JANUARY 2025

STRENGTHENING THE PATHWAY TO CERVICAL CANCER ELIMINATION

A policy roundtable report on the critical role of screening and treatment in the elimination of cervical cancer.

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The Commonwealth

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Strengthening the pathway to cervical cancer elimination

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January 2025

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EXECUTIVE SUMMARY

Broad access to quality screening, timely diagnosis, treatment and vaccination is essential for helping people live longer and healthier lives. Cervical cancer is no exception. The first cancer in history that's poised for elimination, progress depends on a successful holistic approach to vaccination, screening and treatment programmes. While HPV vaccination has benefited from significant investment, a major challenge lies in ensuring national and international efforts remain coordinated and balanced, so that vaccination initiatives complement rather than overshadow the essential screening, triage, diagnosis and treatment programmes.

The Commonwealth Secretariat and TogetHER for Health, with the support of Roche Diagnostics International Ltd., held a high-level policy roundtable discussion on 18 September 2024 in Geneva, Switzerland, as part of the 2024 World Cancer Congress. Bringing together 24 experts from public and private sectors and civil society, the event was convened around a single question:

"Have you noticed that we hear less and less about the elimination of cervical cancer and more about HPV vaccination as a standalone intervention?"

EMERGING THEMES INCLUDED:

- The acknowledgement of cervical cancer as a global health priority affecting women and people with a cervix* across the world, particularly women living in low- and middle-income countries (LMICs), those living with HIV, and marginalised communities in high-income countries (HICs).
- Recognition of advances in cervical cancer prevention and management, including the advent of prophylactic vaccines, high performance diagnostics, precancer and invasive cancer treatments.
- Endorsement of a holistic approach that embraces progress across the three cervical cancer elimination pillars.
- Discussion around the complexities involved in tackling cervical cancer holistically, and a recognition of key implementation and access barriers.
- Recognition of the role and potential of digital technology as an enabler that improves clinical decision-making, promotes the exchange of health information, and the evaluation and tracking of cervical cancer programmes.
- Case study examples of countries and initiatives that are breaking new ground in the design and implementation of elimination strategies that work across all three pillars of the World Health Organization elimination strategy.
- Recommendations for policy and decision makers to support the acceleration and evaluation of cervical cancer elimination programmes.

The following document provides a summary of these discussions and linked recommendations. The event participants call on policy and decision makers to recognise the value and benefit of an integrated and holistic approach to accelerating global efforts towards cervical cancer elimination.

All linked case studies are provided in Appendix 1.

*Available data does not disaggregate between women and people who have been assigned female at birth. For consistency, this document will refer to "women" as the primary at-risk group, but recognises that cervical cancer is a risk to all people with a cervix, and that associated health programming should target all those affected.

No woman should ever die from a preventable disease. Together we can eliminate cervical cancer.

CERVICAL CANCER ELIMINATION IN CONTEXT

Cervical cancer is one of the most common cancers in women globally. In 2022, 660,000 women were newly diagnosed with the disease, with 350,000 women losing their life to it.[1] Over 90% of these deaths occurred in LMICs,[2] where 21 countries report cervical cancer as the number one cause of cancer-related deaths (20 in sub-Saharan Africa).[3] In the Commonwealth, cervical cancer continues to present a significant threat, with GLOBOCAN predicting that by 2030 the Commonwealth's share will have increased to 38% of global incidence (265,627 new cases) and 42% of global mortality (168,012 deaths).[4]

Data also show that women living with HIV[5] and in marginalised communities in HICs (e.g. Hispanic and black women in the US) are more likely to be affected by cervical cancer.[6]

If nothing changes, models indicate that by 2050 cervical cancer incidence and mortality rates could reach 948,000 and 543,000 (an increase of 43% and 56%, respectively).[7] They don't have to. Ninety-nine percent of cervical cancer cases are linked to infection with high-risk human papillomaviruses (hr-HPV).[8] Not only is this cancer preventable, early diagnosis and treatment can yield 5-year survival rates of over 80%.[9]

In 2020, the World Health Organization (WHO) launched a global strategy to eliminate cervical cancer as a public health problem. The following targets must be met by 2030 for countries to make this vision a reality.[10]

90% of girls vaccinated with the HPV vaccine by age 15.

70% of women screened with a high performance test by age 35 and 45.

90% of women with cervical disease receiving treatment.

The pillars of effective cervical cancer management [11,12,13]

Primary prevention

VACCINATION

A game-changer for cervical cancer, available vaccines are highly efficacious in preventing HPV 16 and 18 (around 70% of cases globally).

RECOMMENDATIONS

Vaccination programmes target girls aged 9-14 years and are administered as a single or two-dose schedule (2-3 doses for immunocompromised patients).

Secondary prevention

SCREENING

WHO guidelines recommend high-performance HPV testing (clinician and self-collected) over VIA or cytology.

RECOMMENDATIONS

Women should be screened every 5–10 years starting at age 30 using an HPV DNA test. Women living with HIV should be screened every 3-5 years, stating at age 25.

Treatment

TREATMENT (PRECANCER)

Positive results should be followed by triage assessment and treatment for precancerous lesions (if necessary).

RECOMMENDATIONS

Same-day treatment is recommended when possible. Options include ablative procedures for small, localised lesions and excisional treatments for extended lesions.

TREATMENT (INVASIVE CANCER)

Untreated lesions lead to invasive cancers, which require comprehensive management in a specialised setting.

RECOMMENDATIONS

Treatment approaches are determined by cancer stage, and may require access to pathology, medical imaging, surgery, radiotherapy, chemotherapy, and palliative care services.

By 2120

74 million new cases averted in LMICs.

62 million deaths avoided in LMICs.

* Reducing the incidence rate of cervical cancer to fewer than 4 cases per 100,000 women per year.

THE IMPORTANCE OF A THREE-PILLAR APPROACH

> **“It’s the lives saved on the way that matter, and we can only save those lives with screening and treatment.**
>
> Karen Canfell, Director of the Daffodil Centre, Sydney, Australia

The elimination of cervical cancer depends on the integrated delivery of all three strategic pillars. Despite this, vaccination programmes are increasingly seen as a standalone “silver bullet.”

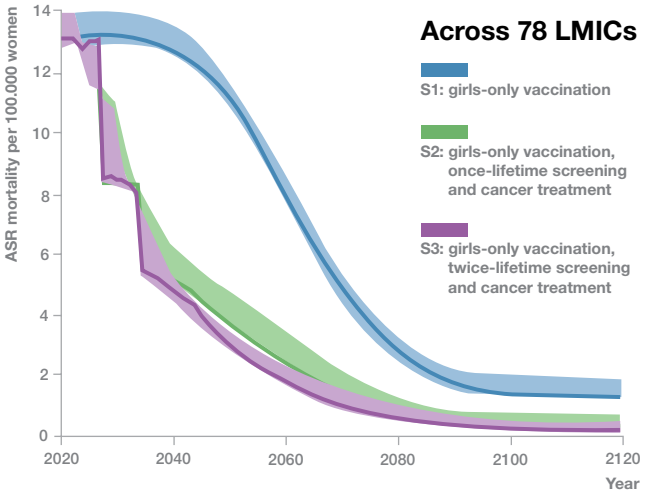
As a result, not only does investment in cervical cancer prevention fall critically short of the required US$10.5 billion,[14] funds are disproportionately focused on vaccine-centric solutions.

The investment in HPV vaccine programming in LMICs in 2023 reached US$202.8 million (244.5% increase from 2022) compared to US$54.9 million in test-and-treat solutions (18.2% decrease).[15]

Average total investment in cervical cancer vaccination, screening and treatment from 2018 to 2023.[15]

THE BENEFITS OF A 3-PILLAR MODEL

Screening and treatment programmes offer an essential level of secondary protection and early impact on mortality. Models[16] show that a holistic, 3-pillar approach will bring the mortality curve down faster than a single-strategy approach. To eliminate cervical cancer, both vaccination and secondary prevention must be adequately resourced and scaled to meet the targets outlined in the WHO strategy. Prioritising only vaccination leaves millions of lives at risk.



Age-standardised cervical cancer mortality over time for all 78 LMICs.[17]

CHALLENGES IN SCREENING AND TREATMENT FOR CERVICAL CANCER

As well as a holistic, 3-pillar approach, strategies to eliminate cervical cancer depend on the strength and capacity of the surrounding health ecosystem. In addition to low and disparate vaccination rates, analysis and group discussions reveal critical shortfalls in the uptake of HPV screening, triage and treatment. This situation is compounded by a number of economic, societal and social factors, as discussed below.

FAST FACTS

The shortfall in cervical cancer screening

36% **of eligible women globally have been screened at least once in their life time.[18]**

Most are screened with a low-performance test. Screening remains a challenge, with only 7% of women aged 30-49 receiving HPV-specific tests globally in 2022 (estimated global HPV-based screening coverage).

AVERAGE NUMBER OF WOMEN AGED 30-49 YEARS SCREENED IN 2018

29% **in Latin America and the Caribbean[19]**

9% **across Asia[20]**

4% **in sub-Saharan Africa[21]**

20% **of countries in the African region have national cervical cancer screening programmes. Of these, only two currently use HPV testing routinely.[22]**

ECONOMIC FACTORS. Cervical cancer screening and treatment have been identified by WHO as one of the "best buys"* for noncommunicable diseases,[23] that yield an immediate return on investment. Despite this, HPV testing is often still mistakenly seen as a high-cost alternative to visual inspection with acetic acid (VIA) and cytology, as only the upfront investment is taken into account and aspects such as frequency of screening and repeat screens and follow-up are not factored in. The situation is compounded by:

- **Current demand**
  The demand for HPV testing in LMICs often does not align with need, resulting in low testing volumes and fragmented, inconsistent ordering patterns. This discourages manufacturers from engaging with markets in LMICs and can lead to higher costs and other challenges in managing orders.[24]

* The most cost-effective interventions for prevention and control of noncommunicable diseases.

- **Variations in access pricing**
  Reports highlight a concerning discrepancy in the prices offered by global donors, procurers, and NGOs compared with those offered by local distributors for government and other local public sector providers. In some cases, local distributors have been known to mark up their prices by as much as four to five times the global access price indicated.[25] This issue is further compounded by the fact that individuals in low-income settings often have to pay for these services out of pocket, significantly increasing their financial burden.

- **Funding shortfalls**
  Domestic funding remains an ongoing challenge, particularly in LMICs, although a lack of transparency around health budgets makes it difficult to assess the extent of the funding gap.[26]

SOCIETAL FACTORS shape the demand for HPV testing by influencing how individuals understand and engage with available services. Recognised challenges include:

- **Social and cultural barriers**
  Limited public awareness and understanding of cervical cancer, which may be shaped by a woman's education level, and especially in comparison to more well-known cancers like breast cancer,[27] can significantly reduce demand for screening, including HPV testing.

  Other elements, such as cultural norms, religious beliefs, and associated myths and social stigmas also play a role in discouraging women from seeking screening.[28, 29, 30]

- **Sampling methods**
  Some women may delay screening due to concerns about the invasive nature and discomfort of available screening methods.[31, 32, 33] To counter this, WHO recommendations have been updated to include self-collection,[34] although the uptake of such methods is still gaining traction.[35, 36]

STRUCTURAL FACTORS. As with any public health intervention, the success of HPV screening and treatment programmes depends on the healthcare infrastructures around them, with noted limitations including:

- **Human resources for health**
  A shortage of trained providers at primary healthcare levels, and inadequate resources at secondary and tertiary level care, may limit access to more complex interventions, including chemotherapy, radiotherapy and surgery.[37, 38, 39]

  Lack of awareness among health personnel around cervical cancer as a health problem in general, and on the benefits of HPV testing, also impacts public demand. Healthcare providers prescribe available test modalities, and/or services that they are familiar with — most often VIA or cytological methods.[40, 41]

- **Laboratory system capacity**
  HPV testing requires a more complex laboratory infrastructure and workforce than VIA models. Limited access to these services, inadequate sample referral systems, and a shortage of trained laboratory technicians, all impact the delivery of effective screening and triage programmes.[42, 43, 44]

- **Health information systems**
  Weak information systems and data registries (including digital systems) jeopardise programme success, causing inconsistent test results and delays in diagnosis. They also limit the ability to track and evaluate cervical cancer interventions and impair decision-making.[45]

- **Availability of clinically validated tools**
  A global assessment of HPV Nucleic Acid Tests (NAT) tests found 264 unique assays and 511 variations. While these numbers may suggest a healthy and rapidly growing market, the reality is very different. Data shows that 79% of these tests lack published clinical data, regulatory clearance, or WHO prequalification. Many also do not include the option of self-collective sampling.[46, 47]

  The use of unverified tools in both private and public healthcare settings poses a risk to public health, as they may not provide accurate results and could result in further delays in diagnosis.

ENABLING ACTIONS

Such challenges are not insurmountable. Across the world communities and countries are pioneering comprehensive approaches initiatives that work to address financial, cultural and systemic challenges and bring HPV testing and cervical cancer treatment closer to the women who need it (see Appendix 1). The results speak for themselves, with each success providing insights and learning that can be used to drive future developments and accelerate action towards disease elimination. The recently announced partnership between Unitaid and Gavi, aiming to co-ordinate vaccination and secondary prevention in Nigeria and Côte d'Ivoire, will serve as a further example of how holistic strategies can be effectively implemented.[48]

A SUMMARY OF KEY RECOMMENDATIONS GLEANED FROM THIS DISCUSSION IS PROVIDED BELOW.

1 POLITICAL COMMITMENT TO A HOLISTIC MODEL OF CARE

Vaccines alone are not enough to reach elimination targets in high burden countries. To reach the elimination threshold in all countries, we need to act on all three pillars: investing in and scaling up vaccinations, supporting the transition to HPV screening, and building high-quality treatment capacity.

2 DEVELOPMENT OF INNOVATIVE FINANCING SOLUTIONS

By implementing market-shaping activities and pooled procurement for agreed packages of screening commodities, countries can leverage new economies of scale — with increased demand and reliable forecasting stimulating the production of high-quality diagnostics and attracting a diverse array of varied funding sources.

Within this, it should be noted that Gavi will be supporting 25 to 30 countries with HPV vaccination programme roll-out through to the end of 2026. This will include funding for community mobilisation and grassroots awareness raising, which will provide an opportunity to promote the HPV vaccines, but also to amplify the message about the importance of screening.

3 POLITICAL WILL AND DOMESTIC RESOURCING

While global funding can provide critical catalytic programme support, only domestic investments guarantee the continuity, scalability and sustainability needed to reach elimination targets. Countries must prioritise these investments as a cornerstone of their health strategies and develop transparent, budgeted national cervical control plans.

4 EXPEDITED SYSTEMS FOR WHO PREQUALIFICATION

Expediting WHO prequalification for cervical cancer testing technologies will help ensure the rapid availability of high-quality, clinically validated diagnostic tools. This promotes consistency in cervical cancer screening and builds confidence among healthcare providers and the communities they serve in the technologies and collection methods available to them.

Experts and advocates are therefore calling for the development of a global procurement mechanism to be expedited by WHO taking a stronger role in the fast-tracking of prequalification.

5 A FOCUS ON COMMUNITY ENGAGEMENT

There is an urgent need to scale up community initiatives to educate the public at large and women of eligible age on cervical cancer and the benefits of HPV prevention and timely follow-up. Empowering them to take up available services will generate demand and create a sense of political urgency – putting pressure on governments to deliver.

6 ADOPTING PERSON-CENTRED PRACTICES

The perspectives of individuals and communities with lived experience of conditions like cervical cancer are vital for creating effective, inclusive, and equitable health interventions. Their involvement enhances the uptake of screening, including self-collection, and treatment, and is fully aligned with WHO recommendations for meaningful engagement of people with lived experience.[49]

7 TRAINING AND CAPACITY BUILDING

Training programmes to enhance the skills of health workers are crucial for transitioning from VIA to HPV testing and expanding access to cervical cancer services at the primary healthcare level. Targeted training in triage and the treatment of precancerous lesions will promote early diagnosis and preventive care, reducing the risk of invasive cancers and improving health outcomes.

8 SHARING LEARNING AND BEST PRACTICES

Celebrating data and learnings from early investments and multi-partner implementation programmes will help shape best practices and demonstrate the impact of HPV testing, community sensitisation, capacity and system-wide development activities. This will provide inspiration to elimination planners, strengthening guidelines and quality of care at the national level and facilitate access.

9 INVESTING IN LABORATORY SYSTEMS

Strengthening laboratory capacities requires investment in a skilled workforce and supporting laboratory infrastructures. Countries can optimise available resources by integrating HPV testing into systems established for COVID-19, HIV, and TB, utilising current molecular instruments, human resources, and expertise.

10 BUILDING CAPACITY FOR HEALTH INFORMATION MANAGEMENT

Digital tools and health information systems are critical for collecting and analysing the data that drives local and global policy making. Robust information systems also promote accountability, facilitate programme evaluation, and support resource and diagnostic network optimisation.

CONCLUSION: A TURNING POINT IN HISTORY

Cervical cancer is the first cancer in history that is poised for elimination. Science has given us everything we need to deliver. But there is no shortcut. Equitably eliminating cervical cancer is a long-term commitment that can only be achieved through a holistic 3-pillar approach that sees screening and treatment receive the same level of attention — and financial resourcing — as vaccination efforts.

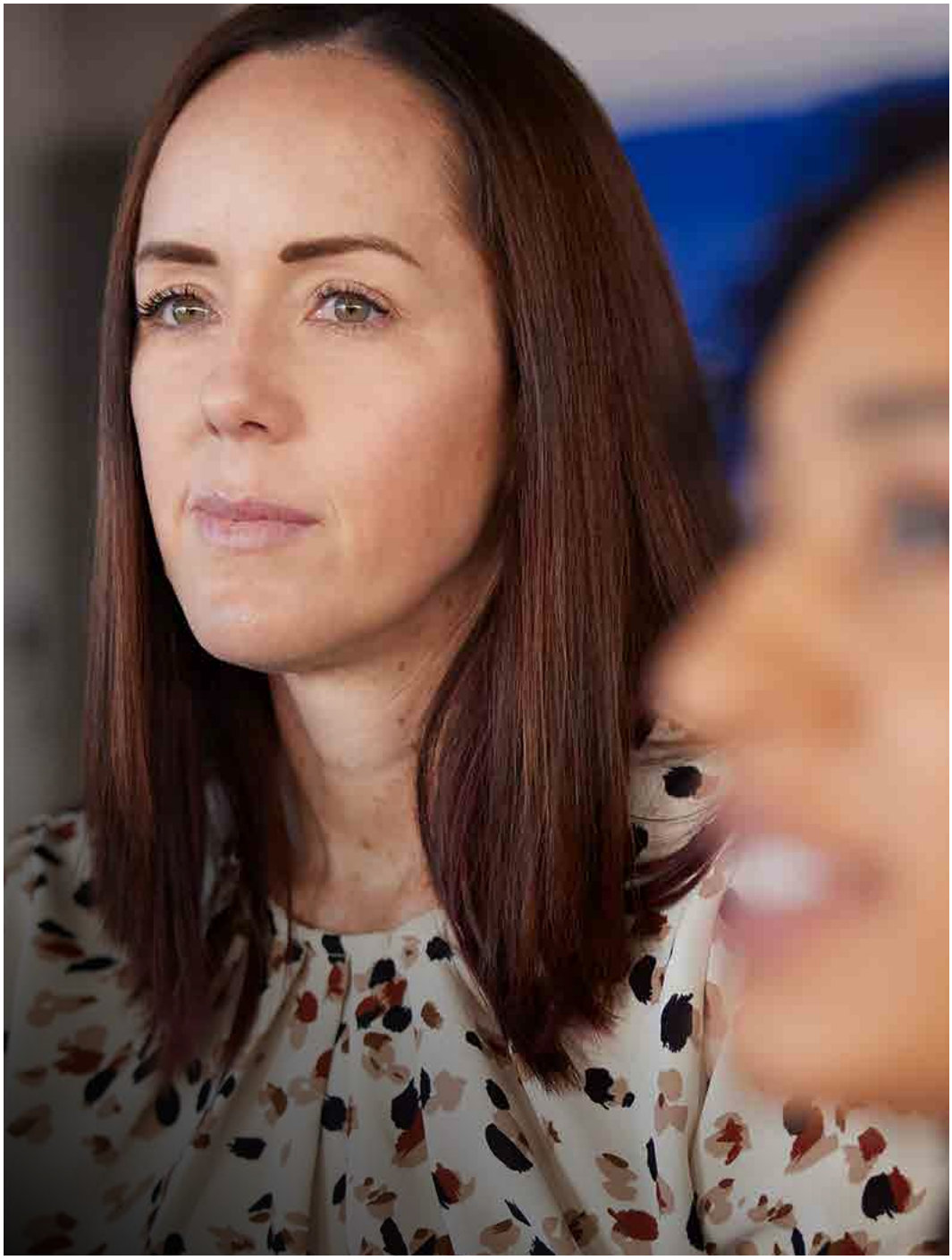
These initiatives do not stand in isolation. To be successful, we must recognise the health ecosystem within which these interventions are inextricably linked, and promote a systemic approach that breaks down financial barriers, dispels myths and stigma, and builds workforce and capacity to make quality tests and treatment available to every woman, everywhere. These investments to strengthen cancer health systems will also benefit prevention and control of other cancers.

To do this, we call on all governments, policy makers and the international health community to support the development of a comprehensive approach to cervical cancer elimination.

The Commonwealth and TogetHER for Health firmly stand behind this commitment and advocate for actions that will bring us closer to eliminating cervical cancer as a public health threat.

ESPECIALLY, WE URGE:

- **Policy makers** to publicly endorse the combined impact of vaccination, screening and treatment by making a commitment to national elimination of cervical cancer..
- **Governments** to commit to prioritising cervical cancer elimination and mobilise the financial and human resources needed to accelerate action.
- **Donors** to allocate resources to screening and treatment at levels commensurate with the needs outlined in the WHO strategy, ensuring comprehensive support for all pillars, including the transition from VIA to HPV testing.
- **Private sector partners** to facilitate public-private collaborations that accelerate the resourcing and delivery of vaccination, screening and treatment programmes.
- **Civil society members** to support awareness raising and advocacy, mobilising community-level and international demand for holistic service programmes.
- **Individuals with lived experience,** including patients, families and caregivers to share their stories and actively participate in shaping policies and programmes that support the elimination of cervical cancer.



We have the opportunity. Together we can end cervical cancer.

APPENDIX 1: **CASE STUDIES**

1 ENHANCING CERVICAL CANCER SCREENING AND TREATMENT IN NIGERIA

> **We must adopt a multi-pronged approach in Nigeria that increases awareness and education about the disease, addresses cultural and social stigma, and improves access to affordable screening and treatment services with primary healthcare as first contact, serving communities nationwide.**
>
> **Dr Zainab Shinkafi-Bagudu, Medicaid Cancer Foundation**

Partners: Clinton Health Access Initiative (CHAI).

Study objective: To pilot cervical cancer screening programmes linked to treatment at sub-national primary healthcare agencies in Lagos, Kaduna and Rivers State.

Study design: Conducted in 177 government health facilities and involved 83,593 women, of whom 6,043 were living with HIV (WLHIV). Two screening methods, VIA and HPV DNA testing, were evaluated. Women in whom precancerous lesions were detected were referred for treatment.

Results: HPV testing confirmed HPV-positive cases in 16% of WLHIV and 8% of the general population, compared with 7% and 3% who were VIA-positive. Access to screening and treatment was increased, and 96% of women with precancerous lesions received treatment, often on the same day.

Factors for success:

- Civil society engagement to drive demand generation at the community level.
- Implementation of screening services in primary healthcare facilities.
- Available services included same-day treatment (thermal ablation) for precancerous lesions.

Challenges and lessons learned:

- Gaps in referral and follow-up were identified, with just 21% of HPV-positive women completing a triage examination, and 44% with suspected cancer attending referral visits.

2 INTEGRATING CERVICAL CANCER SCREENING AND CARE IN GHANA

> **Integrated cancer screening is the way to leverage opportunities, optimise resources and enhance women's access to cancer care.**
>
> **Dr Somesh Kumar, Senior Director, Jhpiego**

Partners: Jhpiego, Ghana Health Services (GHS), Bekwai Municipal Hospital.

Study objective: To integrate cervical cancer screening with HPV testing and thermal ablation for treating precancerous lesions into existing sexual and reproductive health and primary health care services.

Study design: A "hub and spoke" model decentralised cervical cancer screening to district hospitals, leveraging community sample collection points and existing GHS sample transportation pathways. Healthcare providers, laboratory staff, and community health workers received training.

Results: Among women screened using HPV DNA testing, 811 (16.2%) tested positive, and 609 (75%) of HPV-positive women underwent triaging and received treatment with thermal ablation. The integrated approach to screening was well-received, with strong provider support and high acceptance of self-collection for HPV testing.

Factors for success:

- Service delivery integration with other reproductive health activities.
- Active involvement of health management teams.
- Male family member involvement and increased awareness.
- Inclusion of management of other gynaecological conditions.

Challenges and lessons learned:

- High-throughput testing linked to primary care and community sample points required dedicated training and laboratory optimisation to reduce sample turnaround time.

3 INCREASING UPTAKE OF HPV SCREENING IN ANTIGUA AND BARBUDA

> **A commitment to achieve the 90-70-90 WHO targets for cervical cancer elimination in LMICs requires a commitment to invest in the improvement of entire healthcare systems.**
>
> **Cherie Tulloch, Cervical Cancer TaskForce MohWSTE Antigua and Barbuda**

Partners: Pan American Health Organization (PAHO), Basic Health International (BHI).

Study objective: To increase access to and uptake of HPV screening in public primary care.

Study design: Pilot study in five clinics, utilising primary HPV testing and cytology triage.

Results: In total, 1545 women were screened within 4.5 months. The HPV positivity rate was 21.7%. Of 200 women who had colposcopy, 46.5% had high grade lesions; 76.3% of these women received treatment within 6 months. Data suggested that HPV screening led to cervical cancer being detected earlier, with many women treatable with surgery rather than chemotherapy or radiotherapy. Following the successful pilot study, the first national cervical screening and treatment guidelines were developed, and HPV testing and colposcopy services were scaled up.

Factors for success:

- Political will and regional collaboration.
- PAHO support for training, supplies, stakeholder involvement and guideline development.
- Establishment of a dedicated team for scale up.

4 INTEGRATING HPV SCREENING IN UTTAR PRADESH, INDIA

> **With community engagement, competent service providers and tailored strategies, HPV DNA testing and decentralisation of thermal ablation within primary health care is acceptable, feasible and replicable.**
>
> **Dr Somesh Kumar, Jhpiego**

Partners: Government of Uttar Pradesh, Institute of Medical Sciences, Kalyan Singh Super Specialty Cancer Institute (KSSSCI).

Study objective: To evaluate a model of integrated HPV screening and thermal ablation for secondary prevention of cervical cancer within the existing national framework of VIA testing.

Study design: Self-collection of samples for HPV testing was offered to women in their homes, facilitated by Accredited Social Health Activists (ASHAs) from their villages. A “hub and spoke” model was used to transport samples to a laboratory for HPV DNA testing. Precancer treatment capacity was increased at sub-district level, with referral to KSSSCI for advanced lesions.

Results: With 10,000 women screened, coverage increased dramatically from 1.5% to over 45%. Over 75% of samples collected were facilitated by ASHAs. HPV positivity rates ranged from 3.3% to 4.7%. More than 50% of women who tested positive for HPV underwent thermal ablation.

Factors for success:

- Government ownership of the project, and a well-defined workflow.
- Integrated service delivery within primary healthcare, leveraging existing front-line workers.
- Robust sample transport systems and community engagement efforts.
- Holistic counselling and messaging to guide patients through every step of the care pathway.

Challenges and lessons learned:

- The current cost of HPV DNA test kits in India is prohibitive, but increased demand will provide economies of scale.
- Scale up requires increased laboratory capacity and infrastructure, enhanced technological capabilities, and a well-trained workforce to handle large volumes of tests.

5 IMPROVING ACCESS TO CERVICAL CANCER SCREENING IN RURAL CAMEROON

> **A well-implemented patient navigation programme can significantly reduce disparities in cervical cancer screening rates, ensuring that all individuals have equal opportunities for early detection and improved outcomes.**
>
> **Tata Mayaah Eveline, H@H**

Partners: Humanity At Heart International Association (H@H).

Study objective: To assess the effectiveness of a community-based navigation programme to accelerate the uptake of cervical cancer screening and treatment among women aged 30–65 years in the Tiko Sub Division of the South West Region of Cameroon.

Study design: Education on cervical cancer prevention was provided before initiating services. H@H navigators accompanied women to screening to ease fear and ensure adherence to follow-up.

Results: Among 484 women who received education, 372 (76%) stated that they gained new knowledge on cervical cancer prevention and expressed readiness to take up screening services. In total, 112 (23%) of women attended screening with patient navigator support. Pre-cervical lesions were identified in five (4%) women, all of whom were treated by thermal ablation.

Factors for success:

- Engagement of community leaders and community health workers to build community trust and facilitate a collaborative approach.
- Structured discussion guides to enable rapid assessment of individual and group perceptions regarding cervical cancer and screening preferences.

Challenges and lessons learned:

- An initial low uptake rate highlighted a need for a deeper exploration of reasons for non-attendance of screening and repeated information sessions to build community health literacy.

6 SCALING UP CERVICAL CANCER SCREENING AND PREVENTION IN RWANDA

> **Success in Rwanda is proof that with commitment, collaboration and innovation, we can make this a global achievement. Elimination of cervical cancer – it's not a dream but an attainable reality."**
>
> **Marc Hagenimaha, Rwanda BioMedical Center and Lacy Hubbard, Elekta Foundation**

Partners: Rwanda BioMedical Center (RBC), Elekta Foundation.

Study objective: To scale up cervical cancer screening using the FAST system (F=fast HPV testing; A=affordable cost; S=systematic tracking via digital tools; T=timely diagnosis and treatment).

Study design: Rapid self-collection of samples and HPV testing were enabled, with centrally located open-system laboratories able to process 800–1000 samples daily on a single PCR machine. Quality control was supported by a mobile colposcopy device for VIA at participating clinics. A team of gynaecologists and nurses provided ongoing training and mentorship to local health providers, and patient navigators supported patients from biopsy to cancer treatment.

Results: More than 105,000 women were screened over a period of two years. More than 2,500 women with precancerous lesions were treated, and more than 50 with cervical cancer were identified.

Factors for success:

- Overcoming myths, stigma, and fear through local partnerships to increase screening uptake.
- Onsite laboratories with open-PCR platforms, using existing machines to reduce costs.
- Community engagement with local civil society, community leaders, and health workers.
- Digital tools to improve tracking, quality of care, and reporting.

7 A COLLABORATIVE DISTRICT MODEL FOR CERVICAL CANCER SCREENING IN INDIA

> **Collaboration is crucial for accelerating cervical cancer elimination across India. This project is a testament to the impact we can achieve when we work together towards a future free from cervical cancer."**
>
> **Mridu Gupta, CEO, (CAPED)**

Partners: Cancer Awareness Prevention and Early Detection Trust (CAPED), American Cancer Society (ACS), Gurugram District Health Department, Haryana.

Study objective: To pilot a model for collaboration between community organisations and District Health Departments to strengthen cervical cancer screening and prevention.

Study design: Nurses were trained to conduct VIA, and community health workers were trained on community mobilisation strategies. A patient navigation programme was implemented.

Results: Overall, 5,653 women across 73 villages were screened, representing a five-fold increase. In total, 91 women who tested positive were supported through the navigation programme. Processes are being integrated into the government health system to ensure continuation of services. An implementation guide was developed to act as a blueprint for other districts.

Factors for success:

- Political buy-in and support from district and state health departments.
- Role of community and village leaders in promoting awareness and encouraging participation in the screening programme.

Challenges and lessons learned:

- Limited community awareness and engagement, and social stigmas and myths pertaining to cervical cancer screening.
- Inadequate training of healthcare workers and inconsistent screening services at primary healthcare centres.

APPENDIX 2
EVENT SPEAKERS AND ATTENDEES

MODERATOR

JULIE TORODE
Board Member, Institute of Cancer Policy, Director of Strategic Partnerships, Community and Patient Engagement and visiting researcher at King's College London.

SPEAKERS

MARIBEL ALMONTE PACHECO
Implementation Scientist for Cervical Cancer Elimination Initiative (CCEI), World Health Organization

KAREN CANFELL
Director, the Daffodil Center (Joint venture between Cancer Council New South Wales (NSW) and the University of Sydney

MIRIAM MUTEBI
Consultant Breast Surgical Oncologist & Assistant Professor in the Department of Surgery at the Aga Khan University Hospital, Niarobi, Kenya
Chair, International Taskforce on Cervical Cancer Elimination in the Commonwealth

MARION SAVILLE
Executive Director and Public Officer, Australian Center for the Prevention of Cervical Cancer

HEATHER WHITE
Executive Director, TogetHER for Health

PARTICIPANTS

SOFIAT AKINOLA
Director, Health Policy & External Affairs, Roche Diagnostics International Ltd.

CARMEN AUSTE
Vice President, Cancer Coalition Philippines

CAROLINE BARRETT
Associate Director, Global Cervical Cancer, Clinton Health Access Initiative (CHAI)

LEONIDAS GALERIDIS
Policy and Research Officer, European Parliamentary Forum for Sexual & Reproductive Rights (EPF)

MRIDU GUPTA
Chief Executive Officer, Cancer Awareness Prevention and Early Detection (CAPED) Trust

MARC HAGENIMANA
Cancer Diseases Senior Officer, Rwanda Biomedical Centre

LISA HUANG
Director, SUCCESS (Scale Up Cervical Cancer Elimination with Secondary prevention Strategy), Expertise France

LACY HUBBARD
President, Elekta Foundation

EMILY KOBAYASHI
Head, HPV Vaccine Programme, GAVI

BENDA KITHAKA
Executive Director, Kilele Health Association

SOMESH KUMAR
Country Director, Jhpiego, India

EVELINE TATA MAYAH
Executive Director & Holistic Health Advocate, Humanity at Heart International

KAREN NAKAWALA
Executive Director, Teal Sisters Foundation

KATHLEEN SCHMELER
Associate VP of Global Oncology, Professor of Gynecologic Oncology, MD Anderson Cancer Center

ZAINAB SHINKAFI-BAGUDU
Founder/CEO, Medicaid Cancer Foundation

EDWARD (TED) TRIMBLE
Senior Advisor for Global HPV and Cervical Cancer Control, US National Cancer Institute

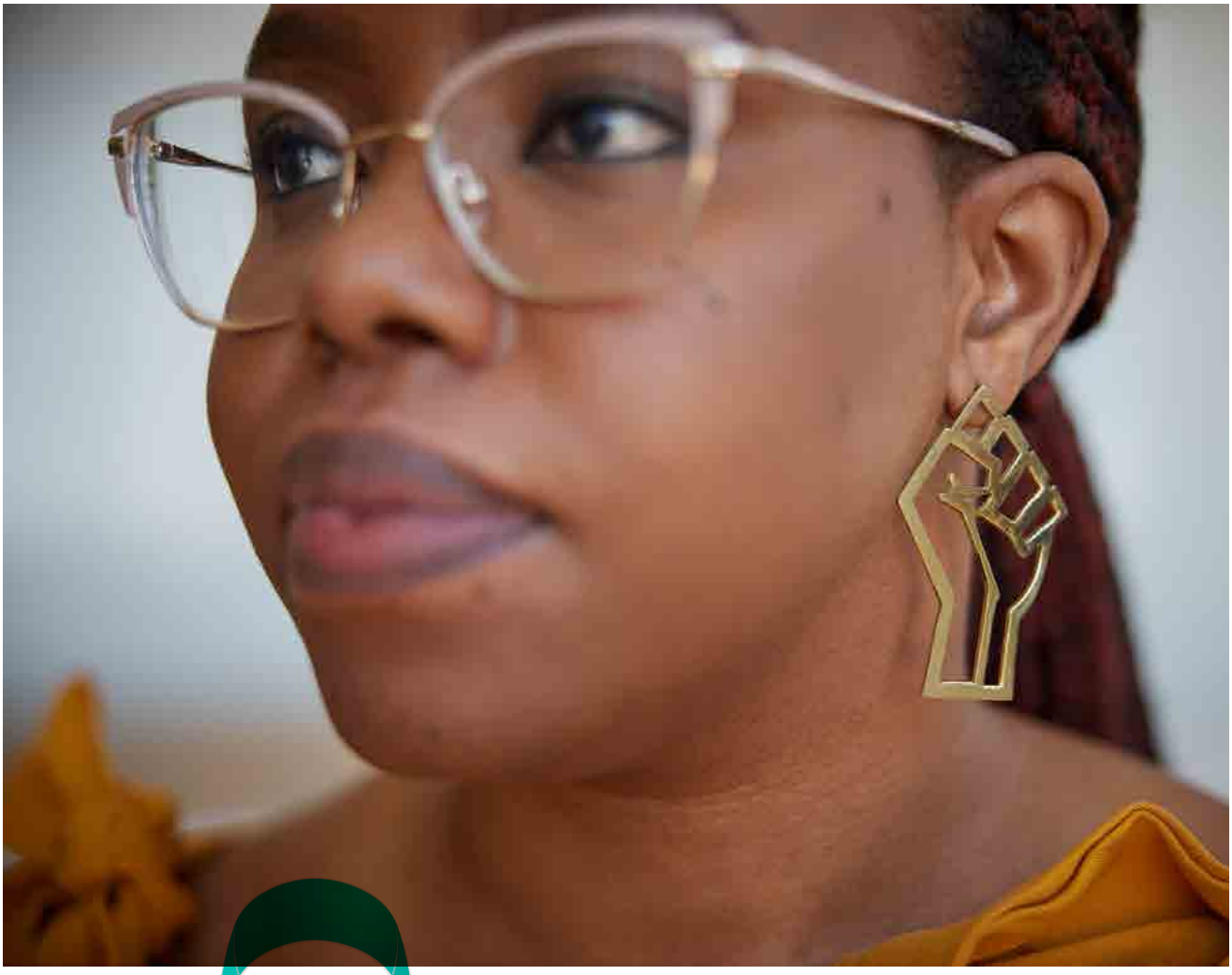
CHERIE TULLOCH
OBGYN, Chairperson of the Cervical Cancer Task Force, The Cervical Cancer Elimination Programme, Ministry of Health Antigua and Barbuda

WITH THE SUPPORT OF

TOM HARMON
External Affairs Director, TogetHER for Health

DR JANNETH MGHAMBA
Health Advisor, Commonwealth Secretariat

DR ESTHER NAYEU
Young Health Professional, Commonwealth Secretariat



APPENDIX 3
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ANNEX1
STRENGTHENING THE PATHWAY TO CERVICAL CANCER ELIMINATION

Cervical cancer is the first cancer in history that's poised for elimination, with success depending on the successful implementation of holistic of vaccination, screening and treatment programmes.

In 2022[1]

660,000
new cases

350,000
lives lost

Targets to accelerate cervical cancer elimination by 2030[2]

90% of girls vaccinated with the HPV vaccine by age 15

70% of women screened with a high-quality test by age 35 and 45

90% of women with cervical disease receiving treatment

By 2120[2]

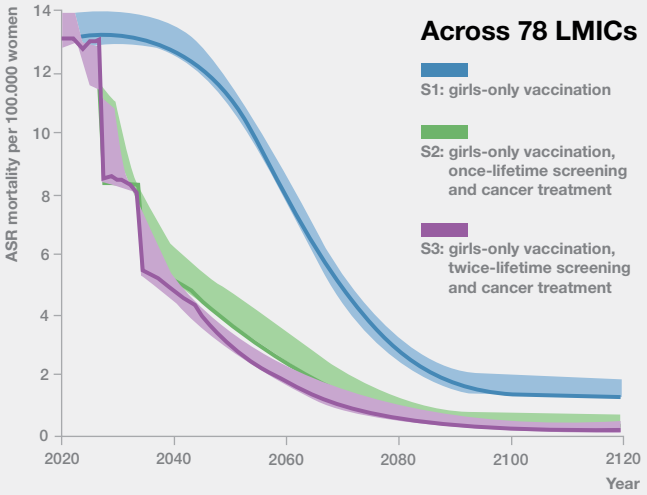
74 million
new cases averted

62 million
deaths avoided in LMICS

THE REALITY

A holistic, 3-pillar approach will bring the mortality curve down deeper and faster than single-strategy action.[3]

However, investment in screening, triage, diagnosis and treatment lags substantially behind investment in HPV vaccine.



Barriers to HPV testing, triage and treatment

Enabling actions for governments and policy makers

PRIORITISATION AND AWARENESS

Political commitment to a holistic, 3-pillar model of care will drive action in prevention, screening and treatment.

Sharing learning and best practices will help demonstrate the impact and drive the adoption of similar practices.

ECONOMIC

- HPV testing is seen as a high-cost initiative for LMICs.
- Low demand for tests increases prices.
- Funding shortfalls limit purchasing capacity.

Political will and domestic funding will guarantee the continuity and scalability needed to reach elimination targets.

Development of innovative financing solutions including market shaping and pooled procurement.

SOCIETAL

- Low awareness on cervical cancer and the benefit of testing reduces demand for screening.
- Cultural and social barriers stop people seeking screening.
- Self-collection is an emerging model, with roll-out and uptake still in the early stages.

Adopting person-centred practices and harnessing lived experience will support the development of effective, inclusive interventions.

A focus on community engagement and education will empower people to seek care and generate demand.

STRUCTURAL

- A shortage of trained professionals (including lab technicians) restricts service development.
- Weak laboratory systems undermine diagnostic processes.
- Poor health information systems. jeopardise programme success and impede policy making.
- There is a lack of validated HPV testing tools on the market.

Expedited systems for WHO prequalification will help ensure the availability of clinically validated diagnostic tools.

Training and capacity building Health workers and laboratory professionals will increase access to HPV testing, triage and treatment.

Investing in laboratory systems and optimising existing resources (e.g. for COVID-19 and HIV) will strengthen diagnostic processes.

Improved health information management (e.g. through digital tools) will promote accountability, and support resource and diagnostic network optimisation.

WE HAVE THE OPPORTUNITY. IT'S TIME TO MAKE CERVICAL CANCER HISTORY.

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