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*ICPD+25:
Status of SRHR in Asia and the Pacific*

REPRODUCTIVE CANCERS *in* ASIA *and the* PACIFIC REGION

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ABOUT THIS BRIEF

This brief is part of ARROW's State of the Region Report on Sexual and Reproductive Health and Rights: International Conference on Population and Development (ICPD+25), developed as a result of monitoring of 25 years of implementing the ICPD programme of Action in the region by ARROW and our partners. This is the fifth five-yearly review, research and monitoring report contributing to insights on progress, gaps and challenges to ICPD PoA implementation in the region. This brief provides an overview of the status of SRHR in Asia and the Pacific region with a focus on 19 countries. The monitoring series also includes country level research findings around the status of ICPD implementation in 13 countries in the region.

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**REPRODUCTIVE
CANCERS**
in **ASIA** *and the* **PACIFIC
REGION**

Nadia Rajaram

Introduction

Context

Not too long ago, cancer and other non-communicable diseases were regarded as problems of high-income countries, and the focus in the Global South was to curb maternal mortality and the consequences of infection. However, in the last decade, we have observed an exponential growth in the number of people who have been diagnosed with non-communicable diseases, and cancer bears no exception. That, in combination with poor awareness and lack of access to life-saving healthcare services, explains the increase in the number of people in this region who have died due to cancer.

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Asia accounts for half the global burden of cancer, and cancer incidence is estimated to increase from 6.1 million in 2008 to 10.6 million in 2030. The increase in incidence is attributed largely to population ageing, changes to lifestyle and reproductive patterns, as well as socio-economic changes.¹ Women in Asia and the Pacific are disproportionately affected by the epidemiologic transition, and they now face the double burden of both communicable and non-communicable diseases. In developing countries, breast cancer and cervical cancer are projected to parallel maternal factors as main causes of mortality in women, especially if current cancer incidence and mortality trends continue.²

The general approach to cancer care globally is to prevent the cancers that can be averted (by reducing the prevalence of infection or through lifestyle modification), to treat the cancers that can be cured (through education, early detection, and appropriate treatment), and if these two approaches fail, to offer adequate and affordable palliative care.³ However, access to cancer care in the region is greatly hindered by the cost of such services. Many countries lack public health financing programmes, such as affordable health insurance schemes and health services subsidies, which often leads to high out-of-pocket expenses for the woman and her family.⁴ The cancer divide, a term used to describe the disparities in outcomes between higher and lower income countries or subpopulations, is a direct consequence of the lack of access to quality prevention, early detection, and treatment services, which leads to increased death and disability, disruption of family life and the exacerbation of poverty.^{5, 6, 7}

International and National Commitments

Attention to the cancer burden, particularly reproductive cancers, have only recently been highlighted as a global agenda. In the ICPD PoA of 1994, a brief and general recommendation for cancer care in Article 8.7 called for greater community participation in programmes for early detection and treatment of reproductive cancers, and encouraged governments to improve primary health care referral systems to enable timely diagnosis and treatment.⁸ In September 2011, the high level meeting in the United Nations General Assembly acknowledged that the prevention and control of non-communicable diseases is an important global health target.⁹ Cancer as a global agenda is also captured under Target 3.4 in the Sustainable Development Goals, which is to reduce mortality due to non-communicable diseases by one third through prevention.¹⁰ Indicator 3.4.1 can be effectively used to monitor the changes in the pattern of deaths due to reproductive cancers, but as is highlighted in this section, this is not a sufficient measure of the burden and inequalities borne by women in the region, which can only be measured through disaggregated data.

As will be discussed in this section, however, reproductive cancers have not been incorporated into the broader women, poverty, or health agendas, or even in the primary, maternal or sexual and reproductive health platforms in countries in Asia and the Pacific.¹¹ In the ICPD Beyond 2014 Global Report, only 37% of Asian governments reported reproductive cancers as a priority for sexual and reproductive health in their countries.¹² Lack of cancer reporting and effective vital registration greatly hinders the accurate measurement of the number of women who are affected by reproductive cancers.

Scope of the Section

This thematic brief seeks to anchor the morbidity and mortality due to reproductive cancers as a problem of social inequity and of unfulfilled rights of women in Asia and the Pacific. We report on the burden of reproductive cancers in this region, and the lack of population-based registries and vital registration systems that precludes the understanding of the true number of women who are affected by these cancers. We also discuss the intersecting barriers faced by women, including financial, socio-cultural and geographical barriers, which prevent women from seeking the care that they need to reduce their risk. Finally, we lay out some potential solutions and areas for improvement that could turn the tide in the battle against reproductive cancers in this region.

The Burden of Reproductive Cancers Among Women in the Region

Reproductive cancers include neoplasms of the breast, cervix, uterus and ovaries. Collectively, these cancers affect up to 1.2 million women per year in Asia and the Pacific and have resulted in 0.5 million deaths in the region.¹³ The cancers with the highest incidence rates and the focus of this section, however, are breast cancer and cervical cancer.

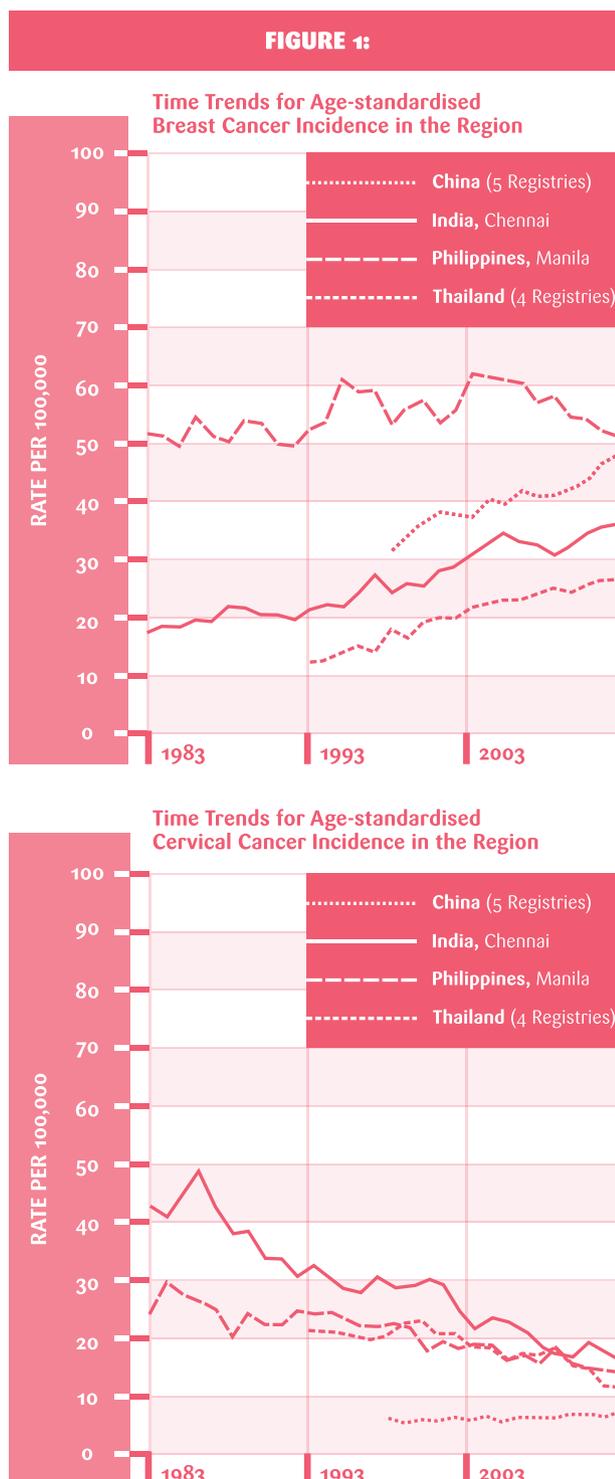
Breast Cancer

Half of the global burden of breast cancer arises from Asia and the Pacific. In 2018, up to 940,000 women in this region were diagnosed with breast cancer, and 315,000 women died from it in that year alone. While breast cancer incidence here is lower than in developed countries, the incidence is increasing at an alarming pace (see Figure 1). Over the next twenty years, up to 45% or more women will be affected by breast cancer in the region.

The shift towards a higher burden of breast cancer in these countries is multifactorial. Breast cancer is a strongly heritable disease, but there is good evidence now to show that the rise in incidence in the Global South are due largely to globalisation and rapid urbanisation in these countries. Changes in environmental exposures, diet, physical activity, and reproductive factors explain much of the rise in incidence here. Furthermore, the changing population structure in these countries could explain the higher occurrence of breast cancer among younger women in this region. Younger Asian and Pacific women are experiencing the effects of the societal and economic transition first-hand. Without intervention, this generation of women will continue to accumulate risk over their lifetime, and they will contribute to the expected increase in the number of women diagnosed with breast cancer in the near future.

While the incidence rate continues to rise in the Global South, so does morbidity and mortality due to cancer. This contrasts with developed countries, where a majority of women who are diagnosed will survive the disease. The two main factors associated with survival of breast cancer are timely access to appropriate treatment, and the stage at which the cancer is diagnosed. In developed countries, most breast cancer patients are diagnosed early (Stages 0-2), when the cancer is small and has not invaded the lymph nodes or metastasized to other parts

of the body. However, diagnosis of breast cancer at later stages is more common in Asia and the Pacific, particular in lesser developed areas.¹⁴ The reasons for late stage at presentation vary greatly across communities but is most likely due to lack of access to information and services, fear, and cultural barriers.¹⁵



Source: International Agency for Research on Cancer (IARC), Globocan 2018.¹⁶

TABLE 1: INCIDENCE, MORTALITY AND MORBIDITY DUE TO BREAST CANCER IN ASIA AND THE PACIFIC

	Age-standardised Incidence Rate (Per 100,000)	Age-standardised Mortality Rate (Per 100,000)	Mortality Incidence Ratio	Age-standardised DALY Rate (Per 100,000)	% Change from (2005-2013)
EAST ASIA					
China	36.1	8.8	0.24	104.2	-4.0
Mongolia	11.3	4.0	0.35	95.9	11.5
SOUTH ASIA					
Bangladesh	17.0	9.3	0.55	153.1	4.4
India	24.7	13.4	0.54	147.9	2.5
Maldives*	41.2	16.6	0.40	114.4	11.2
Nepal*	15.0	7.6	0.51	164.0	6.6
Pakistan	43.9	23.2	0.53	454.7	1.3
Sri Lanka	22.2	8.1	0.36	132.6	1.0
SOUTH EAST ASIA					
Cambodia*	21.7	11.6	0.53	229.8	8.4
Indonesia	42.1	17.0	0.40	167.8	3.1
Lao PDR*	32.7	16.2	0.50	186.7	9.4
Malaysia	47.5	18.4	0.39	240.0	4.3
Myanmar*	21.0	10.2	0.49	335.6	4.7
Philippines	52.4	17.5	0.33	313.3	4.1
Thailand	35.7	10.9	0.31	150.3	-18.2
Vietnam	26.4	10.5	0.40	81.1	-1.4
PACIFIC					
Fiji	63.4	36.9	0.58	713.2	-4.9
Papua New Guinea*	45.8	25.2	0.55	439.6	7.0
Samoa	80.1	24.3	0.30	192.6	4.1

Source: IARC, Globocan 2018.²² *Data extrapolated from neighbouring countries.

Five-year survival is the best indicator for the burden of mortality due to cancer.¹⁷ However, there is currently little data on the five-year survival in Asia and the Pacific, primarily due to the lack of the well-structured cancer registries and poor cause-of-death reporting mechanisms. For countries with available data such as India, Malaysia and Thailand, the five-year survival was reported at 65-70%, which means that up to 70% of women with breast cancer will survive for at least five years from their diagnosis.¹⁸ It is important to note that five-year survival data are only available for countries or states that have population-based registries, and that the data may only be representation of parts of the

population. For example, an independent study from Malaysia indicates that the 5-year survival may be poorer, closer to 50%.¹⁹

In the absence of the 5-year survival data, the mortality-to-incidence (MIR) ratio can be an important indicator of cancer survival and, in particular, of the disparities to cancer care (see Table 1). In East Asia, the MIR ratio is low, where there are 2 deaths for every 10 women diagnosed with breast cancer. However, this ratio varies greatly throughout the region, and is as high as 7 deaths for every 10 cases, such as in Cambodia.

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The MIR has to be interpreted cautiously, however. For any given year of data analysis, the women enumerated in the mortality rate are not necessarily the same women enumerated in the incidence rate.²⁰ It is also important to note that the lowest rates observed in Table 1 are primarily in countries where data was not available and was extrapolated from neighbouring countries, and therefore, may not accurately capture the true burden of cancer in these countries. These considerations, coupled with poor cause-of death registration in most of the region, hinder the accuracy of MIR as a proxy of cancer survival.

The treatment of cancer is often a long, arduous journey, which can greatly hamper the quality of life of women. Morbidity or disability due to cancer is, therefore, an important measure of the burden women face after a cancer diagnosis. The age-standardised DALY rate can provide an approximation of this burden. One DALY (disability-adjusted life year) represents one year of life lost due to the disease, and hence, this leads to the consideration of the years of life lost due to death or disability.²¹ Using this indicator, high rates are observed in Pakistan, Myanmar, and Philippines, as well as the countries in the Pacific. In these countries, the DALY rate has not changed significantly between 2005 to 2013. Thailand has observed the greatest reduction in the DALY rate since 2005, by 18%. Most countries in the region, however, observe no change or an increasing burden of breast cancer; a burden carried by women.

Cervical Cancer

Cervical cancer disproportionately affects women of the Global South. Up to 85% of all cervical cancer cases occur in this region.²² While current trends indicate that cervical cancer incidence is decreasing in a few countries in this region, such as in India, Philippines and Thailand (see Figure 1), the WHO foresees a 40% increase of the incidence of cervical cancer among women in countries with already high disease burden.²³ In this region, mortality due to cervical cancer is highest in the Pacific (see Table 1), where 20-21 in every 100,000 women die from cervical cancer every year. In South Asia, countries like India, Nepal and Bangladesh also have a high mortality rate because of cervical cancer in which 12 per 100,000 women die from the disease every year.

Almost all cases of cervical cancer can be attributed to chronic infection with the human papillomavirus (HPV), with 90% of these attributed to the carcinogenic HPV types 16 and 18.²⁴ HPV is a common sexually transmitted virus, and infection rates are high during peak sexual activity years.²⁵ While in most cases the infection resolves without treatment, a weak or compromised immune system may be inefficient in clearing the virus from the system, thereby resulting in a long term chronic infection. At this point, a woman is at an increased risk of cervical cancer. The resolution of the cervical cancer problem, therefore, hinges on appropriate control of sexually transmitted infections in the region.

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Survival from cervical cancer is poor, in general. In this region, there are between 5 to 8 deaths for every 10 women diagnosed with cervical cancer per year (see Table 2). Compared to breast cancer, where symptoms are likely observable or palpable, the early symptoms for cervical cancer are often hard to distinguish from those due to common menstrual problems. Therefore, cervical cancer is often diagnosed at more advanced stages of the disease. The only way to increase early detection of cervical cancer is through regular access to effective screening for cervical cancer.

On a positive note, there are marked improvements in the number of life years lost to mortality and morbidity due to cervical cancer across the region. In East Asia, there was a 20% reduction in the DALY rate between 2005-2013, whereas South Asia, South East Asia, and the Pacific observed between a 10-20% reduction. However, there is urgent need to make further improvements for countries that have a disproportionately larger burden of cervical cancer, such as Myanmar and Papua New Guinea, and for countries in the region that have yet to see improvements in the mortality and morbidity due to cervical cancer.

TABLE 2: INCIDENCE, MORTALITY AND MORBIDITY DUE TO CERVICAL CANCER IN ASIA AND THE PACIFIC

	Age-standardised Incidence Rate (Per 100,000)	Age-standardised Mortality Rate (Per 100,000)	Mortality Incidence Ratio	Age-standardised DALY Rate (Per 100,000)	% Change from (2005-2013)
EAST ASIA					
China	11.9	4.4	0.37	52.2	-23.6
Mongolia	23.5	10.2	0.43	213.5	-20.2
SOUTH ASIA					
8 Bangladesh	10.6	7.1	0.67	104.0	7.6
India	14.7	9.2	0.63	121.5	-19.0
Maldives*	23.2	13.4	0.58	22.7	-18.4
Nepal*	21.5	14.3	0.67	113.4	-7.4
Pakistan	7.3	5.2	0.71	59.4	-14.0
Sri Lanka	7.8	4.2	0.54	31.1	-10.9
SOUTH EAST ASIA					
Cambodia*	13.5	10.1	0.75	203.9	-13.1
Indonesia	23.4	13.9	0.59	171.2	-10.8
Lao PDR*	11.4	7.0	0.61	230.9	-7.0
Malaysia	10.5	6.0	0.57	78.4	-9.0
Myanmar*	21.5	13.1	0.61	403.5	-12.7
Philippines	14.9	8.8	0.59	120.4	1.8
Thailand	16.2	9.0	0.56	130.7	-21.4
Vietnam	7.1	4.0	0.56	79.0	-23.5
PACIFIC					
Fiji	25.9	19.7	0.76	244.2	-11.3
Papua New Guinea*	29.1	19.8	0.68	431.8	-7.2
Samoa	12.6	7.5	0.60	144.7	0.5

Source:
IARC, Globocan 2018. *Data extrapolated from neighbouring countries.

Compared to breast cancer, where symptoms are likely observable or palpable, the early symptoms for cervical cancer are often hard to distinguish from those due to common menstrual problems. Therefore, cervical cancer is often diagnosed at more advanced stages of the disease. The only way to increase early detection of cervical cancer is through regular access to effective screening for cervical cancer.



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Access to Screening, Diagnosis, and Treatment

Breast Cancer Screening

Most countries in the region have reported the adoption of a national screening programme for breast cancer (see Table 3). Since population-based screening is not a cost-effective approach in the Global South, where many more women will have to be screened to detect one breast cancer, many countries in the region have therefore adopted an opportunistic screening modality. With opportunistic screening, women are offered screening if and when they interact with the health care system and if they meet the risk profile. However, these programmes have had little to no impact on mortality,²⁶ likely due to low uptake of screening in these countries. Efforts are underway to refine opportunistic screening by identifying high risk groups for targeted screening;²⁷ based on their family history of cancer, mammographic profiles, and/or genetic profiles. Currently, effective risk modelling approaches are still under study and the cost- or resource-effectiveness in this part of the world is largely unknown.

The gold standard for breast cancer screening is mammography, which has contributed to a 34% drop in breast cancer mortality in countries with widespread implementation.²⁸ There are, however, financial and logistical constraints in accessing mammography services, both for the healthcare system and for the women in these countries. Inadequate healthcare funding has led to the concentration of few mammogram machines in urban hospitals. For example, each mammogram machine in Thailand serves up to seven times more women compared to each mammogram machine in the US.²⁹ Furthermore, women across the country are required to travel to urban or larger hospitals for screenings.³⁰

Widespread implementation of quality clinical breast examination (CBE) may be the solution in low resource settings. Research has shown that CBE can effectively downstage cancer, by detecting abnormalities that are smaller and at early stages.³¹ In a projection study in India, it was reported that annual CBE screening can have a similar impact on breast cancer mortality as biennial mammography screening, but for half the cost.³² Breast self-examination, on the other hand, does not appear to have an impact on earlier presentation of the disease,

but it is a useful tool to empower women to be more aware of their body and to move them to action.

Several countries in the region have yet to develop and adopt a national screening programme for breast cancer (see Table 3). As of 2017, countries like Cambodia, Lao PDR, and the Philippines reported a lack of a national screening programme for breast cancer. For the Pacific islands studied here, all reported that there are no screening programmes for breast cancer. The high incidence of breast cancer and high burden of mortality and morbidity in these countries warrant immediate implementation of an effective national screening programme.

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Cervical Cancer Screening

Cervical cancer is preventable. In high income countries, population-based cytology screening has achieved up to 80% reduction in the number of women diagnosed with cervical cancer.³³⁻³⁴ However, cervical cancer screening has not been successfully implemented in low resource settings due to human, financial and infrastructural constraints.³⁵ Most countries in this region have a national strategy for cervical cancer screening, but implementation varies. The uptake of screening reported in countries with opportunistic screening programmes is typically between 10-50% or even less than 10%, compared to countries with population-based programmes, where up to 70% of the eligible population have been reported to have undergone screening (see Table 3).

Cytology screening involves taking a specimen from the cervix, which is then sent to a clinical laboratory for analysis. It is an invasive procedure. A study in Thailand showed that 27% of women were reluctant to attend

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TABLE 3: NATIONAL CANCER SCREENING PROGRAMMES

	Existence of a National Screening Programme for Breast Cancer	Existence of a National HPV Vaccination Programme	Existence of a National Screening Programme for Cervical Cancer (Type)	Coverage of National Cervical Cancer Screening	Availability of Palliative Care in Primary Care
EAST ASIA					
China	Yes	No	Yes (Population-based)	50 - 70%	No
Mongolia	Yes	No	Yes (Population-based)	10 - 50%	Yes
SOUTH ASIA					
Bangladesh	Yes	Yes	Yes (Opportunistic)	DK	No
India	Yes	No	Yes (Population-based)	> 70%	No
Maldives	Yes	No	Yes (Opportunistic)	< 10%	Yes
Nepal	No	Yes	Yes (Opportunistic)	10 - 50%	No
Pakistan	Yes	No	No	—	No
Sri Lanka	Yes	No	Yes (Population-based)	10-50%	No
SOUTH EAST ASIA					
Cambodia	No	Yes	No	—	No
Indonesia	Yes	Yes	Yes (Population-based)	10 - 50%	No
Lao PDR	No	No	No	—	No
Malaysia	Yes	Yes	Yes (Opportunistic)	10-50%	Yes
Myanmar	Yes	No	Yes (Opportunistic)	< 10%	No
Philippines	No	Yes	Yes (Opportunistic)	< 10%	No
Thailand	Yes	Yes	Yes (Population-based)	50 - 70%	Yes
Vietnam	Yes	No	Yes (Population-based)	10 - 50%	No
PACIFIC					
Fiji	No	Yes	Yes (Population-based)	10 - 50%	Yes
Papua New Guinea	No	Yes	No	—	No
Samoa	No	No	No	—	Yes

Source: World Health Organization (WHO), Global Health Observatory Data Repository.³⁶

cytology screening because they were shy, and 14.7% were afraid of pain associated with the procedure.³⁷ Also, because the laboratory analysis cannot be processed within the same day, women are required to return to the clinic again to review their results, which poses an additional barrier to proper management of cervical abnormalities.

To overcome these barriers, a new modality or cervical cancer screening is currently being pilot-tested in Malaysia under Project ROSE (Removing Obstacles to Cervical Screening).³⁸ This programme integrates self-

sampling, rapid HPV-DNA testing, and e-health so that women receive their appointment reminders and test results by text messaging. While HPV-DNA testing is still unaffordable for most low resource health care settings, this new screening modality may be a suitable option for many countries in Asia and the Pacific.

Currently, VIA (visual inspection with acetic acid) remains the most affordable alternative approach to cytology screening. In India, a single VIA visit was associated with a 25% reduction in incidence and 35% reduction in mortality.³⁹ When VIA was provided every

two years, the reduction in incidence observed was 31%. While the reductions in incidence and mortality are far less than that for cytology screening, it is more feasible in low resource settings, and may be an interim approach in creating a screening culture among women.⁴⁰

The lack of national HPV vaccination programmes in low-income countries is primarily due to the cost of the vaccine.

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Many vaccination programmes in these countries are funded through demonstration projects by international organisations such as PATH and GAVI, but scalability remains an issue.

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- Universal HPV vaccination has been suggested as a means to reduce up to 420,000 deaths due to cervical cancer worldwide.⁴¹ National vaccination programmes have been implemented in many countries in South East Asia and the Pacific. In recent years, Indonesia, Thailand and Cambodia have adopted a national HPV vaccination programme (see Table 3). In South Asia, only Bangladesh and, more recently, Nepal have adopted a national HPV vaccination programme. Full-dose vaccine coverage in these countries is approximately 62.5% of the target population, lower than the global goal of 80%.⁴²

The lack of national HPV vaccination programmes in low-income countries is primarily due to the cost of the vaccine. Many vaccination programmes in these countries are funded through demonstration projects by international organisations such as PATH and GAVI, but scalability remains an issue. However, efforts are underway to reduce the cost or the 3-dose requirement of the current HPV vaccines to better reach the women and girls who need it the most.

Cancer Treatment

The availability of screening programmes alone will not reduce the mortality due to breast cancer. For example, WHO only recommends a population-based mammogram screening programme for women 50-69 years old if the healthcare system can adequately accommodate the spectrum of cancer care. A holistic approach to cancer care has to be in place to complement screening capabilities, such as having a way to recruit eligible

women for screening, having sufficiently trained radiologists, oncologists, and pathologists, and having adequate facilities for diagnosis and treatment.⁴³

Up to 70% of breast cancer patients who need surgery, chemotherapy, radiotherapy or hormone therapies are unable to access these therapies⁴⁴ due to the high costs and the lack of infrastructure to support these therapies. For example, low- and middle-income countries only account for 30% of the world's radiotherapy facilities when it is home to 56% of cancer patients. The coverage of radiotherapy services in Asia and the Pacific is highly variable, as low as <20% in Indonesia, the Philippines, Myanmar, Laos, and Cambodia.⁴⁵ Most Asian countries are faced with a shortage of oncologists, where one oncologist provides care for between 500 to 1000 new cancer cases per year.⁴⁶ Sri Lanka faces an extreme shortage in which the ratio is 1,300 cancer cases to each oncologist, with only 18 registered clinical oncologists in the country.

Strategies to improve the quality of life of survivors are seldom incorporated into treatment plans, which is an important aspect of the fulfilment of a woman's right to physical, emotional and sexual well-being.

Furthermore, the cost of cancer treatment in low resource countries is primarily borne by the patient. In India, for example, there is a high dependency on the private sector for health care, which now makes up 93% of the total number of hospitals in the country, compared to 8% in 1947.⁴⁷ A study of eight Asian countries show that 48% of cancer patients experienced financial catastrophe just one year after diagnoses.⁴⁸ Footing the bill for cancer can push already vulnerable households into poverty. In these settings, the marginalised groups face the greatest risk of financial catastrophe.

Treatment is often focused on resolving physical symptoms of cancer and increasing survival. Often, however, strategies to improve the quality of life of survivors are seldom incorporated into treatment plans, which is an important aspect of the fulfilment of a woman's right to physical, emotional and sexual well-being. Changes due to treatment contribute to low self-esteem and perceived body image issues, as well

as decline in sexual desire and satisfaction.^{49, 50} Across many societies, a woman's hair and her breasts are still regarded as symbols of femininity and sexuality, and the loss of these features could negatively impact her and her relationships.⁵¹

Access to Palliative Care

Palliative care is an important component of managing cancer progression in women. Unfortunately, palliative care is underfunded and is often overlooked as part of cancer care.⁵² In this region, when there are many competing healthcare priorities with limited resources, there is a lack of urgency to understand the comprehensive palliative care needs of women in Asia and the Pacific. This is evident as “[m]illions of people with advanced or untreatable cancer, but without access to true palliation, will die with great and preventable suffering, impoverished from attempting to meet even the most basic treatment costs.”⁵³

For palliative care to effectively reach its' intended population, a continuum of care must be in place, including hospital-based palliative care, ambulatory palliative care, hospice care, and home care. A report on palliative care in Asia shows poor integration into healthcare and community settings for many of the countries studied here.⁵⁴ Only a few countries offer palliative care as part of their primary care services, generally, but there is a lack of data in services provided for the unique needs of cancer patients for whom palliative care may be more intensive, expensive, and prolonged. Furthermore, the lack of community or home-based palliative care often results in high out-of-pocket expenses of long-term pain management in hospitals that are already underfunded and overcrowded in this region.

A supportive health care delivery system should also include helping women overcome financial and logistical barriers to health seeking. . . Distance to the health facility was an issue for at least a quarter of the women in most Asian countries, which is an indicator of the insufficient geographical distribution of health services across the country.

Barriers to Cancer Care in Asia and the Pacific

The combination of lack of awareness of the disease, lack of access to treatment, the multiple competing priorities in women's lives, the lack of autonomy and the influence of cultural perception, all prevent women in this region from getting diagnosed early and receiving effective, timely treatment that is required to save their lives.

The current understanding is that the lack of awareness about cancer, its' signs and symptoms, and its' consequences is the main reason why women delay seeking care in low resource countries. However, efforts to increase knowledge about cancer risk and the benefits of screening have not been effective in enabling women to attend screening. In a Thai study, many women believed that they did not need cervical cancer screening (23%) or that they were not at risk for cervical cancer (16%).⁵⁵ National policies in India on primary prevention have not led to higher levels of cancer awareness or any other improvements, likely due to poor financing, access, availability and quality of care.⁵⁶ Educational campaigns, by itself, may increase screening intention but does not increase screening rates.⁵⁷ The key to improving coverage of screening, therefore, is not only through education, empowerment, and awareness, but also in enabling a locally-relevant, equipped health care delivery system to support the needs of the women it serves.

A supportive health care delivery system should also include helping women overcome financial and logistical barriers to health seeking. In South East Asian countries such as Cambodia and the Philippines, the proportion of women who reported that they faced problems getting money for treatment has reduced over time but still remains high (65% and 48%, respectively, as shown in Table 4). In Nepal, more than half of the women population reported that they faced problems getting money for treatment and problems with the distance to the nearest health facility as well as difficulty getting transport there. Distance to the health facility was an issue for at least a quarter of the women in most Asian countries, which is an indicator of the insufficient geographical distribution of health services across the country. These are also the reasons why many women do not follow up with definitive diagnosis and treatment after screening positive.^{58, 59} For example, high out-of-pocket fees in Bangladesh results in fewer patients returning for breast cancer surgery.⁶⁰

Third, women in low resource settings often face greater competing priorities when it comes to decision making about their health. Women in this region are often the main care providers in the household⁶¹ and are faced with the responsibility and social pressure of putting the priorities of their families before their own. Therefore, taking care of children or the elderly, working, or household responsibilities are regarded as more important than going for a health check or seeking care for a symptom. For these women, it is also almost unquestionable that their already stretched funds be dedicated to the needs of the family, and not her own health needs. Beyond competing priorities, in many parts of Asia, the decision about a woman's health is not her own. Up to a quarter of women in South Asia and South East Asia reported that they faced problems in securing permission to go for any

health treatment, and for countries with data available, this has not changed much over time (see Table 4). Women's autonomy in making cancer-related health-seeking decisions, however, is not well studied⁶² and is likely further exacerbated by the high costs and social stigma associated with a diagnosis of cancer.

Beyond competing priorities, in many parts of Asia, the decision about a woman's health is not her own. Up to a quarter of women in South Asia and South East Asia reported that they faced problems in securing permission to go for any health treatment.

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TABLE 4: BARRIERS TO ACCESSING HEALTHCARE AMONG WOMEN

	Year	Problems Getting Permission to go for Treatment	Problems Getting Money for Treatment	Problems With Distance to Health Facility	Problems Having to Take Transport	Not Wanting to Go Alone	Concern There Will Not be a Female Provider
SOUTH ASIA							
Bangladesh	2004 ⁶³	17.4	14.0	8.4	12.4	19.1	17.4
India	2005 - 2006 ⁶⁴	6.7	17.3	25.2	22.9	11.7	18.7
	20015 - 2016 ⁶⁵	17.9	25.4	29.9	27.1	19.5	37.4
Maldives	2009 ⁶⁶	2.3	11.4	26.0	28.2	23.7	57.0
Nepal	2001 ⁶⁷	17.0	66.3	50.5	—	57.2	49.2
	2011 ⁶⁸	12.6	46.8	46.6	—	60.2	—
	2016 ⁶⁹	23.5	54.9	53.0	51.0	67.8	66.9
Pakistan	2012 - 2013 ⁷⁰	17.7	29.7	37.1	40.3	53.1	63.2
SOUTH EAST ASIA							
Cambodia	2000 ⁷¹	22.6	88.1	40.3	42.0	44.5	32.6
	2005 ⁷²	14.3	74.1	38.7	38.7	45.0	36.9
	2014 ⁷³	21.4	64.4	35.0	—	45.4	—
Indonesia	2002 - 2003 ⁷⁴	4.2	23.7	12.4	11.5	8.6	5.7
	2012 ⁷⁵	5.1	15.2	10.5	—	22.8	—
Myanmar	2015 - 2016 ⁷⁶	4.3	34.0	23.4	—	31.4	—
Philippines	2003 ⁷⁷	10.7	67.4	27.2	25.6	28.1	20.5
	2013 ⁷⁸	9.2	47.7	27.4	—	21.1	—

Source: Various Demographic and Health Survey (DHS) of countries reviewed.

Fear of the disease consequences and fear of stigma and discrimination both limit women’s choice and access to screening and treatment, and aggravate the problem of increasing incidence of reproductive cancers in developing countries.⁷⁹ Fatalism, the notion that cancer is a death sentence, is still prevalent in this part of the world.⁸⁰ Fear that the cancer is incurable or that the treatment has unbearable consequences has been shown to reduce the likelihood of initiating medical treatment.⁸¹ Furthermore, cultural norms and local traditions, as well as the mistrust in “Western” medicine approaches, may inhibit women from attending current screening practices.⁸² Lack of understanding about the disease translates to perceived and received stigma and discrimination. A study in Karnataka, India showed that fear of “catching” cancer from someone who was diagnosed is still prevalent in the community, and that the woman, through some fault of her own, is responsible for the development of cancer.⁸³ These misconceptions have led to women being fearful of coming forward for screening or early diagnosis; fearful of the disease and fearful of her place in society.

Cancer Registration

We can only assess the burden of cancer and any progress made in reducing cancer incidence and deaths if we have an accurate measure of the problem. Unfortunately, at least 80% of cancer patients live in an area that is not covered by a population-based cancer registry.⁸⁴ Population-based registries are available in parts of China, India, and many South East Asian countries, while other countries in the region have hospital-based cancer registration (see Table 5). Population-based registries are preferred over hospital-based registries as they allow for estimating cancer incidence in the country and can be used to direct cancer control programmes. When a population-based registry is not available, statistics for the country are extrapolated from the next best-options, such as hospital or community-based registries, data from smaller studies, or data from neighbouring countries.

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TABLE 5: EXISTENCE OF CANCER REGISTRATION

	Existence of an Operation of an Operation Policy/Strategy or Action Plan for Cancer	Existence of a Population-based Cancer Registry (Last Year of Data)		Existence of an Operation of an Operation Policy/Strategy or Action Plan for Cancer	Existence of a Population-based Cancer Registry (Last Year of Data)
EAST ASIA			SOUTH EAST ASIA		
China	Yes	Yes (2009)	Cambodia	Yes	No
Mongolia	Yes	Hospital-based (2012)	Indonesia	Yes	Yes (2007)
SOUTH ASIA			Lao PDR	Yes	No
Bangladesh	Yes	No	Malaysia	Yes	Yes (2011)
India	Yes	es (2008)	Myanmar	No	No
Maldives ^o	Yes	No	Philippines	Yes	Yes (2003)
Nepal	Yes	Hospital-based (2011)	Thailand	Yes	Yes (2009)
Pakistan	No	No	Vietnam	Yes	Yes (2010)
Sri Lanka	Yes	Hospital-based (2007)	PACIFIC		
			Fiji	Yes	Hospital-based (2011)
			Papua New Guinea	Yes	Hospital-based (2012)
			Samoa	No	Hospital-based (2012)

Source: WHO, Global Health Observatory Data Repository.⁸⁵

The complement to a representative population-based registry is accurate cause of death reporting and vital registration systems, and the ability to effectively link these systems. However, these are lacking or are not well implemented in most of the countries in the region. For example, a cancer death that occurs at home could be mistaken as death due to old age or due to the secondary manifestation of cancer (i.e. organ failure). This weakens the accuracy of mortality data, which is the foundation for many of the cancer burden indicators used globally.

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Conclusion

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The evidence is clear: the burden of reproductive cancer disproportionately affects women in Asia and the Pacific, and this disparity continues to widen. If we do not introduce effective prevention interventions that are acceptable and adaptable by women in Asia and the Pacific, we will see a two-fold increase in the number of women diagnosed with reproductive cancers in the next decade. If we do not increase awareness and access to affordable cancer screening, diagnosis and treatment, half of the women who are diagnosed will die without access to adequate palliative care. Other women may suffer from poor quality of life due to disability and insecurity. Some women will be forced into financial catastrophe. We are long past the point of saying that cancer is only a problem in high-income countries. Therefore, investments into implementing sound, evidence-based national strategies that will increase access and availability of life saving cancer screening, diagnostic and treatment service for the women who need it the most, as well as the research to support it, deserve a high priority on global and national agendas in the next decade.

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Potential Solutions to the Growing Reproductive Cancer Problem

1. Develop, adopt and implement effective, appropriate, and translatable national cancer care policies or strategies, which incorporate integration and implementation of cancer care at all stages, from health-care systems to community and home care and include cancer care within the umbrella of universal health care.

In order to be sustainable, cancer care has to be incorporated into existing health systems, such as within the reproductive health care frameworks. Only with high coverage of cancer screening and early diagnosis, as well as adherence to appropriate treatment, can there be meaningful change in the current cancer trajectories. However, the model of cancer control and care in high-income countries, which include specialist care as well as expensive and state-of-the-art therapies, is unlikely to be sustainable for many countries in Asia and the Pacific.⁸⁶ Rather than relying on expensive, technology-based solutions, the focus of cancer care in lower resources settings should be on adapting and strengthening appropriate existing systems to cater for the needs of women it serves.⁸⁷

The Breast Health Global Initiatives, for example, outlines the minimum requirements of a functioning cancer health care system by resource availability. For countries with basic or limited resources for cancer, this includes culturally-tailored patient and family education, the triaging of patients through cancer care by health care professionals or patient navigators, and adequate training of physicians, nurses, pathologists, and community or volunteer workers to support the health care system.⁸⁸

2. Decentralise cancer care, including access to screening, diagnostic and treatment facilities and services.

In many countries in Asia and the Pacific, cancer services are often concentrated in urban areas. This greatly hinders timely screening, diagnosis and treatment of women who live in more rural or geographically distant areas. This not only increases a woman's financial burden, which will now include the cost of transportation and visit to urban hospitals, it is also logistically challenging. Seeking help,

therefore, becomes a last resort. Ensuring that all sections of the population have reasonable access to these services, as well as the implementation of user-friendly referral systems, should remain a priority in this region.

Rather than relying on expensive, technology-based solutions, the focus of cancer care in lower resources settings should be on adapting and strengthening appropriate existing systems to cater for the needs of women it serves.

3. Increase national capacity to develop and maintain national population-based cancer registries to collect accurate, representative, disaggregated data at the national level.

Without accurate measurement of cancer burden, we cannot truly know how many women are affected by cancer, nor who are affected the most. Collecting disaggregated data on cancer incidence, mortality, survival, and cancer characteristics will not only inform countries of the total amount of people suffering from the disease, but it will also inform on key aspects necessary for effective policy development and implementation, especially in identifying key affected groups.

4. Increasing capacity also includes adequate training for government bodies and health care personnel in capturing these data. Furthermore, investments in a proper reporting mechanism and the use of technology will allow for effective cross-linkage across various health reporting mechanisms, thus leading to a more sustainable and efficient way of capturing and analysing data. Increase national and international investment in the research, development and implementation of evidence-based primary and secondary prevention for reproductive cancers, including comprehensive sexuality education.

If, at least, a part of the rise in incidence of reproductive cancers is due to changes in women’s lifestyle, then we can intervene. There is great potential to stop the rise in breast and cervical cancer by implementing prevention interventions. For cervical cancer, prevention by HPV vaccination is key, as well as ensuring safe sex practices to reduce sexually transmitted infections. The evidence

on prevention for breast cancer is less concrete, but recent studies have shown that a proportion of breast cancer can be prevented by limiting unhealthy behaviours such as smoking and excessive alcohol drinking, and increasing healthy behaviours, such as physical activity and maintaining a healthy weight.⁸⁹ From 1990 to 2013, obesity increased by up to 9% in the Pacific and up to 40% in Asia.⁹⁰ It becomes easy to draw the correlations here. Therefore, investments into evidence-based, community cancer prevention programmes, as part of the larger national agenda, is necessary to reduce the burden of reproductive cancers in this part of the world.

Early sexuality education programmes could play an important role in communicating this information to young girls. In the case of cervical cancer, sexuality education can assist in creating awareness about protection from HPV infection, identifying the symptoms of such infections, and it can provide them with information about vaccination, screening and treatment options and venues. This is yet another problem that can be solved with adequate implementation of comprehensive sexuality education in the region.

Patient and community navigation programmes provide individualised care to help individuals or communities break through the barriers to cancer screening and treatment and has been successfully implemented in low resource Asian communities.

5. Identify innovative and culturally-relevant approaches to address the barriers to cancer awareness, prevention, screening and treatment.

Reproductive cancers in low resource settings affect women in the prime of their life.⁹¹ Women are the main caregivers in their families, and often, have been taught to prioritise the needs of their family over their own needs. Therefore, there needs to be adequate support for women (and their family) when they are diagnosed with cancer. Patient and community navigation programmes provide individualised care to help individuals or communities break through the barriers to cancer screening and treatment and has been successfully implemented in low resource Asian communities.⁹² Successful downstaging of cancer can only occur if governments incorporate effective

programmes that specifically address the multiple, intersecting barriers faced by women in seeking their cancer care needs.

What is clear globally is that cancer care is a complex journey that is different for each person affected by it. A one-size-fits-all approach is no longer a solution we should be working towards. Instead, we should be looking at culturally acceptable, risk-based approaches, where every woman can be counselled on her individual risk, is empowered with sufficient information to make decisions about her health and her body and can access the services needed to save her life, with the right help along the way.

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6. Increase international and national funding for cancer, particularly for strengthening health systems, access to effective prevention and treatment options, and for research.

Most countries in Asia and the Pacific cannot afford the cost of cancer for their people. Despite global commitments to reducing the burden of cancer, only 3% of the global development assistance for health is directed at non-communicable diseases,⁹³ and only 5% of global spending on cancer is directed towards countries in the Global South.⁹⁴ In 2008, Marge Berer reported that “Almost no money or resources worth mentioning have gone into implementing any form of screening let alone early treatment, for cervical cancer and its precursors in the countries that need it the most.”⁹⁵ There remains a need to redirect global funding for cancer to the countries that require it the most.

Part of the problem is also the lack of funding for research that matters to women in the Asia and the Pacific. Otis Brawly, the Chief Medical and Scientific Officer of the American Cancer Society, states that “Politicians almost always support basic research, but rarely support studies on the effectiveness of treatment.”⁹⁶ This is the unfortunate reality of the current grant funding mechanisms, where priority is often given to technologically advanced, state-of-the-art research. While these are important in finding new frontiers in the fight against cancer, it does not provide immediate benefit to women in the Global South.

Research and practice in high-income countries are typically not concerned with value for money or affordability of services, and less than 10% of cancer research in developed countries are focused on improving health systems to reduce cancer mortality and morbidity.⁹⁷ Although research into the latest technology is much needed, we also need to recognise the need for investments into cancer research focused on programmes that improve outcomes, affordability of cancer treatment, and quality of life where the disparities are the greatest for women.

What is clear globally is that cancer care is a complex journey that is different for each person affected by it. A one-size-fits-all approach is no longer a solution we should be working towards. Instead, we should be looking at culturally acceptable, risk-based approaches, where every woman can be counselled on her individual risk, is empowered with sufficient information to make decisions about her health and her body and can access the services needed to save her life, with the right help along the way.

A woman with dark skin and short hair is smiling warmly at the camera. She is wearing a bright yellow short-sleeved top with a decorative pattern of small red and black dots around the neckline. A pink and white checkered cloth is draped over her left shoulder. She is also wearing a patterned skirt with large red and pink floral designs. The background is a blurred outdoor setting with green foliage and a wooden post to the left.

*In the ICPD Beyond 2014
Global Report,*

only 37

Asian governments

*reported reproductive cancers as a priority
for sexual and reproductive health
in their countries.*

BREAKING THE BARRIERS: UNDERSTANDING CANCER SERVICES, SCREENING & TREATMENT AVAILABLE FOR WOMEN IN FIJI

PROJECT:

Fiji ICPD+25 Monitoring Report

PARTNER:

20 Fiji Women's Rights Movement (FWRM)

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CONTEXT OF THE COUNTRY

The review of the International Conference on Population and Development (ICPD) in 2019 will mark the twenty-fifth anniversary of the ICPD Programme of Action (PoA), a historic consensus document where 179 countries stood in solidarity to advance women's sexual and reproductive health and reproductive rights everywhere. Much has been achieved since the adoption of the ICPD PoA but more needs to be done to ensure that the commitments adopted in Cairo remain at the heart of the global agenda. Monitoring the implementation of this international commitment is a vital way of holding governments accountable and transparent. In our bid to ensure that the Fiji Government remains committed and accountable towards the promises made in Cairo, the Fiji Women's Rights Movement (FWRM) decided to carry out a research study that focused on the state of cancer services, screening and treatment in Fiji because of the high prevalence rate of reproductive cancers affecting women to date. As it stands, breast and cervical cancer remain among the top five causes of death in women around the country. Given these statistics, the need for FWRM to investigate the state of cancer services and treatment available for women became apparent, as well as the intersectional barriers that women face in accessing these services.

KEY FINDINGS

The introductory section of the research study aims to set the context of the selected research topic, providing an interlinking narrative on the significance of the ICPD PoA and other international and regional commitments; the overall health of women in the world and in the Pacific; the status of implementation of the ICPD PoA

since Cairo; and the prevalence rate of reproductive cancers globally and in the Pacific. Linking our research area to these areas is FWRM's approach in keeping the Fiji Government accountable to the promises pledged at the world stage.

In summary, the findings of the main research topic provide a snapshot of existing gaps within Fiji's public healthcare system in terms of basic cancer screening coverage and methods; the accessibility of proper information; the increasing rate of late presentation; and the limited treatment available locally. Additionally, the findings of the research included the lived experiences of women who have gone through Fiji's public healthcare system during their journey with cancer. The research comprises of informant interviews with key stakeholders and women who are cancer survivors; and a stakeholder meeting.

OVERARCHING RECOMMENDATIONS

Very little is done to understand the health seeking behavior of diseases among women from different ethnic groups; an area that needs further research which can strengthen MOH and MOW's plans in addressing the prevalence of cancer among women. More funding is needed towards efficient patient navigation structures in order to help patients navigate through the public healthcare system, as well as an increase in cancer screening and awareness programmes. Amidst that, there is a need to improve the counselling services provided within the support services so that it empowers women to cope during treatment and post-recovery stages. There is a need to review the essential drug list so women living in rural areas are able to access essential drugs without having to travel far to get the help needed. There is a lack of comprehensive sexuality education integrated into the school-education curriculum, so CSOs in partnership with government need to conduct more evidence-based research studies in this area.

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