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Follow-up of Breast Cancer Patients in Ghana: Challenges to Community-based Surveillance

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Objective

To identify challenges to community-based surveillance and follow up of breast cancer cases in Ghana

Introduction

Cancers are among the leading causes of deaths globally. In sub-Saharan Africa, cancer-related deaths have been projected to increase significantly in the next few decades. Information on cancer is essential in planning and implementing cancer control and prevention activities. Registration and follow-up of cancer cases to estimate survival are useful tools in cancer control programmes. In Ghana, despite the existence of a national cancer prevention and control strategy, not much attention has been given to the problem. Cancer survival has been found to be poor in most developing countries due to late reporting. While late reporting may be a significant factor in cancer survival, the ability of clinical and community health staff to follow-up on cases can help and provide accurate information on cancer survival.

Methods

We set out to follow-up 136 breast cancer cases diagnosed from 2006 to 2008 among residents in the city of Kumasi. We reviewed the case notes to determine their places of residence and other relevant demographic information. Cases were contacted via telephone calls or visits to the stated residential addresses. The status of the case on contact (dead or alive) was noted.

Results

A total of 51(37.5%) out of the 136 cases could be contacted either personally or by contact with relations where death had occurred. Forty one of those contacted were by phone (41) and the remaining (10) by residential address. All remaining 85(62.5%) cases could not be contacted by telephone. Twenty six of these contacts did not have a phone number indicated in their folders. Of the remaining 59 cases with phone numbers in the folders, attempts to call the numbers resulted in the following responses: 'wrong phone numbers' (n=16), 'phone number switched off' (n=13) or 'number not reachable' (n=30). Examination of clinical records for the residential addresses, of all 85 cases who could not be reached by phone revealed 3 cases with no residential addresses 21 with incomplete addresses, 33 with addresses that could not be located and 28 were unknown to current occupants of the residential address given. One (1) case had neither an address nor a telephone number indicated in the folder. Among those for whom contact was established, 23 representing 45.1% were alive at the time of contact.

Conclusions

This study has highlighted challenges associated with following up patients in low resourced settings such as Ghana. Such situations may present a public health risk in cases of communicable disease. There is the need to ensure that demographic data captured for patients are verified in order to allow for easy tracing when necessary. While mobile telephony may be useful in surveillance, multiple mobile phone numbers including those of relatives may facilitate easier follow-up of patients. There is a general need to ensure a more robust addressing system in Ghana to ensure that residences can be easily traced.

Keywords

cancer; follow-up; noncommunicable disease surveillance

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