Journal of Cancer Policy 16 (2018) 73–81

Contents lists available at ScienceDirect

Journal of Cancer Policy

journal homepage: www.elsevier.com/locate/jcpo

African cervical cancer prevention and control plans: A scoping review

Tapati Duttaa[a,*], Beth Meyerson[b], Jon Agley[c]

[a] Rural Center for AIDS/STD Prevention Research Assistant, Indiana Prevention Resource Center Department of Applied Health Science Indiana University School of Public Health-Bloomington 1025 E 7th Street Bloomington, IN 47405, United States

[b] Department of Applied Health Science, Deputy Director (Institute for Research on Addictive Behavior), Indiana Prevention Resource Center, Indiana University School of Public Health-Bloomington, 501N Morton Street, St. 110, Bloomington, IN 47404, United States

[c] Indiana Prevention Resource Center Department of Applied Health Science Indiana University School of Public Health-Bloomington 501N Morton Street, St 110, Bloomington, IN 47404 United States

A R T I C L E I N F O

Keywords:
Cervical cancer
HPV infection
Promotion of health
Monitoring and evaluation
Primary and secondary prevention
Community involvement

A B S T R A C T

Africa has a disproportionate burden of cervical cancer. As a part of the strategic approaches to contain the disease, several African countries have developed cervical cancer prevention and control (CCPC) plans. Such plans can help to create policy and program enabling environments to reduce cervical cancer. To date, there has not been any review of these plans.

Method: A scoping-review was conducted of African country-level plans available online between June-October 2016 to describe the existence and focus of cervical cancer planning using adapted measures from the Healthy Public Policy Model.

Results: Less than one quarter of countries (22.2%, n = 12) had plans available for analysis. Of these plans, 69.2% had expired. The majority of countries with any stated plan for cervical cancer had CCPC elements embedded in other disease-focused plans. Five plans framed cervical cancer as cancer, and rest as the outcome of human papillomavirus (HPV), which is sexually transmitted. All plans emphasized survivorship more than early HPV diagnosis and prevention. Planned interventions targeted only women and girls. Rudimentary monitoring and evaluation (M&E) systems, and lack of integration of cervical cancer M&E with national health management information systems and cancer registries were shared issues. Plans reflected a top-down framing of community as beneficiary rather than an equal partner to technical experts in plan formulation and evaluation.

Conclusion: A comprehensive picture of African CCPC efforts will require engagement with Ministry of Health (MoH) in each country. Extant evidence suggests that lack of resources is a major barriers to plan development and deployment.

1. Introduction

The burden of cervical cancer is alarmingly high in Africa and continues to be one of the leading causes of death among women in these regions, despite availability of promising prevention methods [1–3]. Health promotion advocates have criticized this situation as a denial of the right to the highest attainable standard of healthcare and quality of life [4].

Lack of organized efforts to combat cervical cancer has been linked with higher rates of morbidity and mortality in Sub-Saharan Africa [5,6]. Since structural elements such as cervical cancer prevention and control (CCPC) plans are instrumental in providing strategic directives for advocacy, funding, and systems change [7–10], the World Health Assembly Resolution 58.22 urged member countries to intensify and organize their approaches for disease control. In response, some African countries developed CCPC plans [11]. While Todare has described the development of cancer control plans in Africa [12] and two others have reviewed CCPC plans in USA and Europe, there has not been a systematic description of African CCPC plans [8,9,13]. This study identifies and examines CCPC plans in African countries [14].

2. Methods

A scoping review guided by an adaptation of Hancock's Healthy Public Policy Model (HPPM) was used to analyzen the African CCPC plans [15–17]. Studies in Norway, Canada, Australia and Thailand have used HPPM to ground analyses of health implementation projects [17–20]. While HPPM offered an ecological conceptualization of health promotion observed in CCPC policies, HPPM indicators were adapted to clarify underlying complexities in plan structure and development [21].

* Corresponding author.
E-mail addresses: dutta1108@gmail.com (T. Duttaa), bmeyerso@indiana.edu (B. Meyerson), jagley@indiana.edu (J. Agley).

https://doi.org/10.1016/j.jcpo.2018.05.002
Received 20 February 2018; Received in revised form 17 April 2018; Accepted 9 May 2018
2213-5383/ © 2018 Published by Elsevier Ltd.

Table 1
Healthy Public Policy Model Principles, Study Variables and Measures used to Evaluate African Cervical Cancer Prevention and Control Plans, 2016.

Principles of HPPM	Variables adapted to corresponding HPPM Principle	Measures
Principle 1: Longer-term Vision of the Plan	Plan title or description	Scope of the document: plan, policy, strategy or guideline
	Prioritization of CCPC	Exclusive for CCPC or integrated into any other public health/disease-centric plan
	Year	Plan initiation year
	Time-span	Term of the plan
	Age of the plan	Current or out-of-date or expired
	Plan-cycle	First or second
	Goal statement	Specific to CCPC or broad
	Framing of cervical cancer	Cervical cancer grouped with non-communicable disease (NCD) or sexually transmitted disease (STD) or sexual and reproductive health (SRH) issue
Principle 2: Commitment and Accountability	Plan formulators	Represented national, pan-African or global organizations
	Ministerial ownership	Minist or Ministries which endorsed the plan
	Monitoring and evaluation	Monitoring and evaluation mechanisms for CCPC
Principle 3: Multifaceted Strategies	Cervical cancer prevention strategies	HPV vaccination, Screening, Treatment (invasive therapy), Palliative care
	Eligible population groups	Gender and age-groups of populations targeted or served through services mentioned above
		Any population sub-groups who were served in addition to those mentioned above
Principle 4: Community driven-ness	Community involvement	Expressions of community involvement

Variables of interest aligned with HPPM's principles: 'longer-term vision,' meaning strategic foresight to achieve the plan's goals;'political commitment and accountability' referring to inter-sectoral structures needed for a sustainable policy; 'multifaceted strategies' meaning different interventions in addressing cervical cancer prevention and control; and 'community driven-ness', meaning is the extent to which plans involved local communities, and how community autonomy is expressed in plan efforts [17–19]. Variables were dummy coded (yes/no) and are displayed in Table 1.

In this study 'CCPC plan' is refers to any national-level strategy, action-plan, plan-section or policy published by an African country government, exclusively addressing cervical cancer prevention and control of the same.

Boolean Internet search was conducted between June and October 2016 using MeSH and additional words and phrases to identify the plans: Africa' OR 'Sub-Saharan Africa' OR 'country by name in Africa' AND 'cervical cancer prevention and control 'policy' OR 'plan' OR 'strategy' OR 'guideline' for Human Papilloma virus (HPV) vaccination' AND 'cervical screening'. The most recent plan document available online in English was selected for review and analyzed. Plans which mentioned cervical cancer less than twice were excluded.

An *a priori* coding structure with elements listed in Table 1 was used, followed by open coding to allow additional theme emergence. Two researchers independently coded a sample of five plans in August 2016, and met to discuss and manage coding discrepancies. All plans were re-coded by the primary researcher using the resulting revised coding structure. Internationally standardized ISO 3166-1 country codes are used to identify and report the respective country's CCPC plan [22]. The study was deemed exempt by the Indiana University Institutional Review Board.

3. Results

3.1. Existence and distribution of plans

CCPC plans were available online and in English for 12 of 54 (22.2%) African countries: Ghana [GH], Kenya [KE], Mauritius [MU], Malawi [MW], Republic of Gambia [GM], Sierra Leone [SL], South Africa [ZA], Sudan [SD], Tanzania [TZ], Uganda [UG], Zambia [ZM] and Zimbabwe [ZW]. The final sample included 13 CCPC plans from these 12 countries, because both the cancer and non-communicable disease control plans of Ghanahad CCPC components. Kenya and Uganda had exclusive CCPC plans, while 11 plans had CCPC elements embedded in other disease-focused plans.

For the remaining 42 (54–12 = 42, 77.8%) countries, there were five countries [LR,NG,RW,SC,TN] who had online CCPC programmatic and advocacy literature, but did not have CCPC plans available on the internet [32–36]. Five other countries were excluded because they contained fewer than two mentions of cervical cancer: Egypt's Regional Public Health and Nutrition Strategy for Syrian Refugees, Lesotho's HIV and AIDS Strategic Plan, Namibian Policy for Reproductive Health, Nigeria's Reproductive Health Strategic Framework and Plan, and Swaziland's Sexual and Reproductive Health Policy. Although there was some evidence of CCPC plans of Ethiopia and Tanzania, they were not available online. However, Tanzania'sHIV/AIDS Strategic Plan had components of CCPC and was reviewed (Fig. 1).

Among plans reviewed, Sudan's was the earliest (2006–2010), Zambia's the most recent (2016–2021) and two countries had second-cycle plans [KE,GH/NCD]. Seven plans had time-frames of five years, while the remainder ranged from three to eight years. Nine plans' term had expired between 2013 and 2016 (see Table 2).

3.2. Plan's goals

Ten of these twelve plans were 'strategy'/'strategic plans', one, a 'program action-plan,' and two were embedded in policy documents. Most plans (10) were aligned to the country's health strategy and three were aligned with the country's reproductive health policy/strategy [SL,GM,KE].

Improving cervical cancer survival outcomes was a stated goal in all plans. Nine plans associated disease reduction with improving quality of life among those with cervical cancer and their families while fewer plans aimed to improve cost-effective services (2), increase access (1), and reduce stigma (1).

3.3. Framing of cervical cancer

Cervical cancer was conceptualized as a form of cancer by five plans, and as the outcome of sexually transmitted infection (STI) by eight plans. Cancer framing was found primarily in plans authored or edited by technical groups such as: *Cancer Technical Working/Advisory Group* [MW,KE,TZ,UG,ZM], *National Cancer Steering Committee* [GH/C], *National Cancer Prevention and Control Strategy Development Committee* [ZW] and *Cancer Action-Plan Task Force* [MU]. Only the GH/C plan had a cervical cancer sub-committee.

Five plans conceptualized cervical cancer as an outcome of sexually

Download English Version:

https://daneshyari.com/en/article/8787329

Download Persian Version:

https://daneshyari.com/article/8787329

Daneshyari.com