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CANTREAT INTERNATIONAL

THE HIDDEN EPIDEMIC: WOMEN'S CANCER IN LOW- AND MIDDLE-INCOME COUNTRIES

EXECUTIVE SUMMARY

Once considered a disease of wealthy societies, cancer is an increasing burden for the poorer regions of the world. More than half the 12.4 million estimated new cancer cases in 2008, and two-thirds of the estimated 7.6 million cancer deaths worldwide, occurred in low- and middle-income countries¹, where cancer kills more people each year than AIDS, TB and malaria. Changing lifestyles, increasing longevity and high rates of cancer-causing infections lie at the root of this growing epidemic in less-developed countries.

Estimates suggest that about half of all new cancer cases could be prevented. However, the disease remains a low priority for governments in poor countries and for donor nations alike: only about 5% of global resources for cancer are spent in the developing world².

While all cancers require much greater attention in the poorer regions of the world, breast and cervical cancer warrant particular focus. Together they account for more than one quarter of all female cancer deaths worldwide³, with the majority – including more than 85% of all cervical cancer deaths⁴ – occurring in developing countries. However, a small number of highly effective programs demonstrate that much can be done to reduce risk and increase sustainable access to diagnosis and treatment for these high-mortality cancers in low-resource settings.

Myths, misconceptions and prejudices about cancer are widespread. A crucial first step in addressing women's cancers is public education designed to reduce stigma and misinformation, as well as to promote changes in women's behavior to minimize risk and to encourage them to seek timely treatment for any symptoms.

Further challenges to be overcome in addressing women's cancers in low- and middle-income countries include:

- Lack of awareness and knowledge about cancer among health workers
- Lack of surveillance and statistical data as a basis for planning
- Poor health infrastructure -- and the concentration of scarce services in urban areas
- Shortages of skilled personnel, and high costs of drugs and diagnostics
- Inadequate and inappropriate health care systems, geared to dealing with short-term infections rather than long-term chronic diseases

BREAST AND CERVICAL CANCER

Breast cancer is the single most prevalent cancer worldwide⁵. Since 1990 the incidence of this cancer has been increasing globally by about 0.5% per year, but in the poorer regions of the world it has been rising as much as ten times faster⁶.

Rates of cervical cancer vary widely between countries, ranging from 7/100,000 women per year in China, to 87/100,000 women in Haiti^{7 8}.

Early detection is the single most important factor in surviving cancer. For many reasons, however, around 80% of cancer patients in poor countries are not seen by the health services until their disease is advanced, difficult and costly to treat⁹.

Screening a woman for cervical cancer only once between the ages of 35 and 40 reduces her lifetime risk by 25-35%¹⁰. Currently, however, only around 19% of women in the developing world are covered by cervical screening, compared with 63% in developed countries¹¹.

Where laboratory facilities and expertise for Pap smears are not available, screening can be carried out effectively and inexpensively by visual inspection of the cervix, using staining with acetic acid (vinegar) or Lugol iodine to identify abnormal cells. Such screening can be performed by nurses, even in the most basic primary health care settings.

Mass screening for breast cancer with mammography is not feasible in resource-poor settings, but evidence suggests that clinical examination of the breasts by a nurse can be equally effective as a screening method, and is applicable even in remote clinics and health centers.

Cancer screening is only effective and ethical if it is part of a well-organized system of follow-up and treatment. In low-resource settings, small precancerous lesions in the cervix can be treated at primary health care level using cryotherapy, a simple procedure that destroys tissue by freezing. Another relatively simple procedure for treating early disease is loop electrosurgical excision (LEEP), which uses a thin wire heated with electricity to remove abnormal cells.

Radiotherapy plays a major role in treatment protocols for both breast and cervical cancer. However, more than 30 countries in Africa and Asia have no radiotherapy services at all¹².

LATE-STAGE TREATMENT AND PALLIATIVE CARE

Almost no literature exists on the issue of treatment for late-stage cancer in resource-poor settings. The reality for most women with advanced cancers is that they are sent home to face excruciatingly painful deaths with little or no treatment or care.

Palliative care services for people with untreatable disease are especially important in the poorer regions of the world, where 80% of cancer patients present with advanced disease. Yet palliative care is rarely mentioned in national cancer control programs. Access to morphine – the mainstay of cancer pain control and a basic human right according to the World Health Organization – is virtually non-existent in 150 of WHO's 193 member states¹³.

RECOMMENDATIONS FOR ACTION

- * Governments should take a public health approach to cancer control that addresses the root causes and risk factors in the population of women at large
- * The extent and epidemiological pattern of breast and cervical cancer must be well-established as a basis for effective planning of programs
- * Greatly increased communication is needed to raise public and professional awareness of women's cancer, and to encourage women to use and demand services
- * Other measures should be taken to help prevent cancer including the promotion and support of healthy lifestyles and behavior, and the provision of screening services

- * Industry, in partnership with governments, should explore innovative ideas for improving access to medicines and diagnostics, including differential pricing strategies
- * Services for breast and cervical cancer should be integrated with general health care services, so that the system as a whole is strengthened by the new skills and resources made available
- * Addressing women's cancers will require "women friendly" services that are sensitive to women's feelings and fears and designed to cater for their special needs
- * Palliative care must be a key constituent of health worker training. Access to pain-relieving medication, especially morphine, must be made available as medically appropriate.

The tools and knowledge exist to lessen the burden and tragedy of women's cancers in developing countries. What is needed now for progress to be made are political will and a much fairer share of world resources.

Fast Facts

- * Cancer kills more people each year in low- and middle-income countries than AIDS, TB and malaria
- * Over half of all new cancer cases and almost two-thirds of cancer deaths in 2008 occurred in the low- and middle-income countries
- * Breast cancer is the single most prevalent cancer in the world
- * In 2007, an estimated 1.3 million new cases of breast cancer worldwide brought the total number of people living with the disease to 4.4 million
- * In 2007, there were an estimated 464,854 breast cancer deaths worldwide, of which an estimated 255,576 were in the developing world
- * Late stage breast cancer is up to nine times more costly to treat than early disease, and the outcomes much poorer
- * 80% of cancer patients in the poorer regions of the world are not seen until their disease is advanced
- * In 2007 there were an estimated 555,094 new cases of cervical cancer and an estimated 309,808 deaths from the disease worldwide.
- * More than 85% of global deaths from cervical cancer occur in the developing world, where it is the leading cause of cancer death among women
- * Only about 5% of global resources for cancer are spent in developing countries

ENDS

The Informal Working Group on Cancer Treatment in Developing Countries (CanTreat International) comprises experts from leading global cancer organizations working in an individual capacity to develop new models for the delivery of treatment and palliative care for cancer, in particular women's cancers, in developing countries.

¹ International Agency for Research on Cancer. *World Cancer Report 2008*. Lyon, International Agency for Research on Cancer (p15)

² World Health Organization. National cancer control programmes: policies and managerial guidelines. Geneva, Switzerland, WHO 2002.

³ American Cancer Society. *Global Cancer Facts and Figures 2007*. Atlanta, GA. American Cancer Society. (p3)

⁴ American Cancer Society 2007, *ibid*, (p3)

⁵ International Agency for Research on Cancer 2008, *ibid*, (p100)

⁶ International Agency for Research on Cancer 2008, *ibid*, (p100)

⁷ International Agency for Research on Cancer 2008, *ibid*, (p418)

⁸ Ferlay et al. Globocan 2002; Cervix Uteri Incidence Age Standardized Rates

⁹ Kanavos P, The rising burden of cancer in the developing world. *Annals of Oncology* Vol.17, Supplement 8, June 2006.

¹⁰ American Cancer Society 2007, *ibid*.(p9)

¹¹ Gakidou E, Nordhagen S, Obermeyer Z. Coverage of Cervical Cancer Screening in 57 Countries: Low Average Levels and Large Inequalities. *PLoS Med* 2008 5(6): e132 [doi:10.1371/journal.pmed.0050132](https://doi.org/10.1371/journal.pmed.0050132)

¹² International Agency for Research on Cancer 2008, *ibid*, (p35-36)

¹³ World Health Organization, *Access to Controlled Medications Programme: Biennial Report 2006-2007*. Geneva, Switzerland, WHO 2008, pp. 1-2.