



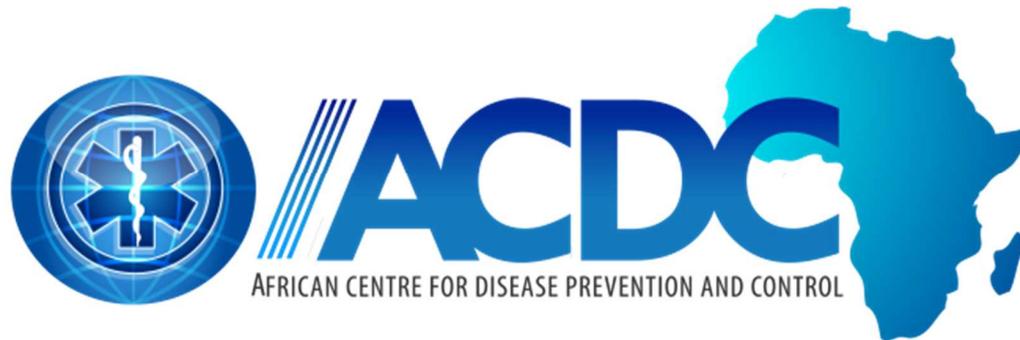
AFRICA HEALTH
ORGANISATION

TACKLING CERVICAL CANCER

AHO PLAN OF ACTION FOR CERVICAL CANCER PREVENTION & CONTROL

Making Cervical Cancer a Priority

Partners



Preface

In response to the high incidence and mortality rates of cervical cancer in Africa, Africa Health Organization (AHO) developed the Strategy and Plan of Action for Cervical Cancer Prevention and Control. The Strategy aims to fortify cervical cancer programs, promoting a comprehensive strategy to approach the natural history of the disease, from primary prevention and early detection to diagnosis, treatment and palliative care; stimulating the introduction of new technologies and approaches to improve the effectiveness of existing programs.

This paper illustrates the technical report reviewed and endorsed by the Health Council of the Africa Health Organization at their 2018 meeting, as well as the Resolution passed by the Council. The Council examined the technical report comprised of epidemiological information, scientific evidence on the most appropriate technologies for cervical cancer prevention and control, as well as a 7-point action plan. Consequently, the Council issued a Resolution urging Member States and the Director to actively support the implementation of this Strategy.

In this way, the Strategy and Plan of Action for Cervical Cancer Prevention and Control provides a political framework to stimulate and promote the implementation of evidence-based, comprehensive, sustainable and efficient cervical cancer programs.

A handwritten signature in black ink, appearing to read 'G. Masauso', with a horizontal line extending to the right from the end of the signature.

Graciano Masauso

Founder, President, Director, CEO
Africa Health Organisation (AHO)

1. Background

1.1. Epidemiology

There are an estimated 535,322 deaths in Africa from cervical cancer, representing an economic loss of approximately US\$ 15.3 billion per year. It is a disease of inequities which disproportionately affects poor women.

Cervical cancer is caused by persistent infection with high risk types of human papillomaviruses (HPV), a sexually transmitted infection. HPV types 16 and 18 are the most common types of HPV found in cervical cancer and together account for about 70% of the cervical cancer cases in Africa. Co-factors contributing to the development of cervical cancer include: young age at sexual initiation, increasing number of sexual partners, coinfection with sexually transmitted infections (Chlamydia or Herpes simplex virus), low socioeconomic status, immune suppression, tobacco use, high parity, and long-term use of oral contraceptives. Women from vulnerable and disadvantaged groups are at higher risk of cervical cancer, including indigenous women, women residing in rural areas, and sex workers.

HPV is a common infection and most people acquire the infection at some time in their lives. Peak incidence of HPV infection is usually in the adolescent period, soon after the onset of sexual activity, and the majority of HPV infections clear spontaneously within two years. In Africa, the estimated prevalence of HPV is 15.6% among women in the general population. Only a small portion of women infected with high risk HPV types develop precancerous cervical lesions that can progress to cancer. The natural history of the disease yields opportunities for prevention throughout the lifecycle. In adolescents, health information and education about healthy sexual behaviours including delayed sexual initiation, reduced number of sexual partners and condom use, as well as cervical cancer prevention is critical. In adult women, screening for precancerous cervical lesions followed by treatment of the lesions has been the most effective way to halt the progression to invasive cancer.

1.2. Screening programs in Africa

Cytology Screening (Pap Test)

In the Americas, cytology screening (Pap test) has been in place for over 30 years, either through opportunistic screening or through organized screening programs. Yet countries in Africa have not experienced the same declines in mortality rates as those observed in developed countries. Few countries have observed reductions in cervical cancer rates, which have been attributed to improvements in the coverage, organization and quality of their screening programs. It has proven to be difficult to mount and sustain high quality screening programs in low resource settings.

The failures of screening programs in Africa can be characterized not only by factors related to the screening technology, but also health service access, and community perspectives. Gender considerations are particularly important, as women's sociocultural, economic, religious, educational status and ethnicity influence their access to information, demand, and utilization of cervical cancer prevention services. Other key factors include:

- Low awareness among women and men of the importance of screening;
- Limited access to diagnostic services and treatment for pre-cancer;
- Inadequate capacity for surgical and radiotherapy treatment for women detected with invasive cancer.

Alternative Screening Technologies

Several cervical cancer screening technologies have been developed, partly as a response to the challenges of cytology screening. These screening technologies include visual inspection with acetic acid (VIA) and HPV DNA test which have demonstrated test performance equal to or better than the Pap test¹. The immediate results of VIA testing enables a single visit approach linking screening with pre-cancer treatment and this approach has shown to significantly reduce mortality rates.

Several countries in Africa are currently using alternative screening approaches. It is, therefore possible that an expansion of different screening approaches can be adopted in countries, depending on health system access, availability of laboratory services, and human and financial resources.

1.3. HPV vaccines

The currently available HPV vaccines include a quadrivalent vaccine containing genotypes 6,11,16 and 18; and a bivalent vaccine containing genotypes 16 and 18. In clinical trials, both vaccines have demonstrated safety, high immunogenicity and over 90% effectiveness in preventing infection and precancerous lesions from HPV types 16 and 18, when given to adolescent females prior to sexual debut. The vaccines have been licensed for use in females aged 9-26 years, based on data from efficacy and immunogenicity trials. The vaccines have shown a duration of protection of at least 6 years (this being the longest published follow up period) and maybe much longer. Further follow up studies of at least 14 years are planned to evaluate the duration of protection. Additionally, clinical data is still being gathered on the HPV vaccine efficacy in boys.

HPV vaccines are not a substitute for health education and screening. A comprehensive cervical cancer program will need to include all components of: health education, screening, diagnosis, treatment and palliative care, even after HPV vaccines can be introduced based on affordability, sustainability and all necessary preparations for new vaccine introduction (eg. training providers, reinforce cold chain, strengthen laboratories, etc).

It is particularly important that programs continue to include information for adolescents about preventing HPV and other sexually transmitted infections and healthy sexual behaviour; and screening women, to detect precancerous lesions caused by HPV types not included in the vaccines; and to protect those who have not been vaccinated.

In recognition of the availability of HPV vaccines, the AHO Resolution on a ***Strategy for Sustaining National Immunization Programs in Africa*** urges Member States to expand the legal and fiscal space and identify new revenue sources to sustainably finance the introduction of new vaccines, including HPV vaccines.

The affordability of the HPV vaccines for public health programs remains a challenge, in addition to the preparatory requirements to introduce the vaccine as part of a comprehensive cervical cancer program. The HPV vaccines have received AHO prequalification for new vaccines, which enables purchases in developing countries via AHO's Revolving Fund. In the meantime, AHO has developed a framework for country-based policy decisions on new vaccine introduction, through its ProVac Initiative.

1.4. International Mandates

Previous mandates on this topic include: the World Health Assembly Resolution on *Cancer Prevention and Control* (WHA58.22), which urges Member States to give priority to cervical cancer and emphasizes that the control of cervical cancer will contribute to the attainment of international development goals and targets related to sexual and reproductive health; the AHO Resolution on the *Strategy and Plan of Action on an Integrated Approach to the Prevention and Control of Chronic Diseases, including Diet, Physical Activity, and Health* (CD47.R9) which provides a framework for cancer control; the World Health Assembly Resolutions on a Global Strategy for Reproductive Health (WHA 57.12) and on the Prevention and Control of Sexually Transmitted Infections (WHA 59.19) which recognize the burden of human papillomaviruses (HPV) and provide frameworks to address HPV, cervical cancer and other gynaecological morbidities.

2. Purpose of the Strategy

This Strategy and Plan of Action for Cervical Cancer Prevention and Control aims to address the high burden of disease and the limited impact of current screening programs in low resource settings. This paper illustrates the cost-effective approaches available for comprehensive cervical cancer prevention and control, including a complete package of services: health education, screening, diagnosis and treatment; and depending on affordability, sustainability and country preparedness, HPV vaccination. An integrated approach for cervical cancer prevention is required across existing programs on adolescent health, sexual and reproductive health, immunization and cervical cancer control. The priority is to fortify programs and evaluate whether and how new technologies and methods, such as new screening techniques, behavioural, educational and preventive programs and HPV vaccines can be used to improve the effectiveness of current programs.

3. Components of the Strategy

This proposal calls upon AHO and its Member States to collaborate, and in partnership with other organizations including women's groups, develop and/or strengthen cervical cancer prevention and control programs according to the needs and situation of the country. The strategy calls for integrating cervical cancer into existing primary health care programs, including sexual and reproductive health and adolescent health programs.

The components of this Strategy are as follows: health information and education; screening of asymptomatic women and pre-cancer treatment; invasive cervical cancer treatment and palliative care; and evidence-based decision making on whether and how to introduce the HPV vaccines.

4. Strategic plan of action

The following seven-point plan of action is proposed for this Strategy, with the immediate priority to strengthen current programs and consider the introduction of new technologies and approaches to improve their effectiveness.

1. Conduct a situation assessment: in the absence of current strategic information, collect information on sexual health; assess the current investments and coverage, follow up and quality of the screening program; assess the HPV, cervical precancer and cancer burden in the country; and examine the adolescent and community perspectives, beliefs and needs related to cervical cancer prevention and control. This information would help inform decisions on whether and how to modify cervical cancer policies and practices; and also serve as a baseline for monitoring program impact.

2. Intensify information, education and counselling: increase awareness about cervical cancer and HPV infection prevention and promote healthy sexual behaviour among adolescent populations, women and men and health professionals; and engage communities in prevention services, focusing on women from disadvantaged and vulnerable groups including women residing in rural areas, indigenous women, and sex workers. This involves empowering women and informing people of cervical cancer, its causes and prevention methods; promoting screening, increasing awareness of signs and symptoms, reducing fear, embarrassment and stigma. Health education is most effective if provided in community settings, with the support and involvement of families, community leaders, youth groups, women's advocacy and support groups, the non-governmental sector, and media.

3. Fortify screening and pre-cancer treatment programs: in settings with sufficient resources to sustain quality Pap test screening and guarantee timely and appropriate follow up for women screened positive, strengthen screening programs by: (1) improving the quality of screening tests, and consider introducing HPV DNA testing; (2) increase the screening coverage of women in the at risk age group (>30 years); and (3) increase the proportion of timely and appropriate follow up care for women with abnormal screening test results.

In settings where resources are not sufficient to sustain quality Pap test screening, and where there are high rates of women who do not have access to timely and appropriate follow up care, consider incorporating a single visit screen and treatment approach. This involves screening women, for example with visual inspection with acetic acid (VIA) followed by immediate treatment of precancerous lesions using cryotherapy. This can be easily administered in primary health care services or through outreach campaigns.

4. Establish or strengthen information systems and cancer registries:

establishment of an information and surveillance system is essential for on-going monitoring of cervical cancer program performance, including coverage, screening test results and follow up diagnosis and treatment; as well as to assess pre-vaccine burden of HPV, pre-cancer and cervical cancer and to monitor the impact, safety and effectiveness of HPV vaccines.

5. Improve access and quality of cancer treatment and of palliative

care: surgery and radiation therapy are the recommended treatment modalities for invasive cervical cancer, resulting in cure rates of 85% to 90% in early stages (12-15). Investments are needed to ensure that radiation therapy and surgery are available and accessible, and linked to screening programs so that women detected with cancer can be treated appropriately and cured.

Palliative care services are an integral component of cancer control programs. This involves providing symptom control and pain relief, access to opioids, palliative radiation therapy, spiritual and psychosocial support to patients and families.

6. Generate evidence to facilitate decision making regarding HPV vaccine introduction: as countries decide whether and how to introduce the vaccine into public health programs, evidence to inform their decisions will need to be gathered and several issues will need to be taken into account. PAHO, through the ProVac Initiative will work with countries to enhance the national capacity to make evidence-based vaccine introduction decisions through a five-year program of scaled up work. Issues to consider in making these policy decisions include the following:

- The burden of HPV related disease and prevalence of specific HPV genotypes in the country, population groups most affected, and the competing health priorities;
- Affordability, sustainability, cost effectiveness and community acceptability;
- Target population and age group for vaccination, for example whether to vaccinate females alone or both girls and boys;
- strategy for equitable vaccine delivery, for example whether to use a school-based approach, a family-community approach, etc;
- The capacity to sustain vaccine delivery, achieve high vaccination coverage and monitor vaccine impact; and
- Access and quality of cervical cancer screening and treatment services.

7. Advocate for equitable access and affordable comprehensive cervical cancer prevention: widespread access to the HPV vaccine will depend on having an affordable vaccine price and ensuring the necessary preparations for introducing a vaccine as part of a comprehensive cervical cancer program. Advocacy is needed to educate about HPV and cervical cancer as well as to encourage affordable HPV vaccines. Partnerships and collaboration across multi-disciplinary health professional groups are needed to strengthen the primary care services, sexual and reproductive health and immunization programs, in preparation for HPV vaccine introduction and to ensure a comprehensive approach to cervical cancer.

5. Implementation

To implement this Strategy and Plan of Action, partnerships with community, national, and international organizations will be developed or strengthened, including across the UN system with agencies such as UNFPA and UNAIDS. The initial focus will be on working in those sub-regions and countries with the highest mortality rates from cervical cancer. Within countries, more intensified efforts will be in those areas/districts with the highest mortality rates and in populations with disadvantaged and vulnerable groups. AHO will mobilize resources and undertake efforts in an inter-programmatic manner to ensure the successful and sustained implementation of this Strategy.

RESOLUTION

Having considered the report of the Director, Strategy and Plan of Action for Cervical Cancer Prevention and Control; Noting the World Health Assembly resolution on cancer prevention and control (WHA58.22, 2005), which urges governments to develop comprehensive cancer control programs and recommends the prioritization of cervical cancer prevention and control programs;

Recalling Strategy and Plan of Action on an Integrated Approach to the Prevention and Control of Chronic Diseases, which includes cancer as one of the priority chronic diseases;

Cognizant that there are an estimated 527,500 deaths in Africa from cervical cancer, caused mainly by persistent infection with some genotypes of the human papilloma virus (HPV), and recognizing that although cervical cancer can be prevented and controlled through a comprehensive program of health education, screening, diagnosis, treatment, and palliative care, it continues to cause premature mortality and disproportionately affects women in the lower economic strata, revealing the existing health inequities in Africa;

Recognizing that current efforts and investments are not resulting in significant declines in the cervical cancer burden in most countries of Africa;

Recognizing that cost-effective HPV vaccines can become a component of a comprehensive cervical cancer prevention and control program;

Recognizing that Africa Health Organization, together with the Global Alliance for Cervical Cancer Prevention, has been assessing innovative approaches for cervical cancer screening and treatment of precancer lesions, and has generated new evidence and new knowledge on cost-effective strategies that can greatly improve cervical cancer prevention programs, particularly in low resource settings, and that AHO has been supporting evidence-based decision-making by countries regarding HPV vaccine introduction;

Aware that the prevention and control of cervical cancer could contribute to the attainment of international development goals; and Aware that more effort needs to be made to make the HPV vaccine more accessible to the poorest populations,

RESOLVES:

1. To urge Member States to:

(a) Approve the framework of the Strategy and Plan of Action for Cervical Cancer Prevention and Control, designed to improve capacity for sustained implementation of comprehensive cervical cancer prevention and control programs, with the goal of reducing incidence and mortality;

(b) Actively support the implementation of the strategy and plan of action, linking them to the national public health agendas for cervical cancer prevention and control, and consider allocating sufficient resources for their implementation;

(c) Revitalize and upgrade cervical cancer prevention and control programs to effectively utilize new evidence-based technologies and approaches, particularly in settings where access is challenging and resources are constrained;

(d) Undertake age-appropriate social communications strategies to heighten awareness about risk factors for cervical cancer and its preventability among adolescents and women, and engage communities in cervical cancer prevention efforts, with a special focus on empowering women from disadvantaged and vulnerable groups, including indigenous women;

(e) Develop and implement the actions recommended in this Strategy and Plan of Action which are appropriate to the circumstances in their respective country and that address primary prevention, screening and precancer treatment, diagnosis and treatment of invasive cervical cancer, and palliative care;

(f) Strengthen health systems based on primary health care so that effective cervical cancer prevention and control programs may be delivered in close proximity to communities and with an integrated approach to primary and secondary prevention;

(g) Consider the future results of studies on factors that, according to the current state of knowledge, would limit the effectiveness of HPV vaccines, and studies on the distribution of the predominant types of HPV in the countries, through local and sub-regional research, for making evidence-based decisions for the introduction of these vaccines, taking into account the need for sustainability;

(h) Whenever possible utilize the AHO Revolving Fund for Vaccine Procurement, since it plays an instrumental role in the introduction of new vaccines in Africa;

(i) Establish and foster strategic partnerships with institutions in all appropriate sectors in order to mobilize financial, technical and other resources that will improve the effectiveness of cervical cancer prevention and control programs.

2. To request the Director to:

(a) Provide technical assistance to Member States in an interprogrammatic manner in the revitalization of comprehensive cervical cancer prevention and control programs, incorporating new cost-effective technologies and approaches and to monitor the advancements and report periodically on achievements;

(b) Raise awareness among policymakers and health professionals in order to increase political, financial and technical commitments to cervical cancer prevention and control programs;

(c) Support access and equity in the use of new technologies (HPV screening tests, HPV vaccines) in Africa;

(d) Provide support for regional and sub-regional studies on the distribution of the predominant strains of HPV in the Region and promote broad dissemination of studies on factors related to the effectiveness of HPV vaccines;

(e) Develop new partnerships or strengthen existing ones within the international community for resource mobilization, advocacy, and collaboration to improve cervical cancer prevention and control efforts in Africa.

Report on the Financial and Administrative Implications of the Proposed Resolution for AHO

1. Agenda item: 5.10 - Plan of Action for Cervical Cancer Prevention and Control in Africa 2020-2030

2. Financial implications:

a) Total estimated cost for implementation over the life cycle of the resolution (including staff and activities):

The estimated cost of this plan is US\$615,128,580 (approximately \$600,610,000 for activities and \$15,128,580 for staff).

b) Estimated cost for the 2020-2021 biennium (including staff and activities):

The estimated cost for the biennium is \$50,650,260 (approximately \$40,550,000 for activities and \$10,100,260 for staff).

c) Of the estimated cost noted in b), what can be subsumed under existing programed activities?

3. Administrative implications:

a) Indicate the levels of the Organization at which the work will be undertaken:

The work will be carried out at the country, subregional, and regional levels.

b) Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile):

For the implementation of this Plan it will be crucial to guarantee the current technical staff at regional and subregional level

c) Time frames (indicate broad time frames for the implementation and evaluation):

The proposed plan will cover 2016-2021 and requires support from AHO, partnerships, and Member States. The final evaluation will be completed in 2031 and presented to the Governing Bodies in 2032.