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CANCER EDUCATION, PREVENTION

EFFORTS CAN REDUCE ZIMBABWE'S CANCER BURDEN

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Cancer is a growing problem in Zimbabwe and worldwide. According to the National Cancer Prevention and Control Strategy 2014-2018, more than 5 000 new cancer cases are diagnosed in Zimbabwe each year. About 1 500 Zimbabweans die of cancer annually.

"This is just the tip of the iceberg," says Health and Child Care Minister, David Parirenyatwa, in the cancer strategy document.
He notes that resource constraints and other reasons prevent many cancer cases and cancer deaths being reported to Zimbabwe's National Health Information System.

Globally 12 million new cancer cases and 7,6 million cancer deaths occurred in 2008. The World Health Organisation expects those worldwide numbers to grow to 26 million new cases and 17 million deaths annually by 2030. These increases will largely be due to the natural growth and aging of each nation's population.
About 60% of the world's cancer cases and 70% of cancer deaths occur in low and middle income countries, nations that can least afford the high cost of cancer diagnosis and treatment.

Zimbabwe carries a heavy burden of infectious diseases that demand immediate attention. As an oncologist told me recently, infectious diseases such as HIV, TB and malaria consume much of the nation's scarce health resources. "Cancer is often given a low priority," the oncologist said.
I know that cancer, while not as visible as Aids, TB and malaria, is a cause of great suffering in Zimbabwe. Since 2000, I have worked in various ways to help the doctors at St Albert's Mission Hospital in Centenary provide care for the people in its district.
I worked closely with Dr Elizabeth Tarira until her death from breast cancer in 2012. I have worked since then with the hospital director, Dr Julia Musariri. I have visited the hospital and Zimbabwe many times.

In 2009, a group of friends and I started Better Healthcare for Africa (BHA), a non-governmental organisation that would enable us to help St. Albert's more broadly.

Since 2012, BHA has worked closely with Dr Lowell Schnipper, an oncologist with Beth Israel Deaconess Medical Center in Boston, USA, to help St Albert's and Karanda Mission hospitals initiate cervical cancer prevention programmes to reduce suffering from that disease,

Cancer education programmes can promote national and local cancer prevention efforts.

the leading cause of cancer death in women in Zimbabwe and other counties in southern Africa.
Based on my experience in Zimbabwe and as a medical writer on cancer at Ohio State University, I have two practical suggestions that will not eliminate Zimbabwe's cancer burden but can help reduce it and the suffering it causes.

First is a concerted cost-effective emphasis on cancer-prevention at the national and local levels. This might be done through stand-alone efforts and by including cancer awareness and prevention messages in HIV/Aids awareness campaigns.

Sustained cancer prevention efforts also help prevent other serious non-communicable diseases such as heart disease, hypertension, diabetes and obesity.

A national cancer-prevention effort would include actions to control the use of tobacco, alcohol and cancer-causing chemicals It would involve bringing the HPV vaccine to Zimbabwe and encouraging parents to have their adolescent and pre-adolescent children vaccinated, as well as reminders to wear a hat and guardagainst excessive sun exposure to prevent skin cancer, particularly in people with less skin pigmentation.

Cancer rates in Zimbabwe are closely intertwined with the nation's 15% HIV prevalence rate. An estimated 60% of Zimbabwe's cancer cases are associated with HIV infection. HIV infection leads to cancer indirectly.

Without antiretroviral therapy, the virus damages the immune system, leaving a person susceptible to cancers caused by infectious agents. Those cancers include Kaposi's sarcoma, bladder cancer and liver and cervical cancers.

Zimbabwe has taken steps to prevent cervical cancer. This prevention programme is often called VIAC (Visual Inspection with Acetic Acid and Camera) screening. It is designed to identify precancerous changes on a woman's cervix and to treat the changes before they become cancerous, thereby preventing the disease.

VIAC screening is offered at national and provincial hospitals and some mission hospitals, such as St Albert's and Karanda.

These programmes have been well accepted by women in the districts these hospitals serve. From the beginning of the St Albert's programme in 2013 through the end of 2016, the hospital screened nearly 7 000 women, identified 308 women with precancerous changes on the cervix and 71 cases of probable advanced cancer, and conducted 143 community cancer awareness campaigns.

Another step Zimbabwe can take to reduce the national cancer burden is to promote broad-based cancer education. Zimbabwe's National Cancer Prevention and Control Strategy calls for an 80% cancer literacy rate by 2018. There is much to be gained by a sustained cancer education effort.

A better understanding of cancer, its causes, diagnosis, treatment and prevention will encourage a stronger commitment to cancer prevention. A better understanding of cancer at local levels can reduce the unnecessary suffering caused by myths and misinformation about cancerand the serious problem of cancer stigma. The oncologist I mentioned earlier spoke of a patient who said, after learning she had cancer: "Doctor, I wish I had HIV."

A cancer education effort will be aided by Zimbabwe's 90% literacy rate and should be aimed at the professionals who provide health information to the public. These include doctors, nurses, community health workers, social workers, health reporters and news editors, secondary school teachers and nursing and medical students.
A cancer education effort could begin by identifying physicians, nurses and other public health professionals who can train trainers in the basics of cancer.

Help in providing this training is available online. One possibility is a free, non-credit online course called "Introduction to the Science of Cancer". It is provided by The Ohio State University Comprehensive Cancer Centre — Arthur G James Cancer Hospital and Richard J Solove Research Institute (OSUCCC-James). I was closely involved in developing the course and frequently had the staff of St. Albert's in mind as I worked on its content.

The full course has five modules and 35 videos, each 10 to 15 minutes long. In the videos, OSUCCC-James oncologists and cancer researchers explain cancer-related concepts in understandable terms.

The course covers the nature of cancer; the diagnosis, treatment and prevention of cancer; and cancer research. It includes downloadable readings and slides that contain the information provided on each video. (To watch the first course video, visit

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Universal health coverage
requires sustainable funding

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The way a healthcare system is designed, financed and performs has consequences for inequality. User fees, for example, prevent people from accessing healthcare and push the majority poor people each year into greater poverty.

The Abuja Declaration signed by African governments in 2001 committed them to allocating at least 15% of their budgets to health with the goal of ensuring that every member of society has access to healthcare when it is needed without risk of financial ruin.

Sixteen years later, less than 10 countries in Africa have increased their health budgets to at least 15% of their national or provincial budget, as stipulated in the declaration.

Less than 10% of Zimbabweans are reported to be protected from the financial risks associated with using healthcare services, even though healthcare plays an important role in the over ambitious business of achieving the Sustainable Development Goals.

Unless health budgets are adequate to meet priority health needs, inequalities in access to health services will remain high and these goals will not be achieved for all.

The concept of universal health coverage (UHC) offers an opportunity to address these challenges. UHC is seen as a means to deliver on the principle of health for all that was set out more than 35 years ago in the Alma-Ata declaration.
In 2005 there were calls to revitalise primary health care (PHC). The principle of universal coverage was reaffirmed in the 2008 World Health Report on PHC and various subsequent World Health Assembly resolutions.
In May 2012 in the World Health Assembly, World Health Organisation director general, Margaret Chan, asserted that UHC is "the single most powerful concept that public health has to offer" to reduce the financial impoverishment caused by people's spending on healthcare and to increase access to key health services.

In December of that year, the United Nations General Assembly adopted a resolution on UHC, urging governments to move towards providing all people with access to affordable, quality healthcare services, given the important role that healthcare plays in achieving international development goals.
Achieving these goals is, however, first and foremost a political process. It involves a political negotiation between different interest groups in society over what services are provided, how services are allocated and who should fund them.

Moving towards Universal Health Coverage calls for progressive steps year by year to widen access to services, to ensure that services are adequately financed and expanded, to not burden people financially and to expand services appropriately to address major health problems, such as the increasing levels of non-communicable diseases.

The 2013 Zimbabwe Constitution provides the legal framework in terms of the right to health services. The Public Health (Amendment) Bill, which is now at an advanced stage, will provide an updated umbrella law for UHC.

A number of measures need to be implemented to improve access to healthcare services. Among these are re-equipping and supporting primary care and community level services, including Community Health Workers (CHWs). This will require unfreezing nursing posts, training and deploying primary healthcare nurses and improving the supply of vital and essential medicines at primary care level.

Domestic health financing must be improved in order to sustain delivery of such measures, to address new challengessuch as the rising levels of non- communicable diseases (NCDs) and to meet the policy goal of total enforcement of user fee abolition at primary care level and fee abolition for specified essential services at district level.

While financing initiatives such as the AIDS Levy Fund, the Health Transition Fund (HTF) and the Health Services Fund have complemented budget resources, these are insufficient to meet the costs of health services for the SDGs or the wider set of health needs that include the rising levels of NCDs.

Zimbabwe has gone through several variations of free healthcare over time. Although the current policy provides for free services for children under five years old, pregnant mothers, those above 65 years old and those with specified chronic conditions and infectious diseases, experience has shown that access has been denied to many, especially from mid-2000, mainly due to financial constraints.

There are efforts to implement free health services for selected groups but this is often reliant on external funding. There is a need to look seriously at a sustainable mechanism for domestic health financing.

The Constitution of Zimbabwe Amendment (No. 20) Act (2013) 76 Right to Health Care page 37/38 clearly states that every citizen and permanent resident has a right to access basic healthcare services, including reproductive healthcare services, and that no person may be refused emergency medical treatment in any healthcare institution.
The State must take reasonable legislative and other measures, within the limits of the resources available to it, to achieve the progressive realisation of the rights set out in this section.
The advent of the new Constitution means that government, as the guarantor, must commit itself to health as a human right and mobilise domestic resources to fund a health benefit that is accessible to all.
UHC implies that all people can access and use the preventive, palliative and curative services that they need (as opposed to demand). These services must be of sufficient quality to be effective, while their utilisation must not expose people to financial hardship or impoverish them.
It also means closing inequalities in healthcare provision and being accountable and transparent when it comes to how finances are managed in the delivery of these entitlements.

Progress will depend on political leadership in navigating it. The constitutional obligation to deliver health services is now a bottom line that the Ministry of Health and Child Care will have to ensure it delivers on. We also need to act and learn by doing!

http://go.osu.edu/cancercourse). The videos can be viewed individually and in any order.

In 2015, I worked with St Albert's to organise a cancer education workshop for hospital staff. A physician at the hospital conducted the workshop, which included 12 videos covering the topics of greatest interest. One or two videos were shown at a time, followed by discussion about how the information pertained to Zimbabwe and answering questions from staff.

With limited ability to diagnose and treat cancer, efforts to prevent these diseases become urgent. Encouraging cancer education through the use of free online courses such as "Introduction to the Science of Cancer" can help improve cancer literacy among key professionals who can then provide accurate information that promotes cancer prevention and reduces suffering.