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Challenges of Setting up Cervical Cancer Prevention Research Infrastructure in A Low Resource Setting

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Abbreviatations: HPV: Human Papillomavirus; HDI: Human Development Index; VIA: Visual Inspection Acetic Acid

Background

I have always asked myself why we, in the so-called developing world, depend heavily on evidence from the developed world to guide our clinical care, rather than having highquality evidence from our own settings, but I have come short of finding real answers. This is because this is a cross-cutting issue and if I may say, a double-edged sword, which requires a complex solution(s). Let me begin with a statement I have heard from my current boss and one of my mentors, Professor Kathryn Anastos, that; "Almost everyone in Rwanda knows someone who has been affected by or died of cervical cancer while most Americans have never never personally known anyone who died of cervical cancer..." This is because many developed countries have, for decades, been screening their women for cervical cancer , and will see even prevention as they implement other interventions such as immunization against Human Papillomavirus (HPV) and we, in the developing world, have not done so.

According to the 2018 GLOBOCAN data, cervical cancer killed 311,000 women and 570,000 developed it, ranking it as the fourth leading cause of cancer death in women and the fourth most frequently diagnosed cancer among women globally in 2018 [1]. In lower Human Development Index (HDI) countries, cervical cancer ranks second in incidence and mortality and in some countries, it is the most commonly diagnosed cancer among women. The incidence of new cervical cancer cases ranges from 40.1-43.1 per 100,000 in women living in Eastern and Southern Africa compared to 6.4-6.8 per 100,000 women in Northern America and Western Europe.

Opinion

Let us take time away from the science and numbers and go back to our opening question. One of the main reasons we use evidence from the developed world is because we do not have our own evidence and as I usually say, doing something small is better than doing nothing at all. Therefore, using evidence from elsewhere is better than doing anything without evidence at all. In addition, we have limited funding or commit little to conducting research and hence depend on international funding to do our research. This is not a bad thing in itself if, through it, we are not obliged or forced to do things the way the funders want them to be done although we, at the end of the day, may owe them that privilege. For the cervical cancer prevention, in Rwanda for example, we do not have concrete guidelines for cervical cancer screening and we are swung around by multiple funders on which method to use for screening. One group may come in and say that we should use Visual Inspection with Acetic acid (VIA) as the primary screening tool and yet evidence has it that HPV testing is a better screening tool.

Others come in and say that you need to use such and such a HPV assay without considering its feasibility in our setting as well its sustainability, not forgetting cost-effectiveness. We end up developing a number of assays, which are sometimes only used for that particular funding period and practically ends with it Much of this inconsistency of methods across studies could be avoided by the inclusion of the local teams as proposals are planned and developed, rather than waiting till. This implies that we need to develop concrete cervical cancer screening guidelines, which should be followed by everyone who comes in with support towards reducing the burden of cervical cancer but this should be done after conducting research locally to provide the evidence required for the development of any guidelines. In addition, we need to commit some monies towards local research initiatives and actually work towards sustainable research funds.

In light of using locally derived evidence for practice and policy formulation, our team working under the Einstein-

Rwanda Research and Capacity Building Program at Rwanda Military Hospital has been conducting a cervical cancer screening study among women living with HIV to find out which screening method would better suit our setting and our study protocol has been published for reference [2] This study is funded by the US National Cancer Institute of the National Institutes of Health (NCI/NIH) under the U54 funding mechanism (5U54CA190163-05-Anastos/Castle/Mutesa, MPIs).

In addition to the above challenges, we need to build capacity to conduct research especially in areas of local, regional or international disease significance and burden and our program has been supporting this for the past 15 years and I am a product of that initiative. Plus, our institutions need to change their mindset and welcome, learn and try to fully understand how research is done, what is required to conduct research and hence facilitate these initiatives by removing all barriers that hinder smooth management of research grants with a limited timeline.

Rwanda Military Hospital has been evolving to become a facilitator of research initiatives for the past four years but we need to continue to improve systems to facilitate research development and implementation. This concept of facilitating collaboration and working together with international partners is not new in Rwanda as we, Rwandans, have been awarded multiple

times for being among the best performers in Africa for the ease of doing business ranking 29th globally and second in Africa early this year. This ease in doing business should therefore be translated into the ease of doing science by facilitating and funding locally initiated research as well as building research human capacity and infrastructure.

Conclusion

The WHO Director General made a bold call for global cervical cancer elimination in May last year [3] indicating that cervical cancer, as a preventable disease, can be eliminated if we immunize young girls and boys against HPV, the infectious cause of cervical cancer, and screen older women for recancerous lesions and treat them before they become cancer. He further indicates that if we do not act, deaths from cervical cancer will rise by almost 50% by 2030. Therefore, we should not sit back and wait for a miracle to happen without action and as I recently learned from my immediate mentor and professional role model, Professor Philip E. Castle, and I quote; "...15 years ago, I co-authored the blue print for cervical cancer prevention. With a few exceptions, like Rwanda's vaccination program, there has been little progress. Which probably means five (5) million women have died of cervical cancer in that period."

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