

A commentary on cancer prevention and control in India: Priorities for realizing SDGs

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Abstract

In India, cancers along with cardiovascular diseases contribute to significant mortality and morbidity. With less than 10 years remaining towards achieving Sustainable development Goals (SDGs), public health systems in India need to be critically assessed and strengthened, for addressing non-communicable diseases (NCDs) in general and cancers in particular. Our Commentary address the public health response to cancer prevention and control, with specific pointers based on emerging evidence. The relevant issues are stratified as: emphasis on the critical appraisal of national programs, strengthening primary health care (PHC) systems, enhancing focus on client and community centricity, exploring integrative approaches to cancer management and stepping up implementation and multi-disciplinary research. Ongoing surveillance is essential to assess the current and future trends of cancer as well as the outcomes of prevention and treatment measures. For revitalizing comprehensive PHC, much depends on our epidemiological capacity and surveillance systems which impart information for local planning. It is imperative to address the cultural barriers and societal norms, which limit the acceptability and participation in screening programs. SDG 3 has ushered the wellbeing agenda at an opportune time. There is a compelling need to conduct research on an integrated approach (ayurveda complimenting allopathic medication) for the treatment of cancer. The unique challenges posed by the rise in NCD morbidity in LMIC, requires horizontal integration of the health systems with new services focused on cancer control.

KEYWORDS

cancer, health priorities, primary health care, sustainable development

1 | INTRODUCTION

Of the global cancer burden, approximately 60% of cancers occur in low-middle income countries (LMIC). However, only approximately 5% of the global expenditure on cancer is directed towards these

countries.¹ In LMIC, approximately 25% of cancers could be attributed to a communicable etiology, which mandates uniquely synergized public health interventions.¹ In India, all the cancers considered together contribute 5.0% of the total DALYs (Disability adjusted life years) and 8.3% of the total deaths during 2016. The

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crude cancer incidence rate in India was 81.2 per 100,000 in 2016, but there was no change in the age-standardized incidence rate. The crude cancer death rate in India was 61.8 per 100,000 during 2016.² The Indian Council of Medical Research (ICMR) had then predicted that there will be approximately 1.73 million new cancer cases until 2020. approximately 1–1.4 million cases are unregistered or undiagnosed.³

The cancer mortality in India is 68% of the annual incidence. It means approximately 30% of Indian patients with cancer survive 5 years or longer after diagnosis.⁴ During 2015, the 2030 Agenda for sustainable development was adopted by the member states of the United Nations (UN). This includes 17 SDGs, which is a universal call for action towards ending poverty, protecting the planet, and ensuring that all the people experience peace and prosperity by 2030.⁵ It includes 17 goals and 169 targets. Goal 3 seeks to ensure healthy lives and promote the well-being of people at all ages, by reducing the prevalence of debilitating diseases,⁶

The targets related to cancer include:⁶

1. Reduce by one-third the premature mortality from NCDs through prevention, treatment and promotion of mental health and well-being.
2. Achieve universal health coverage including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

Projecting the trends from 2010 to 16, the population of India and China will show a 4%–15% reduction in the risk of premature death from four NCDs: cancer, cardiovascular disease, chronic respiratory disease, and diabetes by 2030, which is not sufficient to meet the SDG target 3.4.⁷ Between 2010 and 2030, the predicted overall increase in incidence of global cancer is 51%, which reflects the scenario from low-income countries (LIC): 81% and LMIC: 68%, than from upper-middle income countries (Up MICs): 60% and high-income Countries (HIC): 38%.⁸

Individuals from rural areas tend to present with late stage cancers which are locally advanced and incurable. This could be a result of the myths and stigma related to cancer in this geography, and lack of appropriate diagnosis and referral by the primary care physicians and traditional healers.^{9,10} In response to the rising burden of cancers, many advances have been made in relation to cancer diagnostics, treatment modalities and supportive care, which include essential processes such as chemotherapy, surgery, radiotherapy, anesthesia, supplementary medicines, pathology, diagnostic radiology and palliative care.⁸ However, the response within the public health services has been suboptimal for various reasons including health system capacities, magnitude of the problem, lack of trained manpower, inadequate budget allocation, issues with data quality, and so forth.^{11,12}

The prolonged disability due to cancer and its potential for premature mortality, tend to have substantial economic impact. In this backdrop, the focus of our commentary is on emending our

public health systems for effective prevention and control of cancers in India.

2 | CONTENT

The challenges of the public health system and the recommended interventions are categorized as:

2.1 | Critical review of national programs

Government of India launched the National Cancer Control Program (NCCP) in 1975, and revised the strategies during 1984–1985 which stressed on primary prevention and early detection of cancer. Interventions were devised for primary prevention of tobacco related cancers, secondary prevention of cancer of the uterine cervix, oral cavity, breast, and so forth. Tertiary prevention measures append the extension and strengthening of therapeutic services, such as pain relief, on a national scale through regional cancer centers, medical and dental colleges. The objectives of the National Cancer Registry Program (NCRP) include collection of authentic data on the occurrence of cancer, conducting epidemiological studies and developing human resource in cancer epidemiology and registration.¹³

Given the similar risk factors for cancer and other NCDs, the Indian Ministry of Health conceptualized an integrated program for facilitating their prevention. The merging of NCCP with the NCD Program during 2008 gave rise to the National Program for Prevention and Control of Cancer, Diabetes, Cardiovascular disease and Stroke (NPCDCS). A decade has since elapsed, and this merger needs to be critically evaluated from the point of view of the envisaged outcomes.¹⁴ Given the wide spectrum of cancer prevention in India, and the varied strata of health system readiness for the continuum of care approach (screening, diagnosis and management of cancers), it is important to assess the benefits of 'integration' at the district/subdistrict level.

Shah et al.¹⁵ have identified four key priority areas which promote health services for cancer control:

1. capacity building in oncology related health service research in LMIC, the relevant policy and planning,
2. developing high quality sources of health data (eg: population based cancer registries) which can identify the process and outcomes of cancer management for achieving quality cancer control,
3. oncology related economic evaluation in LMICs, and
4. explore high quality models of cancer control in LMICs,

WHO's overall strategy to diminish the global cancer burden is anchored on surveillance, primary prevention, secondary prevention, diagnosis, treatment and palliation.¹⁶ It is inappropriate to extrapolate the experience of cancer control programs of high income

countries to LMIC. Ongoing surveillance is essential to assess the current and future trends of cancer as well as the outcomes of prevention and treatment measures. The four key components recognized by WHO in its action plan include: prevention, early detection and diagnosis, treatment and palliation.¹⁶

2.2 | Revitalizing Comprehensive Primary Health Care (CPHC)

The deficits in our primary health care system include lack of access, and the disparate and fragmented services which exist distant from the community. CPHC has been strengthened by the Ayushman Bharat initiative during 2018.¹⁷ This is premised on two complementary schemes: Health and Wellness centers, and National health protection scheme.

The existing primary care centers which will be remodeled as wellness centers, will provide comprehensive primary care, free essential drugs and diagnostic services. The vulnerable and marginalized households along with below poverty line (BPL) families will benefit from the health protection scheme, which encompass provision of coverage upto INR 500,000 (equivalent to USD 6400) per family per year for secondary and tertiary care hospitalization (including services from the private sector).

Services which address the rise in NCD morbidity include provision of preventive care and primary health infrastructure, facilitating access to the diagnostics and therapeutics, and provision of technology. Other nurturing care comprise catering services to the specific needs of elderly and migrant population. Strengthening primary health care services include additional resources, administrative assistance, appropriate training, improvised health information systems, and promotion of medical products and services.

Since the last few decades there has been a long stint of verticalization of national programs, however the concept of CPHC is concurrently resurfacing.¹⁷ The epidemiology of cancer varies between and within the states, as well as in urban and rural areas. For revitalizing CPHC, much depends on our epidemiological capacity and surveillance systems which impart information for local planning.¹⁸ Epidemiological capacity as defined by the Council of State and Territorial Epidemiologists (CSTE), United States, is the ability of the State health department to lead activities, provide subject matter expertise, and apply for, receive, and manage resources to conduct key activities.¹⁹ This capacity gap has been exemplified in the context of COVID-19, and needs priority attention. The two important areas where the Covid-19 pandemic has challenged our health system includes.²⁰:

- i). delay in treatment of non-covid conditions, due to reconfiguration of hospital systems towards Covid-19 care,
- ii). effect of lockdown in accessing healthcare for acute conditions, emergency care, cancer treatment, chronic conditions, blood transfusion, patient care and other logistics.

Examples of primary measures for cancer prevention include curtailing the use of tobacco, provisioning avenues for promoting physical activity for weight control, reducing occupational exposure to carcinogenic chemicals or pollutants, and specific protection measures such as vaccination against Hepatitis B virus (HBV) and Human Papilloma virus (HPV). Secondary measures include timely diagnosis for symptomatic individuals and screening of high-risk asymptomatic persons. Community education programs can provide awareness regarding cancer signs and symptoms. Optimal treatment results in improved survival outcomes of cancer patients. Palliative care can positively impact the quality of life of patients (with advanced stage disease) and their caretakers.

2.3 | Retaining focus on client and community centrality

Despite the policy guidelines in this context, the implementation at the grass-root level remains suboptimal. The United Nations (UN) 75th assembly focused on the realization of 'people centered care' for NCDs, towards addressing the existing inequities and maximizing the social impact.²¹ With regard to cancer, this concept assumes greater significance as its diagnosis is associated with high anxiety and stress among the clients and their families, which tends to preclude their health seeking behavior.²² Such issues are addressed in tertiary care centers by professional counselors, but the impact is grim for care seekers at primary care centers given the prevailing understaffed or under-capacitated systems.¹¹ Unless we build community advocacy, the possibility of early screening and effective management of cancers will remain a challenge. Qureshi S.A report the implementation of a community based intervention, based on Heron's framework, which aims to increase the participation of immigrant women in a cervical cancer screening program in Norway.²³

Motivating communities to adopt healthy lifestyle and a behavior without the risk factors, continues to be a challenge. In this regard, there is a compelling need for pilot exploration of scalable methods and tools for the front line health workers.²⁴ This includes technology to systematically and consistently assess, and respond to the needs of their population. It is imperative to address the cultural barriers and societal norms, which limit the acceptability and participation in screening programs.

2.4 | Enhancing wellbeing and quality of life

SDG 3 has ushered the wellbeing agenda at an opportune time.⁶ In recent times, people are living longer and succumbing to chronic diseases, which draws attention to the concepts of 'wellbeing' and "quality of life" (QoL).^{24,25} Maximizing the "QoL" for clients at all stages of cancer is a priority and warrants a multidisciplinary approach. In this regard, regulation on the supply of morphine and other opiates which are critical for relief from malignant pain, and the

lack of trained manpower have a certain impact on the palliative care services.¹⁵ Role of Yoga, meditation and other complementary approaches have been explored in research studies.²⁶ In particular, the Heartfulness Meditation and Mindfulness practices have shown to impact stress, anxiety, inter-personal relationship, and are apparent approaches which could be integrated within cancer programs in particular, and health programs in general.²⁷⁻²⁹

2.5 | Integrative approach to cancer management

Disparity in cancer outcomes is a result of incongruity in early diagnosis treatment effectiveness or the severity of drug related side effects. As cancers are biologically dissimilar, its treatment requires a multimodal and tailored approach. Access to real-time advanced treatment is a challenge for the Indian population, given the financial preclusion.^{11,30} Alternate forms of treatment such as ayurveda (Indian traditional medicine) are affordable, and possess great potential for the cure of cancer. Such scientific formulations work on multiple biochemical pathways and nourish the body's inherent defense systems.³¹ There is a compelling need to conduct research on an integrated approach (ayurveda complimenting allopathic medication) for the treatment of cancer. The benefits of ayurveda also include mitigating the side-effects of allopathic treatment and enhancing the QoL of patients.^{32,33}

2.6 | Accelerate implementation research, program science, and multidisciplinary research

India has a good number of policies and plans, but challenges curtail field implementation. Emerging evidence on implementation research and program science approach has positively influenced the program implementation and its effectiveness at the level of the community.^{34,35} Unless these capacities are scaled pan-India encompassing the district and subdistrict levels, the population-based outcomes across the care continuum will continue to be suboptimal.³⁶

The two important considerations which determine progress towards SDG target 3.4 include⁷:

1. Drafting national NCD strategies based on the existing epidemiology and feasibility,
2. Equitable health system which integrates population-based prevention with the entire continuum of care utilizing efficient referral pathways, including long term care.

WHO "Best buys" updated 2017 (Appendix 3, WHO Global Action Plan for NCDs 2013–2020),³⁷ is a series of interventions for the four key risk factors (tobacco use, harmful use of alcohol, unhealthy diet and physical inactivity) and four key disease areas (cardiovascular disease, cancer, diabetes, and chronic respiratory disease) in controlling NCDs. The "Best buys" include prevention measures which will affect survival over a period of several decades.

An essential requirement is to strengthen health systems for management of NCDs and other health-related SDG targets.⁸

We need to reduce expenditure on cancer care interventions which are low-impact and high cost, and reallocate resources to a package of essential cancer services which are cost-effective¹ In this regard, healthcare providers should be proactive in diagnosing cancer at an early stage when treatment is more effective and less expensive. Inequitable access to secondary prevention (early diagnosis and treatment) measures is explained by barriers such as the socio-cultural norms, demographic factors such as age, geography, poverty indices and inadequate coverage by insurance schemes.

A number of cancers fail to be diagnosed early or managed effectively. In our country, very few centers are pioneering in high quality drug discovery, genetics and bio-technological research, which needs to be expanded.¹² The National Cancer Institute (NCI) at Jhajjar, Haryana, acts as the principle agency for conducting innovative research and development of novel interventions for the prevention and treatment of cancers. The compelling priority is to strengthen academic and industrial linkages for conducting high-end multi-disciplinary research. This includes exploring the novel biomarkers, simple to use noninvasive screening tests, harnessing nanotechnology and precision medicine for refined management of cancer, minimizing the side-effects and the intended costs. We need to build credible databases regarding cancer morbidity, outcomes and mortality, and the knowledge translation should enable evolving the national cancer control policies and programs. Collaborative initiatives with major cancer centers will facilitate implementing the best practices, thus resulting in improved standard of services and QoL of cancer patients.

3 | CONCLUSION

Public health policies pave the way for national health systems. The unique challenges posed by the rise in NCD morbidity in LMIC, requires horizontal integration of the health systems with new services focused on cancer control. Community-based screening for a few common cancers is an opportunity to integrate the prevention and control of cancer into primary healthcare services in our country.³⁸ These activities should be broadened to include risk factor assessment and management, as NCDs share the common risk factors. Some aspects of the health system which influence the patient outcomes include the structuring of process and quality of services offered, training and competencies of the workforce, evidence based treatment protocol for patients and data acquisition from cancer registries.¹ We have less than 10 years to realize SDGs, and NCDs in general and cancers in particular will need to be managed pertinently. This is possible through a critical review of existing gaps and potential opportunities within the realm of public health, which in-turn facilitates the optimization of outcomes.³⁹

AUTHOR CONTRIBUTIONS

Vinod K Ramani: Methodology; resources; writing—original draft.
Krishnamurthy Jayanna: Conceptualization; investigation; validation;

writing—review & editing. **Radheshyam Naik:** Funding acquisition; project administration; supervision; writing—review & editing.

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The authors declare no conflicts of interest.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

TRANSPARENCY STATEMENT

The lead author Vinod K. Ramani affirms that this manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any discrepancies from the study as planned (and, if relevant, registered) have been explained.

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