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Inequities in Cervical Cancer Care in Indigenous Peruvian Women

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Among Peruvian women, cervical cancer has the highest incidence of all cancers and is the leading cause of cancer death among females in reproductive age.¹ The coastal capital, Lima, hosts the country's National Institute of Cancer (INEN) and has substantially lower rates of cervical cancer, partially due to higher socioeconomic status and better access to specialized care,² such as chemotherapy and radiotherapy. This has important implications in Peru, where early screening Pap test uptake is low,³ particularly for rural-residing, low-socioeconomic status women who speak indigenous languages.⁴ Conceptualized by the household head's native language, approximately 25% of Peru's population is indigenous.⁵ Peruvian indigenous populations are more concentrated in the Amazonian and Andean regions, where women are less likely to have had a Pap smear than women living on the coast³ and where the country's highest cervical cancer mortality rates are found.⁶ Rural-residing indigenous populations face multiple barriers to cancer services, including limited access to care, poor quality of care, cultural misconceptions, language barriers, and communication challenges with health care providers.⁷

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Authors' Contributions

MB, DR, and YM developed study design and managed data acquisition. PEN, PGJ, MB, DR, and YM participated in data analysis and interpretation. PEN, PGJ, MB, DR, and YM participated in the drafting and revising of the manuscript. All authors approve the final manuscript.

We declare no competing interests.

In 2012, to address geographic and economic cancer inequities, the Peruvian government approved the first national cancer plan, “Plan Esperanza,” which aims to reduce cancer morbidity and mortality, “in a pluralistic and decentralized way.”⁸ Plan Esperanza provides free comprehensive cancer care for poor and vulnerable Peruvians through the Peruvian Comprehensive Insurance System (SIS). Plan Esperanza attempts to address the financial barrier of referrals to Lima from rural areas by covering, “the transfer and accommodation for the patient... and if necessary that of a companion,”⁸ for low-income Peruvians living outside the capital. A Spanish-language brochure for patients from rural communities who are transferred to Lima, provides logistical guidance and contact information for unanswered questions.⁹

A 2017 *Lancet Oncology* article reported that, “with the implementation of Plan Esperanza, oncological coverage now reaches 100% of low-income population, covering prevention to comprehensive treatment for all neoplasms...”¹⁰ Unfortunately, this is not consistent with our experiences working with marginalized populations. In 2015 and 2016, we interviewed 18 rural-residing, self-identifying indigenous Peruvian women (11 Shipibo women from the Amazon region and 7 Quechua women from the Andean region) diagnosed with cervical cancer. We used snowball sampling and thematic analysis to explore their experiences accessing care. The mean age of the women was 52, and >60% had a primary education or less. Study procedures were approved by the institutional review boards at the University of Washington (United States) and Cayetano Heredia University (Peru).

A predominant theme among the women was the continuous lack of decentralized services and the burden of traveling to Lima both before and after the implementation of Plan Esperanza. Here, we highlight some of the experiences of women who had SIS and were diagnosed after Plan Esperanza had been implemented. When informed she must to travel to INEN for care, a patient from the Andean region told us:

“I started crying, begging the doctors, ‘I don’t even have enough money to eat. I don’t have a job. How am I going to travel to Lima where I don’t even have family to stay with?’”

Similar to several participants, a woman from the Amazon region, who had SIS and was referred to INEN for free care, did not have the means to travel and sought local traditional herbal remedies, remaining in pain for over a year without treatment. Of the women who were able to travel to Lima, finding accommodation was a significant barrier to care. Despite receiving care under Plan Esperanza, a woman referred from the regional cancer center in Arequipa, who was unable to walk due to pain, was forced to sleep on pews in the hospital’s chapel with other patients and families, who were unable to afford other housing options:

“I slept in the chapel there (INEN) because I didn’t have anywhere else to go and I don’t know anyone... by myself with my shawl and some cardboard, I slept there until they started chemo...the majority of people without money or family sleep there.”

Her experience is unfortunately, not uncommon. A 2017 newspaper article highlighted the growing number of cancer patients from rural communities forced to sleep on the ground at the foot of INEN’s chapel while awaiting care.¹¹ While the experiences of these women may

not be generalizable, their stories are not consistent with 100% coverage of cancer care and their voices deserve to be part of the conversation. In their communities, barriers related to centralized cervical cancer care persist.

There is no denying that Plan Esperanza has made positive contributions toward the reduction of inequity in cancer care access and has greatly reduced out-of-pocket spending for low-income Peruvians.¹⁰ However, if individuals do not have the means to access free cancer care due to additional barriers, the price of services is irrelevant. Further, women who are able to travel for care, but do not have the resources to travel with a family member, face an additional burden of experiencing a traumatic health condition in an unfamiliar environment, using a language they may not speak fluently, without vital social support. The persistent need for travel to receive cervical cancer care indicates that the emphasis on decentralization in Plan Esperanza may be falling short, whether it be due to a lack of dissemination about resources or lags in systematic implementation of resources.

The inconsistency between these women's experiences and existing policy highlights the need to assess the gap between the promise of Plan Esperanza policy development and its implementation. Their experiences reflect the importance of comprehensive access to early cervical cancer detection services to reduce the need for advanced treatment that requires travel. The Peruvian Ministry of Health's new Clinical Practice Guide for Prevention and Management of Cervical Cancer¹² aims to address this need, using new technology to improve screening throughout the country. Yet, what will happen to rural-residing indigenous patients who remain in need of advanced treatment, even with improved screening? This is an important opportunity for community-engaged research to empower marginalized populations and identify gaps in policy implementation. Such work will ensure that the benefits of national cancer control plans are truly accessible to all Peruvians.

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