Cameroon Townhall for Healthcare Professionals

Meeting Minutes, October 31, 2026

Host: Cameroon Townhall for Healthcare Professionals

Date: October 31, 2026

Time: 1:00 PM to about 3:50 PM New York time (6:00 PM to about 8:50 PM Cameroon time)

Session: No. 136

Chair: Dr. Munoh Kenne Foma

Co-Moderators: Dr. Bryan Tegomoh (moderator for this session)

Guest Speaker: Dr. Munoh Kenne Foma, MD, MPH, FACP, FACO; hematologist and medical oncologist, Presbyterian Healthcare Services, Albuquerque, New Mexico; founder and Chair, Cameroon Town Hall for Healthcare Professionals

Distinguished Guests: Dr. Florence Zeh Kakanou, Permanent Secretary, National Cancer Control Committee (CNLCa)

Title: Pink October 2026 in Cameroon: From Breast Cancer Awareness to Action

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Agenda Items:

1. Welcome by the moderator, Dr. Bryan Tegomoh, and introduction of the Chair
2. Presentation by Dr. Munoh Kenne Foma on "Pink October 2026 in Cameroon: From Breast Cancer Awareness to Action"
3. Remarks by Dr. Florence Zeh Kakanou, Permanent Secretary of the National Cancer Control Committee
4. Discussion and Q&A
5. Final comments from participants
6. Closing remarks by the Chair and the moderator

Opening Remarks:

- Dr. Tegomoh welcomed participants to Session 136, held on the last day of October, and presented the theme: what happens after the Pink October campaigns end. He invited questions in English or French and introduced the Chair, Dr. Foma, as presenter.

Presentation Points:

Presentation by Dr. Munoh Kenne Foma: "Pink October 2026 in Cameroon: From Breast Cancer Awareness to Action"

1. The burden, and how to read the numbers:

Dr. Foma presented the IARC GLOBOCAN 2024 modeled estimates for Cameroon: 2,824 new breast cancers (29.6% of female cancers), 1,368 deaths and 6,164 women living with a diagnosis within five years. He cautioned that the earlier 2022 model gave 4,207 cases and 2,285 deaths, and that the difference reflects changed model inputs, not a real fall in incidence. Real progress, he said, can only be tracked with a validated registry, stage at diagnosis, diagnostic intervals and treatment completion.

2. Momentum in 2024 to 2026, and a rule for data:

He reviewed recent milestones: national guideline development work, CanScreen5 data for Cameroon, the ACPA screening mission in Buea in March 2026 (383 mammograms, 591 VIA assessments, 278 PSA tests and 479 FOBT tests, as reported by the organisers), new WHO AFRO and Global Breast Cancer Initiative (GBCI) training manuals, and Pink October activities in all ten regions, including a march in Yaounde on the day of the session. He set one rule: no national outcome claim without a denominator, a date range, a source and a definition of follow-up.

3. A case that shows where care breaks down:

He described a 32-year-old woman in Douala who had a lumpectomy without receptor testing or staging, then a local recurrence and bone metastases, and chemotherapy still without ER, PR or HER2 results. When he had the tissue tested in 2021 it came back ER 100%, PR 90% and HER2 negative, a cancer that endocrine therapy could have treated, and the patient died two days before the result reached him. He said pathology is the decision engine of cancer care, not a report at the end of it.

4. The WHO 60-60-80 targets:

He explained the three GBCI pillars (health promotion and early detection, timely diagnosis, comprehensive management) and the initiative's aim of a 2.5% yearly fall in breast cancer mortality. The operational targets are at least 60% of invasive cancers diagnosed at stage I or II, diagnosis completed within 60 days of first presentation, and at least 80% of patients completing recommended treatment. These require a registry, referral clocks, treatment access and navigation, not mammography alone.

5. Early diagnosis is not population screening:

Dr. Foma said Cameroon's immediate task is the rapid diagnosis of women who already have a symptom, while building the conditions for organised, quality-assured screening later. Breast self-awareness is high yield, and he shared French and English self-examination materials and the twelve visible signs of breast cancer. Every suspicious finding should go through triple assessment: clinical examination, imaging, and image-guided core biopsy before definitive surgery ("no tissue, no issue").

6. Pathology as a treatment intervention:

He said every invasive cancer needs histologic type, grade, ER, PR and HER2, and that receptor testing should be subsidised. Immunohistochemistry is available at only two centres (Centre Pasteur and one other) and costs about 100,000 to 150,000 FCFA, while families of untested patients often spend more than 10 million FCFA. He proposed turnaround standards: symptom to diagnostic appointment within 7 days, imaging to core biopsy within 14 days, biopsy to histology within 10 working days, and receptor status within 14 days.

7. Treatment capacity and the 2026 advances:

Cameroon has a single linear accelerator (private, at the Cameroon Oncology Center), with cobalt units in public hospitals, and MRI in fewer than five regions. Tamoxifen, aromatase inhibitors and paclitaxel are available, yet chemotherapy is still given without receptor results. He reviewed 2026 United States approvals for HER2-positive, triple-negative and ESR1-mutated disease, but said innovation is not implementation: the foundation of early diagnosis, biopsy, receptor testing, surgery, radiotherapy, chemotherapy and endocrine therapy must come first.

8. A system to build, with measurable targets:

He proposed an essential breast cancer package by level of care (primary care, district and regional hospitals, oncology centres, a reference network), a national guideline that defines the full pathway, a population-based registry, routine multidisciplinary tumor boards and patient navigation. His closing targets were more than 60% of cases diagnosed at stage I or II, diagnosis within 60 days, treatment completion above 80% and tracked, every new case reviewed at a tumor board, and a registry capturing 85% of cases. He said a task force would draft a policy document for the Ministry, and closed with "From awareness to survival": one woman diagnosed early, one biopsy on time, one patient who finishes treatment, one dataset proving better outcomes.

Discussions and Q&A Session:

- **Remarks by Dr. Florence Zeh Kakanou, Permanent Secretary, National Cancer Control Committee.** Dr. Zeh Kakanou said the Committee reviewed past Pink October campaigns, found the results poor and changed its strategy. An evaluation during Women's Week in March 2026 showed many women did not know how to examine their breasts and health workers' examination technique was weak, and she wants breast assessment included in the minimum package of care at integrated health centres. The strategy now rests on sensitisation and early detection, and on a referral network: no campaign without a designated referral facility. She called for fewer conferences and simple messages on where to go and what examinations and medicines cost, for involving people living with and after cancer to give hope to others, and noted that many men came for examinations and that the Prime Minister's office and several ministries joined Pink October for the first time.
- **Dr. Tegomoh: how are women with abnormal mammograms tracked to biopsy?** Dr. Tegomoh thanked Dr. Zeh Kakanou and called on Dr. Stella-Maris Adamu of the Patcha Foundation, who was not on the line at that moment, then opened the floor. Dr. Foma said the Buea screenings were done in referral hospitals in coordination with the central level, with the Minister informed and the Permanent Secretary present, while community activities taught self-examination. Most central hospitals now have an oncologist. About 20 women with positive findings from the Buea mission were navigated to care, and their follow-up data are still being traced.
- **Dr. Ntumsi Tontu, clinical and radiation oncologist at Mbingo Baptist Hospital, on young patients and imaging quality.** Dr. Ntumsi Tontu said women under 40 account for 25 to 30% of the breast cancers his team sees, the youngest aged 21. He finds mammogram reports unreliable and uses ultrasound to locate masses for biopsy, citing a report read as BI-RADS 1 in a woman whose biopsy later showed grade 3 invasive ductal carcinoma.
- **Dr. Ivo Ditah, as devil's advocate: is Cameroon ready to screen?** Dr. Ditah set out the criteria for screening: a common condition, an accessible, cheap and low-harm test, and the ability to act on the result (if you cannot intervene, do not screen). He asked whether Western mammography evidence transfers to Cameroon, who paid the follow-up costs after the Buea screening, how many women can reach mammography, how many can afford receptor testing and treatment, and what it costs a woman psychologically to learn she has cancer with no access to treatment.

- **Dr. Zeh Kakanou's response on readiness and follow-up.** She said that under earlier leadership a mammogram cost 5,000 FCFA in public hospitals using government equipment, and that campaigns now pair early detection with a referral hospital set up in advance. The Committee keeps the contacts of everyone examined or referred, calls the receiving doctor daily and calls back women who do not attend. "Cameroon is ready," she said, and it is the responsibility of all. She noted that experts rarely send technical notes to the Ministry and that Cameroon does not yet have national cancer guidelines. Citing hepatitis C, where parliamentary advocacy brought the cost of treatment down from about 40 million to 5 million FCFA and then 3 million within a year, with further reductions since, she argued that cancer funding, now focused on treatment, should put diagnosis (pathology and immunohistochemistry) first. She asked oncologists to harmonise protocols and said that presenting patients at tumor boards would be expected from next year, indicating that clinicians who do not do so may no longer be able to treat cancer patients. She left the meeting early.
- **Dr. Foma's reply on costs and early diagnosis.** Dr. Foma said the Buea programme was coordinated with the central level, with subsidies, a commitment from hospital directors that positive cases would be navigated, and a needs-based financial assessment. About ten women with stage 4 disease seen in Buea had each already spent more than 10 million FCFA. Palliative care, social work and psychosocial evaluation are being developed, and he is working with the Permanent Secretary on national guidelines and tumor boards. He stressed that Cameroon is doing early diagnosis, not mass screening, cited the guidelines of Mozambique and Egypt, and suspected many unrecognised BRCA and Lynch syndrome families. Breast cancer is about 30% of female cancers that present; a receptor test costs about 100,000 FCFA against 6 to 10 million FCFA spent before death, which he called penny-wise and pound-foolish. Cancer infrastructure, he said, is the diagnostic pathway, not chemotherapy.
- **Dr. Franklin Maloba on regional cancer centres.** Dr. Maloba asked about prevalence and proposed regional cancer centres (in the north, in Douala or Yaounde, and in Buea for the South West and North West), stage-by-stage care pathways with cost estimates, and trained personnel to staff them.
- **Dr. Kenedy Foryoung (RAD-AID Cameroon) on mammography capacity.** Dr. Foryoung said Cameroon does not yet have the capacity for mass mammography screening, with perhaps fewer than ten people reading mammograms regularly. Mammography needs machines, medical physicists, engineers, IT support, quality control and trained readers. The focus now should be early detection of palpable disease, using ultrasound through primary care.

- **Dr. Margaret Bejanga Waah on a national plan and coordination.** Dr. Margaret Bejanga Waah, MD, MPH, volunteer Field Medical Director of the Patcha Foundation and Board Member of the Orange Foundation, asked for a review of the existing cancer strategic plan and for cancer to be treated as a priority in the way HIV has been. She proposed mapping cancer centres, checking cancer indicators in the national health information system, making the registry operational, evaluating existing tumor boards, coordinating the many scattered NGOs, an individual cancer risk assessment form for families and communities, and training community health workers and HIV psychosocial workers in breast examination, psychosocial support and palliative care.
- **A physician in private practice and FMSB alumnus on tumor boards and partners.** He said he attends a general hospital tumor board and suggested virtual tumor boards by Zoom or WhatsApp, and artificial intelligence support for reading mammograms, as computer-aided detection is used for tuberculosis chest X-rays. He raised the profit motive among some health workers, said cancer lacks a major partner of the kind HIV has, and suggested using HIV psychosocial workers and data clubs. Dr. Foma added that, with a general surgeon in Douala, he had reviewed more than 20 cancer patients, more than 18 of whom had been poorly managed.
- **Dr. Joshua Tambe, radiologist who led the ACPA screening in the South West.** Dr. Tambe said population screening is unaffordable and should be encouraged for those who can pay. ACPA covered the direct screening costs and hospital directors mapped care for positive cases. Stereotactic biopsy is available only in Yaounde, and some surgeons perform mastectomy before workup, putting the cart before the horse. There is no cancer institute and no local guidelines yet (he is working with the National Cancer Control Committee), no dedicated breast clinics, and no quality control or accreditation for mammography readers, whose reads are poorly paid compared with CT. Pink October 2026 brought many self-referred women.

Call to Action and Closing:

- Dr. Foma said the whole system must work together: tumor boards, a registry, screening guidelines adapted to Cameroon, and communication between surgeons, radiologists and the rest of the team. Cameroon has no colonoscopy infrastructure, and cancer will rise as age, the biggest risk factor, increases and deaths from infectious disease fall.
- He asked the diaspora to answer Dr. Zeh Kakanou's challenge by proposing solutions and adapted guidelines to the Ministry.

- Dr. Tegomoh thanked the Chair, Dr. Zeh Kakanou and all participants, and announced that a website holding all 136 sessions is being built. The recording was stopped and an unrecorded parking lot followed.

Next Meeting

The next session is scheduled for Saturday, November 14, 2026, at 1:00 PM New York time (7:00 PM in Cameroon, one hour later than usual because United States clocks change on November 1).

Submitted by: Co-Moderators, Cameroon Townhall for Healthcare Professionals