course of

their treatment. This is considerably higher than that reported by Bolarinwa et al. (2023), who found that fewer than half of nurses at a Nigerian tertiary hospital consistently incorporated spiritual care into their practice, suggesting a gap between nursing behaviour as self-reported by nurses and spiritual care as perceived and experienced by patients.[12] The discrepancy may reflect differences in how spiritual care is defined and recognised, where the patients may perceive informal acts of prayer, encouragement, and compassionate conversation as spiritual care even when nurses do not consciously label them as such. This interpretation is supported by Moosavi et al. (2019), who found in their qualitative study in Iran that patients identified spiritual care not only through formal religious rituals but also through the quality of the nurse-patient relationship itself.[13] In another study by Moosavi et al. (2019), nurses who held strong personal religious beliefs were more likely to initiate spiritual interactions with patients, suggesting that the high prevalence of spiritual care at this centre may be driven partly by the nurses' own faith orientation rather than by formal training or institutional policy.[14]

The most frequently reported form of spiritual care was offering prayer or religious support (56.9%), encouraging hope and meaning (52.3%) and listening to spiritual concerns (40.0%). This pattern is broadly consistent with the findings of Epstein-Peterson et al. (2015), who identified prayer, encouragement, and attentive listening as the most commonly provided forms of spiritual care in advanced cancer settings in the United States.[7] Referral to a chaplain or faith-based leader was reported by only 10.8% of respondents, which suggests that interdisciplinary spiritual care pathways remain underdeveloped at the centre. Puchalski et al. (2019), in their review of interprofessional spiritual care in oncology, emphasised that effective spiritual care requires the coordinated involvement of nurses, chaplains, social workers, and other members of the multidisciplinary team.[1] The relatively low rate of referral observed in this study points to a gap that oncology nurse education and institutional policy could meaningfully address.

The majority of respondents reported receiving spiritual support from nurses frequently (68.7%), while a slightly higher proportion (73.5%) expressed a preference for frequent support, with a much lesser proportion preferring occasional support (22.1%). The difference suggests that spiritual care at the Asi-Ukpo Cancer Centre largely meets the level desired by patients. The finding is consistent with evidence from Shi et al. (2023), who reported in their cross-sectional study that a substantial proportion of patients had unmet spiritual needs, even in settings where spiritual care was nominally provided.[9] This implies that the frequency of provision alone does not capture the full extent of patients' spiritual needs, and that the quality and intentionality of spiritual care interactions are equally important considerations.

The small proportion of respondents who prefer not to receive spiritual support (2.9%) confirms that spiritual care is broadly accepted by the patient population at this centre and is not perceived as intrusive or inappropriate. This is an important practical consideration for nurses who may hesitate to initiate spiritual conversations out of concern that patients will find them unwelcome. Völz et al. (2024), in

their vignette-based study of nurses' and physicians' responses to spiritual distress in neuro-oncology units, found that many clinicians avoided engaging with spiritual distress precisely because they feared overstepping professional boundaries or making patients uncomfortable.[15] The data from this study suggest that such hesitance, while understandable, is not well-founded in the preferences of cancer patients at the Asi-Ukpo Cancer Centre.

Prayer or meditation was the most preferred (75.8%) coping strategy among respondents, a finding that underscores the centrality of prayer as a resource in the spiritual and

psychological lives of cancer patients in this Nigerian oncology setting. This is consistent with findings by Balboni et al. (2007), where over 72% of advanced cancer patients in their United States sample reported that religion helped them cope with their illness, and a study by Alcorn et al. (2010), who documented in detail how patients with advanced cancer drew on prayer and divine agency as primary meaning-making tools.[4,5] The close alignment between what nurses are providing and what patients prefer in this domain is a strength of spiritual care practice at the Asi-Ukpo Cancer Centre and reflects an intuitive responsiveness by nurses to the spiritual culture of their patients.

Words of affirmation were preferred by a slightly higher proportion (51.5%), indicating that nurses could increase their use of this strategy to better match patient preferences. Talking with others was also identified as their preferred approach (45.5%), suggesting that patients value this somewhat less than the more explicitly spiritual modalities, and this finding resonates with the evidence from Wang et al. (2024).[10] Positive reframing was preferred by even fewer patients (28.8%). This gap may reflect cultural or individual differences in how patients relate to cognitive reframing approaches, within a faith context where prayer and divine trust are the primary frameworks through which illness is interpreted. These findings collectively suggest that there is room to personalise spiritual care more deliberately, a recommendation that is consistent with calls from Puchalski et al. (2019) for spiritual care to be individually tailored through formal spiritual history taking and ongoing reassessment.[1]

A combined 91.1% of respondents either agreed or strongly agreed that the spiritual care they received helped them cope better with their illness, and 92.4% reported that their emotional and psychological well-being had improved as a result of the spiritual support provided by nurses. These figures are notably high and reflect a consistent pattern in the international literature. Moosavi et al. (2019) found that cancer patients who received spiritual care from oncology nurses reported feeling more at peace, less isolated, and better equipped to face their illness.[13] Winkelman et al. (2011) similarly reported better quality of life scores compared to those with unmet spiritual needs.[6]

The magnitude of positive response observed in this study may partly reflect the religious homogeneity (93.8%). In such a context, spiritual care that is aligned with patients' own faith framework is likely to be experienced as deeply affirming with existing coping

resources. Whitford and Olver (2012) found in their study that the dimensions of spiritual wellbeing most strongly associated with positive coping were peace and meaning rather than formal religious observance, suggesting that what matters most is not the specific form of spiritual care but whether it resonates with the patient's own framework for understanding their experience.[3] At the Asi-Ukpo Cancer Centre, the convergence between nurses' practices and patients' faith orientation appears to create this kind of resonance.

The findings also carry implications for the broader discourse on holistic cancer care. A longitudinal study by Wen et al. (2022), found that adequate death preparedness, facilitated in part by spiritual and existential conversations, was significantly associated with better mental health and quality of life outcomes.[16] The high levels of perceived benefit reported in the current study suggest that nurse-led spiritual care at the Asi-Ukpo Cancer Centre is contributing meaningfully to patients' psychological resilience, even if this has not yet been measured using formal, validated instruments. Future research using standardised tools such as the Functional Assessment of Chronic Illness Therapy Spiritual Well Being scale would allow these perceived benefits to be quantified more rigorously.

The univariable logistic regression analysis revealed that disease stage was the only statistically significant predictor of preference for prayer-based spiritual care. Patients with advanced stage cancer (Stage 3 or 4) were 4.67 times more likely to identify prayer- based support as the most helpful form of spiritual care compared to patients with early-stage disease (OR = 4.67; 95% CI: 1.34 to 16.24; p = .015). This is a clinically meaningful finding that extends beyond the descriptive results of this study and provides evidence for tailoring spiritual care provision according to disease stage. This finding aligns with the theoretical framework proposed by Balboni et al. (2007), who demonstrated that spiritual needs intensify as cancer advances and patients confront the existential reality of a life-threatening illness. Alcorn et al. (2010) similarly found in their study of patients with advanced cancer that as the disease progressed, patients increasingly drew on divine agency and prayer as their primary means of constructing meaning and maintaining hope.[4] The present study extends this evidence by quantifying the relationship between disease stage and spiritual care preference in a Nigerian oncology population for the first time, providing statistically grounded evidence for what has previously been observed qualitatively.

Age range showed a borderline association with preference for prayer-based care (OR = 2.60; 95% CI: 0.93 to 7.29; p = .069), with patients aged 40 to 50 years showing a trend towards stronger preference for prayer-based support compared to other age groups. While this did not reach conventional levels of statistical significance, the effect size is substantial, and the finding may reflect limited statistical power due to the sample size of this study. A larger, multi-site study would be better placed to determine whether this age group effect is a genuine pattern in the Nigerian oncology population. Gender and religion were not significant predictors of spiritual care preference, suggesting that the primacy of prayer-based support as the

preferred form of care transcends both sex and religious affiliation within this predominantly Christian sample.

Majority of respondents (90.0%) recommended that spiritual care be formally integrated into routine oncology nursing practice at the Asi-Ukpo Cancer Centre. This level of endorsement exceeds that reported in comparable studies. Bolarinwa et al. (2023) found that the majority of cancer patients in a Nigerian tertiary hospital recognised the importance of spiritual care, though fewer were actively receiving it in a structured manner.[12] Similarly, Sewkarran and Gumede (2023) found in their qualitative study that patients valued spiritual care highly but described receiving it in an informal, ad hoc manner that was dependent on individual nurses' initiative rather than institutional expectation.[17]

In this study, 75.0% of respondents identified prayer or prayer-based support as the type of spiritual support most likely to help them in their care journey, followed by encouragement and words of affirmation (15.0%) and meditation (8.3%). In their quasi-experimental study, Hu et al. (2019)[8] demonstrated that structured training in spiritual care led to measurable improvements in both nurse competency and patient spiritual health outcomes while Sunga et al. (2023) similarly showed that an educational toolkit on spirituality and spiritual care increased nurses' confidence and consistency in addressing patients' spiritual needs.[18]

Overall, the study reveals a high prevalence of nurse-led spiritual care, strong patient engagement with spiritual coping strategies, a compelling association between the spiritual support provided by nurses and patients' perceived ability to cope with their illness, but limited referral linkage to spiritual leaders. These findings, taken together with the strong patient endorsement observed, make a compelling case for the development and implementation of a structured spiritual care competency framework within oncology nursing training programmes in Nigeria and inclusion in institutional/ National policy protocols for supportive care in oncology.

Study limitations

Some of the limitations of the study include the small sample size, the use of self-administered questionnaire with high rate of incomplete response, single centre study, almost homogenous religious practice and the absence of a validated spiritual wellbeing scale, yet the study provides valuable and timely contextual evidence to the growing literature on nurse led spiritual care in a Nigerian oncology setting, and its findings are consistent with and complementary to the broader international literature.

CONCLUSION

The perceived impact of nurse-led spiritual care on patient coping was overwhelmingly positive, and this affirms that the benefit is universal rather than group specific, and strengthens the case for its integration as a standard component of care for all cancer patients.

The high level of patient endorsement (Nine out of every ten respondents recommended that spiritual care be formally integrated into routine oncology nursing practice), grounded in the lived experience of care, constitutes a powerful mandate for action. Spiritual care

should move beyond informal, individually driven towards a structured, competency-based approach that ensures every cancer patient has access to the spiritual support they need and deserve.

Recommendations

1. Implementation of a formal spiritual care policy which recognises spiritual care as a core component of oncology care and establishes clear expectations for its assessment, documentation, and provision across all stages of the cancer care continuum.
2. Structured interdisciplinary referral pathways to chaplains, ordained clergy, and faith leaders should be strengthened and formalised, establishing clear referral protocols and ensuring that appropriate spiritual care resources are accessible to patients.
3. Longitudinal study designs, multicenter studies and validated spiritual wellbeing instruments to provide more rigorous measurement of the relationship between spiritual care and patient outcomes over time and strengthen the generalisability of the findings.

Declarations:

Conflicts of interest: We declare no conflict of interest.

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Data availability statement: Data for this study are readily available should there be any need for them to be presented.

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