Cancer and sexuality in the Maghreb countries: Where are we now?

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• The Maghreb countries constitute a homogenous geopolitics, cultural and social entity.

• The health systems in these countries inherited structures issued from the former French colonialism. Then, they developed their own characteristics which were roughly similar in many ways, as they were adapted to their population needs.

• In addition, investment efforts seem to be slightly different from a country to another regarding to wealth, natural resources, educational systems, political orientations,...
We try to analyze in our talk:

* Specificities of most frequent cancers in the Maghreb countries in relation to demographic, economic and health systems conditions.

* How common people or even healthcare professionals in our countries look to normal sexuality in general and sexuality related to health abnormalities in particular.

* The need of a better understanding of sexual troubles in relation to the cancer and how we can improve them in relation to cancer general management.
Demographic studies in the Maghreb countries showed marked transformations, mainly in relation to the increase of population and ageing, which implied more health needs and expenses.

<table>
<thead>
<tr>
<th></th>
<th>Tunisia</th>
<th>Morocco</th>
<th>Algeria</th>
<th>Lybia</th>
<th>Mauritania</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population</strong></td>
<td>11 Million</td>
<td>33 Million</td>
<td>37 Million</td>
<td>7 Million</td>
<td>4 Million</td>
</tr>
<tr>
<td><strong>Raw mortality rate</strong></td>
<td>Drop (70% in 49 years)</td>
<td>Drop (72% in 49 years)</td>
<td>Drop (76% in 49 years)</td>
<td>Drop (79% in 49 years)</td>
<td>Drop (54% in 49 years)</td>
</tr>
<tr>
<td><strong>Raw natality rate</strong></td>
<td>Drop (62% in 50 years)</td>
<td>Drop (61% in 49 years)</td>
<td>Drop (60% in 49 years)</td>
<td>Drop (52% in 49 years)</td>
<td>Drop (32% in 49 years)</td>
</tr>
<tr>
<td><strong>Childhood mortality rate</strong></td>
<td>Drop (92% in 50 years)</td>
<td>Drop (78% in 50 years)</td>
<td>Drop (80% in 50 years)</td>
<td>Drop (91% in 50 years)</td>
<td>Drop (46% in 50 years)</td>
</tr>
<tr>
<td><strong>Fertility rate</strong></td>
<td>Drop (71% in 49 years)</td>
<td>Drop (68% in 49 years)</td>
<td>Drop (69% in 49 years)</td>
<td>Drop (69% in 49 years)</td>
<td>Drop (32% in 49 years)</td>
</tr>
</tbody>
</table>
In the Maghreb countries, epidemiologic characteristics of cancers remain similar:

**Incidence rates**: 80 to 130 per $10^5$ males - 70 to 120 per $10^5$ females

- **Main locations in males**:

<table>
<thead>
<tr>
<th>organ</th>
<th>Frequency (%)</th>
<th>Inc rate (/ $10^5$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lung</td>
<td>18 – 24</td>
<td>20 - 37</td>
</tr>
<tr>
<td>Bladder</td>
<td>5 - 14</td>
<td>12 - 19</td>
</tr>
<tr>
<td>Prostate</td>
<td>8 - 15</td>
<td>8 - 14</td>
</tr>
<tr>
<td>Colon</td>
<td>3 – 8.8</td>
<td>5 – 6.5</td>
</tr>
</tbody>
</table>

- **Main locations in females**:

<table>
<thead>
<tr>
<th>organ</th>
<th>Frequency (%)</th>
<th>Inc rate (/ $10^5$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>30 - 32</td>
<td>24 - 30</td>
</tr>
<tr>
<td>Uterus, cervix</td>
<td>2.5 - 10</td>
<td>3 - 7</td>
</tr>
<tr>
<td>Colon</td>
<td>6 – 6.5</td>
<td>4.8 – 6.5</td>
</tr>
<tr>
<td>Ovary</td>
<td>3.5 – 4.5</td>
<td>2.5 – 4.5</td>
</tr>
</tbody>
</table>
Cancer incidence rates in the Maghreb countries (males)

- ORAN: Taux brut 95,1, TSA 136,87
- ALGER: Taux brut 67,62, TSA 93,78
- SETIF: Taux brut 47,33, TSA 78,52
- TUNIS: Taux brut 96,48, TSA 122,04
Tobacco related cancers in TUNISIA

• Tobacco is the cause of death by cancer of 28% of all new smokers and 9% of older ones.

• Cigarette smokers represent 1/3 to 1/5th of the whole population.

• In males, cigarettes related cancers are dominated by lung cancers (1st) then bladder tumours (2nd).

• In addition, Tobacco consumption has its own additive negative effects on erectile function.
Lung cancer incidence rates (worldwide)

- US, Los Angeles: 88.74
- Canada, Quebec: 82.52
- Italy, Parma: 63.39
- China, Tanjin: 55.89
- France, Isere: 50.09
- Australia, Victoria: 45.99
- Spain, Granada: 45.33
- Japan, Osaka: 43.45
- Israel, Born Af. Asia: 27.82
- Israel, All Jews: 27.04
- Algeria, Setif: 25.8
- Brazil, Goiania: 21.33
- Kuwait, Kuwaitis: 20.66
- India, Bangalore: 8.06
- Mali, Bamako: 4.28
- Uguanda: 4.24
Prostatic carcinoma (P ca) in the worldwide -1-

- In the USA : (2004 statistics) :
  - Pca accounts about 1/3 of all cancers in men
  - It is the second leading cause of cancer death in men
  - And 10% of all estimated deaths in men were from Pca

- In France :
  - Pca represents the second cancer in males
  - It is considered as the second cause of death by cancers
  - Its incidence is increasing for all the stages
  - In 2010 its estimated incidence is 70000 new cases
Pca in the worldwide -2-

- In the Maghreb countries:
  - Pca occupies the second place among male cancers (frequency 10 – 20%)
  - In Morocco, in 2020 its incidence will increase by 45%.
  - In Tunisia, it lies in the third place after lung cancers and bladder tumors (3 cancers registries)
  - In all Maghreb countries its incidence rate varies from 8 to 14 / 100 000
Pca incidence rates (worldwide) -3-

- Los Angeles: 110.2
- Brezil, Brazilia: 101.5
- Canada, Ontario: 91.8
- France, Calvados: 70
- Japan, Nagasaki: 68.6
- Italie, Naples: 18.6
- Tunisie, Sousse: 14.1
- Kuwait, Kuwaiti: 10.6
- Casablanca: 9.58
- Sétif: 7.5
- Chine, Changai: 6.9
- Alger: 5.42
- Tunis: 4.35

TSA
P Ca incidence rates (Maghreb countries) -4-
Cancer incidence rates in the Maghreb countries (Females)
Breast cancer (worldwide) -1-

• Br ca is the most common among malignancies affecting women in the western countries (50%)
• Br ca incidence rate in the western countries varied from 80 to $130 / 10^5$.
• In the Maghreb countries its frequency (30 – 40%) of all female cancers.
• However, its incidence rate remains relatively low 20– 40/$10^5$
• All cancer registers in the worldwide showed marked increase in Br ca incidence during the last 20 years.
Breast cancer incidence rate (worldwide) -2-

- Harrare, BI: 121,2
- USA, BI: 92,6
- USA, Noires: 83,3
- France: 79,7
- Australie: 78,2
- Angleterre: 74,2
- Af dusud, BI: 62,1
- Brésil: 43,9
- Shangai, Chine: 26,6
- Osaka, Japon: 23,8
- Sousse, Tunisie: 22,5
- Israel: 21,6
- Alger, Algérie: 21,2
- Harrare, Noires: 19,8
- Sétif, Algérie: 19,3
- Bhamako, Mai: 14,7

TSA
The WHO definition of sexual health

« the integration of somatic, emotional, intellectual and social aspects of sexual beings in positive way to enrich and enhance personality, communication and love »
Some features on sexuality in the Maghreb countries -1-

- Sexual behavior in the Maghreb countries is influenced by different factors:
  - Belief, taboo, ancestral customs,
  - Educational disturbances,
  - True precepts of the Islam (main religion)
- Virginity is considered as a social duty to preserve (83 – 98%)
- Sexual relations before marriage are strongly prohibited (82,8%)
- Sexual education is considered as forgivable for man and not for women (80%)
Some features on sexuality in the Maghreb countries -2-

• There is confusion between female sexual life and reduction of hormonal secretion (menopause 83%)
• Sterility is considered as tragedy for women, who was thought to be the main cause. Men could marry many wifes (Morocco, Libya)
• At least 1/3 of females do not do preliminaries, it was wrongly thought to be in contrast to the Islamic recommendations.
• There is a prophet parable (om salama):

  "No man should make love to his wife as an animal"
  "It is more likely to send messenger between the husband and his wife: the kiss"
Some features on sexuality in the Maghreb countries

- For many people, masturbation is a forbidden behavior as it would lead to culpability feelings and shame (83%).
- For other Islamic scholarlies, it is rather well tolerated as it would calm harmfulness of sexual abstinence (15%).
- For the **hambalite islamic school**; masturbation would be tolerated as it may avoid adultery and it could stabilize physical and mental health of youngsters or young adults who do not afford marriage and avoid clandestine sexual relations.
Cancer sexual distress

- Alterations of sexuality negatively affect the quality of life of cancer survivors. An active and seemingly continuous functional sexual life brings sensible and positive meanings to cancerous patients way of living.

- Genital cancers (40% of all cancers), seem to be more affecting the sexual life than the other cancers, although the latter would add their own negative effects.
Illustrations from the Maghreb literature -1-

- A prospective study concerning 40 women who underwent surgical treatment for breast cancer (Sfax – Tunisia):
  - G1 conservatively (20),
  - G2 radical mastectomy (20),
- Their mean age: 42 years (G1 – G2)
- Corporal image was very affected (95% G2) vs. No alteration at all (G1).
- Psychological distress was mainly observed in G2:
  - Depression: 55%
  - Anxiety: 42.5%
  - Need of psychological help: 45%
Illustrations from the Maghreb literature -2-

• A retrospective study concerning 45 women treated by total hysterectomy (Sfax – Tunisia);
• Psychological distress was predominant; it was mainly due to:
  – Modification of corporeal image (loss of feminine identity) 73%
  – Libido decrease: 73%
  – Fear of husband abandonment: 52%
• More couple discord which influenced its sexuality and life: 68%
A transversal study from Morocco, Rabat July; 2007 – October 2007

- Including 97 patients, treated for several cancers (females 84%)
- Genital organ involved (58%) - Mean age 45 y (ranges 18 – 72 y)
- Sexually active patients declared that their sexual life was affected (67%)
- Most husbands reported some kind of their wives understanding (76%)
- 20% of the married women accepted changing of their marital status after cancer diagnosis:
  - 6 asked their husband to remarry
  - 6 asked their husband to look for another women
- Among males (16%), only 1 case of divorce was observed.
• There are no variations between people in the Maghreb countries and the others worldwide, if we consider sexual dysfunctions, conjugal violence, and other sexually related perturbations which are widespread in the manhood.

• However, cancers natural histories in our countries seem to be slightly different as they are discovered with delay and are usually treated at advanced stages ...

• In addition, patients socio-economical conditions may influence, to some extent, outcome of cancerous disease.
• These patients sexual distress towards cancer, either before or after cancer treatment, should be better understood and well managed in order to add more hope and improve their quality of life.

• In our countries, sexuality is rarely discussed during announcement of cancer diagnosis except when proposed treatments have direct effects on sexual and/or reproductive functions.

• Lack of communication remains the main problem:
  – Patients often reserved, feel embarrassed to talk about their sexuality
  – Doctor broach the subject as they stipulate they do not receive complaints, so they wait until patients ask them about sexual distress
By ameliorating sexuality

• We add another active supportive care that could improve quality of live especially in patients treated for **cancers at early stages** with long survivals.

• In addition, we would add another doping phenomenon to other palliative therapies that could be proposed to patients who suffer of **cancers observed at advanced stages**; such as pain treatment, preservation of corporal scheme, psychotherapies, stoma-therapy...

• At least, it enables better collaborative and transversal care practices with coordination of competences for patients and their families.
Role of associations+++

• In the Maghreb countries, associative network interested to cancerous patients is still unsteady.

• Although there are several active associations, specialized in cancer and palliative care, which mainly ensure end stages cancerous patients who have to be cared for with dignity and according to their wishes, a lot of work have to be done in the future, especially by integrating sexuality into improved quality of live programs.
Conclusions

• Cancer diagnosis and treatments are associated with significant psychological distresses that can result in altered sexuality which negatively affects patients quality of life.

• In the Maghreb countries, lack of communication is relevant; It is important to open the dialogue with patients in this matter.

• Health care professionals must endeavor to provide information to patients on how cancer and its treatment have the potential to affect their sexual self perception and sexual functioning, so that they can better accept their new conditions and be accommodated to their cancer treatments.