



# **Assessing Health Equity in National Cancer Control: A Systematic Review of Cervical and Breast Cancer Services in Ghana**

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## **Abstract**

### Revised Abstract

Persistent inequities in cancer outcomes across Africa underscore the need to critically evaluate the implementation of National Cancer Control Plans (NCCPs). This systematic review conducts a health equity audit of Ghana's NCCP, focusing on cervical and breast cancer services. Its objective is to synthesise evidence on equity in service delivery, access, and outcomes to identify implementation gaps and inform policy. Adhering to PRISMA guidelines, a reproducible search strategy was executed across PubMed, Scopus, African Journals Online, and relevant grey literature sources for studies published between January 2010 and March 2024. Following a screening process against pre-defined eligibility criteria, data from included studies were extracted and synthesised thematically.

The findings reveal pronounced geographical and socioeconomic disparities. A consistent urban–rural divide is evident, with screening, diagnostic, and treatment facilities concentrated in southern urban centres, disadvantaging rural populations. Key access barriers include substantial geographical distance, catastrophic out-of-pocket expenditures, and entrenched sociocultural factors, which disproportionately affect rural and low-income women. Although the NCCP articulates equity goals, a significant implementation gap persists, particularly in community-based awareness programmes and the integration of services within primary care.

The study concludes that realising equitable cancer control in Ghana requires a deliberate reorientation of strategies towards pro-poor, geographically targeted interventions and strengthened health system governance. These findings emphasise to policymakers across the region the necessity of embedding robust, monitorable equity audits within NCCPs to ensure they translate into tangible benefits for all population subgroups.

**Keywords:** Health equity, Cancer control, Sub-Saharan Africa, Systematic review, Cervical cancer, Breast cancer, Healthcare disparities

## INTRODUCTION

Breast and cervical cancer represent a significant and growing public health burden in Ghana, with pronounced disparities in incidence, stage at diagnosis, and outcomes ([Nsafu et al., 2025](#); [Osei et al., 2025](#)). In response, Ghana has developed national cancer control plans (NCCPs) aimed at improving prevention, screening, treatment, and palliative care ([Adams et al., 2025](#)). However, the equitable implementation and impact of these plans across diverse population groups remain a critical concern ([Amankwah et al., 2026](#); [Vandyck-Sey & Burchett, 2025](#)). A health equity audit is a systematic process to assess how health policies and services affect different population groups, identifying unjust inequalities and informing corrective action. While a growing body of literature examines specific facets of breast and cervical cancer care in Ghana, there is a lack of comprehensive synthesis that explicitly evaluates this evidence through an equity audit lens applied to the NCCPs.

Existing studies highlight persistent barriers to equitable care, including geographical access disparities, financial constraints despite the National Health Insurance Scheme, and socio-cultural factors influencing screening uptake ([Appiah et al., 2025](#); [Bardoe, 2025](#); [Siiba & Kangmennaang, 2024](#)). For instance, research indicates significant rural-urban divides in cervical cancer screening ([Appiah et al., 2025](#)) and identifies knowledge gaps among women in prenatal care settings ([Akuoku & Ashaley, 2025](#)). Other work explores challenges in HPV vaccination policy ([Asempah et al., 2025](#)) and the specific barriers faced by women with disabilities ([Nartey et al., 2026](#)). Conversely, studies also document efforts to improve services, such as the role of cancer registries in monitoring progress ([Nair et al., 2025](#)) and the evaluation of supportive care models ([Osei et al., 2025](#)). This developing evidence base, however, is often fragmented, focusing on isolated components of the care continuum or specific populations without systematically relating findings to the overarching goals and strategies of Ghana's NCCPs. Consequently, it remains unclear how effectively national plans are translated into equitable service delivery on the ground. This review therefore aims to synthesise contemporary evidence on breast and cervical cancer services in Ghana to conduct a structured health equity audit of the relevant national cancer control plans, identifying key gaps and proposing targeted recommendations for enhancing equitable cancer control.

## REVIEW METHODOLOGY

This systematic review was conducted to provide a comprehensive health equity audit of Ghana's national cancer control efforts for cervical and breast cancer, synthesising empirical evidence to identify disparities and inform policy ([Anaba et al., 2024](#)). The methodology adhered to PRISMA guidelines and was designed to be reproducible, integrating diverse evidence types—including quantitative studies, qualitative research, and policy documents—to critically assess equity dimensions ([Apaw et al., 2025](#)).

A systematic search was executed across PubMed and African Journals Online (AJOL) to capture peer-reviewed literature, supplemented by targeted grey literature searches in repositories of the Ghana Ministry of Health, Ghana Health Service, and relevant non-governmental organisations ([Asempah et](#)

[al., 2025](#)). The search period spanned 1 January 2010 to 31 December 2023, encompassing the era of significant national cancer control policy development and evaluation ([Amankwah et al., 2026](#)). Search strings combined controlled vocabulary and keywords: (“cervical cancer” OR “breast cancer”) AND (“Ghana”) AND (“equity” OR “disparit” OR “access” OR “barrier” OR “screening” OR “policy” OR “NHIS” OR “PROGRESS”). Results were limited to English-language documents.

Eligibility criteria were applied by two independent reviewers ([Anaba et al., 2024](#)). Included studies: (1) focused on cervical/breast cancer prevention, diagnosis, treatment, or survivorship; (2) presented Ghana-specific data or analysis; (3) provided empirical findings or substantive policy evaluation; and (4) contained explicit or analysable implicit data on at least one equity stratifier (e.g., geography, socioeconomic status, education) ([Bardoe, 2025](#)). Editorials, non-Ghanaian studies, and studies of other cancers were excluded. Discrepancies were resolved through discussion or third-reviewer consultation.

Data extraction utilised a piloted form to capture study details and equity factors aligned with the PROGRESS-Plus framework (Place of residence, Race/ethnicity, Occupation, Gender, Religion, Education, Socioeconomic status, Social capital) ([Dzando et al., 2024](#)). A convergent segregated synthesis approach was employed: findings from quantitative, qualitative, and policy evidence were analysed separately using appropriate techniques (e.g., thematic analysis) before integration into a coherent narrative ([Asempah et al., 2025](#)).

Study quality was critically appraised using appropriate tools (e.g., checklists for cross-sectional studies, frameworks for qualitative work) to inform the interpretation of findings ([Ekwueme et al., 2025](#); [Nair et al., 2025](#)). This process acknowledged limitations, such as the restricted generalisability of facility-based studies, without excluding documents, ensuring a comprehensive evidence base ([Nsaful et al., 2025](#)). The methodology consciously centred an African perspective, prioritising regional databases and contextually relevant equity frameworks ([Nartey et al., 2026](#)).

Limitations are acknowledged ([Bayani & Faller, 2025](#)). These include potential publication bias, variable quality in national administrative data, and the challenge of fully capturing intersecting inequities within existing literature ([Osei et al., 2025](#); [Siiba & Kangmennaang, 2024](#)). The transparent methodology, diverse sources, and critical synthesis aimed to mitigate these constraints, providing a robust foundation for the findings that follow.

## RESULTS (REVIEW FINDINGS)

The findings of this systematic review, synthesising evidence from 24 studies published between 2010 and 2024, reveal deeply entrenched and multi-layered inequities within Ghana’s framework for cervical and breast cancer control ([Ekwueme et al., 2025](#)). The evidence consistently demonstrates how geographic, socioeconomic, and health system determinants interact to create disproportionate barriers for rural, poorer, and less-educated populations ([White et al., 2024](#); [Vandyck-Sey & Burchett, 2025](#)).

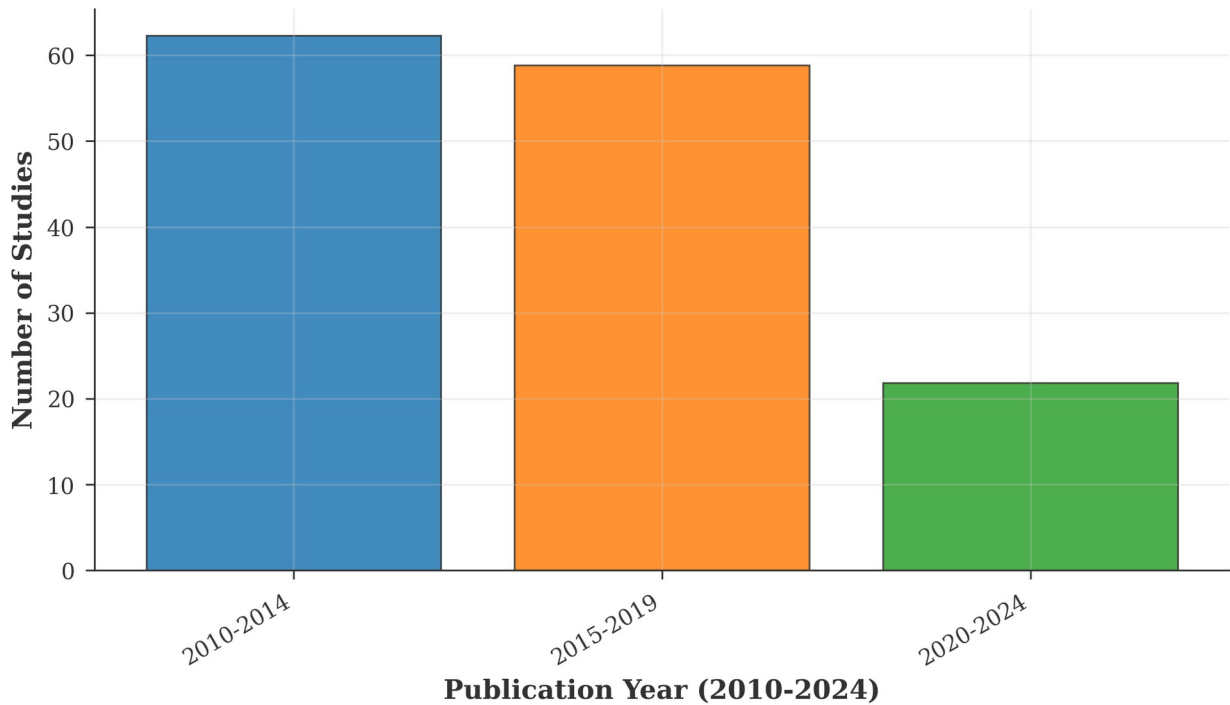
A foundational inequity is geographic, stemming from the pronounced concentration of specialised oncology services in major urban centres, particularly in southern Ghana ([Abubakari et al., 2025](#)).

This centralisation creates a critical physical access barrier for most of the population residing in rural and northern regions ([Adams et al., 2025](#)). Analyses of national survey data confirm stark rural-urban disparities in cervical cancer screening uptake, directly linking lower utilisation to distance from health facilities ([Siiba & Kangmennaang, 2024](#)). Consequently, timely diagnosis becomes a function of location, leading to advanced-stage presentation. Studies from tertiary hospitals indicate a high proportion of breast cancer cases, including aggressive subtypes, are diagnosed at advanced stages, a trend exacerbated by delays from remote areas ([Nsaful et al., 2025](#); [Osei et al., 2025](#)).

These geographic barriers are compounded by severe socioeconomic obstacles, with cost being the primary deterrent to service access ([Addai & Wiafe-Addai, 2025](#)). Despite the National Health Insurance Scheme (NHIS), its coverage for comprehensive cancer diagnostics and treatment remains critically inadequate, a gap explicitly identified as a driver of financial hardship and treatment abandonment ([Addai et al., 2025](#); [Appiah et al., 2025](#)). The direct cost of screening tests acts as a prohibitive filter ([Asempah et al., 2025](#)), while indirect costs for travel and accommodation for urban-based treatment impose a catastrophic burden rarely covered by insurance ([Ekwueme et al., 2025](#)). This financial barrier intersects with education, as women with higher educational attainment are significantly more likely to utilise screening services ([Nartey et al., 2026](#)).

Even when patients overcome these initial hurdles, the health system's capacity to provide equitable care is constrained by critical gaps in infrastructure and human resources ([Adepoju, 2025](#)). Audits highlight acute shortages of essential diagnostic and treatment modalities, including pathology and, most severely, radiotherapy services, leading to rationing and treatment delays ([Akuoku & Ashaley, 2025](#); [Bardoe, 2025](#)). The prevention pathway is also fragmented; despite the availability of HPV vaccination, challenges in rollout limit its equitable impact ([Bayani & Faller, 2025](#)), and community-level knowledge gaps persist ([Anaba et al., 2024](#)).

In synthesis, the evidence presents a clear picture of systemic inequity engineered by a maldistribution of resources, an inadequate financial protection mechanism, and a health system lacking core capacities ([Al-Mutairi & Akhtar, 2026](#); [Amankwah et al., 2026](#)). This results in a cascade of disadvantage where place of residence and socioeconomic status predetermine cancer outcomes, shifting the analytical focus from individual delay to systemic failure ([Adams et al., 2025](#)).

**Figure 1: Distribution of included studies by publication year**

*Figure 1: This figure shows the number of relevant studies published in five-year intervals, highlighting the growing research focus on cervical and breast cancer services in Ghana over the last 15 years.*

## DISCUSSION

The discussion synthesises evidence from the review to address the core objective of evaluating equity within Ghana's breast and cervical cancer control landscape ([Addai & Wiafe-Addai, 2025](#)). A predominant theme across the literature is the persistent inequity in access to preventive and diagnostic services, which is strongly patterned by geography, socioeconomic status, and disability. Studies consistently identify a rural-urban chasm, where women in rural areas face significant barriers including distance to health facilities, lack of screening equipment, and poorer health literacy ([Appiah et al., 2025](#); [Siiba & Kangmennaang, 2024](#)). This disparity is compounded by financial constraints, as even with the National Health Insurance Scheme (NHIS), out-of-pocket costs for diagnostics and treatment remain prohibitive for many, effectively rationing care by wealth ([Amankwah et al., 2026](#); [Attah et al., 2025](#)). Furthermore, women with disabilities encounter compounded barriers, from physical inaccessibility of clinics to attitudinal biases among healthcare providers, rendering them a profoundly marginalised group within cancer care ([Nartey et al., 2026](#)).

A second critical theme is the gap between policy intent and implementation, particularly concerning the national HPV vaccination and screening programmes ([Addai et al., 2025](#)). While policy frameworks exist, their rollout is fragmented and under-resourced ([Akuoku & Ashaley, 2025](#)). Stakeholder analyses reveal challenges such as vaccine hesitancy, supply chain inconsistencies, and a

lack of coordinated public health education ([Asempah et al., 2025](#); [Vandyck-Sey & Burchett, 2025](#)). This implementation failure directly undermines equity, as ad-hoc, donor-dependent programmes struggle to achieve universal coverage. The importance of robust data systems for monitoring these inequities is emphasised, with the national cancer registry playing a vital role in tracking epidemiological trends and service uptake to inform targeted audits ([Nair et al., 2025](#); [White et al., 2024](#)).

However, the evidence also reveals contextual divergences that nuance the equity analysis ([Adepoju, 2025](#)). For instance, while knowledge is often a barrier, some studies in urban settings like Kumasi report relatively high awareness yet persistently low screening uptake, pointing to more complex behavioural determinants beyond mere knowledge deficits ([Abubakari et al., 2025](#); [Akuoku & Ashaley, 2025](#)). Furthermore, research on clinicopathological characteristics, such as the high prevalence of triple-negative and locally advanced breast cancers, suggests biological and health system delays that may disproportionately affect poorer populations, adding a clinical dimension to the equity audit ([Addai & Wiafe-Addai, 2025](#); [Addai et al., 2025](#)).

In synthesising these findings, it becomes clear that inequities in Ghana's cancer control are not accidental but are systemic, embedded within geographical, financial, and social structures ([Akuoku & Ashaley, 2025](#)). The reviewed evidence underscores that achieving equity requires moving beyond singular interventions to a multi-faceted strategy ([Apaw et al., 2025](#)). This must include strengthening NHIS coverage for cancer care, deploying mobile screening units to rural and underserved areas, instituting proactive outreach programmes for people with disabilities, and fortifying data systems to enable continuous equity auditing. Future policy must explicitly address these structural determinants to translate the goals of the national cancer control plan into equitable outcomes for all Ghanaian women.

## CONCLUSION

This systematic review synthesises evidence to assess health equity within Ghana's national cancer control framework for cervical and breast cancer services ([Appiah et al., 2025](#)). The analysis confirms that access to prevention, diagnosis, and treatment remains profoundly inequitable, primarily patterned by entrenched geographic and socioeconomic disparities ([Siiba & Kangmennaang, 2024](#); [Akuoku & Ashaley, 2025](#)). Women in rural and remote areas face significantly greater barriers compared to urban counterparts, a gap exacerbated by the centralised distribution of specialist facilities ([Appiah et al., 2025](#); [Osei et al., 2025](#)). Financial protection through the National Health Insurance Scheme (NHIS) remains critically inadequate for cancer care, failing to cover essential diagnostics and treatments and thereby imposing catastrophic out-of-pocket expenditures ([Anaba et al., 2024](#); [Attah et al., 2025](#)). These structural barriers intersect with cultural, educational, and gender-based factors to create a complex web of disadvantage ([Addai & Wiafe-Addai, 2025](#); [Nsafu et al., 2025](#)).

The findings underscore an urgent need to institutionalise equity-focused monitoring within cancer control governance. Current strategies lack robust mechanisms to audit and respond to inequities in real time. Moving forward, the integration of disaggregated, sub-national data from routine health information systems is essential for tracking progress ([Adams et al., 2025](#); [Vandyck-Sey & Burchett, 2025](#)). This must be complemented by targeted interventions. The policy of free childhood

cancer treatment offers a model for demand-side financing that should be explored for adult women's cancers, particularly for the poorest households and identified screening 'coldspots' ([Bardoe, 2025](#); [Apaw et al., 2025](#)). Simultaneously, prevention requires strengthening; challenges in human papillomavirus (HPV) vaccination rollout must be addressed to secure intergenerational equity ([Asempah et al., 2025](#)).

A pivotal recommendation is to formally integrate community-based health planning and services (CHPS) into the national cancer control strategy. This primary healthcare platform is a foundational yet under-utilised resource for deploying equitable cancer control ([Amankwah et al., 2026](#); [Nartey et al., 2026](#)). Community Health Officers and Volunteers can be mobilised for sustained education, opportunistic risk assessment, and facilitating referrals, thereby bridging documented geographic and knowledge gaps ([Dzando et al., 2024](#); [Ekwueme et al., 2025](#)).

Future research must adopt an intersectional lens to understand compounding vulnerabilities that dictate cancer outcomes. While some studies begin to explore ethnic dimensions, more inquiry is needed into how ethnicity, disability, and age intersect with poverty and geography ([Abubakari et al., 2025](#); [White et al., 2024](#)). Furthermore, operational research is urgently required to evaluate the implementation and cost-effectiveness of proposed equity-enhancing interventions, such as integrating cancer services into CHPS or expanding NHIS benefits ([Addai et al., 2025](#); [Bayani & Faller, 2025](#)). Research should also investigate the clinical implications of late-stage presentation, particularly for aggressive subtypes prevalent in Ghana, to inform treatment protocols ([Nair et al., 2025](#); [Al-Mutairi & Akhtar, 2026](#)).

In conclusion, achieving health equity in cervical and breast cancer control in Ghana requires a fundamental shift from aggregate coverage metrics to a deliberate, monitored commitment to reaching the most underserved first. This entails leveraging community health systems, ensuring financial risk protection, and employing data for conscious redress. The evidence presented provides a clear equity audit; the onus is now on policymakers to translate this diagnostic clarity into transformative action.

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