

Review Article

Post-mastectomy breast reconstruction in sub-Saharan Africa: a scoping review of availability, uptake, techniques, outcomes and barriers

Oluwatosin G. Afolabi^{1*}, Damilola T. Ishola², Abiodun Idowu Okunlola³,
Mayowa E. Oluwajuyigbe³, Adedamola B. Adegbamigbe³

¹Faculty of Clinical Sciences, University of Ilorin, Ilorin, Nigeria

²Kharkiv National Medical University, Kharkiv, Ukraine

³Department of Surgery, Federal Teaching Hospital, Ido-Ekiti, Nigeria

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*Correspondence:

Dr. Oluwatosin G. Afolabi,

E-mail: otosinafolabi@gmail.com

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ABSTRACT

Breast cancer survival in sub-Saharan Africa (SSA) is low, mastectomy predominates, and breast loss without reconstruction carries a documented quality-of-life cost. Post-mastectomy breast reconstruction may improve quality of life and the acceptability of surgery; however, its availability, uptake, and outcomes across SSA are poorly characterized. We aimed to map the existing evidence on this topic. Following the PRISMA extension for Scoping Reviews and the Arksey and O'Malley framework as refined by Levac and colleagues and the Joanna Briggs Institute, we searched PubMed/MEDLINE, Embase, Scopus, Web of Science, CINAHL and African Journals Online, with grey-literature and reference-list searching, for sources addressing post-mastectomy breast reconstruction in women treated for breast cancer in SSA. Sources were screened in Rayyan and charted across five domains: availability, uptake and techniques, patient perspectives, outcomes, and barriers and facilitators. The evidence was sparse, concentrated in a few countries, and dominated by qualitative studies and service surveys rather than by reconstruction outcome series. Reconstruction was often described as scarce and centralized, available at very few facilities, within mastectomy-dominated and largely out-of-pocket care pathways. Patient-level evidence concerned perceptions and acceptability, shaped by life stage, culture, and religion, rather than experience of reconstruction. No source reported oncological or standardized aesthetic outcomes after reconstruction; the only robust outcome evidence concerned the quality-of-life harm of mastectomy alone. Barriers include a scarcity of services, workforce shortages, costs, and cultural factors. Post-mastectomy breast reconstruction in SSA is a largely unmapped field characterized by minimal availability and an almost complete absence of outcome data in the literature. Registries, prospective outcome studies, and resource-stratified service planning are needed to support equitable, patient-centered breast cancer care.

Keywords: Breast reconstruction, Mastectomy, Breast cancer, Sub-Saharan Africa, Scoping review

INTRODUCTION

Breast cancer is the most commonly diagnosed cancer and a leading cause of cancer death among women worldwide.¹ In sub-Saharan Africa (SSA), the burden is rising and outcomes remain poor, with three-year overall

survival of approximately 50% in the multicountry African Breast Cancer-Disparities in Outcomes cohort, well below figures reported in high-income countries.² A substantial proportion of women present with locally advanced or metastatic disease, reflecting a high frequency of late-stage diagnosis across the

region.³ Improving survival therefore depends not only on earlier diagnosis but also on strengthening the surgical and reconstructive pathways that underpin curative treatment.^{4,5}

Surgery remains the cornerstone of curative breast cancer treatment in SSA; however, the operative burden is large and unevenly resourced, and most women undergo mastectomy rather than breast-conserving surgery.^{5,6} Mastectomy without reconstruction has measurable consequences. Prospective evaluation using the BREAST-Q in Ghanaian and Ethiopian women has documented reductions in breast-related quality of life and body image after mastectomy alone, and cross-sectional work from Ethiopia reports similar mastectomy-related quality-of-life decrements.^{7,8} Fear of mastectomy and of its bodily and social sequelae is itself a recognised contributor to delayed presentation in the region.⁹

Breast reconstruction offers a means of restoring breast form after mastectomy and may improve both the quality of life and the acceptability of oncological surgery. Qualitative research in Ghana and Ethiopia indicates that women hold complex, life-stage- and belief-dependent views about reconstruction, balancing its value for confidence and symmetry against cultural and religious considerations.¹⁰ In high-income settings, reconstruction has become an integrated component of breast cancer surgery, but its availability, uptake, and outcomes across SSA are poorly characterized. National service surveys in Ghana suggest that reconstruction is offered at only a handful of facilities, and regional service-mapping and access studies similarly point to scarce, centralised provision and predominantly out-of-pocket payment.¹¹⁻¹³

Surgical literature from the SSA has begun to be synthesized. Systematic reviews have broadly mapped breast cancer surgery broadly and oncoplastic breast-conserving surgery in African women, describing volume-replacement and volume-displacement techniques used within breast conservation.^{6,14} These reviews, together with single-center series comparing breast conservation and mastectomy, address surgery performed to conserve or remove the breast.¹⁵ None synthesizes post-mastectomy whole-breast reconstruction, that is, implant-based and autologous flap reconstruction undertaken to rebuild the breast mound after mastectomy, as a distinct field of practice in the region.

Given the scattered, heterogeneous, and largely descriptive nature of the available evidence, a scoping review is the most appropriate method to map what is known, identify the techniques and settings described, and locate the gaps that should guide future research and service planning.¹⁶⁻¹⁸ This review therefore aims to map the availability, uptake, techniques, reported outcomes, and barriers and facilitators relating to post-mastectomy breast reconstruction for women with breast cancer in sub-Saharan Africa.

METHODS

Study design and protocols

This review was designed and reported in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR), and the methodological frameworks proposed by Arksey and O'Malley, refined by Levac and colleagues, and operationalised in the Joanna Briggs Institute guidance for scoping reviews.¹⁶⁻¹⁹ A protocol was prepared a priori and registered on the Open Science Framework (<https://doi.org/10.17605/OSF.IO/NKWQY>) The flow of sources through the review is reported using the PRISMA 2020 flow framework.²⁰

Review questions

The review addressed the following: where and to what extent is post-mastectomy breast reconstruction available in SSA; what is its uptake and which techniques are described; how do patients and providers perceive reconstruction; what oncological, aesthetic, and quality-of-life outcomes are reported; and what barriers and facilitators are documented.

Eligibility criteria

Eligibility followed the population–concept–context framework. The population consisted of women aged 18 years or older who were treated for or at risk of breast cancer in a sub-Saharan African country. The concept was post-mastectomy breast reconstruction, including immediate or delayed, implant-based, or autologous (pedicled or free flap) reconstruction, together with its availability, uptake, techniques, outcomes, perceptions, and barriers or facilitators. The context was any healthcare setting in SSA. We included primary studies of any design (quantitative, qualitative, or mixed methods), service surveys, and audits. We excluded studies confined to oncoplastic breast-conserving surgery without mastectomy reconstruction, studies conducted outside the SSA, and studies from which no reconstruction-relevant data could be extracted. Reviews and editorials were retained for context and reference list screening but were not charted as primary sources. No language or date restrictions were applied.

Information sources and search

We searched PubMed/MEDLINE, Embase, Scopus, Web of Science, CINAHL, and African Journals Online from database inception to March 30th. The search combined controlled vocabulary and free-text terms across four concept blocks: breast cancer, mastectomy, breast reconstruction (specific techniques), and sub-Saharan African countries. Grey literature and reference lists of the included sources and relevant reviews were hand-searched for additional eligible records. The full PubMed/MEDLINE search strategy is presented in Table 1.

Table 1: PubMed/MEDLINE search strategy.

#	Concept	Search terms
#1	Breast cancer	"Breast Neoplasms"[Mesh] OR breast cancer[tiab] OR breast carcinoma[tiab] OR breast tumour*[tiab] OR breast tumor*[tiab] OR breast neoplasm*[tiab] OR breast malignan*[tiab]
#2	Mastectomy	"Mastectomy"[Mesh] OR mastectom*[tiab] OR breast removal[tiab] OR breast amputation[tiab]
#3	Breast reconstruction	"Mammaplasty"[Mesh] OR "Breast Implantation"[Mesh] OR "Breast Implants"[Mesh] OR "Free Tissue Flaps"[Mesh] OR "Myocutaneous Flap"[Mesh] OR "Perforator Flap"[Mesh] OR reconstruct*[tiab] OR mammaplasty[tiab] OR mammoplasty[tiab] OR "breast implant*[tiab] OR "tissue expander*[tiab] OR (flap*[tiab] AND breast[tiab]) OR "autologous reconstruction"[tiab] OR DIEP[tiab] OR TRAM[tiab] OR "latissimus dorsi"[tiab] OR "deep inferior epigastric"[tiab]
#4	Sub-Saharan Africa	"Africa South of the Sahara"[Mesh] OR "sub-Saharan Africa"[tiab] OR Nigeria[tiab] OR Ghana[tiab] OR Kenya[tiab] OR Ethiopia[tiab] OR "South Africa"[tiab] OR Uganda[tiab] OR Tanzania[tiab] OR Zambia[tiab] OR Zimbabwe[tiab] OR Namibia[tiab] OR Cameroon[tiab] OR Senegal[tiab] OR Rwanda[tiab] OR Malawi[tiab] OR Botswana[tiab] OR "Cote d'Ivoire"[tiab] OR Mozambique[tiab] OR Sudan[tiab] OR Mali[tiab] OR "Burkina Faso"[tiab] OR Benin[tiab] OR Togo[tiab] OR Gabon[tiab] OR "Sierra Leone"[tiab] OR Liberia[tiab] OR Gambia[tiab] OR Guinea[tiab] OR Niger[tiab] OR Chad[tiab] OR Angola[tiab] OR Congo[tiab] OR "DR Congo"[tiab] OR Eritrea[tiab] OR Somalia[tiab] OR Burundi[tiab] OR "South Sudan"[tiab] OR Lesotho[tiab] OR Eswatini[tiab] OR Mauritania[tiab] OR Madagascar[tiab]
#5	Combined	#1 AND (#2 OR #3) AND #4

Other databases

For the other databases, the same four concept blocks were adapted to local syntax. In Embase, the breast cancer, mastectomy, breast reconstruction and sub-Saharan Africa blocks were mapped to Emtree explosion terms for breast cancer, mastectomy, breast reconstruction, mammaplasty, breast prosthesis, autologous flap and Africa south of the Sahara, combined with free-text synonyms. Scopus used TITLE-ABS-KEY and Web of Science used Topic searches with the same synonym sets joined by AND across the breast cancer, reconstruction and geographic blocks. African Journals Online and African Index Medicus used simplified breast-cancer-plus-reconstruction searches without the geographic block, since these sources are already Africa-specific. Registries and grey literature were screened, with backward and forward citation chasing of all included sources and relevant reviews.

Selection of sources

Records were de-duplicated and screened by two reviewers in Rayyan.²¹ Titles and abstracts were screened against the eligibility criteria, and potentially eligible full texts were retrieved and assessed. Screening is performed in duplicate by two independent reviewers (DTI and MEO), with disagreements resolved by discussion or a third reviewer (OGA).

Data charting and synthesis

A piloted charting form was used to extract the authors and year, country and setting, study design, sample, type

and timing of reconstruction, techniques described, outcomes reported, and documented barriers or facilitators for each source. Charting was undertaken iteratively, with the form refined as familiarity with the sources developed. Consistent with the scoping review methodology, formal risk-of-bias appraisal was not the primary purpose; however, study designs were recorded to indicate the nature of the evidence. Findings were collated and summarized narratively and mapped across the five charting domains, supported by a tabular presentation of source characteristics and an evidence map.

RESULTS

Search and selection

The search identified 636 records, comprising 612 from database searches and 24 from grey literature and citation searches. After the removal of 165 duplicates, 471 records were screened by title and abstract, of which 408 were excluded. Sixty-three full-text records were assessed for eligibility, and 51 were excluded, most commonly because the setting was outside the SSA, the surgery described was oncoplastic breast conservation without mastectomy reconstruction, or no reconstruction-relevant data could be extracted. Twelve sources of evidence were carried forward to charting (Figure 1).

Characteristics of the included sources

The principal charted sources spanned 2017 to 2025 and were drawn from five sub-Saharan African countries, with Ghana being the most frequently represented,

followed by Ethiopia, a single-country contribution from South Africa, and multi-country data from Kenya and Nigeria. Their designs were heterogeneous and predominantly descriptive in nature. One was a qualitative interview study of 46 women in Ghana and Ethiopia exploring perceptions and acceptability of reconstruction, one was a prospective cohort of 133 women in Ghana and Ethiopia evaluating breast-related quality of life and mental health after mastectomy alone using the BREAST-Q, PHQ-9, and GAD-7, and a further cross-sectional study from Ethiopia assessed mastectomy-related quality of life.^{8,10} Service provision was characterized by two Ghanaian surveys, a nationwide assessment of 328 facilities with a 95% response rate, and a regional service-mapping pilot in the Eastern Region, while a three-country retrospective observational study of 862 women described the breast cancer care pathway and surgical patterns across Ghana, Kenya, and Nigeria.^{11,12} A retrospective cohort study of 445 women in Soweto, South Africa, compared breast conservation with total mastectomy and provided the only explicit account of post-mastectomy reconstruction practice.¹⁵

review of oncoplastic breast-conserving surgery in African women, comprising 26 studies and 1896 patients, was retained for context and boundary-setting; it concerns reconstruction performed within breast conservation rather than whole-breast reconstruction after mastectomy and was not charted as a primary source of evidence for this review.¹⁴ This is summarized in Table 2.

Volume and nature of the evidence

The evidence was sparse, geographically concentrated, and methodologically heterogeneous. Identified sources were clustered in a small number of countries, principally Ghana, Ethiopia, Nigeria, Kenya, and South Africa, and were dominated by qualitative interview studies, cross-sectional service surveys, and retrospective record reviews rather than reconstruction outcome series.¹⁰⁻¹⁵ The designs ranged from semi-structured patient interviews to a nationwide hospital survey and a multicountry chart abstraction, reflecting a literature assembled largely from access, service delivery, and quality-of-life research in which reconstruction features as one element rather than the primary focus.¹⁰⁻¹³ No multicenter prospective study reporting oncological or aesthetic outcomes of post-mastectomy reconstruction across the region was identified, and reconstruction, where it appeared, was more often described as a service that was largely unavailable than as a procedure whose results were being reported. This distribution shaped the charting itself: the availability and patient perspective domains were comparatively well populated, whereas the technique and outcome domains were sparse or empty, a pattern summarized in the evidence map (Table 3).

Availability and provision of reconstruction services

Availability was the dominant theme. A nationwide hospital survey in Ghana, which assessed 328 facilities with a 95% response rate and stratified them against resource-defined treatment levels, found that the most comprehensive level of care, the only level that includes breast reconstruction, was available at only two hospitals, while nine offered intermediate surgical care with tamoxifen, and none offered the next tier incorporating radiotherapy and sentinel node biopsy.¹¹ Modelling of hypothetical targeted expansion suggested that even optimistic upgrading of existing facilities would leave much of the population beyond the reach of comprehensive services, underlining how far provision sits from need.¹¹ Regional service-mapping in Ghana similarly described limited and centralized infrastructure, and a multicountry observational study of 862 women in Ghana, Kenya, and Nigeria documented mastectomy-dominated care pathways, advanced-stage presentation in Ghana and Kenya, and mean travel distances to tertiary care ranging from 45 km in Ghana to 121 km in Nigeria, with care largely funded out of pocket.^{12,13} The single most direct account came from a Soweto surgical cohort, whose authors reported performing only a few primary and delayed post-

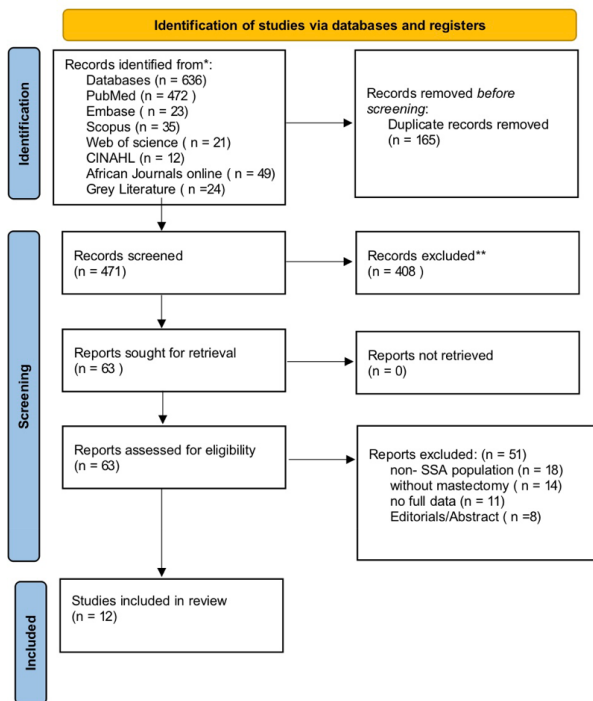


Figure 1: PRISMA-ScR flow chart.

Across these sources, the populations were adult women treated for or at risk of breast cancer, and the review questions were addressed to differing degrees: availability and provision were examined chiefly in the Ghanaian and multicountry surveys, patient perspectives in the qualitative work, and the consequences of mastectomy without reconstruction in the quality-of-life studies.^{7,8,11-13,16} None of the included sources was a dedicated outcome series of post-mastectomy reconstruction; therefore, reconstruction-specific technical and outcome data were limited. A systematic

mastectomy reconstructions because of resource constraints, specifically a shortage of operating-theatre time, an inconsistent supply of breast implants, and limited availability of plastic surgery services, compounded by consequently limited patient

demand.¹⁵ Together, these sources indicate that reconstruction is concentrated in a few tertiary and private centers and is effectively inaccessible to most women.

Table 2: Characteristics of the principal charted sources of evidence.

Sources (year)	Country / setting	Design	Reconstruction focus	Key charted findings
Guzman et al (2025)¹⁰	Ghana; Ethiopia	Qualitative interviews (n=46)	Perceptions and acceptability	Attitudes shaped by self-identity vs function, life stage, and religious or cultural framings; limited awareness of reconstruction.
Kennedy et al (2023)⁷	Ghana; Ethiopia	Prospective cohort, BREAST-Q (n=133)	Sequelae of mastectomy alone	Significant decline in BREAST-Q breast satisfaction and body image after mastectomy alone, with improvement in anxiety and depression.
Abebe et al (2020)⁸	Ethiopia	Cross-sectional	Sequelae of mastectomy alone	Mastectomy-related quality-of-life decrements.
Schoenhals et al (2023)¹¹	Ghana (national)	Cross-sectional hospital survey (328 sites)	Availability of services	Comprehensive services including reconstruction present at only two facilities nationwide.
Moustafa et al (2021)¹²	Ghana (Eastern Region)	Cross-sectional service mapping	Availability of services	Limited, centralised breast cancer service infrastructure.
Twahir et al (2021)¹³	Ghana; Kenya; Nigeria	Retrospective observational (n=862)	Care pathway and surgery type	Mastectomy-dominated pathways, long travel distances, care largely funded out of pocket.
Cubasch et al (2017)¹⁴	South Africa (Soweto)	Retrospective cohort (n=445)	Surgical pattern and reconstruction	Total mastectomy in 79.6% versus breast conservation in 20.4%; few post-mastectomy reconstructions performed owing to resource constraints.
Adesunkanmi et al (2024)¹⁵	Multi-country Africa	Systematic review (26 studies; n=1896)	Oncoplastic technique (adjacent)	Reconstruction within breast conservation; latissimus dorsi volume replacement most common. Distinct from post-mastectomy reconstruction.

Table 3: Mapping of charted evidence across the five review domains.

Domains	What the evidence shows	Principal gap	Representative sources
Availability and provision	Reconstruction is scarce and centralised, offered at very few tertiary or private centres.	No regional mapping of reconstructive capacity or workforce.	Schoenhals et al 2023; Moustafa et al 2021; Twahir et al 2021 ¹¹⁻¹³
Uptake and techniques	Mastectomy predominates; whole-breast reconstruction rarely described; techniques reported mainly within breast conservation.	Uptake rates and implant-based or autologous flap technique data are absent.	Cubasch et al 2017; Adesunkanmi et al 2024 ^{14,15}
Patient perspectives	Perceptions shaped by life stage, culture and religion; awareness limited.	Demand and acceptability incompletely characterised beyond two countries.	Guzman et al 2025 ¹⁰
Outcomes	Evidence limited to quality-of-life harm of mastectomy alone.	No oncological, complication or standardised aesthetic outcomes after reconstruction.	Kennedy et al 2023; Abebe et al 2020 ^{7,8}
Barriers and facilitators	System scarcity, workforce shortage, cost and cultural factors documented.	No evaluated interventions to expand access or uptake.	Twahir et al 2021; Guzman et al 2025 ^{10,13}

Uptake and techniques described

Few sources have reported the uptake or technical conduct of post-mastectomy reconstruction, and procedure-level details available in high-income series are largely absent. Where surgical patterns were described, mastectomy predominated over breast conservation, even for early-stage disease. In the Soweto cohort of 445 women, 354 (79.6%) underwent total mastectomy and only 91 (20.4%) underwent breast-conserving surgery, with mastectomy used in 72% of stage I and II disease and 94% of stage III disease.¹⁵ Reconstructive techniques were described chiefly within the adjacent literature on oncoplastic breast-conserving surgery in African women, a systematic review of 26 studies and 1896 patients in which latissimus dorsi volume replacement was the most frequently reported approach and seroma the most common complication; that body of work, however, concerns reconstruction performed to fill a lumpectomy defect within breast conservation rather than whole-breast reconstruction after mastectomy.¹⁴ The implant-based and autologous free-flap techniques that dominate post-mastectomy reconstruction internationally, including tissue expanders, direct-to-implant reconstruction, and deep inferior epigastric perforator flaps, were not systematically reported in the sub-Saharan African sources identified, and no source described case volumes, the balance of immediate versus delayed reconstruction, or technique selection at the procedural level.

Patient perspectives, awareness and acceptability

Patient-level evidence was almost entirely qualitative and concerned perceptions rather than the experience of reconstruction. In semi-structured interviews with 46 women across Ghana and Ethiopia, attitudes toward reconstruction were organized around three themes: a tension between viewing the breast as central to self-identity and viewing it as primarily functional; the influence of life stage, with perceived benefit greater for younger and partnered women and felt to diminish with age; and religious and cultural framings that cast reconstruction either as a welcome restoration of the body or as contrary to naturalness and divine will.¹⁰ Reconstruction was valued by some women for restoring confidence and symmetry, yet for others it conflicted with cultural or religious beliefs, and awareness of reconstruction as an available option was limited.¹⁰ These perceptions were closely connected to the fear of mastectomy that is itself a documented contributor to delayed presentation in the region, suggesting that demand, awareness, and acceptability are incompletely characterized, vary across sociocultural contexts, and on present evidence are described for only two countries.⁹

Outcomes

Reconstruction-specific outcome data were scarce. No identified sub-Saharan African source reported

oncological outcomes such as local recurrence or survival, complication profiles, or standardised aesthetic or patient-reported outcomes following post-mastectomy reconstruction. The closest outcome evidence concerned the consequences of mastectomy without reconstruction. A prospective study of 133 women in Ghana and Ethiopia, assessed with the BREAST-Q, PHQ-9 and GAD-7 before surgery and at three and six months afterwards, found significant reductions across most BREAST-Q subscales by three months and a sustained fall in breast satisfaction at six months, although symptoms of anxiety and depression improved over the same period.⁷ Cross-sectional Ethiopian data reported comparable mastectomy-related quality-of-life decrements.⁸ This asymmetry, abundant evidence of the harm to body image and breast-related quality of life associated with breast loss alongside near-absent evidence on the results of restoring the breast, was among the clearest findings of the review and defines the principal empty region of the evidence map.

Barriers and facilitators

Documented barriers operated at health-system, provider and patient levels. The most concrete were described in the Soweto cohort, where the limited delivery of post-mastectomy reconstruction was attributed to a shortage of operating-theatre time, an inconsistent supply of breast implants and a scarcity of plastic surgery services.¹⁵ These were reinforced at the system level by the marked centralisation of comprehensive services and the consequent travel and out-of-pocket costs evident in the Ghanaian and multicountry surveys.^{11,13} Patient-level barriers included limited awareness of reconstruction, financial constraint, and cultural and religious considerations, several of which overlap with the determinants of late presentation.^{9,10} Facilitators were less frequently described but included the concentration of capability at tertiary and private centres and the potential for culturally tailored counselling and decision support to align reconstruction with women's values and life stage.¹⁰ No source evaluated an intervention designed to expand reconstructive access or uptake in the region, and the facilitators identified were largely inferred from descriptions of where services do exist rather than from formal evaluation.

DISCUSSION

This scoping review mapped the available evidence on post-mastectomy breast reconstruction in sub-Saharan Africa and found it to be sparse, geographically concentrated and weighted toward availability and perception rather than technique and outcome. Reconstruction was most often characterised as a service that is scarce, centralised and unaffordable, available at only a small number of facilities, while the patient-level literature described perceptions and acceptability rather than the experience or results of reconstruction.¹⁰⁻¹³ Strikingly, the region's literature documents the quality-

of-life harm of mastectomy without reconstruction but provides almost no data on the oncological or aesthetic outcomes of reconstruction itself.^{7,8}

This pattern contrasts sharply with high-income settings, where reconstruction is an integrated and frequently audited component of breast cancer surgery. It also distinguishes the present review from existing African syntheses: systematic reviews have mapped breast cancer surgery broadly and oncoplastic breast-conserving surgery specifically, but these concern conservation or removal of the breast, and reconstruction within conservation, not whole-breast reconstruction after mastectomy.^{6,14} The gap identified here is therefore not merely one of fewer studies but of an almost entirely unmapped field, in a region where mastectomy predominates and where breast loss carries documented psychosocial cost.^{5,7-9,15}

The findings have implications for practice, research and policy. Clinically, the scarcity and centralisation of services means that for most women in SSA reconstruction is not currently a realistic option, which should be acknowledged transparently in counselling while equitable expansion is pursued. Because acceptability is shaped by life stage, culture and belief, any expansion should be accompanied by culturally tailored information and decision support.¹⁰ For research, the priority is to generate the missing descriptive evidence: multicentre registries and prospective series reporting the techniques used, complication profiles, oncological safety, and patient-reported aesthetic and quality-of-life outcomes of post-mastectomy reconstruction in African settings. For policy, integrating reconstructive capacity into resource-stratified cancer-control planning, including the training of reconstructive surgeons and financial protection for patients, aligns with broader efforts to strengthen breast cancer care and improve survival in the region.^{4,5}

This review has some limitations. As a scoping review, it maps the extent and nature of the evidence rather than appraising or pooling it, and a formal risk-of-bias assessment was not undertaken. The reported counts are provisional pending the completion of dual independent screening, and the final number and composition of charted sources may change. The restriction to English-language and indexed literature may have missed relevant grey literature, theses, and non-English reports, which is particularly relevant in a multilingual region. Finally, the concentration of evidence in a few countries limits generalizability across the diverse health systems of SSA.

CONCLUSION

In conclusion, post-mastectomy breast reconstruction in sub-Saharan Africa remains largely unmapped. The available evidence consistently portrays a scarce, centralized, and unaffordable service and a population whose perceptions of reconstruction are shaped by

culture and life stage, while offering almost no data on the techniques, safety, or outcomes of reconstruction performed in the region. Closing this gap through registries, prospective outcome studies, and resource-stratified service planning is a necessary step toward more complete, patient-centered breast cancer care in SSA.

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