

Women's Cancer Care in Iran

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Abstract

Breast cancer (BC) and cervical cancer (CC) are the first and fifth common cancers in Iranian women. Although age-standardized incidence rate of BC and CC in Iran is low, the mortality to incidence ratio is high due to late diagnosis. Except an old and a quite comprehensive cancer registry, women's cancer care encounter many challenges in Iran. Lack of a customized national and inclusive protocol to control cancer care along with the fragmented health system is the first and foremost cancer care challenge. Many high-risk women miss the opportunity of early diagnosis and treatment because of poor knowledge, low accessibility, or affordability to health care, stigma, and spouse negligence. Although the most effective BC screening method is mammography, it is not equally available for all Iranian women. Furthermore, the cost of BC is very high and screening is accompanied by stigmatized sociocultural beliefs. Unfortunately, while Iran has a good primary care system, low coverage of clinical breast examination and poor knowledge of women indicate that this system has not operated effectively. Also due to the limited resources, the Pap smear test has not been applied to the majority of Iranian women. Despite the high basic health insurance coverage in Iran, it does not cover diagnostic test and full treatment of cancers which intensified underutilization of cancer care. In conclusion, developing a national policy and guideline for full coverage of early diagnosis of BC or CC should be prioritized. In this regard, health insurance companies should be committed to including BC and CC screening and care for their basic service packages. The second strategy could be training skillful, responsible, and motivated health-care providers. They are able to decrease the stigmatized view of doing mammography. Survivorship care including follow-up care, posttreatment issues, and psychosocial support should also be considered.

Keywords

cervical cancer, breast cancer, cancer screening, cancer prevention, early diagnosis

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Breast cancer (BC) and cervical cancer (CC) are the first and the fourth most frequent cancers among women worldwide. Breast cancer causes the greatest number of cancer-related deaths among women. In 2015, 570 000 women died of BC—that was approximately 15% of all cancer deaths, while CC accounted for 7.9% of all female cancers.^{1,2}

Both BC and CC are also the first and fifth common cancers in Iranian women, respectively. Breast cancer is responsible for 24.4% of all malignancies with age-standardized incidence rate (ASR) of 17.1 per 100 000 and affects Iranian women 10 years earlier than Western countries.³ The BC mortality in Iran increased from 3.93 in 2006 to 4.92 per hundred thousand people in 2010. The CC incidence rate increased after age 30 and peaked between ages 55 and 65. The ASR of CC is low and about 6 per 100 000. The prevalence of human papillomavirus (HPV) infection was 76% in Iranian patients with CC, while it

was reported 7% among healthy women.⁴ The mortality to incidence ratio of CC was more than 44%. Although ASR of BC and CC in Iran is low, the mortality to incidence ratio is high, which was due to late diagnosis where the cancer prognosis is poor.^{4,5} Abovementioned statistics clearly emphasize on BC control as a priority over the CC in Iran as a low-resource country.

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Except an old and a comprehensive cancer registry, women's cancer care encounters many challenges in Iran. Evidently, lack of a customized national and inclusive protocol to control cancer care along with fragmented health system is the most important challenge. Thereby, many high-risk women miss the opportunity of early diagnosis and treatment because of their poor knowledge, low accessibility, and/or affordability to health care, stigma, and spouse negligence.⁶ Although the most effective BC screening method is mammography, it is not equally available for all clusters of the Iranian women and its coverage is less than 15%. Furthermore, the direct cost of BC in Iran including medication and surgery is very high, which is not affordable for all women.⁶ In addition to the high cost, another obstacle for screening is sociocultural beliefs that breasts are part of sexual organs and discussing publicly is accompanied with the stigma. Notably, because of sociocultural taboo, improvement in women's health literacy program including BC or CC care through public media has not been successful so far.⁷ Unfortunately, while Iran has a good primary care system, previous studies showed limited access to clinical breast examination (CBE), ranges from 4% to 20%. Low coverage of CBE and poor knowledge of women indicate that this system has not operated effectively.^{6,8} Even though basic health insurance coverage in Iran is high,⁹ it does not cover diagnostic test and full treatment of cancers, which intensified underutilization of cancer care by Iranian women.

As neoplastic changes in Pap smear results are low in Iran, HPV screening should be focused, especially in the case that the high-risk types of HPV virus are more prevalent in younger women.¹⁰ Although, and evidently, HPV screening and vaccination is an effective method to predict and prevent cervical or breast cancer, unfortunately, due to limited resources, Iran could not apply this strategy.

Based on the abovementioned issues and to have an effective cancer care program, several strategies would be considered by health policy-makers, including (1) a comprehensive registry system, (2) inclusive preventive and promotive program, (3) accessible screening/early detection program, (4) quality diagnostic program, (5) right management guideline, and (6) survivorship care¹¹.

The core component of all strategies should be developing a national policy and guideline for full coverage of early diagnosis of BC or CC and quality treatment and survivorship care of the patients. Due to the effectiveness of the HPV test, performing HPV diagnostic test for women, especially at-risk individuals, and providing HPV vaccine for teenage girls up to 12 years should be considered in the national guidelines. Furthermore, due to limited financial resources to make available mammography to all women, self-breast examination and CBE would be contemplated at the primary level as the first line of screening. The Ministry of Health (MOH) would be responsible to allocate enough resources and define a close collaboration between public and private sectors to provide integrated cancer care services and to improve the efficiency of existing resources. In this regard, health insurance companies should be committed to include BC and CC screening and

care in their basic service packages to guarantee equitable access to all Iranian women.

The other responsibility of MOH as part of its stewardship role is to assign and motivate health-care providers to make women aware of the necessity of early diagnosis. Noticeably, at the first level, Iran has a quite well designed primary care system through which community health workers and family physicians are able to provide high coverage of CBE and decrease the stigmatized view of doing mammography. Strengthening primary care level for designing and implementing health-promoting program among women is a good alternative to compensate imperfect performance of public media due to sociocultural barriers.

To guarantee full coverage of screening and women cancer care, establishing a surveillance system with the focus on a comprehensive registry and monitoring and evaluation system is crucial. To this end, MOH should consider survivorship care including follow-up care and other posttreatment issues in the registration. The last but not least component for providing a good cancer care service by MOH for Iranian women is sociopsychological support of patients with cancer to reduce mental and physical burden of disease through attracting women's health-related societies and social welfare organizations cooperation.

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