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CANCER OF THE CERVIX IN THE AFRICAN REGION: CURRENT SITUATION AND WAY FORWARD

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BACKGROUND

1. Cancer of the cervix is the commonest cancer and the leading cause of cancer mortality among women in developing countries. According to WHO, in 2002, there were more than 500 000 new cases of cervical cancer worldwide, over 90% of which were recorded in developing countries. In sub-Saharan Africa, 72 000 new cases were recorded in the same year and 56 000 women died of the disease.[1]

2. High incidences of cervical cancer are reported in Africa at rates exceeding 50 per 100 000 population and age-standardized mortality sometimes exceeding 40 per 100 000 population (see Table attached). For example, between 1981 and 1990, data from Nairobi hospital records showed that cervical cancer accounted for 70%–80% of all cancers of the genital tract and 8%–20% of all cancers.[2]

3. The major risk factor associated with cervical cancer is human papillomavirus (HPV) infection which generally occurs in adolescence after the first acts of sexual intercourse. In Africa, HPV infection prevalence is estimated at 21.3%, with significant variations from region to region: 33.6% in East Africa, 21.5% in West Africa and 21% in Southern Africa.[3] Other major risk factors include tobacco use and lack of screening and adequate treatment of precancerous lesions. Human papillomavirus and human immunodeficiency virus (HIV) coinfection accelerates progression towards cancer.

4. Primary prevention of cervical cancer is based essentially on healthy lifestyles and vaccination against HPV. Two types of vaccines against HPV infection are currently available on the market: one acts against HPV genotypes 6, 11, 16 and 18 (quadrivalent vaccine) and the other against genotypes 16 and 18 (bivalent vaccine).[4]

5. Secondary prevention of cervical cancer is by screening for precancerous lesions and early diagnosis followed by adequate treatment. The main techniques used are cytological screening of cervical cells and visual inspection of the cervix. Pilot projects initiated in six countries[5] of the African Region and coordinated by WHO have shown the efficacy, safety and effectiveness of visual inspection as a method of screening.[6]

6. Tertiary prevention of cervical cancer involves the diagnosis and treatment of confirmed cases of cancer. Treatment is through surgery, radiotherapy and sometimes chemotherapy. Palliative care is provided to patients when the disease has already reached an incurable stage.

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1 Ferlay J. et al. GLOBOCAN 2002: Cancer incidence, mortality and prevalence worldwide. IARC CancerBase No. 5, Version 2.0 Lyon: IARC Press, 2004.

2 Rogo KO et al. Carcinoma of the cervix in an African setting. International Journal of Obstetrics and Gynaecology, 1990, 33: 249-255.

3 WHO/ICO Information Centre on HPV and Cervical Cancer (HPV Information Centre). Human Papillomavirus and Related Cancers in Africa. Summary Report 2009. Available on www.who.int/hpvcentre.

4 Human Papillomavirus and HPV vaccine: Key information for policy-makers. Geneva, World Health Organization, 2006.

5 Madagascar, Malawi, Nigeria, Tanzania, Uganda and Zambia.

6 Mwanahamuntu MH et al. Integrating cervical cancer prevention in HIV/AIDS treatment and care programmes. Bulletin of the World Health Organization, 2008, 86, 8.

7. Priority interventions have been identified in the document entitled Cancer prevention and control: A strategy for the WHO African Region (Document AFR/RC58/4)[7] and in the recommendations of the Ouagadougou Regional Consultative Meeting on Cervical Cancer Prevention and Control in Africa.[8] The purpose of this document is to propose specific and targeted actions for cervical cancer control in the African Region.

ISSUES AND CHALLENGES

8. *Lack of cervical cancer control policy, strategies and programmes.* Cervical cancer is preventable and curable if detected early enough and treated correctly. In sub-Saharan Africa, lack of effective screening and treatment policy, strategies and programmes largely explains the high cervical cancer prevalence and mortality in countries. With no access to quality prevention and detection services, most women seek consultation only when the disease is already at an advanced stage.

9. *Lack of recent and comprehensive data.* Accurate data on cervical cancer morbidity and mortality in Africa are scarce and generally based on hospital data and estimates. Recording of cancer cases in most resource-challenged countries is hampered by the weakness of health systems in general and national health information systems in particular. Population-based cancer registries are scarce or generate poor-quality data.

10. *Heavy economic and psychosocial burden.* Cervical cancer diagnosed at advanced stages in African women aged 30 to 69 years has devastating physical, psychological and social impact on patients, their families and the community. A 1993 World Bank analysis estimates that the cost of screening a cervical cancer case every five years is US$ 100 per disability-adjusted life year (DALY) gained, compared with US$ 2600 per DALY for treatment and palliative care of invasive cancer.[9]

11. *Insufficiency or lack of information and skills.* In almost all countries of the African Region, the population and care providers lack information on cervical cancer prevention and management methods. Health professionals sometimes adopt inappropriate medical protocols, thus using already limited resources ineffectively. In addition, women are not aware of the available services even when such resources exist. In some communities, ignorance and lack of information regarding the disease pose further obstacles to prevention.

12. *High cost of immunization against HPV.* The cost of the available HPV vaccines remains very high and is beyond the affordable reach of the majority of the population and public authorities of countries of the African Region. The average cost of the three doses needed is estimated at about US$ 400, which poses a problem of universal access to the vaccine and a challenge to the sustainability of any primary prevention policy based on large-scale vaccination.

13. *Unavailability of secondary prevention.* The cost of cervical cancer prevention can be reduced by using simple technologies in the screening of precancerous states. To overcome the difficulty of providing quality cytology services in low-income countries, screening by means of visual inspection

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[7] WHO. Cancer prevention and control: A strategy for the WHO African Region. World Health Organization, Regional Office for Africa (Document AFR/RC58/4), 2008.

[8] Dangou JM. Recommendations of the Ouagadougou Regional Consultative Meeting on Cervical Cancer Prevention and Control in Africa. African Cancer Journal, 2009, 1:56-60.

[9] Jamison, D.T. et al. *Disease Control Priorities in Developing Countries*. New York, Oxford University Press, World Bank, 1993.

of the cervix should receive greater emphasis. However, this service is little developed in sub-Saharan African countries.

14. *Unaffordability of therapeutic resources and neglect of palliative care.* Care providers are regularly consulted by women having cervical cancer at an advanced stage and experiencing financial hardship. The limited resources available for treatment are not enough to provide effective surgical, radiotherapy and chemotherapeutic services. Not much of the palliative care needed at this stage of the disease is available.

15. *Geographical inaccessibility of tertiary prevention.* Treatment used in tertiary prevention is generally not available in countries of the African Region; and even when it is available, the infrastructure, equipment and specialists are poorly distributed and hard to reach.

16. *Lack of collaboration and coordination of interventions.* Initiatives have been taken in countries to prevent and control cancer of the cervix. Significant progress has sometimes been made. However, many issues and challenges remain. Collaboration between the various stakeholders is inadequate and the rare initiatives taken lack coordination. All stakeholders, namely communities, health professionals, Member States and partners, should therefore work together to overcome these obstacles and effectively fight against cervical cancer through the concrete actions proposed below.

ACTIONS PROPOSED

17. **Develop and implement cervical cancer prevention and control programmes based on clearly defined policy.** Control of cervical cancer and other cancers affecting women should be carried out within the context of a national cancer control programme and be integrated into existing primary sexual and reproductive health care services. Programmes should aim to create awareness among women aged 30 to 50 years as regards early detection, adequately treat those who have precancerous or invasive lesions and provide palliative care to those with advanced cancer.[10]

18. **Mobilize and allocate adequate resources.** Countries should mobilize resources and allocate them better in order to put in place well-performing programmes that will make a sustainable impact on women's health. Existing resources should be decentralized and made available to the intermediate and peripheral levels of the health system.

19. **Ensure health promotion and community involvement.** Education and counselling are integral parts of every cervical cancer control programme. Community participation will be essential to establish a dialogue with women, enhance understanding of detection and treatment methods and allay fears, apprehensions and preconceptions. Health education messages aimed at preventing risky behaviours and adopting healthier lifestyles should be reflected in national policy to make the population adopt safer sexual practices and healthier lifestyles. The messages should underscore the use of condoms as a means of prevention likely to reduce sexually transmitted infections as well.

20. **Improve the knowledge and skills of health personnel.** It will be necessary to help care providers to adopt a public health-oriented approach to screening and treatment and to train them to acquire the skills needed to advise their patients and provide quality services at all levels of the health system.

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[10] WHO, Cancer prevention and control: A strategy for the WHO African Region. World Health Organization, Regional Office for Africa (WHO/AFR/RC58/4), 2008.

21. **Implement visual inspection techniques of cervical cancer screening followed by immediate treatment by cryotherapy.** The implementation of this simple and low-cost technique will help reduce cervical cancer morbidity and mortality, hence the need to strengthen capacity in this area. A step-by-step approach to implementation should be adopted so that each stage can have a measurable outcome and the progress can be assessed.

22. **Introduce immunization against HPV as a means to control cervical cancer.** The introduction of the HPV vaccination in national expanded programmes on immunization is conceivable only if the cost of the vaccine is affordable. In this regard, governments, with the support of WHO and development partners, should carry out advocacy among pharmaceutical firms to negotiate for affordable prices. The HPV vaccine should, as a priority, be administered to girls aged between 9 and 13 years and in accordance with the epidemiological context of each country. Member States planning to introduce the vaccine should mobilize the necessary financial resources with the support of partners to ensure full immunization coverage and avoid stock outs of vaccines.

23. **Manage advanced cases of cancers.** The well-being and survival of women with invasive cancer depends on the quality of the care they receive. Primary and secondary care providers should be trained to refer women to specialized management centres having skilled staff and adequate treatment facilities and providing pain management services.

24. **Establish an adequate surveillance system, ensure oversight of interventions and assess the impact of prevention programmes.** Health data on patients follow-up should be recorded to evaluate interventions and assess the impact of programmes. The various cervical cancer management centres should have linkages to national and/or regional databases to evaluate programme performance and needs. The outcomes of the evaluation could be used to mobilize resources and sustain political support.

25. **Strengthen interdisciplinary collaboration and intersectoral and multisectoral partnerships for synergy of action.** The private sector, socioprofessional associations, nongovernmental organizations, WHO collaborating centres and other partners should be involved in the implementation of the specific actions mentioned above within the framework of national cancer control programmes. Such collaboration and partnerships should be coordinated to ensure greater efficiency and more rational use of resource.

26. The Regional Committee is invited to review and adopt the actions proposed in this document.

ANNEX

Table: Estimated cervical cancer incidence and mortality in the WHO African Region (all ages) in 2008

Country	ANNUAL INCIDENCE, 2008			MORTALITY, 2008		
	Cases	Crude rate	ASR (Global)	Deaths	Crude rate	ASR (Global)
Algeria	1398	8.2	10.4	797	4.7	61
Angola	1504	16.5	30.0	1008	11.0	21.9
Benin	925	21.5	35.0	616	14,3	24.4
Botswana	163	16.9	22.2	83	8.6	12.1
Burkina Faso	1230	16.1	28.6	838	11.0	21.5
Burundi	1270	30.8	49.1	900	21.8	37.2
Cameroon	1474	15.4	24.0	995	10.4	17.0
Cape Verde	67	25.7	34.9	40	15.4	21.3
Chad	615	11.2	19.9	425	7.7	14.6
Comoros	110	33.4	51.7	76	23.1	39.1
Central African Republic	284	12.9	19.4	201	9.1	14.1
Congo	304	16.8	27.2	191	10.5	17.6
Côte d'Ivoire	1601	15.9	26.9	1095	10.8	19.1
Equatorial Guinea	59	17.8	25.0	41	12.3	18.5
Democratic Republic of Congo	3839	11.8	21.3	2760	8.5	16.4
Eritrea	180	7.2	12.9	126	5.0	9.8
Ethiopia	4648	11.5	18.8	3235	8.0	14.0
Gabon	130	17.9	24.4	76	10.5	14.6
Gambia	195	23.3	32.4	133	15.9	24.4
Ghana	1736	26.4	39.5	2006	17.4	27.6
Guinea	1736	35.7	56.3	1217	25.0	41.7
Guinea-Bissau	185	23.3	35.1	130	16.4	26.0
Kenya	2454	12.7	23.4	1676	8.6	17.3
Lesotho	279	25.8	35.0	178	16.4	22.7
Liberia	487	25.5	41.8	341	17.9	31.2
Madagascar	1553	16.2	27.2	1085	11.3	20.5
Malawi	2316	31.0	50.8	1621	21.7	38.3
Mali	1491	23.2	37.7	1010	15.7	28.4
Mauritania	364	23.0	35.1	244	15.4	25.5
Mauritius	98	15.20	12.9	64	9.9	8.2
Mozambique	3690	32.1	50.6	2356	20.5	34.5
Namibia	117	10.8	15.8	63	5.8	8.9
Niger	572	7.8	15.6	405	5.5	12.0
Nigeria	14550	19.3	33.0	9659	12.8	22.9
Rwanda	986	19.7	34.5	678	13.5	25.4
Sao Tome et Principe	*	*	*	*	*	*
Senegal	1197	19.4	34.7	795	12.9	25.5
Seychelles	*	*	*	*	*	*
Sierra Leone	670	23.5	41.9	466	16.3	33.0
South Africa	5743	22.8	26.6	3027	12.0	14.5
Swaziland	198	33.1	50,0	116	19.4	31.4
Tanzania	6241	29.3	50.9	4355	20.4	37.5
Togo	595	18.2	30.0	417	12.8	21.8
Uganda	3577	22.6	47.5	2464	15.6	34.9
Zambia	1839	29.1	52.8	1276	20.2	38.6
Zimbabwe	1855	28.8	47.4	1286	20.0	33.4

* = No data; ASR = Age-Standardized Rate; The Crude Rate and ASR are per 100 000 population; The "Cases" and "Deaths" are in absolute figures

Source: IARC, GLOBOCAN, 2008: http://www-dep.iarc.fr