Prioritising preventive cancer services in Zimbabwe as the country struggles with unaffordable healthcare

To the Editor: The health system in Zimbabwe has collapsed, mainly owing to underfunding and the migration of skilled personnel.[1] Treatment services have consequently become unaffordable to those in need, especially the poor, who make up more than 80% of the population. Of particular focus for this letter, Zimbabwe has not been spared from the rising burden of cancers globally.

Cancers account for over a third of premature deaths from non-communicable diseases in Zimbabwe, compared with South Africa, where they account for a fifth.[2] There are currently concerns regarding inadequate capacity to provide quality cancer care in Zimbabwe.[3] A significant number of deaths from cancers that are treatable if identified early enough, such as cervical and breast cancer, continue to be reported. Unfortunately, reports suggest that patients are struggling to access treatment services in the public sector, and are therefore resorting to alternative sources of treatment such as traditional medicine practitioners, or remote mission hospitals which, even if better staffed and equipped than hospitals in the public sector, offer substandard surgical treatments in inadequately worked up cancer patients. These externally funded mission hospitals are overwhelmed and do not offer adequate follow-up treatment services, including chemotherapy and radiotherapy, to all their clients.

Several barriers prevent timely and appropriate cancer treatment in Zimbabwe. Firstly, the lack of medical insurance for the majority of the country's citizens results in delays in seeking diagnostic services for potentially cancerous diseases. It is estimated that at least 90% of the country's population is not medically insured. Owing to the prevailing harsh socioeconomic conditions, they may also not have money to pay cash for services.[4] Secondly, the country has a shortage of medical specialists in fields that include early diagnosis of cancer. Many patients are seen by specialists at provincial and tertiary hospitals when they already have advanced disease. The country has fewer than 15 clinical oncologists,[5] who practise only in the country's two major cities, Harare and Bulawayo. Thirdly, the country imports all the medicines used in the treatment of cancer, including chemotherapeutic agents and biological treatments. With the scarcity of foreign currency in the country, importing these medicines is often a challenge. Fourthly, the country has a huge backlog of cancer patients requiring surgical intervention, owing to lack of operating theatre time, equipment and staff. The ongoing attrition of nurses, worsened by the COVID-19 pandemic, has included hordes of experienced theatre nurses leaving the country. Finally, the country has very few operational radiotherapy machines in the public sector, only available at the Parirenyatwa Group of Hospitals radiotherapy centre. Patients from all over the country must travel to the capital for cancer treatment services.

Ultimately, addressing the public health sector caveats highlighted above will be critical for improving cancer outcomes in Zimbabwe; in the interim, however, reducing the burden of cancer in the country through primordial, primary and secondary prevention is key. Prevention with evidence-based interventions is a cost-effective strategy, with tangible results as witnessed elsewhere. Primordial and primary prevention through behaviour, lifestyle and dietary modifications are beneficial in terms of prevention not just of cancers but of other non-communicable diseases. Such practices include eating fewer refined foods, cessation of smoking and alcohol consumption, practising safer sex, and delaying the onset of sexual debut. For cervical cancer and other human papillomavirus-related cancer, vaccination has been shown to be an effective primary prevention strategy, and the country must consider extending this intervention to adolescent boys.

Some cancers, such as cervical cancer, are amenable to secondary prevention through screening and treatment of precancerous lesions. However, local investment in this is very limited, with most of the work being done by international development partners. Strong campaigns and advocacy programmes, driven by passionate champions keen to see dramatic reductions in preventable cancer burdens, are needed.

The country must invest adequately in epidemiological cancer research locally, especially to understand the modifiable cancer risk factors. The relevant departments in the Ministry of Health and Child Care, public health stakeholders and clinicians must work collaboratively to improve awareness of cancer prevention in the population, to generate these messages and to distribute them widely and effectively, taking advantage of people's increased access to the various forms of social media.

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