



World Cancer Day

Equity Report

Close
the care
gap



World
Cancer Day
4 February



Contents

Introduction

Introduction: Framing the inequities in cancer care, globally

4

Mapping cancer:
A global perspective

6

Western Pacific

To look out the window:
Framing cancer in rural Australia
by Professor Jeff Dunn AO

9

A healthy China
by 2030
by Professor Daiming Fan

12

Strategy is key to closing the cancer care gap in Hong Kong
by Professor Anne Lee

14

South-East Asia

The cost of cancer care in India
by Professor Anil D'Cruz

17

The cancer landscape in post-pandemic Malaysia
by Dr Saunthari Somasundaram

20

Europe

The disparities between income, education and health
by Ulrika Årehed Kågström

23

Tackling inequities across the UK cancer pathway
by Nick Grant

27

Eastern Mediterranean

Piecing together the cancer care puzzle in Lebanon
by Hana Chaar Choueib

31

Prevention and screening are key to closing the cancer care gap in Turkey
by Professor Tezer Kutluk

34

Africa

Health equity and cancer control in sub-Saharan Africa
by Dr Miriam Mutebi

37

The inequities of cancer care in Nigeria
by Dr Zainab Shinkafi-Bagudu

40

South Africa: Seeing the human in the right to health
by Ann Steyn

42

Americas

The unfair and avoidable inequities of cervical cancer
by Dr Ana Cristina Pinho Mendes Pereira

45

Preventing health disparities in Brazil
by Dr Maira Caleffi

48

Barriers in a fragmented health system
by Kenji Lopez-Cuevas

50

Summary

Summary: Closing the global cancer care gap

52

Report made possible by Novartis



Publication by UICC
Av. Giuseppe Motta 31-33
1202 Geneva, Switzerland

Please consider the environment before printing this report

Framing the inequities in cancer care, globally



Inequities in cancer care can be found in every country. However, the cancer burden is often highest in countries, or in regions within countries, where health systems are least able to cope with the impact of a disease that is the leading cause of death worldwide.

For some, the disparities are far greater – **at least half** of the world’s population still cannot access essential health services.

For some, the injustices speak even more loudly – **around 90%** of new cervical cancer cases and mortalities occur in low- and middle-income countries.

And for some population groups, such as women and girls and people with disability, the barriers to accessing cancer care are compounded, leading to poorer cancer outcomes.

For **refugee populations**, cancer is more likely to be diagnosed at an advanced stage; in **New Zealand**, Māori are twice as likely to die from cancer as non-Māori; and globally, **older populations face** disproportionate barriers to effective and personalised treatment, with some 70% of global cancer deaths occurring in people aged 65 or older.

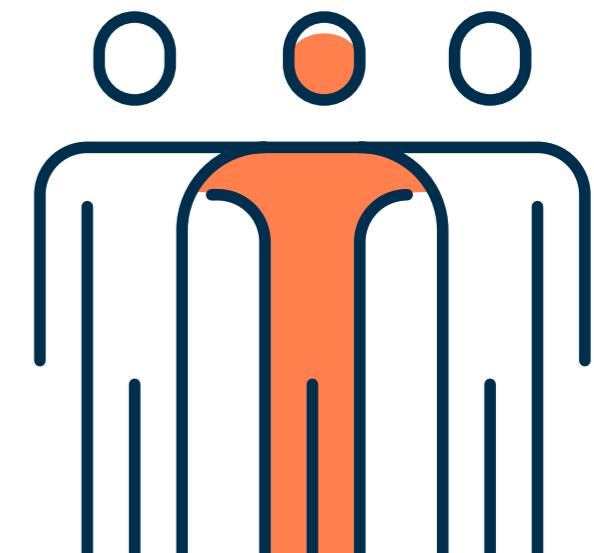
The reality is if you have cancer, who you are and where you live could mean the difference between life and death.

To understand the impact of this reality, the World Cancer Day Equity Report provides local perspectives and experiences from past and present UICC Board Members on inequities in cancer care in their respective countries and regions.

They also offer solutions as to how the gaps can be closed by 2030 to achieve health equity.

Throughout UICC’s 90-year history, equity has been a red thread woven through the very fabric of the organisation and its efforts to unite the global cancer community to fight cancer.

Together as a community, we are building a future where every person, everywhere, can access quality cancer care.



Americas**Brazil**

In Brazil, cervical cancer is the third most common cancer among women. Nearly 17,000 new cases are expected per year, with an estimated risk of 15 cases per 100,000 women.

— Dr Ana Cristina Pinho Mendes Pereira

Increasing health finance expenditure is key to the country's ability to strengthen early detection of cancer through screening and diagnosis to prevent further health disparities from emerging in Brazil.

— Dr Maira Caleffi

Mexico

According to the Mexican Constitution, health is a human right. Yet, in our country, we have a fragmented public health system – this is one of the biggest barriers to cancer care.

— Kenji Lopez-Cuevas

Africa**Kenya**

True learning can occur only in a setting of openness and humility, with a nuanced approach to knowledge sharing that understands disparities are, by nature, complex, intersectional, and frequently transcend geography.

— Dr Miriam Muteti

Nigeria

Outcomes in the management of childhood cancers acutely reflect the disparity; survival rates in high-income countries are above 80%, while in Nigeria, we record a survival rate of just 20%.

— Dr Zainab Shinkafi-Bagudu

Europe**Sweden**

Challenges persist in providing equal access to care depending on where people live in Sweden, their economic status, and their level of education.

— Ulrika Årehed Kågström

United Kingdom

The wider determinants of health are the major root cause of cancer incidence inequity – and they take effect long before the point of diagnosis.

— Nick Grant

Eastern**Mediterranean****Lebanon**

The current cancer care set-up in Lebanon can be described as a dissembled puzzle, with all the right pieces available, but an absence of the necessary systems, collaboration, and leadership needed to assemble it.

— Hana Chaar Choueib

South-East Asia**India**

The cost of cancer treatment is simply out of reach for most people, especially the vast majority who lack health insurance, and those from the lower socioeconomic strata.

— Professor Anil D'Cruz

Western Pacific**Australia**

Just as it takes a village to raise a child, it takes a community to create a world without cancer.

— Professor Jeff Dunn AO

Mainland China

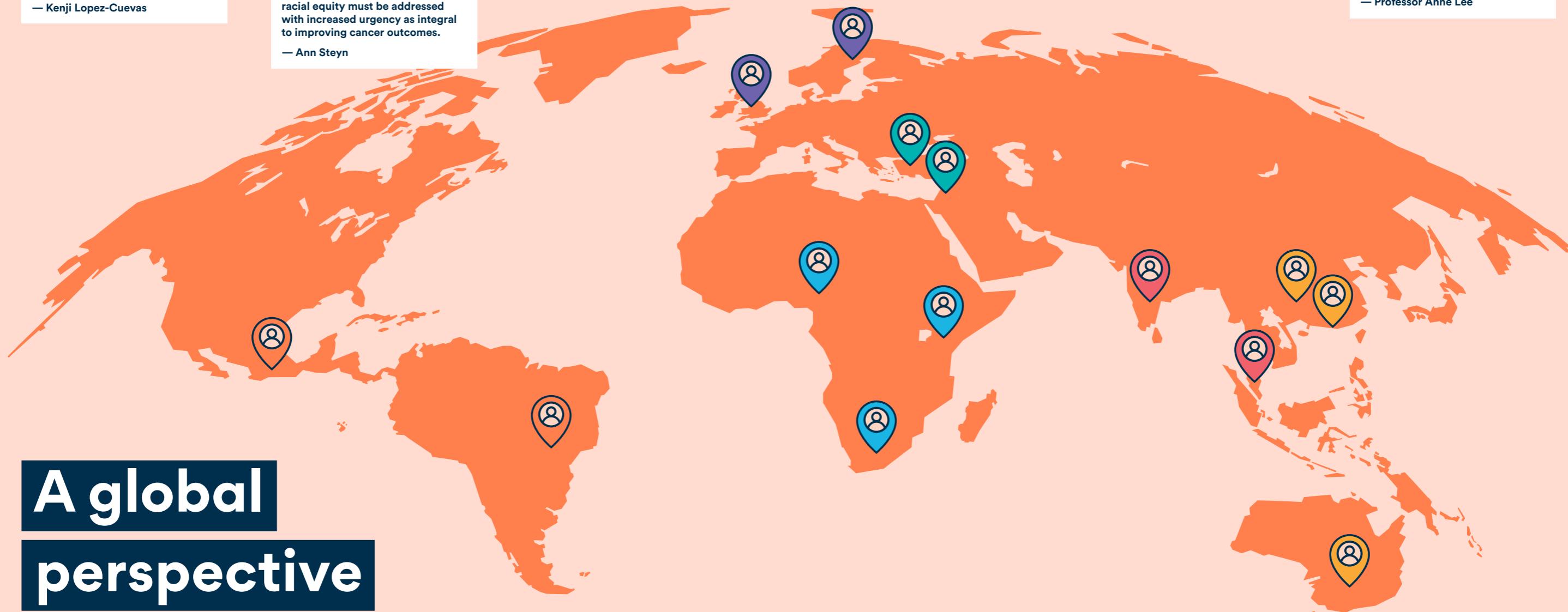
In 2020, China had over 4.5 million new cancer cases, accounting for almost 24% of the global total, and 3 million deaths – more than 30% of the cancer deaths worldwide.

— Professor Daiming Fan

Hong Kong

In Hong Kong, our health service provision essentially followed the British National Health System, with the conviction that, "no one will be deprived of adequate medical care because of a lack of means".

— Professor Anne Lee



Western

Pacific



Australia
Mainland China
Hong Kong



Australia

To look out the window: Framing cancer in rural Australia

I live in a place called **Teviotville**, a rural area inland of Australia's South-East coast, with a population of 114 people. My home is set in a picturesque region in the foothills of Australia's Great Dividing Range, amid World Heritage-listed national parks.

In the local district, the picture of health is less pretty. The average household income is a few hundred dollars below the Australian median, and more than half of the residents are aged over 50.

One in two of my neighbours have serious long-term health conditions, and at least 10 of us have cancer. Including me.

So how do we compare to national and international averages? And what can we learn about the gaps in cancer care by looking out the window to see how my neighbours are faring?

Early last year, I lost a neighbour to prostate cancer. He was in relatively good health when he was diagnosed, but the cancer was detected late and his tumour was aggressive.

He was 70 when he died, but he was by no means old. My dear neighbour was gone before his time, within two years of diagnosis, and it is possible, maybe even likely, that his death could have been prevented if the cancer had been detected sooner.

So begins our understanding of the major cancer control challenges confronting Australia, and the gaps in cancer care that continue to hold us back.

Seeing disparities in cancer care

Every year, **nearly 50,000 Australians die from cancer**, and three times that many will be newly diagnosed with the disease.

Around 55% of those diagnosed will be men, whereby prostate cancer is Australia's leading cause of cancer, and lung cancer is the number one cause of cancer-related death.

Cancer also holds the **inglorious rank** as Australia's number one burden of disease, accounting for nearly 20% of the total disease burden, 30% of all deaths, and at least 10 billion Australian dollars in yearly costs to the health system.

More than 40% of this burden is caused by modifiable risk factors such as smoking, overweight and obesity, and UV radiation from Australia's harsh sun.

Like many countries, Australia has an aging population. More than 60% of people diagnosed with cancer today are aged 65 or older.

In the year I was born, 1958, just over 8% of the population fell into this group. This cohort now comprises more than 16% of our community – a proportion that will **continue to grow** as our population increases.

Widening gaps of cancer care in rural Australia

Screening programmes in Australia are effective but only for those who participate, while those who do not are more likely to die from cancer.

Screening rates in remote areas remain significantly lower, where only **one in five** eligible people take part in Australia's bowel cancer screening programme, despite it being the nation's second leading cause of cancer-related death.

A population-based screening programme is yet to prove effective for prostate cancer. Only 36% of prostate cancers are detected at Stage 1 before the disease has spread, despite the availability of the prostate specific antigen (PSA) test and other diagnostic tests to detect it early.

For men aged 70 and older, such as my neighbour, **more than 40%** of those diagnosed with prostate cancer have high-risk or metastatic disease when they are newly diagnosed.



Experiencing the gaps as a community

When I look out my window, I see gaps that go beyond the foothills of distant mountains, stretching back to a time when our knowledge was limited.

More than one in five men in [my area](#) still smoke, almost 80% of men in Teviotville are overweight or obese, and only 13% of men with prostate cancer in my area are diagnosed at Stage 1. Perhaps because only one in four know the guidelines for testing.

Men in my area, and other regional areas of Australia, also have a higher risk of dying from prostate cancer compared to the national average – a disparity which is true for most forms of cancer.

As the sun sets in Teviotville, we grow older, and our cancer risks climb. Just as it takes a village to raise a child, it takes a community to create a world without cancer.

Addressing the gaps at all levels

Australia is not sitting idle and is taking action at all levels.

The national cancer agency, Cancer Australia, is currently developing a 10-year [Australian Cancer Plan](#), consulting with consumers, policymakers, service planners, and experts in a bid to make best practice cancer care a reality for all Australians – no matter where they live.

In parallel, the Government has commissioned an [independent review](#) of Australia's Health Technology Assessment system – the first review of its kind in 30 years. The review, which includes medical services and pharmaceuticals advisories that are essential to cancer care, aims to reduce time for patients to access services.

A review is also under way of the country's 2016 Clinical Guidelines for PSA testing for prostate cancer in a bid to strengthen testing protocols and [improve survival outcomes](#) for Australia's most common cancer.

But these measures will not be effective by design alone, and implementation is key to our success.

In the Australian context, many of the organisations leading the implementation are UICC members, such as Prostate Cancer Foundation of Australia, who have developed and established a [Survivorship Essentials Framework](#).

The framework encompasses the health and wellbeing of the patient from the point of diagnosis onwards, recognising the physical, psychosocial, spiritual, and economic impacts of cancer – which can be long-lasting – and addressing these so the patient and their loved ones can achieve optimal quality of life.

The significance of this framework is easily explained by returning to Teviotville, and the story of my neighbour, where we can observe that the erosion of quality of life from cancer can be severe.

For men with prostate cancer, 40% of survivors experience poorer health and [lower life satisfaction](#) after their diagnosis. Around two in three have unmet information needs and one in five will develop anxiety and depression, with an increased risk of suicide.

Prioritising survivorship care

On consideration of this growing body of evidence, a strong argument can be made for prioritising survivorship care in national and global health plans, supported by a clear call to action within the UN [Sustainable Development Goals](#), which provides a framework for peace and prosperity.

Cancer survivorship must be core to our focus, recognising quality of life as an essential objective of cancer care, rather than an outcome that is merely nice to have...if you are lucky.

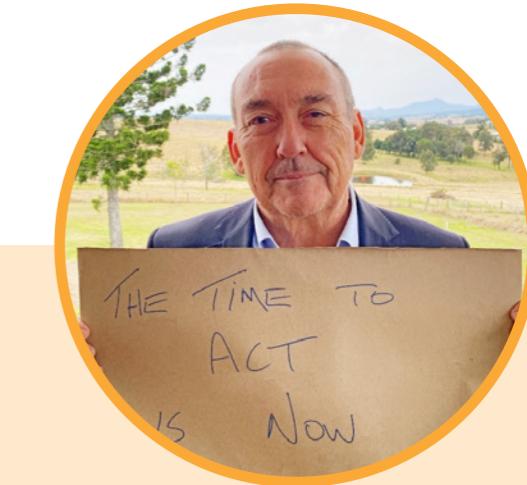
In three decades of cancer research and community building, I have seen the difference it makes to give the patient agency, restoring the life affirming sense of control that cancer takes away.

In my own diagnosis, I have found this effect to be real. I have observed the difference it makes to have quality of life elevated to a fundamental dimension of systemic priority, supported by an overarching goal to see beyond the patient to the person.

To treat the individual and not just the disease, to believe that I am, and we are, more than just cells dividing, and to hope that our sum is always greater than our parts.

This is the great power of UICC – that in the promotion of union, we will prevail.

To look out our windows...



About the author

Professor Jeff Dunn AO
UICC President

Professor Jeff Dunn AO is the President of UICC and has been a serving Board Member since 2014. He is the Chief of Mission and Head of Research at the Prostate Cancer Foundation of Australia.



Mainland China

A healthy China by 2030

Cancer is **the number one killer** that threatens human life and health. According to the World Health Organization, globally there were more than 19 million new cancer cases, and almost 10 million cancer-related deaths in 2020.

Among them, China had over **4.5 million new cases**, accounting for almost 24% of the global total, and 3 million deaths – more than 30% of the cancer deaths worldwide.

The cancer care gap in China

The most significant inequities in cancer care in China are often caused by different medical resources available between cities and provinces; diagnosis and treatment standards between specialised hospitals and community hospitals; levels of medical care between large and small hospitals; and the varying medical skills among doctors.

In China, **nearly 200 oncology** hospitals have been established. There are also more than 5200 general hospitals, and over 680 hospitals of traditional Chinese medicine with oncology departments. The total number of beds in the oncology departments exceeds 200,000.

There are almost **600 tumour registries**, covering more than 30 provinces and around 600 million people nationwide. The five-year survival rate for all types of tumours is nearly 10% higher than a decade ago, reaching just over 40%.

Although access to screening, diagnosis, and treatment has improved, increasing rates of survivorship, inequities in cancer care still exist and need to be addressed.

Addressing inequities in cancer care

To begin to address the inequities, and ultimately achieve the equal right to health, healthcare resources must be integrated and optimised to improve access to care across the cancer continuum.

Public education is also of great importance; ensuring the promotion of scientific knowledge to empower individuals to understand risk factors, live healthier lifestyles, and prioritise health.

At an organisational level

To address the existing inequities, the China Anti-Cancer Association (CACA) published the Guidelines for Holistic Integrative Management of Cancer, which covers 53 kinds of cancer.

They provide guidance to healthcare workers on course management of the whole cancer continuum, which includes prevention, screening, diagnosis, treatment, and recovery.

To enhance knowledge and understanding of the guidelines, a series of academic lectures led by the experts involved in compiling them were held. In total, there were 38 lectures in 13 major cities across China, broadcast by more than 2100 media outlets, and watched by 330 million people.

The guidelines contribute to the goals of cancer prevention and treatment outlined in the Government's national agenda, 'Healthy China 2030', which aims to improve health promotion and coverage by 2030.

At a government level

To bridge the care gap, the Chinese Government has released the Healthy China 2030 blueprint, which is built on four core principles.

The first principle is health as a priority. Health is the foundation for economic and social development – an important symbol of national wealth and strength. Therefore, healthcare should be prioritised and placed at the core of public policy implementation.

The second principle is innovation. The healthcare industry should follow government leadership, allow for the role of market mechanism, and simultaneously speed up reform in key areas, such as hospital management, Universal Health Coverage, and drug supply.

The third principle is scientific development. The blueprint emphasises the importance of both prevention and control to reduce the gaps in basic health services, including different medical resources available between cities and provinces, and varying levels of medical care between large and small hospitals.

The fourth principle is fairness and justice. To promote equal access to basic public health services and to maintain public welfare, especially in rural areas with less access to quality healthcare.

At a community level

The cancer community in China is committed to working together to prevent and control cancer.

In 2022, to promote World Cancer Day and help close the care gap, CACA partnered with the Government, universities, institutions, industry, civil society organisations, and media to carry out cancer prevention and control activities, such as free clinical consultations and public education. A staggering 220,000 professionals, scientists, and volunteers participated in the events.

Through over 4200 targeted activities, more than 31 million people, including cancer patients, benefitted from the campaign. A further 395 million people were reached through the campaign website, helping to spread vital cancer information.

Closing the care gap by 2030

The blueprint to close the care gap and achieve a healthy China by 2030 is ambitious, but possible. We must prioritise the following actions to make this our reality.

1. To advance the realisation of the right to equitable healthcare, healthcare resources must be integrated and resource allocations optimised.
All the sectors of society must work together to combine resources to enhance cancer control.
2. Propel public health education and promotion of scientific knowledge, empowering healthcare professionals and the public with information on management of all stages of the cancer continuum – prevention, screening, diagnosis, treatment, and recovery.
3. The healthcare system must be demand-oriented to meet the needs of cancer patients and people affected by cancer, the healthcare professionals working in cancer, and the wider public.

If we can prioritise these actions to close the cancer care gap and uphold the equal right to health, China can begin drawing the finish line in its blueprint for a Healthy China by 2030.



About the author

Professor Daiming Fan

Professor Daiming Fan is the President of the China Anti-Cancer Association (CACA), a leading non-government organisation improving cancer control in China. He is a former UICC Board Member serving two terms from 2018 to 2022.



Hong Kong

Strategy is key to closing the cancer care gap in Hong Kong

In Hong Kong, our health service provision essentially followed the British National Health System, with the conviction that, “no one will be deprived of adequate medical care because of a lack of means”.

Public health services are heavily subsidised at 84 to 99%, hence, less than 30% of citizens are members of health insurance schemes.

With the well-known high expenses for cancer care, more than 90% of cancer patients seek treatment in public hospitals.

In public hospitals, the charge is only around 15 US dollars per day for in-patient care, inclusive of doctors' attendance, nursing care, meals, and treatment. The charges are waived for citizens of the social assistance scheme.

Citizens can access evidence-based diagnosis and treatment, including state-of-the-art surgery and radiotherapy, and commonly recommended systemic therapy.

The Hospital Authority has a robust system for reviewing inclusion of new drugs by expert teams of clinicians and clinical pharmacists.

Challenges of the public health system

Our public system has shortcomings and faces serious challenges. An obvious threat is financial sustainability.

The principle is that citizens who can afford to, have to pay for expensive self-financed items, often without adequate evidence of the cost-benefit. Cancer medications are categorised as fully sponsored medication or self-financed items.

Services for Computed Tomography (CT) and Magnetic Resonance Imaging (MRI) are accessible free-of-charge, but the services are very limited, and comprehensive genomic testing remains as an out-of-pocket expense.

While there is access to quality treatment in Hong Kong, for patients in the public system, they still experience long waiting times.

The latest report by the Hospital Authority showed that waiting times from diagnosis to first treatment for nine out of 10 people was 81 days for colorectal cancer; 72 days for breast cancer; and 63 days for nasopharyngeal cancer.

Such delays negate the potential benefit of early detection by screening. Patients who can afford the cost may seek treatment in private hospitals, but those with financial difficulty will have to wait with distressing anxiety.

Addressing the challenges and disparities in cancer care

At a government level

Hong Kong has a well-organised social welfare system. Citizens with financial issues are granted social assistance if they meet the eligibility criteria, and medical expenses at public hospitals, except for self-financed items, are waived.

Self-financed cancer medications are subdivided into three groups: those that are fully self-paid; those sponsored by the Government charity scheme (Samaritan Fund); and those sponsored by the community charity scheme (Community Care Fund).

The Hospital Authority has set up a [Public-Private-Partnership programme](#) to sponsor public patients to go to private hospitals for prescribed radiological investigations to help shorten the long waiting times.

As an organisation

As the Hong Kong Anti-Cancer Society, since 2006, we have established a Memorial Medical Assistance Program to assist patients needing cancer medications that are categorised as fully self-paid.

We appeal for both public donations to offer cash support for in-need patients, and to pharmaceutical companies to donate cancer medications. Collaborating with industry partners enhances our capacity to help even more patients.

As of 2021, we had assisted more than 6500 cancer patients to get access to self-financed items, totalling more than 18 million US dollars in cash and more than 43 million US dollars in medication.

As a broader cancer community

In Hong Kong, there are more than 15 non-government organisations (NGOs) that focus on cancer care, as well as the support of many generous donors, including donations of equipment for surgery and radiation therapy, to help provide better access for cancer patients in the public system.

Academia also has an important role to play in the fight against cancer. The University of Hong Kong, in partnership with the Government and industry, is currently conducting a study and offering free comprehensive genomic tests for metastatic lung cancer patients.

Actions to close the cancer care gap

For Hong Kong to close the care gap, there are some key actions to take.

1. Develop and implement a comprehensive cancer control plan with well-defined targets and actions

In May 2018, the Government released a [Strategy and Action Plan to Prevent and Control Non-Communicable Diseases in Hong Kong \(SAP\)](#). The focus is mainly on primary prevention through healthier lifestyles, however, a strategy for treatment and specific targets for improving cancer outcomes have yet to be fully addressed.

2. Reduce waiting times for diagnosis, investigation and treatment

The Hospital Authority needs to measure and monitor the waiting times for cancer care at public hospitals. The National Health Service target is a good reference to work towards, reducing waiting times to less than 30 days from first suggestive symptoms to diagnosis, and less than 30 days from diagnosis to first treatment.

A strategy for pragmatic actions must be planned. While short-term improvement can be achieved by expansion of the [Public-Private Partnership programme](#), a long-term strategy will demand advanced planning on workforce, hospital infrastructure, and medical equipment to meet the escalating cancer burden.

There is also a need for in-depth training to build up the level of expertise required for complex cancer treatment.

3. Engage in concerted efforts to further improve access to expensive cancer diagnosis and treatment

Successful cancer control relies on collaborative efforts by all, including the Government, academia, NGOs, the private sector, industry partners, and individual citizens.

In addition to increasing coverage by charity funds, it is worth exploring efforts to promote and enforce health insurance coverage and tax deductions for cancer treatment.

By global standards, Hong Kong has achieved reasonable equity for cancer care, but a more comprehensive strategy with clear targets and actions by the Government, is needed.

Alongside the strategy, concerted effort by academia, NGOs, the private sector, and industry is crucial to achieve better access to quality cancer care and to close the care gap.



About the author

Professor Anne Lee

Professor Anne Lee is the Clinical Professor and Head of Department of Clinical Oncology at the University of Hong Kong and a past UICC Board Member, serving three terms from 2016 to 2022.

South-East

Asia



India
Malaysia



India

The cost of cancer care in India

A very significant inequity in India is access to cancer care and treatment. While high quality cancer services including new and effective cancer medicines are available, access to different cancer therapies is determined largely by location and financial considerations.

The cost of cancer treatment is simply out of reach for most people, especially the vast majority who lack health insurance, and those from the lower socioeconomic strata.

Breast cancer is the most common type of cancer for women in India, and chemotherapy can cost around 170,000 Indian Rupees (around 2100 US dollars). This figure could be significantly higher with newer forms of therapy – sometimes costing up to five times as much.

In India, very few people have health insurance that can cover the costs of cancer diagnosis and treatment. Consequently, there is very high out-of-pocket expenditure for healthcare in general, and cancer care in particular, that can push people with limited savings, and on a low or irregular income, further into poverty.

Entrenching a cycle of poverty and poor cancer care

In addition to financial barriers, people living in rural areas or in parts of the country with less developed health infrastructure, do not have the same access to cancer care as those living in urban areas.

Therefore, with essential cancer services – including screening and early detection, surgery, chemotherapy, radiotherapy, and cancer medicines – unaffordable and unavailable to much of the population, improving cancer survival in India is a challenge.

These inequities in cancer services lead to delayed diagnosis and advanced stage cancer at presentation. Often, patients resort to poor quality or non-scientific treatment options that are cheaper and invariably worsen the prognosis.

Sadly, this delay means that patients whose cancer could have been detected and treated early with current available diagnostics, medicines, and technologies, develop an incurable disease.

Addressing the inequities in cancer care

As an organisation

Through the initiative of the Tata Memorial Centre, a ‘National Cancer Grid’ was created in 2012 with 14 other cancer centres initially, forming a network of linked cancer care providers working to achieve standardised and high quality cancer care throughout the country.

Over the last 10 years, the National Cancer Grid has grown to 244 centres around India and is now one of the largest cancer networks in the world.

The network promotes the use of digital technologies and tools to ensure data interoperability, reporting and analytics, and encourages the sharing of best practices across cancer care.

For example, through services such as telemedicine and remote patient monitoring, cancer care can become easier for patients to access in rural areas.

At a government level

In 2018, the Indian Government launched the **Ayushman Bharat**, or ‘Healthy India’ in English, to improve access to healthcare in the country.

The Ayushman Bharat has two arms: the National Health Protection Scheme, which seeks to provide financial protection for the poor through publicly funded health insurance coverage; and the Comprehensive Primary Health Care Program, which is focused on restructuring and improving the primary healthcare system.

In 2019, under its health benefits package, the National Health Protection Scheme became linked with the National Cancer Grid to provide secondary and tertiary care hospitalisation.

While more details around how cancer services will be brought under the Ayushman Bharat are needed, increased government financing of cancer care through the National Health Protection Scheme is an important step.

As a broader cancer community

As a cancer community, many non-governmental organisations are working on cancer education, awareness, and supporting patients with navigation services to help them with clinical appointments and supportive care.

Many of these organisations also provide early detection services through mobile screening camps and support patients with treatment costs.



Closing the cancer care gap by 2030

To close the cancer care gap in India by 2030, there are many steps we must take to reduce the existing inequities, especially for people who can least afford healthcare.

1. Increase the number of cancer services included in the Ayushman Bharat benefits package to increase and improve access for patients. The scope of the scheme should also be expanded to include screening and early detection.
2. Create greater awareness about cancer in the population through public education to:
 - Highlight risk factors such as tobacco and alcohol consumption, unhealthy diets and a lack of physical activity;
 - Increase understanding of cancer as a treatable disease among primary care physicians, and the general population, to encourage early detection.
3. Strengthen primary care provision and support integration with key health programmes, such as HPV vaccination, women’s and maternal health, and communicable disease screening, as important routes for early detection of cancer, screening and follow up.
4. Ensure fair pricing control mechanisms for essential cancer drugs, diagnostics, and treatment.
5. Implement and measure quality outcome indicators in both private and public sector treatment facilities to improve outcomes for cancer patients and identify where disparities persist.
6. Establish dedicated cancer care units in every major medical college in the country to improve access to quality care.

Taking these actions would help close, or at least narrow, the health inequity gap by 2030, helping to break the cycle of poverty and poor cancer care currently faced by too many people in India.



About the author

Professor Anil D'Cruz

Professor Anil D'Cruz is the Immediate Past-President of UICC, serving in the role from 2020 to 2022, and was a member of the Board from 2012 to 2020. He is the Director of Oncology at the Apollo Hospitals and the former Director of Tata Memorial Hospital.



Malaysia

The cancer landscape in post-pandemic Malaysia

It is no secret that existing care gaps within the cancer landscape have worsened across the world as we have charted our way through the COVID-19 pandemic.

Malaysia seems to have weathered the worst of the pandemic's health, social, economic, and political impact on our nation, and is slowly transitioning back to normalcy, albeit a 'new' normal.

Unfortunately, the 'new' normal does not seem to be a return to the previous normal in terms of access to cancer care services.

A health system still heavily geared up to combat a possible wave of acute infections, directly translates to gaps in the resources made available for non-communicable disease (NCD) care – and this includes cancer.

With the resource scenario looking even bleaker amidst what seems to be an impending global economic slowdown; efforts may not be focused on closing the cancer care gap in Malaysia, but rather preventing the existing gaps from widening even further.

Pre-pandemic, the country already faced many different gaps in the provision of equitable cancer care across the care continuum as highlighted by the [2019 State of Cancer policy brief](#).

Revisiting these identified care gaps post-pandemic yields nothing but worsening trends across every part of the cancer care continuum; from prevention, screening and diagnosis, to treatment, and survivorship.

Community-level programmes for screening and early detection of the 'screenable' cancers such as breast, cervical, and colorectal cancers, are only now slowly being reactivated in sporadic clusters nationally, while programmes such as the nationwide HPV vaccination programme for teenage girls was severely interrupted, if not [halted entirely](#), since 2020 until recently.

One of the direct economic impacts of COVID-19 has been the loss of jobs for many people, along with its employer-based health insurance coverage.

This has forced many to move to the largely subsidised government sector for care, straining the public health system and causing delays in care provision and scarcity of resources, including drugs for cancer treatment.

Addressing the cancer care gap for equitable access

At a government level

As bleak as the current scenario sounds, many steps are being taken to improve things across the care continuum, both by the Malaysian Government and by civil society organisations.

Far-reaching, system-level improvements are being eased into place, with the country for the first time tabling a Tobacco Product and Smoking Control Bill in Parliament, which included a generational ban on tobacco products for young people born after 2007.

If, and when, successfully passed, this will be a game changer in terms of preventing exposure to tobacco products – long established as one of the [major causes of cancer](#) to future generations of Malaysians.

The Government has also restarted some aspects of stalled cancer treatments, including surgeries via a public-private partnership scheme, allowing better collaboration between the private and public health sector.

A newly [commissioned Parliament White Paper on Health](#) will also help to guide and drive system-wide health reform.

Although this may be a long process in the making, achieving the reality of the reform 'wish list' contained within the White Paper – like increased health financing and widening of care provisions – will provide a clear path ahead for closing the cancer care gap in Malaysia by 2030.

At an organisational level

While eagerly waiting for transformative change to happen across the country's health system, the National Cancer Society of Malaysia has continued its fight against cancer.

In order to revive community cancer screening efforts, we have rolled out an ambitious programme called Jejak Kanser, translated as 'Track Cancer', which involves mobile medical teams travelling into small rural communities across the country to educate Malaysians on cancer control and provide screening.

Beyond prevention and screening, we work to widen equitable access to diagnosis and treatment, partnering with laboratories to make immunohistochemistry tests more widely available; and partnering with private hospitals to expand the availability and affordability of Computed Tomography (CT) scans, Positron Emission Tomography (PET) scans, and other diagnostics for patients.

Actions to close the cancer care gap by 2030

To close the gaps that exist across the cancer care continuum, concerted and collaborative action between sectors is needed.

1. Meaningful reform of health financing, allowing for cancer and other NCDs to be funded comprehensively across all aspects of the continuum, from prevention to treatment, in an equitable, sustainable manner.
2. Acknowledgement and better utilisation of all stakeholders working within and outside the medical landscape to be engaged in providing cancer care, including strengthening of the relationships with non-governmental organisations (NGOs), community health volunteers, and industry partners.
3. Formalisation of more comprehensive navigation systems to close the care gaps from primary to secondary and tertiary care services, both across geographies and between public and private sectors.

A post-pandemic Malaysia has revealed a different cancer landscape – one that may contain more cracks than ever before.

However, there seems to be hope and momentum for change on the horizon. Together, with the Government, NGOs, partners, and the cancer community, we can narrow, and perhaps someday, even close the cancer care gap in Malaysia.



About the author

Dr Saunthari Somasundaram

Dr Saunthari Somasundaram is a physician and the President of the National Cancer Society of Malaysia. She served on the UICC Board from 2014 to 2020, and is co-chair of NCD Malaysia, and a Board Member of the NCD Alliance.

Europe



Sweden
United Kingdom



Sweden

The disparities between income, education and health

Sweden is a country with traditions of good healthcare; all Swedish residents are covered for health services, regardless of their nationality.

While the national Government is responsible for regulation and supervision, the 21 Swedish regions have responsibility for financing, purchasing, and providing health services.

Over the past decade, survival for several different types of cancer has increased in Sweden and is now **amongst the highest** in the EU, reflecting the success of earlier diagnosis and efficacy of treatments.

However, challenges persist in providing equal access to care depending on where people live in Sweden, their economic status, and their level of education.

Disparities and divided responsibilities

Sweden today, is not a country in which access to healthcare is equitable.

For people affected by cancer, the division of responsibilities between 21 autonomous regions is not always an advantage.

The disparities experienced can be seen across the cancer pathway, from participation in screening programmes to survival rates.

At a national level, responsibility is needed to ensure that every citizen, regardless of their place of residence, can be guaranteed equitable care.

Participation in screening

The Segregated screening report published by the Swedish Cancer Society in 2021 highlighted the clear socioeconomic differences in screening participation in Sweden.

Women in areas with higher incomes and higher education participate in cervical and breast cancer screening programmes to a greater extent than women in areas with lower incomes and lower education.

The same gap exists for screening participation for colorectal cancer – the higher the education and income, the higher the participation in screening programmes.

There are also obvious disparities in terms of implementation of new and improved screening programmes between regions in terms of the length of time to implement, and how successfully they are implemented.

Mortality from cancer

Cancer mortality is significantly higher among people who have an education below secondary school level. Among men with only primary school education, the mortality is greatest.

For people with low socioeconomic status, the risk of dying from cancer is notably higher compared to those who belong to more privileged groups – and this is largely influenced by three factors: individual decision making; attitudes of healthcare professionals; and healthcare governance.

People with higher education generally have more time with healthcare professionals to ask questions when seeking care than those with only primary school education who are more likely to refrain from care-seeking in the first place.

Socioeconomic status can also influence the degree to which a cancer patient is likely to follow through on treatment and drug recommendations – ultimately impacting on the cancer outcome.

Evidence shows that inequities within the healthcare system – from diagnosis to treatment and rehabilitation – can arise by the actions, or rather inaction, from healthcare professionals due to preconceived notions about different groups.

The likelihood of receiving a correct cancer diagnosis at an early stage varies between groups. People with lower education are less likely to have access to recommended diagnostics, and after diagnosis, studies show that different demographic and socioeconomic groups are offered different treatments.

In Sweden, how healthcare professionals act in different situations depends to a large extent on the guidelines and structures that organise healthcare.

The country's decentralised model with independent regions is, in many ways, a driving force for local ideas, solutions and traditions.

However, these are not always based solely on science and evidence, but also on other varying considerations, such as local policy, labour market issues, or personal status.

The independence of the regions makes it more challenging to implement common guidelines and approaches that could help to counteract the barriers faced by people from less privileged groups.

Addressing the inequities in Sweden's healthcare system

The Swedish National Board of Health and Welfare has national guidelines in place to support the allocation of resources and provide standards of quality health and social services.

These guidelines are evaluated every few years, and in cases where inequities persist, the Government instructs local authorities or the Regional Cancer Centres to produce proposals on how they could be resolved, and these are then implemented in the regions.

Civil society organisations, similar to our organisation – the Swedish Cancer Society (Cancerfonden) – play an integral role in research, advocacy and accountability, ensuring that the Government and decision makers continue to address existing and emerging inequities to improve cancer care across all regions.

As Sweden's largest charity, we are working to defeat cancer so fewer people in Sweden will be affected by cancer, and those who are have a greater chance of survival.

We strive to support patients, friends, and relatives, by informing them about cancer, treatments, and research, offering information and support via our cancer support services.

We also work to spread knowledge about prevention, and the fact that **30% of all cancers** can be prevented through healthy lifestyle choices.

Closing the cancer care gap by 2030

Closing the cancer care gap by 2030, especially for people with lower education and socioeconomic status, will take concerted action by all actors across the cancer care pathway.

1. Sweden must establish national measurable goals for how the socioeconomic and geographical differences in cancer care are to be reduced.
2. There needs to be national responsibility for levelling out regional differences in cancer care, with regions making positive progress sharing learnings and successes to help other regions improve.
3. Finally, national support and funding are needed to implement lessons learned and proven methods to improve health in the groups where it is lowest.

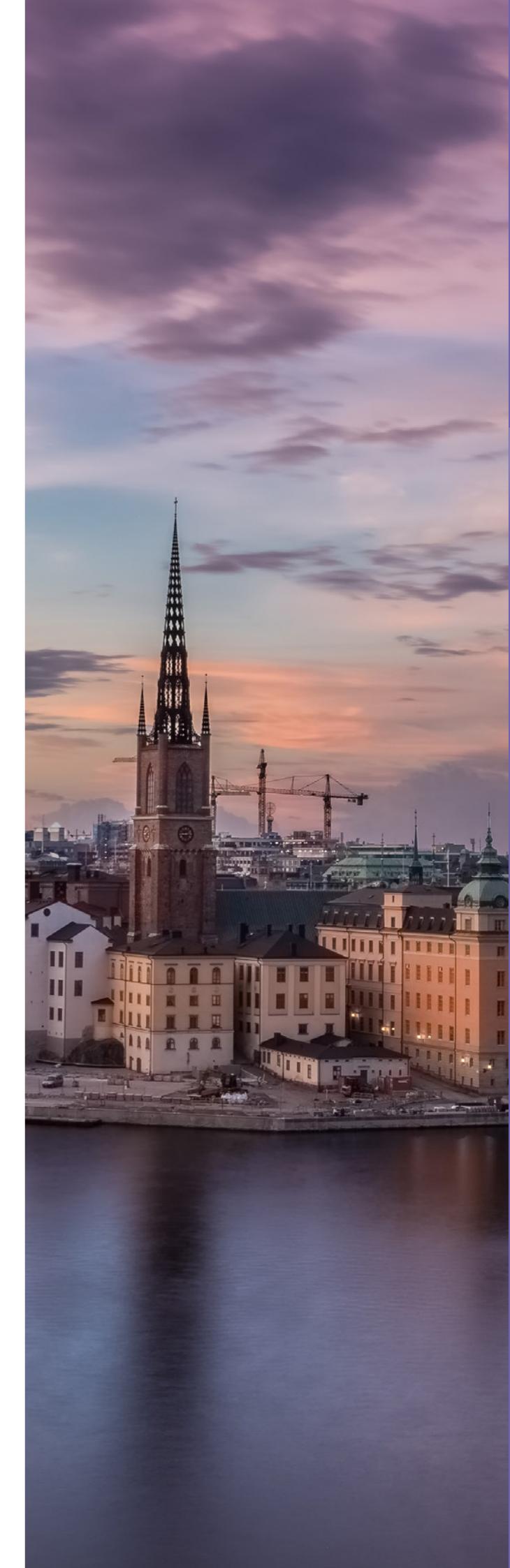
To close the care gap in Sweden, we must focus our attention to where inequity persists to guarantee every citizen equal access to quality healthcare – no matter where they live, what level of education they have, nor what their socioeconomic status is.



About the author

Ulrika Årehed Kågström

Ulrika Årehed Kågström is the President-elect of UICC, past Board Treasurer from 2020 to 2022, and a member of the Board since 2018. She is the Secretary-General of the Swedish Cancer Society, Sweden's largest charity funding more than 500 research projects each year.





United Kingdom

Tackling inequities across the UK cancer pathway

The UK has one of the leading health systems in the world, with a founding principle of providing care for all regardless of ability to pay. It is a high-income country with a history of strong cancer planning, a strong civil society, and a well-established cancer research base.

And yet, very significant inequities exist across every part of the cancer pathway. We have a strong moral imperative to better understand these inequities, their root causes, and to take urgent short-term and long-term action to address them.

Cancer inequity in the UK

Awareness of health inequities was significantly enhanced by [the Marmot Review](#) in 2010, which laid bare the scale of the issue in England and made a series of recommendations.

However, a follow-up [review in 2020](#) found that limited progress had been made since; life expectancy has stalled, and the gaps in life expectancy between the most and least underprivileged areas had widened.

Further, the COVID-19 pandemic has worsened existing inequities, and introduced further pressure across the broader UK health system.

The picture for cancer inequalities reflects that of wider health inequity in the UK. Cancer disparities are apparent across the pathway, from risk and early diagnosis, through to treatment – affecting both cancer incidence and survival.

There is evidence of inequity across multiple characteristics, including, but not limited to, ethnicity, disability, age, and gender.

The largest known cancer inequity exists between areas of higher and lower disadvantage, with more than 30,000 additional cancer cases a year associated with [socioeconomic deprivation](#).

In the UK, many of the causes of health inequities lie not in the health system itself, but in the broader environment.

A range of social, economic, and environmental factors – the wider determinants of health – shape an individual's health, access to care, and exposure to a number of risk factors.

In particular, wider determinants make it harder for some groups to live a healthy life, and with around four out of 10 cancer cases preventable in the UK through modifying risk factors, this directly impacts on cancer incidence.

For example, people living in underprivileged areas are [2.5 times](#) more likely to smoke than those in the least disadvantaged areas – and they find it harder to quit.

Smoking is responsible for nearly twice as many cancer cases in lower income groups compared to higher income groups.

In England in 2019, 35% of people living in the most disadvantaged areas were obese, and this is estimated to increase to 46% by 2040.

In comparison, 22% of people living in the least disadvantaged areas [were obese](#) in 2019, and this is estimated to increase to 25%.

The wider [determinants of health](#) are the major root cause of cancer incidence inequity – and they take effect long before the point of diagnosis.

Inequities across the cancer pathway

From prevention measures to access to screening, treatment and care, inequities exist at every stage of the cancer pathway in the UK.

People from disadvantaged areas are more likely to be diagnosed at a later stage when cancer is less likely to be treated successfully.

This is likely due to a number of factors, including [lower recognition](#) of possible cancer symptoms, and practical and emotional barriers to seeking help.

Additionally, there is inequity in uptake of lifesaving cancer screening programmes, such as for breast, bowel, and cervical cancers, with people in lower income areas less likely to access them.

They also report worse experiences of cancer care and inequities in treatment options.

This is exacerbated by underrepresentation in clinical trials, including for older people, people of colour, and minority ethnic groups.

This not only risks their access to new treatments, but it also affects data collection on the efficacy of these treatments in certain groups.

Finally, and often as a result of inequities experienced earlier in the cancer pathway, there are also disparities in cancer survival in the UK.

If we look at the experience of bowel cancer survival by socioeconomic deprivation in Wales, there is almost a 9% **gap in survival rates**.

We will not beat cancer unless we beat it for everyone – we have a moral imperative to proactively close the gaps in cancer outcomes.

Closing the cancer care gap

Closing the gap requires far-reaching change and concerted action at all levels, including how we conduct and prioritise research, public health activities, screening, and care provision.

This requires intervention and prioritisation from the Government, civil society organisations, and private sector bodies. For example, smoking cessation services are a highly effective and cost-effective intervention, however, funding cuts to public health have limited the reach of these services.

At an organisational level, Cancer Research UK has put tackling inequity at the heart of its vision for the future and works on multiple fronts to build the evidence base needed to raise awareness, advocate for change, and to tackle issues directly.

For many years, we have built the evidence base and campaigned for improved tobacco control – addressing one of the most important underlying causes of cancer inequity.

Similarly, we have campaigned for measures to reduce childhood obesity, which we know disproportionately impacts lower socioeconomic groups.

In targeted disadvantaged areas, we carry out roadshows to help build awareness of ways to reduce risk factors and improve rates of early diagnosis, reaching 50,000 people directly each year.

Access to information for people with cancer, and their support network, is also of vital importance. Our cancer information, which receives more than 20 million unique page views a year, is written in plain English for a reading age of between 9 to 11 years old.

These campaigns are backed by research and strive to include historically underrepresented groups so we can understand the inequities experienced across the cancer pathway and what impact the interventions have in practice.



Actions to tackle cancer care inequities

A broad range of interventions, delivered collaboratively across sectors, will be required to tackle cancer inequities in the UK. Three priorities with the potential to achieve the biggest impact are:

1. Cross-governmental commitment to reducing health inequity. The underlying causes of cancer inequities are closely tied with those of broader health inequity and stretch well beyond the health system. We need a cross-governmental strategy that includes short and long-term commitments and change across all governmental departments.
2. Committed action to reduce inequities in smoking prevalence. A target of 5% or less smoking prevalence across all socioeconomic groups by 2040 is challenging, but achievable. This would have a significant long-term impact on the inequitable burden of lung and other smoking-related cancers.
3. Reduction in barriers to accessing care, including barriers to early diagnosis and participation in screening programmes. Targeted activity is needed to encourage and enable help-seeking and screening participation in underrepresented groups that are less likely to benefit from diagnosis at an early stage, when cancer is more likely to be treated successfully.

To underpin this, and broader progress, health services must continue to improve the collection of consistent data about cancer prevention, cancer patients, and those engaging with cancer services.

This includes the comprehensive collection of demographic information so we can better understand the nature and scale of cancer inequities.

Only then can we tackle the myriad of complex and interconnected factors that drive the inequities we see in the UK today and progress closing the cancer care gap for all.



About the author

Nick Grant

Nick Grant is the Executive Director of Strategy and Philanthropy at Cancer Research UK and a past UICC Board Member, serving from 2016 to 2022.

Eastern Mediterranean



Lebanon
Turkey



Lebanon

Piecing together the cancer care puzzle in Lebanon

Lebanon and the Eastern Mediterranean region are witnessing a rise in cancer cases, and due to crises in several countries in the region, the existing gaps in cancer care are also rising.

The current cancer care set-up in Lebanon can be described as a dissembled puzzle, with all the right pieces available, but an absence of the necessary systems, collaboration, and leadership needed to assemble the pieces and ensure equitable access to comprehensive cancer care for all.

Inequity in cancer care and its impact

Issues of inequity across the cancer care spectrum are complex and far-reaching.

Some of the major issues deepening the cancer care gap are: limitations and inequitable distribution of resources; barriers to access for minority or refugee populations; limited capacities among healthcare workers; lack of cohesive national policies and strategies; and cultural barriers to seek treatments or participate in awareness campaigns.

Across the region, in certain countries and low-resource settings, awareness and cancer prevention campaigns, as well as access to screening services, are scarce.

In crisis zones, these inequities are compounded. Access to adequate healthcare can be extremely difficult, which may delay access to quality cancer services and treatments.

Lebanon has a complex healthcare setting, lacking clear governance structures and clinical pathways, which in turn, lead to higher than necessary healthcare expenditures and inefficiencies in the public health system.

Although cancer represents a considerable public health burden in Lebanon, there is currently no national cancer strategy or governance structure in place, nor any national plan for reaching equity in cancer care.

The lack of a strategic approach to cancer control means that services are disjointed, creating barriers for people to access information and preventative programmes, such as screening and vaccines, as well as integrated treatment and care.

While the country has several advisory committees to focus on different aspects of the national cancer agenda, strengthened collaboration is needed to unify efforts for national programmes and strategies.

The economic collapse and social crisis in Lebanon have further exacerbated the challenges, with newly introduced disparities such as delays in treatments; shortages of cancer medicines; and soaring prices causing an increase in out-of-pocket costs and reduced interventions.

Addressing inequities in cancer care at all levels

At an organisational level

The Children's Cancer Centre Lebanon (CCCL), has expanded its services in Lebanon to reach more than 90% of territories, establishing partnerships with paediatric cancer treating centres and hospitals across the country.

Expanding the reach of our services is one piece, we have also worked to expand the impact of our services to include psychosocial support to patients and families, and grow our awareness programme to include more topics, such as reproductive health and HPV-related cancers.

We lead collaboration and encourage cooperation at all levels to address inequities in cancer care through shaping national and regional dialogues; lobbying the Government on access to treatment and obtaining budget allocation for cancer; and working alongside cancer treatment centres to enhance the quality of the Paediatric National Cancer Registry.

At a government level

Sadly, with the current situation in Lebanon, the Government stands powerless to act and manage many of the disparities the healthcare system is facing.

Like other low- and middle-income countries, there is a **disproportionate cancer burden** in Lebanon where cancer survival is lower than high-income countries. This is due to many factors, including the inequity in access to information, screening, education, and resources, as well as cultural barriers to accessing cancer care.

To achieve health equity in Lebanon, there must be an increase in public awareness campaigns and prevention and screening programmes, together with improved access to quality treatments through better financing of the health system.

At a cancer community level

Non-governmental organisations (NGOs) across the region have developed and launched campaigns to promote awareness; to advocate for access to quality treatment and care for vulnerable patients; and to empower healthcare workers with knowledge to enhance services, treatment, and care to cancer patients.

These organisations play a vital role in raising awareness and shedding a light on inequities faced by people living with cancer.

NGOs have the power to join and amplify their collective voices to be heard with greater urgency by the Government and policymakers.

Closing the cancer care gap by 2030

One of the main challenges we face is the financial burden and the increasing out-of-pocket costs for patients and their families. However, the three most urgent actions that the Government must take to reduce inequities in cancer care are:

1. Ensure treatment and access to cancer medicines to all residing in Lebanon through an international collaboration and agreement with pharmaceutical companies and medical suppliers. This will help reduce inequity by equipping public hospitals to increase efficiency, capacity, and access to quality treatments.
2. Raise awareness about cancer and increase screening programmes as a means of early detection. Launch preventative programmes, such as a stricter no smoking policy, and taxation on sweets, alcohol, and tobacco products.
3. In Lebanon, there is no structured national cancer control plan. It is critical for the Government to bring together ministries, NGOs, medical experts, hospitals, patients, and patients' groups to discuss, plan and implement a clear cancer control roadmap, underpinned by data from the National Cancer Registry.

The roadmap is an essential piece in the cancer care puzzle and must be implemented through a set of methods, improved policies, and the pillars of cancer control: accessibility, affordability, and the right to information.

There are many available pieces to put the puzzle together in order to address rising inequities and close the widening gap in cancer care across Lebanon.

With concerted action and coordinated effort, the pieces can be assembled to ensure equitable access to comprehensive cancer care for all.



About the author

Hana Chaar Choueib

Hana Chaar Choueib is the General Manager of the Children's Cancer Center of Lebanon (CCCL) – a leading national organisation dedicated to the treatment and support of kids and adolescents with cancer, and national cancer advocacy. She has served on the UICC Board since 2020, acting as Board Treasurer from 2022 to 2024.





Turkey

Prevention and screening are key to closing the cancer care gap in Turkey

In 2020, Turkey was estimated to have more than 230,000 new cancer cases, and almost 130,000 cancer related deaths.

Although mortality statistics are reported regularly, centralised national survival rates are not readily available, making it difficult to assess cancer outcomes over time.

National paediatric cancer five-year survival rates were about 70%, which is comparable with other upper-middle-income countries.

Turkey has a National Cancer Control Plan, first released in 2008 and revised in 2008, 2013, and 2021. While there has been significant progress in cancer control and care over the last 15 years, there are areas that need more attention and greater investment from the Government.

Disparities in cancer care

In 2007, the cancer screening rates were as low as 7.5% in Turkey. After the preparation of the first Cancer Control Plan in 2008, Turkey started to invest in cancer screening programmes by expanding the Cancer Early Diagnosis, Screening and Training (KETEM) Centres.

KETEM Centres were established all over Turkey. The number of people screened increased to 7 million in 2019, with screening rates for cervical, breast, and colon cancer at 80%, 38%, and 25% respectively.

Across the regions, East Turkey has relatively lower rates of screening than the West of the country. The lower rates are likely due to differences in level of cancer awareness, health literacy, or perceived stigma.

Over the past few years, the pandemic has impacted heavily on screening rates. The number of people screened fell to 4.5 million in 2020, and 3 million in 2021. Fortunately, in 2022, the rates began to increase once more, with 5 million people screened within the first nine months of the year.

In 2012, Universal Health Coverage was put into force across the country, and there are comprehensive cancer centres available, but many people must travel to major cities to access them.

Addressing the inequities in cancer care

As an organisation

The Turkish Association for Cancer Research and Control (TACRC) works to raise awareness on increasing screening rates, especially in breast and colon cancers.

The TACRC advocates to the public to increase HPV vaccine awareness, and to the Government to cover the vaccine in the National Vaccination Program, so there are no out-of-pocket costs.

We also campaign for strong tobacco control. Although Turkey implemented a nationwide tobacco ban, and it being an area of priority for the Government, high tobacco consumption continues.

At a government level

As part of the National Cancer Control Plan, the Government has had a national screening programme in place for many years, but still, we have not yet been able to reduce the burden of colorectal cancers – it remains the third most common cancer in Turkey.

This is partially because a lack of awareness, stigma around the disease, and people not changing behaviours in relation to risk factors, such as smoking. Lung cancer incidence surpasses colorectal cancer and is the most common cancer in the country due to the height of tobacco use.

While there is political will in Turkey to lower tobacco use, with the country signing the World Health Organization (WHO) Framework Convention on Tobacco Control in 2004, and implementing a comprehensive smoking ban in 2008 that saw tobacco use drop by 13% in the first four years, smoking rates have started to climb again.

While the law is working in some respects, with smoke-free public places as well as a smoking ban inside bars and restaurants, enforcement remains an issue.

There are some initiatives to protect a new generation from the harms of tobacco use with a Bill to protect children – something civil society organisations in Turkey are strongly advocating for.

Closing the cancer care gap by 2030

There are three focus areas for Turkey to make progress towards closing the cancer care gap, especially for cancers where the largest disparities persist.

1. Increase screening rates in breast and colon cancers

The country has made significant progress in screening rates; however, the rates demonstrate the need for additional investment in breast and colon cancer screening.

Awareness is improving, but for most parts of the country, the rates remain below what we are capable of screening. Turkey is an upper-middle-income country, we can do better in screening for high burden cancers, such as breast cancer, to ensure all women with breast cancer can, and do, access the services available to them and start treatment without delay.

2. Free access to HPV vaccines in National Vaccination Program

While Turkey has been able to increase screening rates in women, vaccination for girls is voluntary and not covered by the National Vaccination Program, so people must pay for it out-of-pocket.

This creates many barriers to accessing the vaccine that is key to eliminating cervical cancer. The HPV vaccination must be covered under the National Vaccination Program so there are no out-of-pocket costs and vaccination rates increase.

This is a necessary action, not only to improve cervical cancer outcomes in Turkey, but also to contribute to WHO's Global Strategy to Accelerate the Elimination of Cervical Cancer as a Public Health Problem.

3. More clinical trial and research involvement

The number of global randomised clinical trials involving researchers from Turkey have been increasing, however, the country must make a greater investment in research.

Research is essential. The benefits of participation in clinical trials are two-fold: it enables the country to contribute to cancer research and innovation at the global level; while your people are able to access novel new therapies.

With a population of 86 million, and strong oncology and research capacity, Turkey is well placed to increase clinical trial involvement so more of our people can benefit.

Turkey has made significant progress towards the control of cancer, and care for people affected by it, but we can do more, especially for the cancers where the widest gaps remain.

Through stronger tobacco control, improved access to screening, a free HPV vaccination programme, and an enhanced research agenda, Turkey can end the disparities in cancer care to close care gap.



About the author

Professor Tezer Kutluk

Professor Tezer Kutluk is a paediatric oncologist and the President of the Turkish Association for Cancer Research and Control. He is a Past-President of UICC from 2014 to 2016, and a past UICC Board Member serving three terms from 2008 to 2014.

Africa



Kenya
Nigeria
South Africa



Kenya

Health equity and cancer control in sub-Saharan Africa

As a practicing clinician in Kenya, a lower-middle-income country (LMIC), one frequently asks, what does health equity mean for me, and for the patients whom I serve? What can we, as a global oncology community, do to shift thinking and narratives around cancer in our region?

Patients in LMICs, including many countries in sub-Saharan Africa, **are frequently diagnosed** with cancers at advanced stages and often do not complete their care. This is for several reasons, such as: financial, where patients must pay out-of-pocket costs resulting in financial toxicity; health system barriers due to a lack of equipment and medication; and low health worker knowledge of cancer signs and symptoms where patients will see **on average four to six doctors** before a diagnosis is made, greatly impacting on treatment and survival.

There are also sociocultural barriers to overcome for patients accessing cancer care, like stigma, and collectivism, where decisions are made by the community rather than the individual.

Technology and health in a time of COVID

The COVID-19 pandemic has exposed the collective fragilities of our global health systems and the underlying inequities that exist in all countries – low or high income. It has also provided an opportunity for us to reflect on the gaps and shortfalls of the systems and regroup to build back better.

There's been an upsurge of online platforms and groups, bringing together local, regional, and international experts, to exchange knowledge, learning resources, and healthcare strategies in real-time.

Technological improvements, like mobile phone services, have also benefitted patients with improved patient navigation and cancer screening, leading to an increase in the retention of cancer patients in care.

The pandemic, has of course, had considerable negative effects on the provision of cancer care in LMICs – and Kenya is no exception.

Due to lockdowns and travel restrictions, many patients in East Africa were initially unable to access essential medicines, such as tamoxifen for breast cancer. The cost of imports and subsequent mark-ups on these essential medicines, meant that patients who could afford it, were sometimes paying up to 10 times the previous price for their cancer medications.

Compounding this, as in many parts of the world, the oncology workforce was reassigned to other roles and responsibilities to fight the pandemic. Any future strategies around global oncology should consider these concerns and how best to mitigate them.

Local context key to approaching cancer care

True learning can occur only in a setting of openness and humility, with a nuanced approach to knowledge sharing that understands disparities are, by nature, complex, intersectional, and frequently transcend geography. Translocating a strategy from high-income countries (HICs) directly to LMICs, without considering sociocultural context, is frequently met with failure.

This approach could, for example, explain the high rates of vaccine hesitancy in some countries for the HPV vaccine. Though it remains key to eliminating cervical cancer, the vaccines are still viewed with suspicion in many settings as they are incorrectly linked to promiscuity and infertility.

Failing to understand the social constructs in any setting, and the communities' interpretations of wellness and sickness, are likely to render any health interventions and strategies unsuccessful. Only when local knowledge, context and expertise are recognised, respected, and integrated, can engagement efforts led by HICs help improve local care for patients in LMICs.

Health system strengthening is crucial to this. Healthcare workers who are trained in HICs frequently return to their homes in Africa to find little infrastructural support for their skillsets.

This in turn impacts on clinical outcomes. Cancer surgery in LMICs regularly face scarcity of trained staff and lack of centres offering high quality surgical care.

Patients in sub-Saharan Africa are more likely than patients in other regions to die from elective surgery, underscoring the need to develop perioperative and surgical nursing, monitoring devices, safe anaesthesia, and other support services in LMIC healthcare settings.

Similarly, in medical oncology, many primary healthcare workers in LMICs are often not trained to recognise complications relating to chemotherapy, which can contribute to delays in treatment, and ultimately poorer outcomes for patients.

Solutions to address the existing and emerging gaps

Potential solutions to the system weaknesses include models that strengthen and build the infrastructure and personnel capacity of multidisciplinary, or comprehensive care, units.

Due to low numbers of healthcare workers, strong efforts are required to enhance enrolment and retention of healthcare workers in LMICs. This involves providing appropriate work environments and remuneration to help stem the increasing migration to HICs.

Appropriate resourcing and funding must be considered too. In LMICs, most oncology health workers have high patient-to-clinician ratios. The high patient volumes and focus on service provision – with performance evaluations and remuneration frequently tied to patient numbers – means there is seldom time to carry out vital research.

Moreover, academic institutions in many LMICs are underfunded. For example, institutions in sub-Saharan Africa, **receive less than 1%** of the gross domestic product (GDP) of their countries to fund health research.

Funding matters to health equity

International funders still strongly favour researchers from HICs and align the global research agenda accordingly.

The answers to help close the cancer care gap, both within and between countries, may well be in disruptive models that challenge traditional approaches of funding, academic progression and compensation, and research. Funding mechanisms desperately need redefining in order to support researchers from LMICs.

Representation in the workforce also matters – whether it is at a policy, research, or systems level. The unique role women have in global oncology and health systems – where most of the work is delivered by women, but where women are not adequately represented in health leadership – must be acknowledged and addressed.

In sub-Saharan Africa, female surgeons are less than 5% of the existing surgical workforce, and there is only one unit, in South Africa, with a female Chair of Surgery.

Although this balance is slowly changing, increased efforts are needed to expand the workforce and increase gender and diversity in global health leadership.

How to define success in local and global cancer control

One of the key considerations is to reflect on how cancer control strategies directly affect care in specific regions – whether at the individual or system level.

Our metrics for success should consider global, legal, and moral determinants of health that factor in value-based outcomes, reflecting both the quality and cost effectiveness of cancer control interventions.

Global oncology provides us with an opportunity to harness our shared knowledge and innovate for the collective good. It is also increasingly crucial for global research to represent locally driven research from LMICs and support these countries in developing research agendas that align to national priorities to improve cancer care across the region.

Global oncology is a dynamic entity that is in constant evolution and needs to be iterated, tested, stretched, and developed together with patients and communities always at the centre. It is my hope that through these efforts, patients in all regions, especially LMICs, can begin to benefit from the ethos of a global collective in oncology.

Then, we can start to make real gains in developing frameworks to help achieve health equity in Kenya and across sub-Saharan Africa.



About the author

Dr Miriam Mutebi

Dr Miriam Mutebi is a consultant breast surgical oncologist at the Aga Khan University Hospital in Nairobi, Kenya, the President-elect of the African Organization for Research and Training in Cancer (AORTIC), and a UICC Board Member since 2020.



Nigeria

The inequities of cancer care in Nigeria

Cancer is a leading cause of death worldwide, accounting for almost 10 million deaths in 2020, or nearly one in six deaths.

While significant advances have been recorded in the treatment of most cancers, with improved outcomes in cancer morbidity and mortality in high-income countries, the benefits of these advances are far removed from the experiences of people diagnosed with cancer in Nigeria.

Outcomes in the management of childhood cancers acutely reflect this disparity; survival rates in high-income countries are above 80%, while in Nigeria, we record a survival rate of just 20%.

Barriers to accessing cancer care

The scarcity of investment in public health contributes to the inequities of cancer care in Nigeria. The low health expenditure results in inadequate infrastructure at all levels.

A pertinent example of these inequities in cancer care is the lack of radiotherapy machines. There are less than 10 functional radiotherapy machines serving all of Nigeria. Until recently, there was no Positron Emission Tomography (PET) scan in the country.

Access to cancer services is a major challenge. Cancer screening services are not integrated into our primary healthcare system, leading to late presentation of cases at tertiary health facilities with cancer units.

Three in four women that present with breast cancer at Obafemi Awolowo University Teaching Hospital are diagnosed at either Stage 3 or Stage 4.

The lack of investment in cancer care also negatively impacts access to early diagnosis, targeted therapies, and treatment options, harming cancer outcomes.

Each year, some 14,000 women in Nigeria die from breast cancer, or around 2% of the global breast cancer deaths. Breast cancer treatment can be highly effective – if the disease is detected early.

Addressing the inequities in cancer care

As an organisation

Medicaid Cancer Foundation has worked across the country to increase cancer awareness and generate demand for screening services to help achieve early detection. We do this by providing training to primary healthcare workers in cancer screening services and by supplying equipment.

To improve access to cancer care, we partner with pharmaceutical organisations and donors to offer discounts to 12 therapeutic and screening services.

To further increase access for all people in Nigeria, regardless of their ability to pay, we advocated to the Government to secure investment in the Cancer Health Fund, which provides cancer treatment for poor patients at 10 cancer centres across the country.

At a government level

Access to healthcare has two key sides: patients' ability to gain access to services, and the health sector's ability to serve patients. Like many countries in Africa, Nigeria has an issue in retaining healthcare workers; lured to high-income countries with higher pay, and stronger health systems.

The Government, and non-governmental organisations alike, are trying to reverse this trend. The human ability and skills that Nigerians possess, working at different aspects of cancer care, can be brought back through technology, professional development, and better resourcing for cancer care – both in availability of equipment and in funding.

More than 20 years ago, the Abuja Declaration was formed by African countries to secure a commitment of at least 15% of the national budget for the health sector. But this target has proven elusive for many countries – and Nigeria is no different.

In 2022, the Government allocated 4% of the federal budget towards health, and 0.002% specifically to the Cancer Health Fund – far short of what is needed to fight cancer, but it is a start.

The Government has also been working to expand and enhance cover for cancer treatment in the national health insurance scheme under the newly formed National Health Insurance Authority.

As a cancer community

The insurance scheme, and the covering of cancer within it, is vital to Universal Health Coverage (UHC), which the cancer community continues to advocate strongly for.

The full national adoption and implementation of UHC is necessary to achieve better, and more comprehensive care, for all cancer patients in Nigeria.

Aside from advocacy, civil society organisations lead cancer awareness, prevention, and screening programmes, playing an important role in early detection. They also work to create better access to cancer care for rural populations.

Closing the cancer care gap by 2030

To begin to close the cancer gap in Nigeria, which has widened due to the impacts of the pandemic on our already strained health system, the following actions must be prioritised.

1. Full implementation of UHC, ensuring all people and communities in Nigeria can access quality healthcare services without suffering financial hardship. This must include the full cancer continuum of prevention, early detection, diagnosis, treatment, survivorship, and end of life.
2. Create a cancer care investment fund to secure the required infrastructure for cancer management in each state of Nigeria.
3. Fund an accelerated oncology training programme at teaching hospitals to help attract and retain healthcare professionals, knowledge, and skills in Nigeria.

By prioritising these actions, we can start to reduce the vast disparities that people with cancer face in Nigeria, and begin to benefit from the same advances in cancer treatments and outcomes that exist in high-income countries.



About the author

Dr Zainab Shinkafi-Bagudu

Dr Zainab Shinkafi-Bagudu is the Chief Executive Officer of Medicaid Cancer Foundation in Nigeria and First Lady of Kebbi State. She is also a consultant paediatrician, an advocate for women's health, and a UICC Board Member since 2020.



South Africa

South Africa: Seeing the human in the right to health

As a country, South Africa is recognised to have a progressive constitution that both promotes and respects human rights. And yet, the country has a huge disparity in the healthcare of its people.

Section 27 of the Constitution outlines access to equal healthcare services for all; but what has not been tested, is the individual right of people affected by cancer.

Inequities experienced across the cancer care continuum

With a population nearing 60 million people – many of whom live in rural areas – 84% access the public healthcare system, while the remaining 16% of the population have health insurance, accessing world-class private healthcare systems and hospitals.

The treatment offered by public hospitals varies, with those linked to academic institutions offering more specialised cancer treatment. Such treatment centres are found in only five out of the nine provinces.

In most provinces, there are challenges with diagnostic and radiation equipment, and this is compounded by poor maintenance, lack of funds, and lack of trained staff.

Early detection and screening are mainly centred around primary healthcare facilities, with breast and cervical cancer the only cancers included in the Ideal Clinic Guidelines – a programme aimed at improving quality of care.

This places the responsibility in the hands of healthcare professionals at these clinics and assumes that they have the associated attitudes, skills, and knowledge to manage people who may present with early symptoms.

Sadly, most cancers in the public sector are diagnosed as late-stage disease, impacting on treatment and survival.

Entrenched barriers to equity

In South Africa, only 20% of healthcare professionals are working in the public sector, and of these, 70% are white males responsible for treating a majority of patients that are people of colour.

This can exacerbate challenges for diagnosis and treatment if they do not speak the same language or understand, respect, and consider the cultural background of their patient.

With cancer incidence and mortality set to rise, gender and racial equity must be addressed with increased urgency as integral to improving cancer outcomes.

Affordability and out-of-pocket expenses

For people using the public health system, most of the cancer care services are free, however, there are associated costs to treatment and care that are not covered – or in some cases, the services are not even available.

Despite being on the Essential Medicines List, oncology medicines are often unavailable in the public health system due to the cost.

People affected by cancer also have expenses relating to treatment, such as transport costs; accommodation costs, as many come from a distance; and may be affected by job loss or loss of income.

For people who can afford private healthcare, their experience is very different, but it is not without its problems and inequities still exist.

For members of private healthcare, only 10% can access high-cost cancer medicines as treatment guidelines differ between health insurance schemes, and unless the required treatment is registered, it is not available to the member.

This means that many members have heavy out-of-pocket expenses to obtain the required treatment, or they face the daunting task of looking for a substitute treatment.

This is the human cost of cancer – and this aspect has never been quantified, but it cannot be understated.

Addressing the inequities and barriers across sectors

At an organisational level

The Cancer Alliance is hopeful of changing the face of cancer in South Africa, alongside a coalition of more than 30 registered not-for-profit cancer organisations, working collaboratively to address the gap in cancer care across our country.

We work to the principle of five Ps: Patient, Public, Private, Partnerships, Philanthropy – always ensuring the patient comes first and is prioritised at every stage of the cancer pathway.

Based on the evidence and recommendations of our research reports, we are implementing a series of solution labs with key policy and decision makers across the health sector.

The solutions will be submitted to the National Department of Health for them to consider and include in the proposed National Health Insurance Bill (NHI).

At a government level

A NHI Bill is said to be imminent. Although the draft Bill was published nearly three years ago, there remains a lack of clarity around some key issues: how will it be funded; the role of private health insurance; and whether there will be an exodus of skilled health professionals.

The Bill is hailed as the equalizer for the current inequities, but the private health sector is sceptical, as are many healthcare professionals and citizens.

While there's agreement across both the private and public health sector that all citizens need better access to quality healthcare, the public health system remains extremely challenged with many of the provincial hospitals unable to cope.

At a cancer community level

South Africa has a long history of citizen advocacy to defend and uphold human rights, such as the right to health for people affected by the Human Immunodeficiency Virus (HIV). However, that same fire is not there, or at least not visible, for the rights of people affected by cancer.

The Cancer Alliance has established a partnership with the Treatment Action Campaign, which advocates for access to quality healthcare for people with HIV, as cancers linked to HIV are increasing.

By strengthening relations between health organisations, we hope to improve and leverage advocacy opportunities.

Closing the cancer care gap by 2030

To close the cancer care gap by 2030 in South Africa is an ambitious task, but there are actions we can take to make progress:

1. To establish proper referral pathways for the top 10 cancers between the various healthcare settings – primary, secondary, and tertiary healthcare – including the appropriate staff and resources to manage cancer care across each of the settings.
2. To establish a cervical cancer elimination strategy, with the current Cervical Cancer Policy to inform the strategy.
3. To establish standardised treatment protocols for the main cancers associated with the burden of disease for both the public and private health sector.

By prioritising these actions, and putting the patient and their experience first, South Africa can uphold and propel the human right to health for people affected by cancer.

We've had great success at this in the past, and taking what we have learned in our other advocacy efforts, we can light the fire to effect change and begin to close the cancer care gap.



About the author

Ann Steyn

Ann Steyn is the President of Reach for Recovery International and a past UICC Board Member, serving two terms from 2016 to 2020. Her work includes supportive care and advocacy for cancer patients.

Americas



Brazil
Mexico



Brazil

The unfair and avoidable inequities of cervical cancer

If an intervention has five prerequisites for success, then, by definition, the odds of success depend on the odds of having all five prerequisites simultaneously".

– Thomas Sowell (**Discrimination and disparities, 2018**)

The term 'disparity' is widely used in public health and confusion can arise. If a disparity is avoidable and unfair, then it is considered an inequity.

Cancer health disparities describe the measurable differences in cancer indicators, such as, incidence, mortality, and survival, in various population groups.

Populations that may experience cancer disparities can include groups defined by ethnicity, disability, gender identity, geographic location, income, education, age, and sexual orientation.

Cancer is a leading cause of **premature mortality** in the world. Our ability to make progress against cancer relies on our capacity to eliminate the disparities that exist in the prevention, early detection, and treatment across all population groups.

Cancer mortality provides a measure of the impact of cancer in a given population, whereas the trends can be used to evaluate the progress against cancer.

These trends in mortality are affected by incidence and survival, which helps to evaluate the effectiveness of cancer control over time.

Disparities in cancer mortality in Brazil

Brazil, as in many other countries, has disparities in cancer mortality.

The trend of cancer mortality in Brazil over the last 40 years has not been uniform, with variations in the curve according to geographic regions, place of residence, and gender.

Cancer **mortality has decreased** among residents of Brazil's state capitals, and for those living in the South and Southeast regions.

However, regions in the North and Northeast showed a clear **increase in mortality**, with cancer types compatible with patterns associated with poverty, such as lung cancer from increased rates of smoking, and cervical cancer from a lack of access to the HPV vaccine.

Generally, regions with higher human development indicators, government health spending, and more hospital beds per inhabitants have more favourable mortality trends for all cancers, and many specific cancer types too.

As one moves away from the state capitals and wealthier cities into the country's vast interior and less developed regions, access and availability of resources becomes scarce.

Looking at the trends in mortality, it is no surprise that regions in the North and Northeast have the lowest public health expenditure per capita, lowest human development index, and fewer hospital beds per habitants.

Disparities in cervical cancer

Several cancers could be analysed concerning disparities in care. However, some cancers that are highly preventable, should be highlighted.

Among these, in particular, cervical cancer stands out. Women in low- and middle-income countries (LMIC) are disproportionately impacted, accounting for 85% of cervical cancer cases, and **90% of cervical cancer deaths**.

Therefore, closing the care gap is especially relevant in the case of cervical cancer.

Tracking cervical cancer in Brazil

Brazil, like many middle-income countries, offers screening for the entire female population between 25 and 64 years of age, every three years.

In Brazil, cervical cancer is the third most common cancer among women. Nearly 17,000 new cases are expected per year, with **an estimated risk of 15 cases per 100,000 women**.

By geographic region, cervical cancer **has the highest incidence** in the North, and the second highest in the Northeast and in the Central-west.

In **the South**, it occupies the fourth position and, in the Southeast, the fifth position – the disparities are far-reaching.

According to a recent **national population survey**, the percentages of women who underwent cervical screening in the past three years were approximately 85% in the South and Southeast; 79% in the North and the Midwest; and 76% in the Northeast.

Access to diagnostic procedures after a positive screening also reveal large disparities according to geographic regions.

For those requiring biopsies and coloscopies, **94% and 87%** respectively in the South and Southeast were able to access the necessary procedures, compared to just **29% and 17%** in the North and Northeast.

In the past 20 years, **nearly 60%** of cervical cancers in Brazil were diagnosed as advanced or locally advanced disease. In that same period almost 60% of patients with confirmed cervical cancer waited more than 60 days to start their treatment, greatly impacting their chance of survival.

The mortality rates clearly reflect the disparities between the regions with higher mortality rates in the North and Northeast, and lower rates in the South and Southeast.

Such geographical contrasts reflect differences in exposure to risk factors and disparities in access to adequate screening and diagnosis, and effective cancer treatment facilities.

How is Brazil tackling cervical cancer?

Brazil has had a National Cancer Control Plan since 2005 and a National Cervical Cancer Control Plan since the 1990s.

And while there has been an improvement in cervical cancer indicators in Brazil, the burden of disease remains higher in regions in the North and Northeast, compared to the South and Southeast.

The management of the public health system is shared by the federal, state, and municipal governments, and each level of government has established responsibilities to ensure that all health facilities can provide quality care to people with cancer.

Although efforts have been made to improve cervical cancer control across the three levels of government, difficulties in accessing diagnostic services and in carrying out treatment still persist.

In terms of prevention, multi-vaccination campaigns, including the HPV vaccine, have been reinforced in 2022, and the National Cancer Institute maintains an updated, online national cervical cancer surveillance platform.

Reducing the cervical cancer gap between Brazil's regions

The first step in reducing the gap between the geographic regions in Brazil, is to recognise that cancer control is a task for the whole of society – not just for the Government.

Therefore, reducing disparities is the responsibility of the Government, organisations – both private sector and civil society – and individuals.

The second step is to understand that cervical cancer control is a complex, multi-stage intervention that involves prevention through vaccination, and early detection through screening and treatment of pre-cancer and identified cancer.

As the quote from Thomas Sowell highlighted, the more prerequisites – or interventions – required for success, the greater the chance for disparities to occur.

In the case of cervical cancer, the answer to this problem translates into access to effective vaccines; screening strategies that reduce the frequency of examinations and the subsequent number of diagnostic procedures; and finally, transitioning to more targeted cancer treatments.

This reflects the interventions set out in the World Health Organization's **Global Strategy to Accelerate the Elimination of Cervical Cancer as a Public Health Problem**.

The strategy calls for the scale-up of vaccination, screening and treatment, and management of invasive cancer, often referred to as the **90–70–90 strategy**: 90% coverage of HPV vaccination; 70% coverage of twice lifetime screening with HPV testing; and 90% of women having access to cervical pre-cancer and cancer treatment and management.

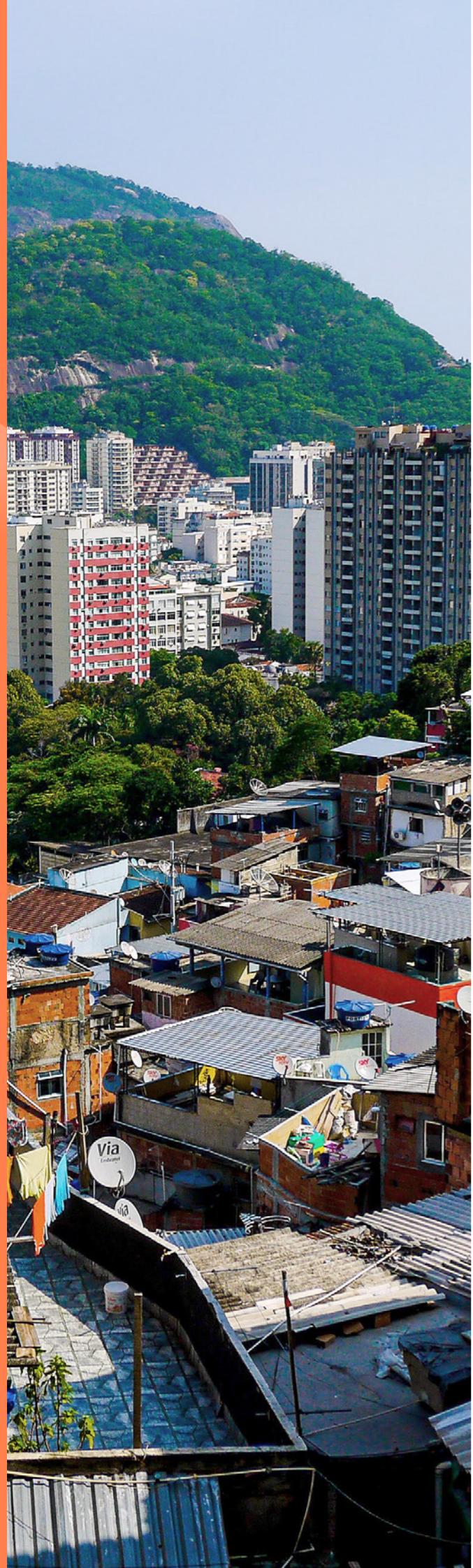
If all health actors – the Government, organisations, and individuals – can simultaneously scale-up the prerequisites required for cervical cancer elimination, Brazil can begin to successfully reduce the disparities between its regions, and close the cancer care gap across all population groups.



About the author

Dr Ana Cristina Pinho Mendes Pereira

Dr Ana Cristina Pinho Mendes Pereira is a physician, the former Director-General of the Brazilian National Cancer Institute (INCA), and a UICC Board Member since 2018.



Brazil

Preventing health disparities in Brazil

According to the Brazilian Institute of Geography and Statistics, the population is currently 215 million, of which **approximately 80%** is dependent on the Unified Health System (SUS), while the other 20% use the system only for access to vaccination campaigns and pay for private health insurance.

Geographical, socioeconomic, and social differences are the main factors of inequity in access to treating diseases in Brazil, including cancer. Such factors make quick and quality access difficult, significantly compromising actions aimed at improving cancer control in the country.

Barriers to accessing quality cancer care

In Brazil, there is often no clear understanding among primary healthcare workers that a good outcome in cancer care depends on an early diagnosis. Unfortunately, most cases are delayed at the beginning of the patient's journey, impacting on treatment options and survival.

The lack of **real-time registry** and disease information are aggravating factors. The state of the country's fragmented health system, with no unified registry of cancer patients in the SUS, compromises strategic actions for the application of already limited financial and human resources in the fight against cancer.

Health financing, as is common throughout the region, is also an issue. Effective action to improve cancer treatment, and education programmes to prevent cancer, have stalled without sufficient allocation of resources – ultimately, increasing the costs of cancer care in the long-term.

A lack of accessible information can harm efforts to reduce risk factors, participation in screening programmes, and early diagnosis, contributing to the rising number of cancer mortalities in Brazil.

The situation is exacerbated by the proliferation of fake cancer news, promoting solutions and treatments without scientific evidence, which confuse public opinion.

Addressing the inequities

FEMAMA, a national network of more than 70 non-governmental organisations throughout Brazil, has been advocating for the expansion of access to quality healthcare services available to cancer patients, including to appropriate diagnostics and treatments.

We work to shift public policy to improve access for cancer patients across the country. The pandemic provided an opportunity to promote a dialogue within the health sector to extract lessons learned and recommendations from public-private initiatives that have proven to be effective in combating **COVID-19 in Brazil**.

The pandemic has shown that access to information is an important tool in disease control, both for the public and civil society organisations.

Through national awareness campaigns, FEMAMA promotes health literacy and the importance of raising people's awareness of being the protagonist in their own care journey, and demanding improvements in health services designed to serve them.

For civil society organisations, there are initiatives such as **FEMAMA University**, an e-learning platform with free courses; and the project **Give Her More Attention**, a public mobilisation platform to boost awareness, empowerment and engagement in social and health movements that demand urgent change.

Closing the cancer care gap

The inclusion of oncology in the Primary Health Care (PHC) policy would mean an advance in the fight against cancer.

It is estimated that PHC has the potential to meet 80 to 90% of a person's health needs throughout their life. At its core, PHC cares for people as a whole, rather than just treating the specific disease or condition.

PHC is responsible for the patient's first access to the public health service in Brazil, and therefore, plays a fundamental role in raising awareness of care and expanding early diagnosis, maximising the chances of cure and reducing the number of deaths from cancer.

In addition to encouraging early diagnosis, the creation of programmes that advocate for patient registration, especially those in which the diagnosis is positive, would enable accurate data collection of the cancer burden in the country.

Accurate diagnosis and data collection ensures strategies for cancer care and control can be informed and developed based on the actual experience of cancer patients, enhancing the impact while minimising the costs for financing national interventions.

Increasing health finance expenditure is key to the country's ability to strengthen early detection of cancer through screening and diagnosis, to prevent further health disparities from emerging in Brazil and improve cancer outcomes.



About the author

Dr Maira Caleffi

Dr Maira Caleffi is a breast surgeon, the volunteer President of FEMAMA, and the Chief of the Comprehensive Cancer Center, Hospital Moinhos de vento, Porto Alegre. She is a UICC Board Member 2022 to 2024, having previously served three terms from 2012 to 2018.



Barriers in a fragmented health system

According to the Mexican Constitution, health is a human right. Yet, in our country, we have a fragmented public health system – this is one of the biggest barriers to cancer care.

The treatment and care a cancer patient can access is largely dependent on the financial resources they have, the social security system they're linked to, and the region, state, or city in which they live.

Every year in Mexico, there are more than 195,000 new cases of cancer diagnosed, and sadly, almost half will not survive cancer. The country faces various challenges in cancer control, from prevention and timely diagnosis, to access to treatment and care.

These can be grouped into five main areas: lack of data; budget insufficiency; challenges in timely diagnosis and prevention measures; challenges in access to care; and limited national legislation.

Challenges to cancer prevention and control in Mexico

Mexico does not currently have a National Cancer Registry, which is essential to generate clear and reliable data to inform decision making and develop health policies based on the specific needs of patients.

Despite the importance of investment and allocation of resources in health, Mexico has a low health budget. Poor investment by the public sector has led to increased out-of-pocket costs for cancer patients.

Mexico's percentage of its gross domestic product (GDP) allocated to **health is lower** than the average in both Latin America and the OECD countries. Currently, the country allocates approximately 3% of its GDP to health spending, of which 50% is attributed to the private sector.

Timely and accurate diagnosis is critical for treatment options and patient survival. Today, only 30 to 45% of cancer cases in the country are detected at early stages of the disease.

There is lack of information and awareness in the general population around cancer and a clear need for awareness campaigns. According to the World Health Organization (WHO), around four out of 10

cancer cases could be prevented if risk factors such as tobacco use, alcohol consumption, unhealthy diet, and physical inactivity are avoided.

Beyond measures to prevent risk factors, implementation of diagnostic tests and screening of at-risk populations, and efforts that promote timely detection and referral, are needed.

There are also challenges in access to cancer care. Mexico came close to having a national strategy for cancer control but progress towards it stalled with a change of government. The consequent fragmentation of the health sector means people have differentiated access to the infrastructure available for their cancer prevention and treatment.

The states with the highest mortality rates due to cancer are found in the South of the country – the least developed. For people with no social security, there is currently no policy or programme to provide access to affordable healthcare.

This also reflects the lack of innovation in treatments offered by public health institutions and the delay in updating care protocols, which guarantee the inclusion of the most effective treatments for patients.

There is one tool that could help alleviate all these challenges – and that is legislation. The WHO recommends that every country have a comprehensive cancer control plan.

Mexico currently lacks a national plan for cancer care, or any general law on the matter, despite constant international reiterations, as well as multiple national efforts.

Addressing the barriers and challenges

Cancer Warriors de Mexico Foundation is a non-governmental organisation (NGO) dedicated to defending the rights of cancer patients by using the law.

We created a legislative initiative to reform three federal laws so parents of children diagnosed with cancer can accompany them during treatment without fear of losing their jobs or income.

Almost 6000 families in Mexico have accessed the new right allowing parents of cancer patients to take up to 364 days off work and receive 60% of their income during this time.

We also created a movement called El Cáncer En La Agenda, or 'Cancer On The Agenda' in English, which is supported by more than 65 organisations focused on the fight and control of cancer in Mexico.

This movement consists of advocating to decision makers in Mexico to create and implement initiatives and programmes that seek to solve the problems faced by cancer patients of all ages.

This has resulted in real and lasting change. In Nuevo Leon, more than 20 million US dollars was allocated from the public budget to develop and implement programmes of comprehensive care for women with breast cancer, and children and young people with cancer.

We are currently working together with 14 civil society organisations along with the legislative and executive sectors, public health institutions, academia, and the private sector to create and promote the creation of the General Cancer Law – a legislative mechanism that functions as an instrument to protect and safeguard the rights of cancer patients in our country.

Closing the care gap by 2030

Creating a historic law in Mexico – the General Cancer Law – will not only benefit the 195,000 new cancer cases that are **diagnosed in Mexico** each year, but every current cancer patient, and every Mexican that could be diagnosed in the future.

Beyond legislation, to dismantle the barriers in Mexico's fragmented health system and close the cancer care gap by 2030, the following actions must be prioritised and budgeted for.

1. Access to medicines, timely detection, and comprehensive care of cancer patients must be prioritised, especially after the compounding impacts of the pandemic.
2. Allocate the necessary resources for implementation of public policies and well-informed programmes to meet the needs of cancer patients.
3. Collaboration between health sector actors, including policy and decision makers, the Government, and both public and private sectors, is essential to benefit cancer patients and their access to quality healthcare.

If these actions, along with the new General Cancer Law were prioritised in our country, Mexico could uphold the human right to health and strengthen cancer care for all – now and into the future.



About the author

Kenji Lopez-Cuevas

Kenji Lopez-Cuevas is the President and Founder of the Cancer Warriors of Mexico Foundation, a lawyer, and a UICC Board Member since 2020.

Closing the global cancer care gap



In framing the global gap in cancer care, it is important to recognise that while there are disparities between countries, there are also many disparities within countries that affect people's ability to take steps to prevent cancer, detect it early, and access the care they need.

In most countries, there are gaps in cancer care depending on where the cancer patient lives – whether urban or rural; their socioeconomic status; the population group they belong to; and how they identify.

The fundamental human right to health should not be dependent on who you are, where you live, and how much money you have – yet, in so many countries it is.

While the disparities are far-reaching, so too are the solutions. Through first-hand perspectives and experiences, we have gained an insight into how countries are closing the gaps in cancer care, and addressing the **wider determinants of health** that affect the health of both individuals and communities.

With **30-50% of cancers preventable** through avoiding risk factors, such as tobacco use and unhealthy diet, implementing evidence-based prevention measures is crucial to reduce health inequity, and the cancer burden.

The burden can also be reduced through screening programmes, early detection of cancer, and access to quality treatment and care for people who develop cancer – regardless of their ability to pay. Many cancers have a high chance of cure, if diagnosed early and treated appropriately.

Across the entire cancer continuum, health workers remain at the centre of the solutions. Greater interventions are needed to nurture and retain health workers and grow the health workforce to meet current and future demand on healthcare systems.

To close the gap by 2030, the solutions that we know work, must be planned and resourced for, so we can build a future where all people have better access to health and cancer care – no matter where they are born, grow, age, work, or live.

As UICC celebrates its 90-year anniversary in 2023, it continues its history of uniting the global cancer community to make this equitable future a reality – and will persevere until it is a reality for all, everywhere.





Thank you for supporting World Cancer Day.

For more information and the latest news, sign up to our newsletter at worldcancerday.org

Have questions? Email us at hello@worldcancerday.org



[worldcancerday](#)



[@worldcancerday](#)



[@UICC](#)



[worldcancerday_official](#)

Visionary Partners



Champion Partners



World Cancer Day is an initiative of the Union for International Cancer Control.



World
Cancer Day
4 February

Close
the care
gap