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FOREWORD

Each year across the world, cervical cancer is diagnosed in 500,000 women and claims the lives of approximately 274,000. Approximately 80% of the cases of cervical cancer occur in women who live in Africa, Asia and Latin America. Globally, cervical cancer is the second most common cancer in women and accounts for 13% of all female cancers. In sub-Saharan Africa, cervical cancer is the most common female cancer and the number one cause of cancer-related death in women. Most cases of cervical cancer are diagnosed in women who are over forty years old. Given the limited treatment options available for advanced cervical cancer, public health experts recommend expanding prevention and screening programmes to detect pre-cancerous changes in cervical tissue.

Women who are HIV infected have a much higher risk of developing pre-cancer and cancer of the cervix than women who are HIV negative and cervical cancer has been described as an AIDS-defining illness. In addition, HIV-related immunodeficiency may also potentially impair the effectiveness of cervical cancer vaccination and treatment, although responses to therapy may improve with antiretroviral therapy (ART).

Even with access to treatment, the prognosis for women with advanced invasive disease remains poor, especially in resource-constrained settings. In such cases, it is better to honestly inform the patient and her family of whatever limited options for care may exist, their potential risks, the costs involved and their likely outcome. Palliative care is essential as soon as cervical cancer is detected, as the illness and the treatment options can cause tremendous anxiety.

Women with cervical cancer endure many difficulties especially in the advanced stages of the disease, including physical pain and other symptoms, psychological symptoms such as depression, social isolation and spiritual distress. Family members also undergo emotional and financial burden. Therefore it is essential to provide palliative care to reduce pain, other symptoms and suffering associated with the condition and its treatment for the woman and her family. This may include avoiding over-medicalised care and non-curative treatments that may simply extend the period of suffering, and, instead, emphasising the provision of end-of-life care.

This monograph therefore discusses some of the benefits of palliative care for women with cervical cancer and provides some case studies of real women who have had some experiences of palliative care. This information is intended to help women living with cervical cancer, their families and others in the community who support them to understand their illness and to help address some of the questions they might have regarding the illness and how they can get help. It is acknowledged that individual situations might require more specific information than what is provided here in this document.

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Executive Director
African Palliative Care Association (APCA)
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<th>Description</th>
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<td>HIV</td>
<td>Human Immunodeficiency Syndrome</td>
</tr>
<tr>
<td>HPV</td>
<td>Human Papilloma Virus</td>
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<td>LEEP</td>
<td>Loop Electro Excision Procedure</td>
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Introduction to Palliative Care for Cervical Cancer

The information in this booklet is intended to help women living with Human Immunodeficiency Virus (HIV) as well as cancer of the cervix, their families and others in the community who support them. Individual situations might require specific information other than what is provided here but this document provides a good start towards understanding the role of palliative care for women living with HIV (WLHIV) and cervical cancer, their families and caregivers and health professionals.

You can use this information:

- As an individual to make good decisions;
- During information sharing within a support group;
- While providing health services to give take home messages; and
- As an advocacy tool to help others support quality care for PLHIV.
Definition of Palliative Care

An approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. (WHO Report, Geneva 2002)

Palliative care:

- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- intends neither to hasten nor postpone death;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;
- offers a support system to help the family cope during the patient’s illness and in their own bereavement;
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;
- will enhance quality of life, and may also positively influence the course of illness; and
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.
Palliative care is an important part of HIV and cancer care for patient and family, and is useful right from the diagnosis, through the disease progression and at the end of life. It helps people with a life limiting illness to live a better quality of life. It involves management of pain, other symptoms and any other problems that come with a serious illness in the family. Think of palliative care as a friend who helps along the way in good and not so good times. Palliative care can help from the early days of learning about cancer. Although cancer treatments can help women to live healthier for longer, when the disease no longer responds to treatments or when late referral means that curative treatments are not possible, palliative care can continue to ensure quality of life. Palliative care can be provided at home, in the hospital, by a hospice service and at the clinic.

3.1 What is Cancer?

This is the uncontrolled growth of some cells in the body. If these cells interfere with normal body function, then they are referred to as cancer. However, benign tumours can do this too. Cells in different parts of the body work differently but most repair and reproduce themselves in the same way. Most of the time, this division takes place in an orderly and controlled manner but should this process get out of control, the cells will continue to divide and develop into a cancerous lump called a tumour. A tumour has cancer cells which have the ability to spread into other parts of the body thus spreading the cancer. There are over 100 types of cancers that can affect the human body.

3.2 HIV and Cancer

Women living with HIV/AIDS are at much higher risk of developing cancer than their HIV-negative counterparts because of the weakened immune systems or body defence mechanisms. The cancers that tend to be common among HIV+ women are cervical cancer, Kaposi Sarcoma, Non-Hodgkin’s lymphoma and cancer of the breast, among others. Due to greater access to antiretroviral drugs and treatment for opportunistic infections, HIV-infected women are living long enough to develop cervical cancer. It is therefore more critical than ever that they have access to cervical cancer screening and treatment services.

3.3 What is cervical cancer?

Cervical cancer is a disease that begins in the cervix of the female reproductive system. It is a low-growing cancer and can take 10-20 years to develop fully.
4 Cervical Cancer

The cervix is the lower part of the uterus that connects the body of the uterus to the vagina or birth canal and it is also known as the opening or the mouth of the womb. Pre-cancer and cancer of the cervix (cancer of the mouth of the womb) are caused by a virus known as Human Papilloma Virus (HPV). This virus is transmitted from a man’s genital organ to a woman’s cervix during sexual intercourse. Women also transmit HPV to men during sexual intercourse. Screening can detect precancer and most abnormal changes found on the cervix at this point are treatable and curable. It usually takes 10-20 years for an HPV infection on the cervix to develop into cervical cancer. The HPV infection first turns into pre-cancer, which later develops into cancer if not treated at an early stage. Cervical cancer can be prevented with early screening and treatment. It is recommended that women between 25-60 years should have regular screening, especially if they are HIV+ as they are the most at risk of developing this cancer.

4.1 Common symptoms of cervical cancer

Women with cervical cancer may experience no symptoms at all. This is why it is so important to check for signs of pre-cancer. However, the majority of women present late when symptoms have set in. Such symptoms include vaginal bleeding during or immediately following sexual intercourse, vaginal bleeding between menstrual periods or after menopause, a foul smelling vaginal discharge that fails to clear up after several treatments.

4.2 Who can get cancer of the cervix?

Any woman who has a cervix and has been sexually active at any time in her life is at risk of getting cervical cancer and needs to be screened for cancer of the cervix at least once in her lifetime. Almost all women are at risk of cancer of the cervix but it is more common among:

- Women who have been sexually active;
- Women who start sexual activity at a young age;
- Women who have had multiple sexual partners;
- Women whose partners have multiple sexual partners;
- Women with poor hygiene habits;
- Women who use herbs in the vagina leading to infection;
- Women who have multiple and close births;
- Women with low immunity from HIV or from poor nutrition;
- Women who smoke tobacco;
- Women who have sexually transmitted infections; and
- Women whose sexual partners are not circumcised.

If you or any one you know has any of these symptoms, it is time to get an examination by a health worker because the earlier pre-cancer or cancer symptoms are found, the better the chance of a cure. DO NOT BE SHY OR EMBARRASSED TO GO TO THE CLINIC.
There are things women and their partners can do to prevent cancer of the cervix. However, it is still necessary to have regular check-ups.

Women can avoid getting pre-cancer or cancer of the cervix by doing the following things:
1. Delay sexual intercourse as long as possible;
2. Avoid unwanted pregnancies and pregnancies at a very young age;
3. Limit the number of sexual partners;
4. Use condoms to prevent Sexually Transmitted Infections including HIV and AIDS and unwanted pregnancies;
5. Avoid smoking tobacco;
6. Eat plenty of fresh fruits and vegetables everyday;
7. Don’t douche or wash the vagina. It interferes with the natural defences of the vagina and cervix;
8. Encourage spouses to be circumcised; and
9. GET SCREENED FOR CERVICAL CANCER REGULARLY.

5.1 HPV vaccination as a prevention strategy

Two vaccines are now available that can protect against HPV infection. These vaccines are targeted against specific types of HPV that most commonly cause cervical cancer and are given to young girls before sexual debut.

Human papillomavirus vaccines may eventually prove the most cost-effective way of preventing cervical cancer in the future, but current vaccine costs are prohibitive in resource-constrained nations.

Men have a role to play in prevention of cervical cancer in women by:
1. Reducing the number of sexual partners they have;
2. Using condoms if they have more than one sexual partner;
3. Using condoms to prevent STIs including HIV and AIDS;
4. Encouraging their partners to be screened if they are over 20 years old; and
5. Being circumcised.

HPV can also threaten men’s health if it persists by causing cancer of the penis.
6 Screening for pre-cancer and cancer of the cervix

- Cervical cancer screening is a simple procedure performed in a medical clinic and requires a vaginal examination by a healthcare professional.
- Any woman who has a cervix and has been sexually active at any time in her life needs to be screened for pre-cancer or cancer of the cervix regularly.
- Pre-cancer of the cervix can usually be treated in a medical clinic by a nurse or doctor by either freezing it or removing it with a small electrical device.

6.1 Methods of screening for pre-cancer and cervical cancer

The only way for a woman to know whether she has pre-cancer or cancer of the cervix is to undergo **CERVICAL CANCER SCREENING**

Early detection of cancer cells can be done through the following ways:

i) **Visual inspection of the cervix** with either acetic acid (VIA) or Lugol’s iodine (VILI) by a trained health professional. After application of acetic acid to the cervix, areas with cells infected with the HPV virus will appear as distinct well defined aceto-white areas with sharp borders. There are no colour changes noted in normal cervical cells. All these changes are seen with a naked eye.

ii) **Pap smear examination** is when a speculum or special instrument is inserted in the vagina and using a special brush or spatula, cells are scraped from cervix and taken to the laboratory for microscopic examination.

Visual inspection with acetic acid (VIA) has been shown to be a cost-effective strategy for cervical cancer prevention in resource-constrained developing nations. VIA is more cost-effective than Pap smear because it allows for screening and treatment within the same visit, does not require sophisticated laboratory facilities and manpower and uses less disposable equipment than other screening methods.

HIV positive women need a yearly VIA or Pap smear while for HIV negative women it is recommended every two years.

6.2 What can be done if there are pre-cancerous cells in the cervix?

Screening for cancer of the cervix enables you to find a problem with your cervix 5 to 10 years before it develops into cancer

If pre-cancerous cells are found on the cervix, there are many things that can be done – taking action is very important. Whatever treatment you have, keep taking ART if you are already on it.

The following treatments or procedures can be performed by a trained health care worker if you are found to have pre-cancerous cells on your cervix:

- **Colposcopy and Loop Electro Excision Procedure (LEEP)** – a special camera helps the doctor examine your cervix in more detail making cells look bigger.
- **Getting rid of the cancerous cell using special X-ray called radiotherapy.**
- **Laser treatment** (a special light) destroys the cells.
- **ART** may reduce the size of the problem cells in women living with HIV because it improves the immune system.
This is a story of how one woman living with HIV prevented getting cancer of the cervix:

Sara, a 25 year old married woman developed herpes zoster (painful rash) on the arm and friends advised her to go to the clinic. She went to the nurse in a local clinic she had been to while pregnant who recommended that Sara should get an HIV test. She agreed and was found to be HIV positive. This news was devastating for Sara as she had been negative throughout her pregnancy. The nurse explained that this could have happened towards the end of pregnancy or soon afterwards as the HIV window period of 3 months would have hidden her real HIV status then. The nurse gave her information on ways through which the HIV infection could be passed on by the mother to the child either during pregnancy, labour or breast feeding and she was therefore advised to bring her baby for testing too as well as her husband.

Sara did not bring her baby as she feared the worst and her husband refused to be tested but agreed to engage in safe sex for future protection.

A few months later, her child started to become unwell. The little girl developed frequent coughs and vomiting. Sara went back to the clinic nurse who persuaded her to have the baby tested for HIV. The child was found to be HIV positive, which was very upsetting news for Sara and her husband. The husband continued to be supportive but refused to be tested. Sara always tries to persuade him to be tested. Both Sara and her child are now on ART and they attend a local support group.

During one of the regular ART clinic visits, Sara agreed to have a visual inspection with acetic acid examination of her cervix (VIA). She was told that she had signs that some of the cells on the cervix could become cancerous if she didn’t receive treatment. She was referred to the nearest hospital where the bad cells were destroyed through a method that freezes the cells in order to destroy them (cryotherapy). She has recovered well but she understood from all the information she was given that if the treatment did not succeed, this kind of cancer can become life-threatening. Because she has to live with that uncertainty and regular visual inspection, she is having counselling from a community caregiver who has received training in palliative care. This counselling will help her learn how to live with such a serious condition and to do everything she can to prevent it from becoming worse.

Points to remember
- HIV infection takes a period of three months to one year or more before causing disease symptoms in the infected person.
- Children born to HIV positive mothers need to have an HIV test within the first 6 weeks of birth.
- It is important to have your cervix checked regularly by a nurse or doctor to detect or exclude disease early.

Ask these questions
- What causes the cells to change in the cervix?
- Can anything be done to avoid the bad cells in the cervix?
- How often do you need to be examined?
Cervical cancer happens when pre-cancerous cells continue to develop. To confirm cervical cancer, a small piece of cervical tissue (biopsy) is taken from the affected areas and sent for further examination under a microscope in a laboratory. When results of the biopsy are received and cancer is confirmed, then the patient is taken to the theatre to determine the extent of the cancer – this is called staging. There are different stages of cervical cancer depending on its extent and the surrounding organs involved. It is important to note that cancer cells continue to grow if not treated or removed early. Below is how a cervix may look like at different stages of cervical cancer.

### PALLIATIVE CARE AND CERVICAL CANCER

<table>
<thead>
<tr>
<th>STAGE 1</th>
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<tbody>
<tr>
<td><strong>Cancer strictly confined to the cervix</strong></td>
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</tbody>
</table>
| 4 cm or smaller | Disclosure of diagnosis by a trained health provider. Counselling on concerns, information about cancer cells and what it means for HIV positive women. | There may be no symptoms particularly in the very early stages. However some symptoms may include:  
• Bleeding during intercourse;  
• Pain in the pelvis during and after sexual activity; and  
• More than usual vaginal discharge slightly yellowish. | Operation by specialised surgeon to remove disease in a cone shape. Total removal of the womb (hysterectomy) and/or Radiotherapy (X-ray treatment). |
| Larger than 4 cm | | | |
## STAGE 2

The cancer extends beyond the cervix but does not reach the pelvic wall, involves the vagina but not as far as the lower third of the vagina.

<table>
<thead>
<tr>
<th>Palliative Care</th>
<th>Symptoms</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Palliative care helps with answers to questions, gives hope along with reality for this stage of the illness. Management of pain and other distressing symptoms is very important.</td>
<td>Pain and bleeding after intercourse. Increase in vaginal discharge which may be offensive¹. Bleeding between menstrual periods or after menopause.</td>
<td>Doctor will assess whether to operate and remove the womb and/or use radiotherapy or chemotherapy treatments.</td>
</tr>
</tbody>
</table>

¹Offensive means something that has a foul smell

### Stage 3a

Involves lowest third of vagina, pelvic side wall to the tube from the kidneys.

<table>
<thead>
<tr>
<th>Palliative Care</th>
<th>Signs and symptoms</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counselling for the possible loss of womb and working towards good health. The team is available during and after treatment. Apply natural yoghurt or sour milk on a pad to get rid of smell.</td>
<td>Incontinence. Patient may find it hard to hold urine. Pain increases in the abdomen. Unpleasant smelly discharge.</td>
<td>Radiotherapy and chemotherapy are the treatments of choice. In rare cases, surgery may remove the womb and all ovaries and glands. The doctor will discuss options with the patient to help her decide which treatment is suitable.</td>
</tr>
</tbody>
</table>

Cancer has grown into the tissues around the cervix

Cancer has grown into the lower third of the vagina

Vagina

Counselling for the possible loss of womb and working towards good health. The team is available during and after treatment. Apply natural yoghurt or sour milk on a pad to get rid of smell.
<table>
<thead>
<tr>
<th>Stage 3b</th>
<th>Palliative care</th>
<th>Signs and symptoms</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tumour extends to pelvic wall and/or causes non-functioning kidney</td>
<td>Same palliative care as above. Wash the vagina regularly in salt water. Pack with iodine and glycerine gauze. Use of a catheter may help with incontinence.</td>
<td>Severe incontinence. Constant unpleasant smell. Severe pain in the abdomen. Poor appetite due to smell. Nausea and vomiting. Some weight loss.</td>
<td>Radiotherapy and chemotherapy are the treatments at this stage.</td>
</tr>
</tbody>
</table>

**STAGE 4**

<table>
<thead>
<tr>
<th>Stage 4a</th>
<th>Palliative care</th>
<th>Signs and symptoms</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>The disease goes further and involves the bladder, rectum and bowels. This is not curable.</td>
<td>Management of the client’s pain (physical, spiritual, social, emotional) and embarrassment in cases of destruction of wall between womb and rectum. Counsel on losses, and impact on sexuality.</td>
<td>Increasing pain in lower abdomen and back, leaking of urine and faecal matter through the vagina.</td>
<td>Radiotherapy is mainly used to relieve symptoms, not to cure patient. Pain management and management of incontinence if present. Bleeding can also be reduced or stopped with radiotherapy.</td>
</tr>
</tbody>
</table>
Occasionally Stage 4b disease involves distant organs such as liver, lungs, peritoneal lining etc.

<table>
<thead>
<tr>
<th>Palliative Care</th>
<th>Sign and symptoms</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emphasis on comfort rather than cure. Explain to the patient what is happening. Emphasis on end of life care. Conferences with the family to explain prognosis and answer any questions they may have.</td>
<td>Significant weight loss, cough with chest pain, abdominal pain with distension.</td>
<td>As above; mainly palliative radiotherapy.</td>
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</table>

CERVICAL CANCER IN PREGNANCY

STAGE I-4

<table>
<thead>
<tr>
<th>Palliative care</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Some women may only be screened when pregnant.</td>
<td>Counselling the mother on fears she may have about the unborn child, effects of treatment on the unborn baby, and treatment options available.</td>
</tr>
</tbody>
</table>

Diagrams and stages adapted from Stage Classification for Cancer of the Cervix, Lawrence Z. Kochi, Radiation Therapist, University of Zimbabwe

7.1 Summary of Treatment and Prognosis of cervical cancer

The standard treatment of cervical cancer may involve surgery or radiotherapy or a combination of both. Early cervical cancer (stage I and IIA) may be treated by either procedure. Radiotherapy is the treatment of choice once the disease has spread beyond the cervix and vagina when surgery is not effective.

Using chemotherapy in addition to radiotherapy may improve the results of radiotherapy in advanced cervical cancer.

The stage of the cancer established by the doctor gives a clear indication for the patient’s quality of life. Other factors influencing survival include general health, nutritional status and HIV sero-status.
**CASE STUDY TWO**

**Story of a woman living with HIV who developed cervical cancer**

Naomi is a 55 year old menopausal grandmother who has recently been diagnosed HIV positive. While at the clinic she mentioned to the nurse that she had a discharge which was slightly pink. She was then examined by a nurse who found abnormal sores on the mouth of her womb after application of acetic acid. Naomi was told that her cervix looked like it had abnormal little patches which could be pre-cancerous or early cancer. She was asked to go to the provincial hospital to see a specialist doctor to carry out more tests to find out exactly what it was. At the referral hospital, a small piece of flesh (biopsy) was taken from her cervix and sent for microscopic examination. The doctor said he was pretty sure this was early cancer. The doctor asked one of the nurses working closely with him to counsel Naomi. Naomi was frightened and anxious. She told the nurse that she thought she would die very quickly because no one she had ever known has survived cancer. “I feel hopeless and frightened”, she said. Her self-esteem was low and she said she did not think anyone would look at her or see her as a woman.

The nurse referred Naomi to a counsellor trained in palliative care. Naomi agreed to be counselled and this helped her come to terms with what was happening to her. They also discussed her fears about the operation. She was told to go back to the hospital where she would be informed about the treatment to be carried out. On the day of the appointment she was seen by a special doctor and given a date for the operation. She was to be in hospital for a few days.

Naomi was successfully operated on and her whole womb was removed. It was explained that she would need to see a doctor every six months for a vaginal smear to check if the cervical cancer was coming back. As a woman living with HIV she was told that cervical cancer can return in another place.

**Several years later**

After some years of good health Naomi decided to return to the hospital for a check-up earlier than her appointment due to abdominal pain. She was examined and tests were carried out. The doctors said the cancer had spread to other parts of the body, notably the bowel and bladder. Naomi was disappointed by this news as she seemed to have been healthy up to then. The nurse reassured her that palliative care would help to control the symptoms and provide the best possible quality of life even though the cancer was incurable. The nurse went on to explain that the doctor had said the palliative care team would also help Naomi with pain and discussion of her worries.

**One year later**

Naomi had lost a lot of weight. Her clothes did not seem to fit her well and she continued to see the palliative care members regularly. Her pain was managed and she also managed to speak to the spiritual counsellor who addressed her spiritual worries. She liked the fact that she could discuss anything with the team and not just illness. Naomi found she slept better and her family members also talked to the palliative care team and learnt how to help her. As her pain increased she got help from the palliative care nurse who gave her medicine for her pain, tiredness and poor appetite.

**At the Clinic**

Naomi tells the other women at the clinic how she feels. She explains that the cancer she had at the mouth of the womb was taken away but it came back. Naomi is looking rather unwell and sad but she tells the group about the help from the palliative care team. She seems positive at this stage and says the team say they will manage the pain even if they cannot take the disease away.
Later
Naomi gradually got worse and her family was helped to look after her at home by the palliative care team who took turns to visit Naomi depending on what help she or the family needed. The nurse always checked on pain and other problems like poor appetite. Naomi died without pain in her home with her family members around her. They were comforted by the fact that Naomi spent her last days free of pain and other troubling symptoms.

Points to remember from Naomi’s story
- Palliative care starts at the time when the diagnosis of cancer is made
- Referral is important for patients with cancer to confirm the diagnosis and plan care
- Palliative care restores hope even when there is no chance for a cure
- Involving the family is important at every stage during the course of the disease
1. Cervical cancer is one of the major causes of death and illness in women globally affecting mainly women who are over 40 years.
2. It usually takes 10-20 years for an HPV infection to develop into cervical cancer. The HPV infection first turns into pre-cancer, which later develops into cancer of the cervix.
3. Any female who has ever been sexually active during her lifetime is at risk of developing cervical cancer. However, the younger she is when she first has sex, and the more different sexual partners she has throughout her lifetime, the higher her risk for developing pre-cancer or cancer of the cervix.
4. Women who are HIV infected have a much higher risk of developing pre-cancer and cancer of the cervix than women who are HIV negative.
5. Cervical pre-cancer has no symptoms.
6. The only way for a woman to know whether she has pre-cancer or cancer of the cervix is to undergo CERVICAL CANCER SCREENING.
7. The treatment for cancer cervix is either surgery or radiation and sometimes both.
8. Antiretroviral therapy reduces the risk of progression to cervical cancer in women with cervical abnormalities only modestly.
9. Palliative care with pain control is important for all women receiving treatment for cervical cancer, especially those with limited or no treatment options.
10. A cancer diagnosis will also lead to great psychological suffering and women and their families require support and counselling.
11. The involvement of a palliative care team in end-of-life care is also important, and quality of life, pain and symptom management should be given just as much emphasis as clinical staging when making decisions about treatment.
12. If the cancer gets worse there is always help with pain from the palliative care team, who will be there till the end.

Important points about Pre-cancer and Cancer of the Cervix

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SOURCES OF INFORMATION

ABOUT APCA

The African Palliative Care Association (APCA) is a non-profit-making pan-African membership-based organisation, which was provisionally established in November 2002 and formally established in Arusha, Tanzania, in June 2004. Acknowledging the genesis of modern palliative care within the United Kingdom, APCA strives to adapt it to African traditions, beliefs, cultures and settings, all of which vary between and within communities and countries on the continent. As such, APCA being a recognised regional voice for palliative care in Africa works in collaboration with its members and partners to seek African solutions to African problems.

APCA’s vision is to ensure access to palliative care for all in need across Africa, while its mission is to ensure that palliative care is widely understood, underpinned by evidence, and integrated into all health systems, to reduce pain and suffering across Africa. APCA’s broad objectives are to:

- Strengthen health systems through the development and implementation of an information strategy to enhance the understanding of palliative care among all stakeholders
- Provide leadership and coordination for the integration of palliative care into health policies, education programmes and health services in Africa
- Develop an evidence base for palliative care in Africa
- Ensure good governance, efficient management practices and competent human resources to provide for institutional sustainability
- Position palliative care in the wider global health debate in order to access a wider array of stakeholders and to develop strategic collaborative partnerships
- Diversify the financial resources base to meet APCA’s current funding requirements and to ensure the organisation’s future sustainability.

APCA works to build effective linkages between all our key stakeholders, including: patients, their families and communities; carers (both family and volunteers); health care providers and educators; African governments, policy makers and decision-makers; its constituent members (both individuals and organisations); national palliative care associations, hospices and palliative care organisations; academic institutions; the media; governmental and non-governmental donors (both within and outside the continent), and the general public, in a network of national, regional and international partnerships.

The development of a core curriculum for palliative care is one of the strategies through which palliative care can be integrated in existing pre service and post service health education programmes. This is instrumental in ensuring that palliative care is integrated into the wider health systems across the African continent.

www.africanpalliativecare.org
ABOUT OSISA

The Open Society Initiative for Southern Africa (OSISA) is a growing African institution committed to deepening democracy, protecting human rights and enhancing good governance in the region. OSISA’s vision is to promote and sustain the ideals, values, institutions and practices of open society, with the aim of establishing vibrant and tolerant southern African democracies in which people, free from material and other deprivation, understand their rights and responsibilities and participate actively in all spheres of life.

In pursuance of this vision, OSISA’s mission is to initiate and support programmes working towards open society ideals, and to advocate for these ideals in southern Africa. This approach involves looking beyond immediate symptoms, in order to address the deeper problems - focusing on changing underlying policy, legislation and practice, rather than on short-term welfarist interventions. Given the enormity of the needs and challenges in the region it operates in - and acknowledging that it cannot possibly meet all of these needs - OSISA, where appropriate, supports advocacy work by its partners in the respective countries, or joins partners in advocacy on shared objectives and goals.

In other situations, OSISA directly initiates and leads in advocacy interventions, along the key thematic programmes that guide its work. OSISA also intervenes through the facilitation of new and innovative initiatives and partnerships, through capacity-building initiatives as well as through grantmaking.

Established in 1997, OSISA works in 10 southern Africa countries: Angola, Botswana, DRC, Lesotho, Malawi, Mozambique, Namibia, Swaziland, Zambia and Zimbabwe. OSISA works differently in each of these 10 countries, according to local conditions. OSISA is part of a network of autonomous Open Society Foundations, established by George Soros, located in Eastern and Central Europe, the former Soviet Union, Africa, Latin America, the Caribbean, the Middle East, Southeast Asia and the US.