COMMENTARY

Gynecological Cancer Services in Arab Countries: Present Scenario, Problems and Suggested Solutions

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Abstract

Gynecological malignancies account for 9% of all female cancers worldwide. In the Arab countries Breast cancer is the leading cancer in women followed by cervical cancer. Ovarian cancer ranks as fourth leading cancer in women. There are huge differences in the available resources among Arab countries. However the challenges facing the provision of gynecological cancers services shared similarities like the cultural and religious background. Most of the gynecological cancers are diagnosed at a later stage in Arab countries due to the lack of reproductive health awareness especially among older women combined with the cultural stigma of seeking medical advice for gynecological symptoms. This article discusses the current situation of gynecological cancer services in Arab countries and suggests some practical solutions.

Keywords: Arab countries - gynecological cancers - oncology - HPV - cervical cancer

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Introduction

Cancer is a leading cause of death worldwide, accounting for 7.6 million deaths mounting to around 13% of all deaths in 2008 (Globocan, 2008). Gynecological malignancies account for 9% of all female cancers worldwide, cervical cancer is the leading gynecological cancer worldwide represents 4% of all female cancers. Half million new cervical cancer cases diagnosed each year, half of them died as a result of their disease. Uterine and ovarian cancers account for 2% each while all others gynecological cancers represent <1% of the total female cancers (Globocan, 2008).

In 2008, the World Health Organization (WHO) identified cancer as one of the four leading threats to human health and development (along with cardiovascular diseases, chronic respiratory diseases and diabetes); therefore all healthcare strategic planning should include cancer management and control in its core plan.

Arab countries are spread in two continents, Asia and Africa. Despite the difference in the available resources among these countries; however there are great similarities in the attitude and behaviors of men and women in these countries along common cultural and religious believes.

There are huge differences in the available resources among Arab countries. This is very obvious in the a huge variation in the Human Development Index (HDI) among these countries. HDI is most widely accepted measure of country's welfare, combining three welfare indicators namely health, education and income. United Arab Emirates is the top Arab country based on this index and ranks on 30th position in the world. However some of the other Arab countries are ranked among the lowest 20 countries in the world. This huge difference in resources make the comparison difficult, nevertheless some of the challenges are common in all of these countries.

All Arab countries (except Algeria) are located within the WHO Eastern Mediterranean Region, this region include all Arab countries plus three other non-Arab countries Iran, Afghanistan and South Sudan. It estimated that 32859 new gynecological cancer cases diagnosed each year in this region. Breast cancer is the leading cancer in women followed by cervical cancer, whereas ovarian cancer ranks as fourth leading cancer in women. The cervical cancer mortality rate in this region is almost double that of Europe (7.7 per 100,000 vs. 3.4 per 100,000 respectively) reflecting huge service gap in the Arab and Middle East countries (Globocan, 2008).

Cancer Management

There are four components of cancer services: primary prevention, early detection or secondary prevention, treatment of established disease and palliative care for advanced disease. In the following sections we will discuss the current status of all four components of cancer care in Arab countries and the challenges for each one of them.

Primary Prevention

Primary prevention means prevention of cancer before it occurs and controlling for risk factors. This is

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the best and for some cancers the most effective way of controlling it. Cervical cancer is a classic type of cancer that can be prevented before any cellular changes. The newly introduced Human Papilloma Virus (HPV) vaccine is the first cancer vaccine ever. It is meant for young girl aged 9-15 years or any time before first sexual contact up to age of 25. The efficacy of the HPV vaccine against cervical precancerous lesions caused by HPV 16 and 18 is up to 98% (Lehtinen, 2012).

The HPV vaccine has recently been successfully introduced to some high resourced Gulf States e.g. Abu Dhabi where up to 80% coverage is achieved (HAAD, 2012). However Abu Dhabi State experience showed some significant challenges to the successful introduction of this highly effective vaccine. One of the biggest challenges is the acceptability of the vaccine among public and parents. It is important to make the public aware of the fact that HPV infection can occur even within a marital relationship. Any sexual contacts either within or outside marital relationship can predispose men and women to HPV infection. In Arabic and Islamic culture where relationship outside marriage is prohibited, there is false perception HPV infection only affect men and women with multiple sexual partners. It goes without saying that increase number of sexual partners is associated with an increased risk of HPV infection.

In low resource countries with fewer resources which cannot afford expensive screening programs like cervical cancer screening, it is wiser to think of some low-cost innovative methods for cervical cancer prevention and screening. It has been suggested that the combination of HPV vaccine and Visual Inspection with acetic acid (VIA) might be a suitable low cost strategy for cervical cancer prevention and screening. Interestingly this approach has been adopted by GAVI Alliance which is an alliance committed to providing vaccinations to children in poor countries, GAVI works together with UNICEF. On the 4th of February 2013 GAVI Alliance announced that More than 180,000 girls in eight developing countries are set to receive HPV vaccine funded by the GAVI Alliance. The Alliance confirmed that Ghana, Kenya, Lao PDR, Madagascar, Malawi, Niger, Sierra Leone and Tanzania will become the first countries to receive GAVI support to start HPV vaccine demonstration programs (GAVI, 2013).

For all other gynecological cancers there is no vaccine as such, but there are known risk factors and behaviors that increase the life time risk of developing cancers. These risk factors are probably similar to most other cancers including unhealthy life style, obesity, smoking and poor diet. Obesity epidemic is global; however it is more prevalent in some rich Arab countries (El-Hazmi and Waresy, 1997; Zaghloul et al., 2011; Zaki et al., 2011). Tackling of obesity epidemic in these countries can reduce the incident of obesity related cancers like endometrial cancer.

Secondary Prevention

Cervical cancer again is a classic example of cancer with effective screening tools. It has an identifiable and treatable precancerous stage, its natural history is well known and treatment of precancerous lesions is easy and effective. Cervical cancer screening is also very cost effective on the long term, however the intial cost of establishment of cervical screening program is hughe and very few countries in Arab world will afford this cost. None of the other gynecological cancers has these features and therefore it is difficult to screen for them.

To date there is no established and organized cervical screening program in any of the Arab countries (except of Emirate of Abu Dhabi), most of women with cervical cancers present in later stages. Cervical cancer screening in Arab countries range from opportunistic screening at the best to no screening for cancer at all. However there is genuine effort in some countries to introduce cervical screening program which will help reduce the incidence of invasive cervical cancer. Unfortunately most of the countries with high incidence and burden of cervical cancer like Sudan have limited resources to implement the cervical cancer screening program.

One of the main problems of cervical cancer screening in Arab countries is the lack of awareness among health care providers and patients (Badrinath et al, 2004), this combined with the reluctance of women to have internal examination. This in turn resulted in low acceptability and weak uptake of cervical cancer screening, even in countries with available resources.

Cervical cancer screening is feasible even in low resourced countries. The World Health Organization (WHO) based on many researches recommends that VIA is suitable option for low resourced countries (Sahasrabuddhe et al., 2012). We do recommend that low resource countries should invest their limited resources on HPV vaccination rather than screening.

Diagnosis and Treatment

Most of the gynecological cancers are diagnosed at later stages in Arab countries (Ahmed et al., 2011). Lack of reproductive health awareness especially among older women combined with the cultural stigma of seeking medical advice for gynecological symptoms usually resulted in late presentation of all gynecological cancers. Endometrial cancer is a classical cancer which is usually diagnosed at an early stage in 75% of cases as it manifest itself at an early stage with an abnormal vaginal bleeding commonly postmenopausal bleeding; however most of women with postmenopausal bleeding in Arab countries are either not aware of the significant of this type of bleeding or reluctant to seek treatment and advice because most of them are embarrassed to discuss reproductive issues at this age. Likewise many of young women with post coital or inter-menstrual bleeding are also reluctant to seek an early advice because of the same reasons (Al-Kadri, 2004).

Holistic approach to cancer management should be encouraged and implemented in all institutions dealing with cancer patients. The infra-structure of cancer services in most Arab countries need either to be established as it is not existing or improved. Multidisciplinary approach to the management of cancer has to be introduced in a wider scale. Centralization of cancer service and

multidisciplinary approach has been shown to improve the outcome and reduce the cost (Tingulstad et al., 2004; Crawford et al., 2012). Patients who had surgery for ovarian cancer performed by trained gynecology oncologists have been shown to have better prognosis than those who had their surgery done by general gynecologist (Engelen et al., 2006).

Cancer service is very expensive and it is not expected that all hospital will be able to have an access to the trained staff and the expensive equipment that is required for cancer service. However it is expected that each hospital even the small one will be able to aid the early detection and diagnosis of cancer.

Early detection of cancer is the most important prognostic factor. Gynecologists should be trained to assess cancer risk in high risks women. It is important that gynecologists ask and enquire actively about cancer symptoms during taking gynecological history, even if the patient presented with non-cancer symptom. Diagnostic and interventional imaging is very essential in any modern cancer service. However trained staff is more important than acquiring first class imaging equipment.

We proposed that in low resource countries gynecologists should look at innovative ways to improve the outcome of gynecological cancers using the available and existing resources. Given the fact that not all countries will have the resources to established modern gynecology oncology service we have started running workshops on improving outcomes of gynecological cancers in low resource setting. The aim of the workshops is to encourage the gynecologists who are working in such settings to approach these cases with more confidence. The main tools to achieve these goal are to improve communication with other specialties, teach them some basic surgical techniques in cancer surgery and encouraging holistic approach to cancer.

Palliative Care

Palliative care services is poor in many of Arab countries. It is not only the lacking of the service which is of concern but also the lack of concept. Most of the women with advanced gynecological cancers live their last months of life in very miserable conditions. Many people including health care professional believe that nothing can be done to help these patients. The concept of treating advanced cancer symptoms and making the patient comfortable as much as possible is not widely practiced. The main concern in the management of patients with advanced cancer is the fact that many of them are not aware of the cancer diagnosis in the first place.

On the other hand there is very good family and social support for patients with advanced cancer. Most of the families are very happy to provide all the needed day to day care to their relatives at home. The culture of Hospice does not exist in this part of the world..

The big challenge for palliative care service in Arab countries is the lack of transparency between the doctors and cancer patients due to family pressure. Many of patients with advanced cancer will not be told of the diagnosis of advanced and terminal stage. Families and relatives think that hiding bad news is something they do for the best interest of their relative who diagnosed with cancer. This cultural behavior should be challenged and changed as it is against basic human rights; it is also against Islamic guidance. Islam encourages people to take control of their own fate and prepare for it. Patients who are diagnosed with terminal illnesses should not denied the chance to make the final decisions on their lives including the place of death.

Heath care provider should be trained to break bad news within the cultural context. Palliative care should be a part of cancer service package. Trained doctors and nurses should be recruited to train others. Training institutes and bodies should be encouraged to develop training programs in palliative care accommodating the Arabic culture and the Islamic values.

Conclusions

Gynecological cancer service in Arab countries is poor. Most of the countries lack the basic infrastructure of cancer services. More investment in cancer services is urgently needed. Women with gynecological cancers seek medical advice very late in the course of their disease due to the stigma of reporting gynecological symptoms. Countries with less resource should consider investing in HPV vaccine program rather than cervical screening and seeking innovative ways of provision of cancer services using the available resource and expertise. Rich countries should invest more in centralization of cancer service and prompting holistic and multidisciplinary approach. Heath promotion and education is the key to any successful cancer control strategy. Palliative care concept need to be introduced and incorporated in all cancer service in Arab countries.

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