Cervical cancer control and prevention in Malawi: need for policy improvement

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Key words: Cervical cancer, policy, cervical cancer control and prevention

Received: 26/02/2015 - Accepted: 30/09/2015 - Published: 17/11/2015

Abstract

Introduction: Malawi has the highest incidents of cervical cancer followed by Mozambique and Comoros thus according to the 2014 Africa cervical cancer multi indicator incidence and mortality score card. Despite having an established cervical cancer prevention program, there is low screening coverage. Studies have been carried out to determine socio-cultural and economical barriers to cervical cancer prevention services utilization and very few have concentrated on health system and policy related barriers to cervical cancer prevention and control. The paper presents finding on a qualitative study which carried out to determine the suitability of the national sexual and reproductive health and rights [SRHR] in mitigating challenges in cervical cancer control and prevention. Methods: a desk review of the Malawi National Sexual and Reproductive Health and Rights [SRHR] policy 2009 was done with an aim of understanding its context, goal and objectives. Analysis of the policy history provided insight into the conditions that led to the policy. Policies from countries within the region were referred in the review. Government officials were interviewed to solicit information on the policy. Results: Malawi does not have a standalone policy on cervical cancer; however, cervical cancer is covered under reproductive cancer theme in the SRHR. Unlike some policies within the region, the Malawian SRHR policy does not mention the age at which the women should be screened, the frequency and who is to do the screening. The policy does not stipulate policy implications on the ministry of health, the SRH programs and health service providers on cervical cancer. Furthermore the policy does not include HPV vaccination as a key component of cervical cancer control and prevention. Conclusion: the policy does not reflect fairly the best attempt to reduce the incidence and mortality of cervical cancer as such we recommend that the Reproductive Health Directorate to consider developing a standalone policy on cervical cancer control and prevention.
Introduction

Globally, cervical cancer is the fourth most common cancer in women. Statistics show that 528,000 new cases were diagnosed worldwide in 2012 and Malawi had the highest rate of cervical cancer, followed by Mozambique and Comoros [1]. According to the 2014 Africa cervical cancer multi indicator incidence and mortality score card, Malawi has an incidence of 75.9 per 100000 women and a mortality rate of 49.8 per 100000 across 10 age groups [2]. The incidence is highest among women aged around 40 years [3]. Regardless of these alarming statistics, the country has had an established cervical cancer prevention program which has been running since the late 1980s [3, 5]. In accordance with the World Health Organization’s (WHO’s) recommendation for cervical cancer control in resource-poor countries and through the Ministry of Health-Reproductive Health Directorate (MoH-RHD) and its partners, Malawi adopted a cost-effective strategy for cervical cancer prevention and control. The ministry introduced cervical cancer screening program using Visual Inspection with Acetic acid (VIA) in 2004 after being piloted between 1999 and 2001 in two districts, one rural and the other urban [6-8]. Since then, the program has been scaled up to all districts and central hospitals [3]. According to MoH-RHD statistics of June 2014, over 100 health facilities across the country were providing VIA services [9]. Cumulatively, a total of 59,217 women have been screened of which 5,744 were VIA positive representing 9.7 percent. However, 1,777 representing 2.9% had suspected cervical cancer [10]. From these statistics, and considering the number of women at risk of developing cervical cancer in Malawi, on the other hand taking into account that the cervical cancer prevention and control program has been in existence for over two decades, one might not be wrong to conclude that the program has been experiencing significant challenges such that it is not able to address satisfactorily the existing cervical cancer challenges in the country. Many of the studies that have been conducted to determine the coverage of cervical cancer in Malawi have focused on socio-cultural and economical barriers to cervical cancer prevention services utilization [3, 7, 11] and very few have concentrated on health system and policy related barriers to cervical cancer prevention and control [12]. This paper presents finding on a qualitative study which was carried out to determine the suitability of the national sexual and reproductive health and rights (SRHR) in mitigating challenges in cervical cancer control and prevention in Malawi.

Methods

A desk review of the National Sexual and Reproductive Health and Rights (SRHR) policy 2009 was done in regards to cervical cancer with an aim of understanding its context, goal and objectives. Analysis of the policy history was done to provide insight into the conditions that led to the policy. The review focused much on the following attributes: At what age does the policy state that women should begin screening for cervical cancer? How often does the policy state that women should be screened? The type of cervical cancer screening to be used? The cadre of health workers to provide the cervical cancer services. Comparison, with regards to cervical cancer, was also made with similar policies from countries within the region. Compared were the National Policy for Reproductive Health (NPRH) of Namibia and the SRHR policies from the Kingdom of Swaziland, Zambia and the cervical cancer policy of the republic of South Africa. Key informant interviews were also conducted with ministry officials to solicit information on whether the ministry or any government agency ever reviewed, evaluated or proposed revision for the SRHR to assure that it reflects current scientific knowledge and best practices for achieving compliance. We also asked them if at all the ministry of health engaged national, local, and special interest advocacy groups when developing policy. Information on who participated (i.e. persons or representatives of stakeholder groups) in the setting the SRHR policy agenda or in defining and prioritizing health needs and services at the national and local levels was also solicited. The ministry officials were from the RHD and the office responsible for non-communicable diseases at the ministry headquarters. A key informant interview guide was used in interviewing the officials.

Results

According to the policy document, the goal of the SRHR policy is to provide a framework for provision of accessible, acceptable and affordable, comprehensive SRHR services to all women, men and young people of Malawi through informed choice to enable them attain their reproductive rights and goals safely. The SRHR policy (2009) originated from the Reproductive Health (RH) policy which the MoH-RHD developed in 2002. The revision of the RH policy into SRHR policy was based on the Maputo Plan of Action [13]. Like many other SRHR policies in the Southern Africa Developing Community (SADC) region, the policy was initiated to accommodate several components of SRHR which were not included in the RH policy. These components included the Basic Emergency Obstetric and Neonatal Care (BEmONC); Community Based Maternal and Neonatal Care; Cervical Cancer Screening; Youth Friendly Health Services, Anti-Retroviral Therapy, and Prevention of Mother to Child Transmission (PMTCT) [14]. Like the SRHR policy of the kingdom of Swaziland, in which the policy statement covering cervical cancer falls under the policy theme of “cancer of the reproductive system”, in the Malawi SRHR policy, cervical cancer is covered under “reproductive cancer policy” theme [15, 16]. The reproductive cancer policy theme aims at reducing the incidence and complications of cancers of reproductive organs in all men and women. Unlike the South African cervical cancer policy, the policy statements on cervical cancer in the Malawi SRHR policy document do not mention about the age at which women should begin screening and neither mention on how often the women should come for screening. Furthermore, the policy does not mention what type of screening test should be used and which cadre of health professionals should be directly involved in providing screening and treatment services. However, like the South African policy, the Malawi national SRHR policy does mention that screening for cervical cancer shall be integrated in primary health care and routinely offered to all women at all levels of health care [17, 18].
Cervical cancer prevention and control is made up of several key components ranging from community education, social mobilization, vaccination, screening, and treatment to palliative care [20]. However our review of the policy has shown that the Malawi SRHR policy, unlike other SRHR policies within the region, does not address all important components of cervical cancer prevention and control and as such does not fully address challenges in cervical cancer control and prevention in prevailing in the country. The policy does not reflect fairly the best attempt to reduce the incidence of cervical cancer and the morbidity and mortality associated with it. Our findings show that the policy lacks information on the type of screening test(s) which should be used and the cadre of health professionals to administer the screening. Furthermore the policy does not recommend the age at which women should start screening. At this time when Malawi is piloting HPV vaccine as one preventive measure against cervical cancer, the policy does not mention anything about the vaccine. This might be understandable considering the fact that at the time the policy was developed, the country had not yet started offering HPV vaccines to the girls. On the other hand cervical cancer screening was never regarded as a priority up until 2012 when it was included in the essential health package under the 2012-16 Health sector strategic plan [21]. However this calls for inclusion of HPV vaccine in the future policy. Findings from this study show that in Malawi, women below the age of twenty years were able to access cervical cancer screening services in public health facilities as long as they demanded the services. Much as this can be considered as a good practice to detect pre-cancerous abnormalities at an early stage, a substantial body of evidence has shown that screening in women younger than 25 years of age has little or no impact on the risk of developing invasive cancer [22]. This practice is not cost effective to a country like Malawi with scares and limited resources more especially in this post-HPV vaccination era.

Conclusion

In view of the findings and considering the increasing incidence of cervical cancer and the high mortality rates of cervical cancer patients in Malawi, it is our recommendation that the MoH-RHD should consider developing a standalone comprehensive national policy on cervical cancer management. The policy should include all the components of cervical cancer control and prevention. At minimum, the policy should tackle issues on primary prevention, including determining how awareness will be raised and information disseminated, and providing guidance on HPV vaccines. The policy should also cover secondary prevention or screening, including the age at which careening should start and the frequency of the screening. Diagnosis, treatment protocols for pre-cancerous lesions and invasive cervical cancer, provision of palliative care and the needs of particularly vulnerable groups, such as those living with HIV should also be covered in the policy [23]. Developing such a policy would signal government's commitment to addressing cervical cancer in the country, identify the steps that need to be taken, and indicate the funding and resources needed to address cervical cancer. The policy will guide and unify various stake holder efforts in the struggle against an increasing cervical cancer burden. On the other hand the policy will also save as a legal framework for service users, NGOs and activists to base their arguments on, when advocating for more financial and technical support from government and its partners that are playing different roles in combating cervical cancer in Malawi.

Competing interests

The authors declare no competing interests.

Authors’ contributions

FCM conducted data collection, data entry and also did the data analysis and interpretation. He also wrote the first draft of the
manuscript. ASM and MC contributed to study design, revision of manuscript and approved the final draft. All authors have read and agreed to the final version of this manuscript and have equally contributed to its content and to the management of the case.

Acknowledgments

This research was supported by the Consortium for Advanced Research Training in Africa (CARLA) and the National Commission for Science and Technology (NCST) of Malawi. CARLA is jointly led by the African Population and Health Research Centre and the University of the Witwatersrand and funded by the Wellcome Trust (UK) (Grant No: 087547/2/08/Z), the Department for International Development (DFID) under the Development Partnerships in Higher Education (DelPHE), the Carnegie Corporation of New York (Grant No: B 8606), the Ford Foundation (Grant No: 1100-0399), Google.org (Grant No: 191994), Sida (Grant No: 54100029) and MacArthur Foundation Grant No: 10-9915-000-INP. The study was partly funded by Wellcome Trust through the Consortium of Advanced Research Training in Africa (CARLA) and the National Commission for Science and Technology (NCST). CARTA is jointly led by the African Population and Health Research Centre and the Carnegie Corporation of New York (Grant No: B 8606), the Ford Foundation (Grant No: 1100-0399), Google.org (Grant No: 191994), Sida (Grant No: 54100029) and MacArthur Foundation Grant No: 10-9915-000-INP. The study was partly funded by Wellcome Trust through the Consortium of Advanced Research Training in Africa (CARLA) and the National Commission for Science and Technology (NCST).

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