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## Round table discussion

## A sexual health prevention priority

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Wittet and Tsu are right to point to the link between cervical cancer deaths and achieving the MDGs and the inequity in the burden of cervical cancer between developed and developing countries. Any programme that reduces cervical cancer incidence and mortality rates in low-income and lower middle-income countries is clearly to be welcomed. Addressing women's welfare, family education and thus poverty through screening, treatment and prevention will play an important role in tackling inequalities, although access to screening and vaccination is likely to be inequitable if programmes are not provided in a systematic and comprehensive way. We would argue, though, that cervical cancer screening and HPV vaccination should be seen as integral parts of, rather than separate from or instead of, a wider sexual health promotion programme.

Cervical cancer prevention can be viewed in a similar way to any other sexually transmitted infection. Screening women for cervical cancer is clearly important but a comprehensive and universal screening programme requires substantial resources and infrastructure and so the opportunity costs of such a programme need to be carefully considered. All cancer screening programmes result in unnecessary intervention or lack of intervention due to the sensitivity and specificity of tests that can be costly in terms of public spending but also in personal anxiety and distress.<sup>1-3</sup> As Wittet and Tsu report, however, new "see and treat" programmes will make an important contribution to cervical cancer treatment.

The recently developed HPV vaccine offers some hope in reducing the levels of cervical cancer but concerns have been expressed about its efficacy and the usefulness of vaccination programmes – particularly with regard to long-term effects and that it only protects against 4 out of the 200 HPV viruses. Key questions need to be asked about how vaccination is offered and to whom. It is only effective in women if given before commencing (heterosexual) sexual activity and herd immunity will only be achieved if both young men and women are vaccinated. Vaccination programme effectiveness would also need to be based on known rates of HPV infection as cervical cancer can also be caused by strains other than those for which the vaccine provides protection. Studies in the United States of America suggest that the incidence for types 16 and 18 is significantly lower than previously thought, that infection rates vary by age and most HPV infections are asymptomatic.<sup>4-7</sup>

This is an important point when considering the primary prevention of cervical cancer and HPV infection. Cervical cancer is usually a sexually transmitted disease, yet as many as two-thirds of women who are infected with the HPV virus will not develop cervical cancer. Primary prevention strategies providing factual information regarding transmission of sexually transmitted infection (STI) and the teaching of safer sex negotiation skills are potentially highly effective at a relatively low cost.<sup>8</sup> Condom use has been shown to help prevent the transmission of the HPV virus as well as other STIs. However, in many circumstances it is not always possible for women to negotiate the use of the condom, especially within marriage. Of particular interest, therefore, are current studies being undertaken in Nairobi and Zimbabwe to examine the use of the diaphragm as a tool to prevent the transmission of not only HPV, but also HIV and other STIs.<sup>9,10</sup> The advantage of the diaphragm for women is that her partner is not necessarily aware that she is using the device, which can be cleaned and reused.

While of obvious benefit and importance, cervical cancer screening programmes and HPV vaccination are not in themselves totally effective strategies. Screening may detect early (or more advanced) lesions but this is not without problems. Likewise, a population vaccination programme for HPV also raises questions that have, so far, not been answered satisfactorily. Primary prevention through education and promotion of safe sexual practices must, therefore, remain a key plank of any programme aimed at reducing cervical cancer deaths in the long term and substantially contributing to the MDGs. ■

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## Cervical cancer prevention and the Millennium Development Goals

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Cervical cancer, a complication of HPV infection, is the second most common cancer in women, with 500 000 new cases each year worldwide, 80% of which occur in low-resource countries in Africa, Latin America and south-east Asia. More than half of women with cervical cancer will die, with deaths projected to rise by almost 25% over the next 10 years according to WHO.<sup>1</sup> In Europe and the United States of America, a woman has a 70% chance of surviving cervical cancer whereas the chance of survival is only 58% in Thailand, 42% in India, and 21% in sub-Saharan Africa.<sup>1</sup> In low-resource countries, only 41% of women with cervical cancer have access to appropriate treatment.<sup>1</sup> Now that immunization against HPV is available, will it meet its expectations?

In medically advanced countries, about 30–40% of women do not comply with available cervical cancer screening.<sup>2</sup> Whether these women will encourage their teenage daughters to have the HPV vaccine is questionable and depends strongly on health insurance coverage. In addition, immunization against the carcinogenic HPV strains 16 and 18 only prevents 70% of cervical cancers.<sup>3</sup> Therefore, it does not exempt women from further regular cervical screening when also considering that the duration and optimal protection of the initial immunization is unknown and that boys are not yet included in the immunization programme.<sup>4</sup>

In low-resource countries where cervical cancer screening programmes and treatments are scarce or absent, HPV vaccine raises considerable expectations, but just as many objections. HPV subtypes vary between regions in the world and the strains targeted by the currently marketed vaccines may not prevail in low-resource countries where no extensive epidemiologic study of HPV-typing has been conducted. A full immunization procedure, three shots over six months, is expected to cost US\$ 360.<sup>1</sup> Such a cost is unaffordable for the one billion individuals living on less than US\$ 1 per day, unless the vaccine is distributed by state-subsidized programmes. Health authorities in low-resource countries, already overwhelmed with public health demands, will have to set priorities when allocating limited resources. The same painful choices are now imposed on international agencies and private foundations with the advent of the HPV vaccine, which puts an additional burden on their available funding. Equity requires dividing the means according to the needs, provided a hierarchy can be established among those needs. Given the HIV epidemic, the devastation caused by malaria or tuberculosis, maternal mortality that is responsible for twice as many women's deaths as cervical cancer, and the four million infants dying each year of avoidable disease, it is likely that the HPV vaccine will be given a low priority. Furthermore, considering that famine is endemic in at least 37 countries, urgent wheat, rice and millet provision competes with the supply of vital drugs. The World Trade Organization and WHO compete in spreading their endeavours with shrinking funds. If the Monterrey consensus (which was the outcome of the United Nations International Conference on Financing for Development in 2002)<sup>5</sup> pledge that urged developed countries to divert 0.7% of gross national product to worse-off populations is not fulfilled, it is very likely that the 2015 MDGs will trail away, regrettably cervical cancer prevention above all. ■

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