

**The global burden of women's cancers: an unmet grand challenge in global health.**

Ophira Ginsburg MD,<sup>1,2</sup>, Freddie Bray PhD<sup>3</sup>, Michel P Coleman FFPH<sup>4</sup>, Verna Vanderpuye MD<sup>5</sup>, Alexandru Eniu MD<sup>6</sup>, S Rani Kotha JD<sup>7</sup>, Malabika Sarker PhD<sup>8</sup>, Tran Thanh Huong PhD<sup>9</sup>, Claudia Allemani PhD<sup>4</sup>, Allison Dvaladze MPH<sup>10</sup>, Julie Gralow MD<sup>10</sup>, Karen Yeates MD<sup>11</sup>, Carolyn Taylor<sup>12</sup>, Nandini Oomman PhD<sup>13</sup>, Suneeta Krishnan PhD<sup>14</sup>, Richard Sullivan MD<sup>15</sup>, Dominista Kombe MD<sup>16</sup>, Magaly Blas MD<sup>17</sup>, Groesbeck Parham MD<sup>18</sup>, Natasha Kassami MPH<sup>19</sup>, Lesong Conteh PhD<sup>19</sup>

1. Women's College Research Institute, Faculty of Medicine, Dalla Lana School of Public Health, University of Toronto, Canada
2. World Health Organization, Geneva, Switzerland
3. Cancer Surveillance Section, International Agency for Research on Cancer, Lyon, France
4. Cancer Survival Group, Department of Non-Communicable Disease Epidemiology, London School of Hygiene and Tropical Medicine, London, UK
5. National Center for Radiotherapy, Korlebu Teaching Hospital, Accra, Ghana
6. Cancer Institute Ion Chiricuta, Cluj-Napoca, Romania
7. Institute for Global Health Equity and Innovation, University of Toronto, Toronto, Canada
8. James P Grant School of Public Health, BRAC University, Dhaka, Bangladesh
9. Hanoi Medical University and National Institute for Cancer Control, Hanoi, Vietnam
10. Seattle Cancer Care Alliance, Fred Hutchinson Cancer Research Centre, University of Washington, Seattle, USA
11. Queen's University Faculty of Health Sciences, Office of Global Health  
Queen's University, Kingston Canada
12. Global Focus on Cancer, NY, USA
13. Independent Global Health Specialist, Washington, DC USA, Former Director, HIV/AIDS Monitor, Center for Global Development (CGD)
14. Research Triangle Institute Global India Pvt Ltd, New Delhi, and St. John's Research Institute, Bengarulu, India
15. Institute of Cancer Policy, Kings Health Partners Comprehensive Cancer Centre, and King's Centre for Global Health, King's Health Partners and King's College London, UK
16. Ocean Road Cancer Centre, Dar es Salaam, Tanzania
17. School of Public Health and Administration, Universidad Peruana Cayetano Heredia, Lima, Peru
18. Department of Obstetrics and Gynecology University of North Carolina, Chapel Hill and University of Zambia, Lusaka
19. Health Economics Group, School of Public Health, Imperial College London

Corresponding author:

O. Ginsburg  
World Health Organization  
20 Avenue Appia  
Geneva 1207  
Switzerland  
[ginsburgo@who.int](mailto:ginsburgo@who.int)

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## **Abstract**

Each year, more than 2 million women are diagnosed with breast or cervical cancer, yet where a woman lives, her socioeconomic status and agency largely determines whether she will develop one of these cancers and will ultimately survive. In regions with limited resources, fragile or fragmented health systems, cancer contributes to the cycle of poverty. There are proven and cost-effective interventions for both these common cancers, yet for so many women access to these is beyond reach. These inequities highlight the urgent need for sustainable investments in the entire spectrum of cancer control, from prevention to palliative care, and in the development of high-quality population-based cancer registries, in low- and middle-income countries. In this first Series paper we describe the burden of breast and cervical cancer with an emphasis on global and regional trends in incidence, mortality and survival, and the impact, particularly among socioeconomically disadvantaged women in different settings.

## Introduction

Cancer is a leading cause of premature death and disability worldwide, particularly in women<sup>1,2</sup>. It is a rapidly growing crisis in low- and middle-income countries (LMICs), where the epidemiological transition continues to shift the burden of disease from predominantly infectious causes to chronic, non-communicable diseases (NCDs)<sup>3</sup>. Many countries, particularly those with weak health systems, are struggling to cope with the rapid rise in non-communicable diseases while still experiencing high maternal and child mortality rates, and high mortality rates from infectious diseases (including malaria, TB, HIV/AIDS) as well as malnutrition.

Globally, more than 2 million women are diagnosed with breast or cervical cancer each year, but where a woman lives, in which country, region, or setting in relation to the nearest health care services, and how she lives- poor or otherwise socially disenfranchised, largely determines whether she develops one of these cancers, how early she presents, and if she has access to affordable, good quality diagnostic and treatment services. This is particularly striking for cervical cancer, as approximately 85% of women diagnosed and 88% of women who die from cervical cancer live in a LMIC<sup>3</sup>. There are proven approaches to reduce these gross inequities, yet for most women there are few opportunities to access these life-saving interventions. In many countries, and in many lower-resource areas within countries, implementation of HPV vaccination is limited<sup>4</sup>, as is the availability of, and access to early detection programmes, cancer surgery<sup>5</sup>, essential cancer medicines<sup>6</sup>, radiotherapy<sup>7</sup>, palliative care<sup>8</sup>, as well as support for those who survive, sometimes called “survivorship care”.

Disability and premature death from breast or cervical cancer is a preventable tragedy for hundreds of thousands of women and their families each year. In 2012, breast and cervical cancer took the lives of 522 000 and 266 000 women respectively<sup>3</sup>; as such, close to half a million more women died from these two cancers alone than from complications of pregnancy or childbirth (303 000 maternal deaths in 2015, according to UNFPA)<sup>9</sup>. A further 152 000 women died from ovarian cancer and 76 000 women from endometrial cancer<sup>3</sup>. But where do women's cancers fit on the global health agenda? In high-income countries there is noteworthy advocacy, media attention and funding for research and treatment of cancer, but in many lower-resource settings, breast, cervical and other gynaecological cancers are effectively “neglected diseases”<sup>10</sup>. That these diseases cause considerable disability, premature death, disruption of family life and loss to the national economy, thus exacerbating the cycle of poverty<sup>11</sup>, has been largely ignored.

Only 5% of global spending on cancer is directed toward the majority of countries where the greatest burden exists<sup>12</sup>. Health inequities are differences in health “...that are unnecessary, avoidable, unfair and unjust”<sup>13</sup>. Poor health within countries and inequities between countries reflect an unequal distribution of power, income, goods, and services that result from “ineffective social policies, unfair economic arrangements, and bad politics”<sup>14</sup>. Cancers that affect primarily women present particular challenges in terms of achieving health equity. Elevating the status of women will be one of the key drivers in reducing disparities in cancer outcomes within and between countries.

The Lancet Series on women's cancers seeks to provide an advocacy and action framework for radically improving progress toward closing the “global cancer divide”<sup>11</sup> for women. The

three papers will focus on the global burden of breast and cervical cancer (Series paper 1), the untapped potential of proven and promising interventions, the challenges and opportunities to take these to scale while strengthening health systems (Series paper 2), and the provision of recommendations for translating evidence to policy, in order to reduce inequities and improve cancer survival for women (Series paper 3).

In this first paper we describe the burden of breast and cervical cancer, with an emphasis on global and regional trends in incidence, mortality and survival; the social and economic impact on women and their families, and the disparities in cancer survival among socioeconomically disadvantaged women. Endometrial, ovarian, and other gynaecological cancers are important contributors to cancer mortality, but this Series will focus primarily on breast and cervical cancer, as two of the greatest contributors to cancer mortality and morbidity in women worldwide. As highlighted in this review, breast and cervical cancer will continue to pose particularly important challenges as well as opportunities to strengthen health systems for decades to come. Cervical cancer is largely preventable through public health interventions, for example, HPV vaccination for girls age 9-13, and screening with treatment of pre-cancerous lesions is among the few cancer-related so-called "Best Buys" or "very cost effective strategies" according to World Health Organization's Global Action Plan for the Prevention and Control of Noncommunicable Diseases (2013-2020)<sup>15</sup>. Both HPV vaccination as well as screening and treatment of pre-cancerous cervical lesions are also included in the package of essential interventions for cancer control in LMIC, in the Cancer Volume of the World Bank Group's Disease Control Priorities, Third Edition (DCP3)<sup>16</sup>. Although breast cancer screening continues to generate significant debate regarding the magnitude of benefits and harms, opportune ages and screening intervals, cost effectiveness, and relevance to lower resource settings (See Series Paper 2), improving access to early diagnosis and treatment for breast cancer can be cost-effective, and promotion of breast cancer early diagnosis and treatment is listed in the DCP3 essential package<sup>16</sup>. We therefore address only these two cancers in this Series, as they fall under the domains of public health and public policy most relevant to women's cancers.

### **Aetiology of breast and cervical cancer**

The major known risk factors for breast cancer include female sex, age, and family history, as well as reproductive factors, including early age at menarche, later menopause, nulliparity, and first childbirth after age 30, all of which are independent risk factors<sup>17</sup>. Breastfeeding is independently associated with a reduced risk, with longer duration associated with a greater reduction in risk<sup>18</sup>. Overweight and obesity is associated with an increased risk for post-menopausal breast cancer, while the effect on pre-menopausal breast cancer is not as clear and remains an area of active study<sup>19</sup>.

The most important risk factor for invasive cervical cancer is the human papilloma virus (HPV), of which there are several major oncogenic subtypes<sup>20</sup> (discussed further in Series paper 2). Other independent risk factors include immunosuppression, particularly HIV<sup>21</sup>, and smoking<sup>22</sup>.

### **Breast and cervical cancer: incidence, mortality and survival**

Each year 1.7 million women are diagnosed with breast cancer, making it the most common cancer in women globally<sup>3</sup>. The highest incidence rates are reported from countries in Northern and Western Europe (e.g. Denmark, Belgium, UK), North America, Australia and New Zealand (**Figure 1a**), but breast cancer is not confined to high-income countries, and it is the most commonly diagnosed cancer among women in 140 countries. With an estimated 522 000 deaths in 2012, breast cancer is the leading cause of cancer death in women (15% of all cancer deaths), ahead of lung cancer (491 000 deaths). Breast cancer survival is lower in many LMIC and mortality rates vary more widely than incidence (**Figure 1b**). For example, breast cancer mortality rates in the Pacific Islands (Fiji), the Caribbean (The Bahamas), Sub-Saharan Africa (Nigeria) and Southern Asia (Pakistan) are among the highest in the world<sup>3</sup>.

It is estimated that 530 000 women were diagnosed with cervical cancer in 2012<sup>3</sup>. It is the fourth most common cancer in women worldwide, but in 38 countries, including many in Sub-Saharan Africa, it is the most common cancer among women. The highest incidence rates are observed in this region (Malawi and Zimbabwe, **Figure 1c**), although rates are also high in parts of Central and South America (Guyana and Bolivia). Unlike breast cancer, the global map of cervical cancer mortality rates is more similar to incidence (**Figure 1d**).

Global surveillance of cancer survival trends was recently initiated by the CONCORD-2 study<sup>23</sup> which analysed individual data from 279 population-based registries in 67 countries for over 25 million adults (15-99 years) diagnosed with one of 10 common cancers during the 15-year period 1995-2009. Net survival up to 5 years after diagnosis was estimated after correction for death from other causes. Data were available from 59 countries for almost 5.5 million women diagnosed with breast cancer. For women diagnosed during 2005–2009, 5-year net survival was 80% or higher in 34 countries, but much lower in India (60%), Mongolia (57%) and South Africa (53%) (**Figure 2**). In the 10 years between 1995-1999 and 2005-2009, 5-year survival from breast cancer increased in Central and South America (e.g. from 66% to 76% in Colombia). Data were available from 61 countries for 602 000 women diagnosed with cervical cancer. The global range in 5-year net survival was very wide. For women diagnosed during 2005-2009, 5-year net survival was 70% or higher in 7 countries, in the range 60–69% in 34 countries, but below 60% in a further 20 countries.

A large international study followed up cancer patients diagnosed 1990-2001 in 12 transitioning countries and noted similarly wide variations in cancer survival<sup>24</sup>. They describe 5-year survival for breast cancer by extent of disease: “localized” versus “regional” (indicating larger tumours or local spread to skin, chest wall or regional lymph nodes), for countries with more-developed or less-developed health services. Information on the extent of disease was not available for the African countries in this study. Survival for women with localized disease was reported to be around 90% for countries with highly developed health services (Singapore and Turkey), compared to 76% in countries where they were less developed (Thailand, India and Costa Rica), with a greater disparity for women with regional disease (75.4% versus 47.4% for more- and less-developed health services, respectively).

While each of these studies have certain limitations, they highlight the urgent need for major investments in population-based cancer registration, in vital statistics including cause of death, and in early detection programmes, health-services infrastructure, and human resources<sup>23,24</sup>.

## Women's cancers and human development

Breast and cervical cancer are indicative of the late phase of the epidemiological transition that characterises the rise of NCDs generally. Increasing life expectancy and declines in infection-related diseases (including cervical cancer) are offset by an upsurge in cancers more common in wealthier countries and associated with a "western" lifestyle<sup>25,26</sup> referred to as the "cancer transition"<sup>25</sup>. The Human Development Index (HDI) is a composite of three basic dimensions of human development<sup>27</sup>: a long and healthy life measured by life expectancy at birth, access to knowledge based on a combination of adult literacy rate and primary to tertiary education enrolment rates, and a decent standard of living, based on GDP per capita adjusted for purchasing-power parity (PPP US\$). It therefore places an emphasis on societal values and capabilities within a country as well as economic growth. Comparing the national incidence burden of the two diseases by level of (HDI), the inequity is clear: cervical cancer comprises up to one-third of all cancers diagnosed (in both sexes) in many low HDI settings, compared with less than 10% in most very high HDI countries (**Figure 3**). In many low (and some medium) HDI countries, the combined burden of breast and cervical cancer represents one-third of the total cancer burden in women; reductions in cervical cancer to rates observed in very HDI countries would effectively reduce this proportion to 10-15%.

Breast cancer is the most common cancer among women in most countries, including many where cervical cancer is endemic. This suggests that breast cancer incidence is largely unrelated to national averages of the HDI. Yet the relative magnitude and the extent to which breast cancer incidence is rising and cervical cancer incidence falling are markers of the extent of social and economic transition in a given country<sup>25</sup>. Changing reproductive patterns, including earlier age at menarche, later first childbirth, lower parity and shorter duration of breast-feeding are considered to be the major causes for the uniformly rising incidence of breast cancer in transitioning countries<sup>26</sup> with overweight and obesity becoming increasingly important factors in post-menopausal breast cancer<sup>19</sup>. In some high-income countries, mammographic screening has generated transient rises and subsequent falls in breast cancer incidence while declines in the use of hormone replacement therapy (following publication of the Women's Health Initiative study in 2002<sup>28</sup>) was associated with a period of declining breast cancer incidence, a phenomenon which seems to have stabilized since 2007<sup>29</sup>. Meanwhile, survival has been improving and mortality has been declining in many high-income countries, due to a combination of more effective treatments<sup>23,30,31</sup> as well as earlier presentation and improved access to care.

Declining cervical cancer incidence and mortality rates in many countries over the last decades are associated with the implementation of effective population-based screening programmes in high-income countries or, in transitioning countries, a diminishing prevalence of factors associated with persistent infection with oncogenic subtypes of the human papilloma virus (HPV)<sup>32</sup>. However, there are notable exceptions. For example, steady increases in cervical cancer incidence have been observed in the high-risk populations in Uganda<sup>33</sup> and Zimbabwe<sup>34</sup>. Increasing premature cervical cancer mortality is clearly evident from the cohort-specific mortality trends in some countries in Eastern Europe, and Central Asia including former republics of the Soviet Union<sup>35</sup>.

This "overlapping challenge" whereby breast cancer incidence and mortality are increasing while the burden of cervical cancer is not yet declining is explored with an equity lens in a study from Mexico, using subnational, time series data<sup>36</sup>. The report emphasizes the need for integrated programmes that consider both prevention and treatment "underpinned by a life cycle approach to effectively respond to the burden of cancer faced by women globally"<sup>36</sup>.

Singh et al<sup>37</sup> reported on global inequities in cervical cancer incidence and mortality as a function of variations in HDI, socioeconomic factors, healthcare expenditures, and the Gender Inequality Index (GII) for 184 countries. GII is a composite score that includes reproductive health (maternal mortality ratio and adolescent birth rates), empowerment (proportion of women in parliament and those with secondary education), and economic status (labour force participation). Incidence and mortality were both correlated with human development and gender inequality. A 0.2 unit increase in GII was associated with a 24% increased risk of developing cervical cancer and a 42% increased risk of dying from the disease. While GII as a composite measure has its limitations, this study suggests that not only poverty reduction but increasing access to preventive health services, and elevating the status of women are essential to reducing cervical cancer disparities.

Inequities in survival from breast and cervical cancer are not limited to the so-called “global south”, but also persist for women in North America and Europe (see Panel 1). Indigenous women, regardless of country income level, face multiple barriers to cancer care, including prevention, early diagnosis, and effective treatments for these cancers (see Panel 2).

### **Predicting the future burden**

**Figure 4** shows the predicted global burden of breast and cervical cancers in 2030. Data available from long-standing high-quality population-based cancer registries from medium, high or very high HDI countries<sup>38</sup> suggest that if these average changes continue and were applicable to all countries of the world, the number of women diagnosed with breast cancer will increase to almost 3.2 million per year. Even if incidence rates can be maintained at 2012 levels, a rise to 2.4 million new cases of breast cancer is predicted on the basis of demographic changes alone. For cervical cancer, even if the average decline would be observed in all countries globally, almost the same number of women will be diagnosed in 2030 as today, around 510 000 cases. If the cervical cancer incidence rates were to remain unchanged, however, the number of women diagnosed annually is predicted to rise to over 700 000 by 2030.

### **The broader impacts on women, families and society**

Breast and cervical cancer are key contributors to the overall burden of disease in women. Breast cancer is the leading cause of life years spent with disability (YLD) in 119 countries while cervical cancer is the leading cause in 49 countries<sup>2</sup>. As a cause of premature death however – as estimated through years of life lost (YLL) – cervical cancer leads breast cancer in 23 countries, mainly in Sub-Saharan Africa and parts of Central and South America. In Figure 5, the DALYs (a composite measure of YLL and YLD) for cervical and breast cancer by four-level HDI are in opposing directions by HDI, while the relative contribution of YLL and YLD to DALYs also differ substantially. Breast cancer is a major contributor to the high overall cancer DALYs in very high HDI countries, with a relatively large contribution of YLD. For cervical cancer, the overall magnitude of DALYs and the large YLL component in low-HDI countries are striking<sup>2</sup>.

A comparative analysis of epidemiologic data on breast cancer in the United States, Canada, India, China, Taiwan, Japan, South Korea and Sweden<sup>39</sup> showed striking differences in the median age at diagnosis. The peak age at diagnosis was 40-50 years in Asian countries, and 60-70 years for Western countries. Breast cancer has also been shown to occur earlier in life

in African countries where such data has been reported, with a median age of approximately 45<sup>40-46</sup>. It remains unclear to what degree the earlier age at diagnosis is related to variations in the patterns of risk factors and breast cancer subtypes, or simply a reflection of the differences in population structures between countries of low, middle, and high income (for example, the median age of women in The Gambia is 20.5 years, and 41.6 in the UK<sup>47</sup>).

The median age at diagnosis for invasive cervical cancer depends on the timing of exposure to oncogenic HPV subtypes, and on the latency between exposure, cervical dysplasia and other factors which can affect the likelihood of progressing to invasive disease, as described in the multistage model of carcinogenesis<sup>48</sup>. Once exposed to an oncogenic HPV subtype, the risk of developing invasive cervical cancer is greatly influenced by immune status, which in turn is related to age at exposure and general immunocompetence. Women who are HIV positive are especially at risk of progression to invasive cervical cancer<sup>21</sup>, particularly in the absence of screening programs.

In high-resource countries, cervical cancer incidence rates increase until the age of 30-35 years, then remain stable throughout older ages, most likely as a consequence of the delivery of effective screening programmes. In the United States, the median age at diagnosis of invasive cervical cancer is 47-48 years<sup>49</sup>, compared with 55-59 years in India<sup>50</sup>. In one multi-centre study in Limpopo, South Africa, the mean age at diagnosis was 41.3 and 59.1 years for HIV-positive and HIV-negative women, respectively<sup>51</sup>.

It is clear that breast and cervical cancer in lower-resource settings disproportionately affect women in the prime of life, and, as such, have significant economic and societal consequences. A mother's death has complex effects on the children and families she leaves behind. Women are central not only in direct care-giving for their own children, but more broadly in society, playing key roles in the socialization, education and health of children<sup>52,53</sup>. Women also make substantial, albeit under-recognized, contributions to the health-care labour force. Langer and colleagues have described women's "crucial roles in the health care of families and communities [as] drivers of the wealth and health of nations"<sup>53</sup>. The Lancet Commission on Women and Health<sup>53</sup> in relation to policy for women's cancers is explored further in the third paper in this Series.

While a close link between maternal mortality and newborn health is established<sup>53-55</sup>, most studies have focussed on the early weeks and months of a child's life, highlighting the direct impact of inadequate nutrition from breastfeeding. It is also important to consider the impact of a mother's disability and untimely death on child survival and well-being at other key periods over the life course, including adolescence. Death from untreated and unpaliated cancer is slow, agonizing, and traumatic for patients and families. To our knowledge there are no published studies that specifically address the impact of a woman's death from cancer on her child's survival. Given the rising mortality, and the young ages at which many so women are affected, we suggest that the scope and scale of the impact of women's cancers on the health and well-being of her children warrants further research.

There is overwhelming evidence that investing in women's health provides significant economic returns<sup>53, 56-59</sup>. As the economic cost of cancer is estimated at up to 4% of global GDP<sup>60</sup>, addressing the global burden of women's cancers should be considered a sound investment by governments<sup>11,61,62</sup>. The case is compelling given the profound impact of these

cancers on premature death and disability, with long-lasting social, financial and economic consequences for the affected women, their immediate family and their wider community.

Beyond evaluating the cost effectiveness of interventions for breast and cervical cancer control (Series Paper 2), there is a critical need for more research on the macroeconomic impact of women's cancers. Of the 1,676,255 studies on breast and cervical cancer examined by this Series, only 3% included an economics component. Furthermore, only one in 10 of these were from a low or middle-income setting. The majority of the economics studies identified were based in high-income countries and concerned cost-effectiveness evaluations of interventions, often under trial conditions. There were very few studies identified on the economic impact of advocacy or survivorship programmes. If we concentrate on studies exploring the wider economic impacts of the two cancers, the cervical cancer studies are quite evenly spread across all World Bank income country classifications. However, there were no studies on the wider economic impact of breast cancer from low-income countries.

Cancer impacts the national economy and society at large through increased health expenditure, labour and productivity losses, and reduced investment in human and physical capital formation. At the micro-economic level there are profound effects on women, their families, individual firms and governments<sup>63,64</sup>. It is important to note that much of the work undertaken by women is not associated with monetary transactions and is therefore unlikely to be reflected in conventional macro-economic indicators<sup>53</sup>. Any calculations aiming to assess the economic burden associated with breast and cervical cancer should therefore capture non-income-generating work, such as gathering water and firewood, preparing food, tending to livestock, and caring for children.

If we go beyond the individual impact on women and include their families, the likelihood of catastrophic expenditures is shockingly high in lower resource settings<sup>66</sup>. Not infrequently, families faced with enormous direct and indirect costs are forced to sell assets and accrue debts<sup>67-70</sup>. This already dire scenario is often exacerbated by employment-related complications such as decreased productivity, job loss, dismissal, and reduction of work-related benefits<sup>71</sup>. A 2015 report of 9513 adults with cancer from eight countries in Southeast Asia<sup>66</sup> found that one year after diagnosis, 29% had died, 48% experienced financial catastrophe, and just 23% were alive with no financial catastrophe. Low income was an independent predictor for financial catastrophe, as was education and stage at diagnosis.

Research conducted in Argentina<sup>72</sup>, at that time a middle-income country, found a marked socio-economic impact on women with cervical cancer, with negative consequences on radiotherapy treatment compliance, despite the fact that 96% of patients reported their radiotherapy was free of charge, either covered by social security, the hospital or other agency. Study participants reported work interruption (28%), a reduction in hours worked (45%), loss of household income (39%) with nearly one in five families reporting a loss of 50% or more, a reduction in the daily amount of food consumed (37%), delays in paying for essential services such as electricity or telephone (43%), and the sale of property or use of savings (38%).

It is crucial to understand the social, economic, and financial impact of breast and cervical cancer on the health system<sup>71-75</sup>. How the health system is structured and financed<sup>16,76</sup> dictates many of the socio-economic determinants and inequities of access to health services. In addition, the efficacy and cost-effectiveness of interventions for breast and cervical cancer control must be critically evaluated to help inform and prioritize evidence-based, resource-

appropriate programs and policy-making. Understanding the political economy in which decisions on resource allocation are made, both nationally and internationally, is essential if we are to address the true impact of breast and cervical cancer<sup>77,78</sup>. These policy implications are examined in greater depth in paper 3 of this Series (ref).

## **Conclusions**

There are huge global inequities in cancer survival for women. In lower-resource settings, breast and cervical cancer disproportionately affect women in the prime of life, resulting in significant economic and societal impact. A woman's country, region of residence, income level, socio-economic, ethno-cultural or migration status should no longer influence the likelihood of dying from these common cancers.

Several global initiatives are broadening their approach to women's health along the life-course<sup>79,80</sup>. The UN Secretary General's Every Woman Every Child (EWEC) Global Strategy 2.0 aims to accelerate efforts to end preventable maternal, newborn, child and adolescent deaths by 2030. At the 2016 World Economic Forum, the new EWEC high-level advisory group was announced to move the new strategy forward, and to ensure that "every woman, child, and adolescent not only survives, but thrives"<sup>81</sup>. On World Cancer Day, 2016, UN Secretary General Ban Ki Moon released a statement that addressed the global inequities in women's cancers, and called for action to eliminate cervical cancer as a public health concern<sup>82</sup>.

International efforts have recently led to major improvements in maternal health outcomes: a similar global drive is urgently needed to reduce the impact of breast and cervical cancer, which currently take the lives of some 800 000 women every year. Cancer control for women may be introduced through the new high priority health and development goals that are beginning to take shape. These topics are explored further in the second and third papers in this Series.

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## **Contributions**

The opinions expressed here are those of the authors and do not necessarily represent an official position of the organizations they are affiliated with. All authors were responsible for key messages and final draft. OG led the Series.

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## Legend to Figures

Fig 1a. Global map of the age-standardised (world) incidence rates of female breast cancer in 2012, with the range divided into quintiles. Source: GLOBOCAN (<http://globocan.iarc.fr>)

Fig 1b. Global map of the age-standardised (world) mortality rates of female breast cancer in 2012, with the range divided into quintiles. Source: GLOBOCAN (<http://globocan.iarc.fr>)

Fig 1c. Global map of the age-standardised (world) incidence rates of cervical cancer in 2012, with the range divided into quintiles. Source: GLOBOCAN (<http://globocan.iarc.fr>)

Fig 1d. Global map of the age-standardised (world) mortality rates of cervical cancer in 2012, with the range divided into quintiles. Source: GLOBOCAN (<http://globocan.iarc.fr>)

Figure 2. Global distribution of age-standardised 5-year net survival (%) for women diagnosed aged 15-99 years with (a) breast or (b) cervical cancer during 2005–09, by continent and country.

Legend: Survival estimates for each country are ranked from highest to lowest within each continent: Africa (grey), America (Central and South) (red); America (North) (light red); Asia (yellow); Europe (blue); Oceania (green). Error bars represent 95% confidence intervals. Survival estimates are flagged as follows: \*=100% coverage of national population; †=not age-standardised, or §=less reliable because the only estimate(s) available are from a registry or registries in this category.

Figure 3. The proportion of new cases of cervical and breast cancer in 2012 compared with the total cancer burden from all cancers combined in both sexes by country and four-level Human Development Index (HDI), and sort by HDI within these quartiles. Source: GLOBOCAN (<http://globocan.iarc.fr>)

Figure 4. Estimated annual percentage change (EAPC) 1993-2007 based on cancer incidence obtained from cancer registries included in several volumes of *Cancer Incidence in Five Continents* (top). Predicted number of breast and cervical cases (thousands) in 2030 assuming average trends in the EAPC are observed in every country up to 2030 seen in the incidence series, or assuming rates remain unchanged in every country from those estimated in GLOBOCAN in 2012.

Figure 5. Age-adjusted DALYs per 100 000 population for cervical and breast cancer in 2008 and four-level Human Development Index. DALYs=disability-adjusted life-years. YLL=years of life lost. YLD=years of life lived with disability. Source: Soerjomataram et al.

## Key Messages

1. Globally, almost two thirds of women who die from breast cancer and nine in ten women who die from cervical cancer live in low- and middle-income countries. This is a largely preventable tragedy for hundreds of thousands of women and their families each year.
2. Most women who develop breast or cervical cancer in a high-income country will survive; the opposite is true for women in most low and many middle-income countries. Where a woman lives, her socio-economic, ethno-cultural or migration status should no longer mean the difference between life and death from these common cancers, for which cost-effective, life-saving interventions exist.
3. The incidence of breast cancer is expected to increase rapidly with human development. While invasive cervical cancer should be predicted to fall in emerging economies, this is not yet the case in many countries where patterns of sexual behavior are increasing the transmission of oncogenic HPV subtypes, and population-based organized HPV vaccination and cervical screening programs are not yet widely implemented.
4. It is crucial to understand the social, economic, and financial impact of breast and cervical cancers, which take a disproportionate toll on women in LMIC, and in the prime of life. The efficacy and cost-effectiveness of interventions for breast and cervical cancer control must be critically evaluated to help inform and prioritise evidence-based, resource-appropriate programs and policy-making.
5. Global efforts, particularly in recent years, have led to significant improvements in maternal health outcomes. Similar efforts are urgently needed to address breast and cervical cancer, which take the lives of three times as many women each year.

### **Search Strategy and Selection Criteria**

Studies were retrieved through systematic searches on the following medical and social sciences electronic databases: EMBASE, Global Health, MEDLINE (OVID), Scopus, Web of Science and Econlit. Variations of search terms related to 'breast cancer', 'cervical cancer', 'low income', 'middle income', 'developing' countries, the individually named countries of relevance, 'economic burden' and 'economic consequence', were combined. We searched Google Scholar, scanned the reference lists of the studies retrieved and hand searched the resources and publications of institutional websites. Searches were limited to studies published in English after 1990 containing original quantitative estimates of economic impact.

## **PANEL 1: Cancer survival disparities in North America and Europe**

Disparities in breast and cervical cancer survival exist within and between high-income countries<sup>25, 83-85</sup>. Age-adjusted 5-year survival from breast cancer varies by as much as 20% between European Union countries, with lower survival recorded in Eastern European countries<sup>85</sup>. The international differences in survival have been attributed to differences in stage at diagnosis, access to optimal treatment and national levels of organisation and investment in health care. A European survey on the availability, reimbursement, and other barriers to access reveals important disparities across Europe in access to cancer medicines<sup>86</sup>. Even in the EU, drug shortages limit access to older, inexpensive medicines that are essential for treatment (with curative or palliative intent), such as tamoxifen for breast cancer, or cisplatin and 5-fluorouracil for cervical cancer. In view of their proven efficacy and low cost, these agents, which are included in the recently updated Essential Medicines List<sup>6</sup> of the World Health Organization, should be made universally available for all who require them.

It is unclear to what extent differences in tumour biology versus social, economic and other factors play a role in survival disparities within countries. A number of studies have found a greater proportion of triple-negative breast cancers among African-American women<sup>87,88</sup>, a subtype associated with a poorer survival. However, a recent population-based study in the US<sup>87</sup> found persistent differences in 7-year breast cancer-specific survival between African-American and White women, even for stage I disease. The difference in breast cancer-specific survival remained important even after excluding triple negative tumours. This study did not explore access and utilization of cancer services.

African-American women<sup>87-95</sup> and women from other minority populations in the US<sup>87-91,94-96</sup>, the UK<sup>97</sup> and Canada<sup>98-100</sup> tend to have lower participation in breast and cervical cancer screening programmes and, with some exceptions<sup>101</sup>, lower cancer survival than the corresponding national averages. Reasons for these disparities are poorly understood and include socioeconomic factors such as economic deprivation, geographic distance to cancer services, lack of health insurance and other social and cultural factors which could affect health-care seeking behaviour<sup>87-89,92,100</sup>.

In recognition of the magnitude and pervasiveness of these inequities, a number of regional, national and international cancer organizations have established programmes and policies to reduce cancer disparities, not only for breast and cervical cancers but also for cancers more generally, in men, women and children.

## **Panel 2: Cancer incidence and survival among indigenous women**

Indigenous people in many high-income countries have disproportionately worse health and lower life expectancy than their non-indigenous counterparts. A study led by IARC comparing the scale and profile of cancer incidence among indigenous and non-indigenous populations in USA, Canada, Australia and New Zealand has revealed high rates of cervical cancer in almost all jurisdictions, emphasising the need for targeted prevention strategies in these populations<sup>102</sup>.

Survival from breast and cervical cancer is lower among indigenous women than the national averages in the US, Canada, and Australia<sup>103-107</sup>. Vasilevska and colleagues conducted a systematic review and meta-analysis of cervical cancer in indigenous women in Australia,

New Zealand, Canada, and the U.S.<sup>103</sup>. Of note, they found no difference in the risk for cervical dysplasia or carcinoma in situ but they did find an elevated risk of invasive cervical cancer (pooled RR 1.72) and cervical cancer mortality (pooled RR 3.45). As the indigenous women had a higher risk of cervical cancer morbidity and mortality but no increased risk of early-stage disease, they suggest, “structural, social, or individual barriers to screening, rather than baseline risk factors, are influencing poor health outcomes”.

There remains, however, little information on cancer incidence, survival, and the level of access to cancer services among indigenous populations in LMIC. Recent global and regional reports reviewing cancer among indigenous communities have highlighted the need for more attention to this issue<sup>102,108</sup>. Efforts to develop joint actions as a partnership between Governments, health professionals and the indigenous communities will be critical in reducing the elevated and avoidable burden of cancer among Indigenous peoples worldwide<sup>102</sup>.