

56th DIRECTING COUNCIL

70th SESSION OF THE REGIONAL COMMITTEE OF WHO FOR THE AMERICAS

Washington, D.C., USA, 23-27 September 2018

Provisional Agenda Item 4.5

CD56/9
11 July 2018
Original: English

PLAN OF ACTION FOR CERVICAL CANCER PREVENTION AND CONTROL 2018-2030

Introduction

1. Cancer is the second leading cause of death in the Region of the Americas. In 11 countries, cervical cancer is the leading cause of cancer deaths and in 12 countries it is the second cause of cancer deaths among women.¹ Each year in the Americas an estimated 83,200 women are newly diagnosed and 35,680 women die from this disease, a significant proportion (52%) of them under 60 years of age (1).

2. Cervical cancer is caused by persistent infection with high-risk types of human papillomavirus (HPV), a sexually transmitted infection. Cervical cancer is preventable through HPV vaccination and also with screening and treatment of precancerous lesions. It can be effectively treated if diagnosed in its early stages. Health promotion and sexual health and HIV/STI prevention programs also contribute to cervical cancer prevention. The HPV vaccine has been introduced in national immunization programs since 2006; cervical cancer screening programs have been instituted in almost all the countries of the Region beginning in the 1970s; and services for treating cervical cancer have been established in almost all the countries. As a result, notable progress has been observed in preventing and controlling the disease, as reported to the 29th Pan American Sanitary Conference in 2017 in the final report of the Regional Strategy and Plan of Action on Cervical Cancer Prevention and Control (2).

3. Nonetheless, significant gaps and challenges persist in reducing incidence and mortality and paving the way toward the elimination of cervical cancer as a public health problem. This Plan sets forth a blueprint to guide Member States and the Pan American

¹ Cervical cancer is the leading cause of cancer deaths among women in Belize, Bolivia, Dominican Republic, El Salvador, Guyana, Haiti, Honduras, Nicaragua, Paraguay, Suriname, and Venezuela. It is the second cause of cancer deaths among women in Brazil, Dominica, Ecuador, Grenada, Guatemala, Jamaica, Panama, Peru, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, and Trinidad and Tobago.

Sanitary Bureau (PASB) in strengthening their capacity for evidence-based, innovative, and effective strategies that will accelerate reductions in cervical cancer incidence and mortality.²

Background

4. Unlike the situation with most other types of cancer, the cause of cervical cancer has been scientifically established and there are cost-effective tools available for its prevention and control (3). HPV 16 and 18 are among the most prevalent types, responsible for approximately 70% of all cervical cancer cases. Since HPV infection also causes other cancers (anus, oropharynx, penis, rectum, vagina, and vulva), prevention strategies will also contribute to the reduction of these other HPV-related cancers. Cervical cancer develops slowly over time, beginning with HPV infection, which in some cases persists and advances to precancerous lesions that can evolve into invasive cancer if undetected and untreated. People who are immunocompromised, such as those living with HIV, are more likely to have persistent HPV infection and more rapid progression to cancer.

5. Screening asymptomatic women for precancerous lesions using the Papanicolaou (Pap) test has led to an average reduction of approximately 2.6% per year in cervical cancer mortality, in countries with robust health systems (4). However, this approach has proven less effective in developing countries, mainly because of requirements for laboratory infrastructure, equipment, and logistic challenges associated with the screening process; as well as the performance of the Pap test itself, which has shown sensitivity of approximately 50% or less (5). New technologies and approaches, including HPV vaccines, HPV tests,³ and a “screen and treat” approach, have been developed and proven to effectively prevent cervical cancer (6, 7). The cost-effectiveness of prevention strategies has been well documented, showing that HPV vaccination coupled with screening is more cost-effective than either strategy alone (8-10). If implemented on a large scale, these new cost-effective interventions and approaches have the potential to accelerate reductions in cervical cancer mortality (9).

6. Since adoption of the Regional Strategy and Plan of Action for Cervical Cancer Prevention and Control in 2008 (11), Member States, with the collaboration of PASB, have strengthened their cervical cancer programs by introducing HPV vaccines and new approaches for screening, as well as improving the quality of cancer treatment, palliative care, and cancer registration. These commitments have been reinforced in three additional

² For the purpose of this Plan, Member States will identify priority populations based on their national context and epidemiological patterns of cervical cancer. They may include persons living under adverse social and economic circumstances, those residing in rural areas, medically underserved populations, indigenous and/or Afro-descendant populations, HIV-positive women and adolescents, sex workers, and/or migrants.

³ There are a number of HPV tests available on the market, each with different characteristics. A summary of the various tests has been prepared to assist Member States in selecting the most suitable one(s) for their purposes. This summary is available on the PAHO website at: http://www.paho.org/hq/index.php?option=com_content&view=article&id=11925&Itemid=41948&lang=en.

PAHO plans of action for the Region: in 2013, the Plan of Action for the Prevention and Control of Noncommunicable Diseases (Document CD52/7, Rev. 1), which includes actions to improve cervical cancer screening (12); in 2015, the Plan of Action on Immunization (Document CD54/7, Rev. 2), which includes HPV vaccination (13); and in 2016, the Plan of Action for the Prevention and Control of HIV and Sexually Transmitted Infections (Document CD55/14), which addresses HPV infection (14). Additionally, in 2017 the Regional Gender Agenda defined governmental agreements for sexual and reproductive health rights and gender equality, among other issues (15). Recently, Member States reaffirmed their commitment to reduce morbidity, disabilities, and mortality from noncommunicable diseases, including cancer, in Goal 9 of the Sustainable Health Agenda for the Americas 2018-2030 (Document CSP29/6, Rev. 3).

7. Moreover, in 2017 the World Health Assembly adopted a resolution on cancer prevention and control in the context of an integrated approach, which, among other interventions, calls on Member States to develop and implement comprehensive cancer prevention and control plans with focus on cost-effective interventions, equity, and access (16). In addition, the WHO Global Strategy for Women's, Children's and Adolescents' Health (17) emphasizes adolescent health and access to quality sexual and reproductive health services, and the WHO Global Health Sector Strategy on Sexually Transmitted Infections (18) calls for the scaling up of effective STI interventions and services, all of which support cervical cancer prevention.

8. Recently, with a view to strengthening cervical cancer initiatives, the UN Joint Global Programme on Cervical Cancer Prevention and Control (19) was established to provide Member States with coordinated technical cooperation across relevant United Nations programs to improve cervical cancer initiatives. Furthermore, a new global elimination strategy for cervical cancer is in the process of being developed by WHO and other United Nations partners, to be presented to the 2019 World Health Assembly. These global and regional plans, together with the present Plan, will contribute toward realization of the Sustainable Development Goals and, in particular, attainment of the following targets by 2030: 3.4, reduce by one-third premature mortality from noncommunicable diseases; 3.7, ensure universal access to sexual health care services; 3.8, achieve universal health coverage and 5.6, ensure universal access to sexual and reproductive health and reproductive rights (20).

Situation Analysis

9. Cervical cancer rates vary widely in the Region, with large differences between lower and higher income countries (Annex A). For example, the cervical cancer mortality rate is 12 times higher in Bolivia than in Canada (21/100,000 women vs. 1.7/100,000 women, respectively). Similar variations are noted within countries, sometimes with marked differences between less and more developed areas. For example, in Argentina the cervical cancer mortality rate is four times higher in the province of Jujuy (15/100,000) than in the city of Buenos Aires (4/100,000) (21). These differences have largely been attributed to variations in distribution of the determinants of health, particularly socioeconomic status, education, and income. HIV infection is also associated

with poorer outcomes. Furthermore, race can be a factor: indigenous and black women have a higher risk of developing invasive cervical cancer than the general population (22, 23). In terms of trends, steady declines in the incidence of cervical cancer since 2000 have only been observed in a few countries (Argentina, Brazil, Canada, Chile, Costa Rica, Mexico, and the United States) (24). Mortality is high and remains relatively unchanged in many countries of Latin America and the Caribbean (24).

10. Three prophylactic HPV vaccines with relatively similar effectiveness in preventing cervical cancer are currently available—namely, the bivalent, quadrivalent, and nonavalent vaccines (6). When HPV vaccines were first introduced, they were licensed and marketed using a three-dose schedule. However, the WHO Strategic Advisory Group of Experts (SAGE) recommended a two-dose schedule in 2014 and this change was approved the following year by the PAHO Technical Advisory Group on Immunization. To date, 31 countries and territories in the Region of the Americas have made HPV vaccines available in their national immunization programs (Annex A), a level higher than in any other region of the world. Data on HPV vaccination coverage were not available for the majority of countries. Where figures were available, coverage varied widely (Annex A). Coverage has been hampered in some countries by important public concerns about vaccine safety, following media coverage erroneously linking the HPV vaccine to adverse events (25).⁴ This situation underscores the need to ensure that health providers and the general public in all countries receive regular information and evidence on HPV vaccine safety and effectiveness from credible scientific sources. Reaching the estimated 37 million girls in the Region in the 9-14 year-old target population will be a challenge, as will be monitoring and consistent reporting on HPV vaccination coverage.

11. With regard to cervical cancer screening, almost all Member States report that such services are available. The Pap smear remains the most common test, although challenges continue to impede the effectiveness of screening services in many countries, including difficulties integrating it into HIV/STI programs, poor quality testing, long delays in providing women with their results, low population coverage, and poor follow-up treatment (26). HPV testing, although it is a much more effective test to detect women at risk of developing cervical cancer, has not been widely incorporated into screening programs, with only nine Member States reporting that they have introduced this test. In these countries, relevant evidence has been generated showing that HPV testing is feasible in settings where resources are limited; it detects more disease than the traditional Pap test, and using this strategy can lead to significant improvements in screening coverage and treatment rates (27–33). HPV testing can eliminate barriers related to accessing screening services, since the sample can be collected by the woman herself. HPV self-sampling has been implemented in a programmatic context in at least five countries of the Region (32, 33),

⁴ As of June 2017, over 270 million doses of HPV vaccine had been distributed worldwide. The Global Advisory Committee on Vaccine Safety has been reviewing the safety data since 2006. Anaphylaxis and syncope have been identified. The risk of anaphylaxis has been characterized as approximately 1.7 cases per 1,000,000 doses. Syncope has been established as a common anxiety- or stress-related reaction to the injection.

and in the case of a demonstration site in Argentina it resulted in a fourfold increase in screening coverage (33).

12. In order to achieve program impact, screening coverage should reach at least 70% of the target population (7). In the Americas, only seven countries report this level of coverage, so there is great need for improvement. Under a business-as-usual scenario, it will be impossible to reach the estimated 32 million women in the Region between 30 and 49 years of age who need to be screened in order to make an impact on the disease burden.⁵ Several factors hinder better coverage: the majority of screening programs are not organized; they are mainly available in urban areas; and they are based on the Pap test, which has been shown to have low sensitivity, especially in limited resource settings, and requires multiple visits (24, 34-36). But screening alone is not sufficient to prevent cervical cancer. Follow-up treatment of women with abnormal screening results is required, but it has been reported to be very low in most countries of the Region and continues to be a challenge (26, 37).

13. Treatment services for invasive cervical cancer are available in almost all the countries, although there are significant gaps in access (Annex A). Access to palliative care also continues to be a challenge, with only 10 countries reporting that they offer palliative care services (Annex A). The overall trend for opioid availability in Latin America and the Caribbean has been increasing, but it is still well below a level that is adequate to meet the needs of cancer patients (38). Far too many people continue to die in pain when very affordable and effective pain medication exists.

Proposal

14. This Plan envisions a future with the elimination of cervical cancer as a public health problem as a result of universal access to sexual health and STI prevention services, HPV vaccines, effective screening and precancer treatment services, treatment of invasive cervical cancer, and palliative care. It foresees that all women and girls, regardless of age, race, ethnicity, socioeconomic status, HIV status, or disability will have timely access to quality cervical cancer prevention, care, and treatment so that they can live in good health throughout the life course and enjoy the health-related human rights.

15. The Plan is based on the recognition of Member States' diverse contexts, priorities, and needs, while adapting the global mandates and initiatives relevant to cervical cancer to the regional context; and involves cooperating with Member States on the implementation of comprehensive strategies to strengthen cervical cancer programs in the Region. It calls for facilitating dialogue; implementing existing PAHO/WHO cervical cancer tools and resources (Annex B); and promoting synergies and coordinating efforts with existing partner initiatives (Annex C), including the RINC Cervical Cancer Prevention and Control Plan for South America (39).

⁵ The estimated total number of women in the Region of the Americas aged 30-49 who would benefit from cervical cancer screening. See: <https://esa.un.org/unpd/wpp/DataQuery/>.

16. The goal is to accelerate progress toward the elimination of cervical cancer as a public health problem in the Americas by reducing incidence and mortality rates by one-third by 2030. This goal is aligned with Target 3.4 of the Sustainable Development Goals.⁶

Goal	Impact indicator	Baseline (2012 latest year available)	Target (2030)
Reduce cervical cancer incidence and mortality in the Americas by one-third, by 2030	1. Cervical cancer incidence rate ^a	14.9/100,000 women ^a	10.0/100,000 women
	2. Cervical cancer mortality rate ^a	5.8/100,000 women ^a	3.9/100,000 women

a. Source: International Agency for Research on Cancer. Estimated cancer incidence, mortality, and prevalence worldwide, 2012 [cited Jan 4 2018]. Available from: http://globocan.iarc.fr/Pages/fact_sheets_population.aspx

Strategic Lines of Action

17. The Plan identifies the following four strategic lines of action:
- Improve cervical cancer program organization and governance, information systems, and cancer registries;
 - Strengthen primary prevention through information, education, and HPV vaccination;
 - Improve cervical cancer screening and precancer treatment through innovative strategies; and
 - Improve access to services for cancer diagnosis, treatment, rehabilitation, and palliative care.

Strategic Line of Action 1: Improve cervical cancer program organization and governance, information systems, and cancer registries

18. Better organization of cervical cancer programs favors higher coverage for vaccination and screening, and contributes to increased follow-up of women with abnormal screening test results, all of which lead to greater impact on cervical cancer incidence and mortality. The following actions are important for improving the organization of cervical cancer programs:

- Formulation/review and alignment of **national cervical cancer program strategies and plans**, with targets and milestones for 2030 in line with regional and global objectives for cervical and other HPV-related cancers, sexual and reproductive health, HIV/STIs, and health system plans.

⁶ Sustainable Development target 3.4: By 2030, reduce by one-third premature mortality from noncommunicable diseases (cardiovascular diseases, cancer, diabetes, chronic respiratory diseases) through prevention and treatment and promote mental health and well-being.

- b) Development/review of national cervical cancer **policies** based on the most up-to-date scientific evidence, with specific mention of HPV vaccination delivery strategies and target groups; screening method(s), including target groups and frequency; and referral mechanisms for diagnosis, treatment, and palliative care—all tailored to the needs of priority populations based on the local situation.
- c) Creation/strengthening of the **managerial structure** in the Ministry of Health to ensure implementation, monitoring, and attainment of the national program's goals and targets, with coordinating mechanisms to ensure effective interprogrammatic coordination between different programs, such as immunization, sexual and reproductive health, HIV/STI, and other HPV-related cancers, as well as multisectoral coordination and the active participation of women, relevant civil society organizations, and indigenous/Afro-descendant networks and communities.
- d) Strengthening of comprehensive **health information systems** that permit data generation and monitoring of cervical cancer programs across the continuum of prevention, care, and treatment services from a programmatic perspective, to include reporting on HPV vaccination coverage, cervical cancer screening coverage, and treatment rates with increased granularity of data by age group and equity variables, as well as the creation/strengthening of **population-based cancer registries** that generate regular up-to-date reports on incidence and mortality, including data on cervical and other HPV-related cancers.
- e) Sustained allocation of sufficient **financial resources** for information and education initiatives and HPV vaccination, screening, diagnosis, treatment, and palliative care.

Objective	Indicator	Baseline (2017)	Target (2030)
1.1 Develop and update comprehensive national cervical cancer plans aimed at reducing cervical cancer incidence and mortality in alignment with related global and regional plans	1.1.1 Number of countries and territories with current comprehensive cervical cancer plans ^a	10	25
1.2 Improve monitoring and evaluation of cervical cancer programs, including screening coverage, treatment rates, and cervical cancer incidence and mortality	1.2.1 Number of countries and territories producing routine monitoring reports on their cervical cancer program ^b	9	25
	1.2.2 Number of countries and territories with population-based cancer registries and published incidence and mortality statistics ^c	11	19

a. Source: PAHO. NCD Country Capacity Survey, 2017.

b. Source: Literature and desk review of national cervical cancer program reports.

c. Source: IARC. Cancer Incidence in Five Continents, 2017.

Strategic Line of Action 2: Strengthen primary prevention through information, education, and HPV vaccination

19. Community mobilization, health education and information, and universal HPV vaccination are essential primary prevention strategies. Health information and education campaigns need to be strengthened, depending on the specific information needs of individuals and communities, by communicating up-to-date scientific information and messages about HPV, HPV vaccines, cervical cancer, and behavior changes that can reduce risks and prevent cervical cancer, presented in simple gender-sensitive, culturally appropriate, understandable language. Sustained HPV vaccination programs also need to be implemented, in accordance with global guidelines for target age and dose, with a view to achieving greater than 80% national coverage of HPV vaccines as part of national immunization programs. To strengthen primary prevention efforts for cervical cancer, it will be necessary to:

- a) Develop/strengthen and implement gender-sensitive **HPV and cervical cancer prevention education and awareness-raising initiatives** to inform people—in particular, girls and boys and priority populations with higher HPV prevalence and in situations of vulnerability—about HPV infection, cervical and other HPV-related cancers, and their causes and natural history; provide education on sexual health, tailored to age and culture, with a view to reducing high-risk sexual behavior; point out the link between HIV and STI prevention and increased access and use of condoms; provide details on HPV vaccine effectiveness and safety; address misinformation and rumors that inhibit acceptance of HPV vaccination; promote screening for age-eligible women; increase awareness of signs and symptoms of cervical cancer; and address ignorance, fear, embarrassment, and stigma related to HPV and cervical cancer.
- b) Develop/review national **HPV vaccine guidelines** to ensure that they are based on the most recent scientific evidence, in alignment with WHO/PAHO recommendations and ethical standards, and tailored to the needs of key populations and others in situations of vulnerability, depending on the local cervical cancer burden. The target age may vary in different settings; it should be determined based on the likelihood of reaching the largest group of people at highest risk prior to initiation of sexual activity.
- c) Begin/continue to implement **HPV vaccination strategies** with the aim of reaching greater than 80% national coverage with the recommended dose in the target female age group as set out in national guidelines, monitoring adverse events and coverage rates, and reporting annually on HPV vaccination coverage by age cohort as part of the routine immunization reporting mechanism.

Objective	Indicator	Baseline	Target (2030)
2.1 Develop and implement national education and information campaigns for HPV and cervical cancer prevention	2.1.1 Number of countries and territories with ongoing HPV and cervical cancer education and information campaigns ^a	9 (2017)	25
2.2 Implement HPV vaccination in a sustainable manner as part of national immunization programs	2.2.1 Number of countries and territories with greater than 80% HPV vaccine coverage in the target female age group according to national guidelines ^b	2 ^c (2016)	15

a. Source: Literature and desk review of national cervical cancer program reports.

b. Source: WHO. Human papillomavirus vaccines: WHO position paper. May 2017.

c. Source: WHO, Joint Reporting Form, July 2017.

Strategic Line of Action 3: Improve cervical cancer screening and precancer treatment through innovative strategies

20. Cervical cancer can be prevented by screening asymptomatic women in the target age group at risk of developing cervical cancer and providing treatment for all those detected with precancerous lesions. The aim is to screen the largest possible proportion of women targeted by the national guideline and ensure appropriate management for all those who have an abnormal test result. Strategies for successfully establishing this crucial link between screening and treatment include both the classical approach of “screen, diagnose, and treat” and also “screen and treat” or “screen, triage, and treat.” A number of effective screening tests are available, including HPV tests, visual inspection with acetic acid (VIA), and cytology. The options for treating precancerous lesions include cryotherapy, the loop electrosurgical excision procedure (LEEP), and cold knife conization, recommended by WHO (10). However, the HPV test, given its superior performance, followed by cryotherapy treatment with or without VIA triage, is recommended over other screening tests and approaches whenever it is feasible (10). Regardless of the screening test, treatment method, or approach adopted, health services need to be organized to ensure high screening coverage in the target group, a high treatment rate for women with abnormal test results, and high quality in testing and treatment.

21. To strengthen screening and precancer treatment services, it will be necessary to:

- a) Review/update national **screening and precancer treatment protocols** to ensure that they are based on the most recent scientific evidence, adhere to WHO recommendations and ethical standards, and are tailored to the needs of priority populations, including those living with HIV who need more frequent screening. The target age may vary in different settings and should be determined based on the likelihood of reaching the largest group of women, focusing on those between the ages of 30 and 49 and expanding to younger and older age groups as resources permit with a view to attaining maximal coverage.

- b) Assess health service capacity and needs with a view to **increasing equitable access**, screening coverage, and treatment rates through clinical outreach services as well as static health services, while tailoring the service delivery model to the needs of women living in vulnerable and disadvantaged communities. Consider ways to deliver screening and treatment services in fewer health service visits so as to reduce loss in follow-up care and maximize impact on cervical cancer mortality. Ensure that cervical cancer services are part of the essential benefits offered by health systems and services at the first level of care with a definite strategy for referrals to secondary and tertiary care.
- c) Strengthen **integrated service delivery** to better address women’s health, sexual and reproductive health, HIV co-infection, and the prevention of cancer and other noncommunicable diseases. This approach includes offering and performing HIV testing and counseling in cervical cancer screening services and HPV testing in sexual health and HIV/STI prevention, care, and treatment services in order to provide more comprehensive, person-centered, and better integrated screening and management of sexual health services.
- d) Ensure that all **primary care providers are trained** and competent in carrying out the procedures for screening and precancer treatment, in assuring high-quality care for women, and in providing comprehensive care through multidisciplinary teams that include community health workers who have been trained to address the clinical, psychosocial, and gender needs of women with persistent HPV infections or cervical precancerous lesions, as well as the elimination of stigma and discrimination in the health services.
- e) Assess infrastructure capacity and needs, including laboratory capacity to process screening tests in a timely and accurate manner, and **ensure provision of the necessary infrastructure, supplies**, and equipment, making use of the PAHO Strategic Fund as necessary, to enable timely screening and precancer treatment services, maximized coverage of the target population, reliable services, and minimal service interruptions as a result of a shortage of providers, malfunctioning equipment, stock out of supplies, etc.

Objective	Indicator	Baseline (2017)	Target (2030)
3.1 Increase equitable access to and coverage of cervical cancer screening and precancer treatment	3.1.1 Number of countries and territories with at least 70% screening coverage among women aged 30-49 or according to national policies for screening by age group ^a	7	20
	3.1.2 Number of countries and territories with a treatment rate of at least 70% among women with abnormal screening test results ^b	No data available	10

a. Source: PAHO. NCD Country Capacity Survey, 2017.

b. Source: Literature and desk review of national cervical cancer program reports.

Strategic Line of Action 4: Improve access to services for cancer diagnosis, treatment, rehabilitation, and palliative care

22. Accurate diagnosis and prompt and appropriate treatment, including rehabilitative care, pain relief, and palliative care, can reduce mortality and improve outcomes and quality of life for women with cervical cancer. Pathology services are essential in order to accurately analyze and guide the diagnosis, treatment, and management of the woman's health. Cervical cancer treatment options include surgery or radiation therapy with or without chemotherapy. The most effective treatment services are those that are: provided in an equitable, human-rights based, and sustainable manner; associated with accurate diagnosis and staging; treated according to evidence-based standards of care; and linked to rehabilitative services as well as palliative care. It is important to address barriers that limit access to safe, quality, effective, and affordable cancer services by working towards universal health access and coverage that include diagnosis, treatment, rehabilitation, and palliative care. Cancer treatment can exert a significant psychosocial and financial impact on women and their families, a factor that should be taken into account when improving access and coverage of cervical cancer services.

23. To strengthen diagnosis, treatment, and palliative care services, it will be necessary to:

- a) Develop/update and implement evidence-based **protocols** for cervical cancer treatment and palliative care based on current scientific evidence.
- b) Improve **equitable access** to pathology, radiation therapy, surgery, chemotherapy, rehabilitation, and palliative care services by ensuring that they are part of universal coverage schemes; adapting service delivery approaches based on people- and community-centered care through integrated health service networks; and integrating palliative care into primary care and community- and home-based care.
- c) Ensure that there are sufficient numbers of **trained health care** workers in place—especially pathologists, oncology nurses, gynecologist-oncologists, radiologists, and medical physicists, among others—with the appropriate competencies and skills for cervical cancer control through appropriate human resources planning, recruitment, continuing education and training, deployment, and retention strategies, including career development opportunities.
- d) Strengthen the supply of quality-assured and essential **cancer diagnostics, medicines, and treatment technologies**, making use of the PAHO Strategic Fund as necessary, and strengthen supply chain management structures and processes (forecasting, procurement, warehousing, and distribution) as well as radiation protection policies and practices.

Objective	Indicator	Baseline (2017)	Target (2030)
4.1 Increase equitable access to cancer treatment and palliative care services	4.1.1 Number of countries and territories with publically available cancer treatment services	27	30
	4.1.2 Number of countries and territories utilizing the PAHO Strategic Fund for essential cancer medicines	3	15
	4.1.3 Number of countries and territories with palliative care services included in primary care	10	20

Implementation

24. Implementation of this Plan will first require the development of biennial work plans aligned with the PAHO biennial planning cycle. It will also require multisectoral, multiagency, intercountry, and interprogrammatic cooperation and collaboration. Key partners include the International Atomic Energy Agency (IAEA), the International Agency for Research on Cancer (IARC), and other United Nations partners; the South American Network of Cancer Institutes (RINC); the United States National Cancer Institute; NGOs, including the American Cancer Society, the Union for International Cancer Control, and Cervical Cancer Action; and other relevant sectors.

Monitoring and Evaluation

25. Monitoring and evaluation of this Plan will be aligned with the Organization's results-based management framework and its performance monitoring and assessment processes. A series of progress reports will be submitted to the PAHO Governing Bodies: the first in 2022, the second in 2026, and a final report in 2031.

Financial Implications

26. An average of US\$ 3 million per year will be required for PAHO technical cooperation on cervical cancer prevention and control over the period 2018-2030. It is also to be noted that cervical cancer prevention and control will require substantial external and domestic resources to scale up efforts and shift away from small demonstration projects to population-based interventions that achieve high vaccination, screening, and treatment coverage in order to significantly reduce the number of cervical cancer cases and deaths and ultimately eliminate cervical cancer as a public health problem.

Action by the Directing Council

27. The Directing Council is requested to review the information provided in this document and consider adopting the proposed resolution found in Annex D.

Annexes

References

1. Ferlay J, Soerjomataram I, Ervik M, Dikshit R, Eser S, Mathers C, et al. GLOBOCAN 2012 v1.0, Estimated Cancer Incidence, Mortality and Prevalence Worldwide: IARC Cancer Base No. 11 [Internet]. Lyon, France: International Agency for Research on Cancer; 2013 [cited 2018 Jan 4]. Available from: <http://globocan.iarc.fr>.
2. Pan American Health Organization. regional strategy and plan of action for cervical cancer prevention and control: Final Report [Internet]. 29th Pan American Sanitary Conference of PAHO, 69th Session of the Regional Committee of WHO for the Americas; 2017 Sep 25-29; Washington, DC. Washington, DC: PAHO; 2017 (Document CSP29/INF/4) [cited 2018 Jan 4]. Available from: http://www.paho.org/hq/index.php?option=com_content&view=article&id=13497&Itemid=2105&lang=en.
3. Castellsagué X. Natural history and epidemiology of HPV infection and cervical cancer. *Gynecol Oncol*. 2008 Sep;110(3 Suppl 2):S4-7.
4. Forman D, de Martel C, Lacey CJ, Soerjomataram I, Lortet-Tieulent J, Bruni L, et al. Global burden of human papillomavirus and related diseases. *Vaccine*. 2012 Nov 20;30 Suppl 5:F12-23.
5. Ginsburg O, Bray F, Coleman MP, Vanderpuye V, Eniu A, Kotha S, et al. The global burden of women's cancers: a grand challenge in global health. *Lancet*. 2017 Feb 25;389(10071):847-860.
6. World Health Organization. Human papillomavirus vaccines: WHO position paper, May 2017. *Wkly Epidemiol Rec*. 2017;92:241–68.
7. World Health Organization. Guidelines for screening and treatment of precancerous lesions for cervical cancer prevention. Geneva: World Health Organization; 2013.
8. Kim JJ, Brisson M, Edmunds WJ, Goldie SJ. Modeling cervical cancer prevention in developed countries. *Vaccine*. 2008;26 (Suppl. 10):K76–K86.
9. Goldie SJ, Diaz M, Constenla D, Alvis N, Andrus JK, Kim SY. Mathematical models of cervical cancer prevention in Latin America and the Caribbean. *Vaccine*. 2008; 26(Suppl. 11):L59–72.
10. Gervais F, Dunton K, Jiang Y, Llargeron N. Systematic review of cost-effectiveness analyses for combinations of prevention strategies against human papillomavirus (HPV) infection: a general trend. *BMC Public Health*. 2017;17:283.

11. Pan American Health Organization. Regional strategy and plan of action for cervical cancer prevention and control [Internet]. 48th Directing Council of PAHO, 60th Session of the Regional Committee of WHO for the Americas; 2008 Sep 29-Oct 3; Washington, DC. Washington, DC: PAHO; 2008 (Document CD48/6) [cited 2017 Jan 5]. Available from:
<http://www1.paho.org/english/gov/cd/cd48-06-e.pdf>.
12. Pan American Health Organization. Plan of action for the prevention and control of noncommunicable diseases in the Americas 2013-2019 [Internet]. 52nd Directing Council of PAHO, 65th Session of the Regional Committee of WHO for the Americas; 2013 Sep30-Oct 4; Washington, DC. Washington, DC: PAHO; 2013 (Document CD52/7, Rev. 1) [cited 2018 Jan 4]. Available from:
http://www2.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=23295&Itemid=270&lang=en.
13. Pan American Health Organization. Plan of action on immunization [Internet]. 54th Directing Council of PAHO; 67th Session of the Regional Committee of WHO for the Americas; 2015 Sep 28-Oct 2; Washington, DC. Washington, DC: PAHO; 2015 (Document CD54/7, Rev. 2) [cited 2018 Jan 4]. Available from:
http://www2.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=31248&Itemid=270&lang=en.
14. Pan American Health Organization. Plan of action for the prevention and control of HIV and sexually transmitted infections 2016-2021 [Internet]. 55th Directing Council of PAHO; 68th Session of the Regional Committee of WHO for the Americas; 2016 Sep 26-30; Washington, DC. Washington, DC: PAHO; 2016 (Document CD55/14) [cited 2018 Jan 4]. Available from:
http://www.paho.org/hq/index.php?option=com_content&view=article&id=12276&Itemid=42078&lang=en.
15. Economic Commission for Latin America and the Caribbean. Montevideo Strategy for Implementation of the Regional Gender Agenda within the Sustainable Development Framework by 2030. [Internet]. Santiago, Chile: United Nations; March 2017 [cited 2018 Jan 18]. Available from:
http://repositorio.cepal.org/bitstream/handle/11362/41013/S1700033_en.pdf?sequence=1&isAllowed=y.
16. World Health Organization. Cancer prevention and control in the context of an integrated approach [Internet]. Seventieth World Health Assembly; 2017 22-31 May; Geneva. Geneva: OMS; 2017 (Resolution WHA70.12) [cited 2018 Jan 4]. Available from:
http://apps.who.int/gb/ebwha/pdf_files/WHA70-REC1/A70_2017_REC1-en.pdf#page=27.

17. United Nations Secretary-General. The Global Strategy for Women's, Children's and Adolescents' Health (2016-2030) New York: United Nations; 2016 [Internet]. [cited 2018 Jan 4]. Available from: http://www.everywomaneverychild.org/wp-content/uploads/2016/12/EWEC_Global_Strategy_EN_inside_LogoOK_web.pdf.
18. World Health Organization. Global Health Sector Strategy on Sexually Transmitted Infections, 2016-2021. Geneva. Geneva: WHO, 2016 [Internet] [cited 2018 Jan 25]. Available from: <http://www.who.int/reproductivehealth/publications/rtis/ghss-stis/en/>.
19. World Health Organization. UN Joint Global Programme on Cervical Cancer Prevention and Control [Internet]. Geneva: World Health Organization; 2016. [cited 2018 Jan 4]. Available from: <http://www.who.int/ncds/un-task-force/un-joint-action-cervical-cancer-leaflet.pdf>.
20. United Nations. Transforming our world: the 2030 Agenda for Sustainable Development [Internet]. General Assembly, Seventieth Session of the General Assembly of the United Nations; 2015 Sep 11-18; New York, NY. New York: UN; 2015 (Resolution A/RES/70/1) [cited 2018 Jan 4]. Available from: <http://www.un.org/sustainabledevelopment/sustainable-development-goals/>.
21. Arrossi S, Ramos S, Paolino M, Sankaranarayanan R. Social inequality in Pap smear coverage: identifying under-users of cervical cancer screening in Argentina. *Reproductive Health Matters*. 2008. 16:32, 50-58, DOI: 10.1016/S0968-8080(08)32410-0.
22. Parikh S, Brennan P, Boffetta P. Meta-analysis of social inequality and the risk of cervical cancer. *Int J Cancer*. 2003;105:687-691.
23. Moore SP, Forman D, Pineros M, Fernandez SM, de Oliveira Santos M, Bray F. Cancer in indigenous people in Latin America and the Caribbean: a review. *Cancer Medicine*. 2014; 3(1): 70–80.
24. Murillo, R., et al., Cervical cancer in Central and South America: Burden of disease and status of disease control. *Cancer Epidemiol.*, 2016. 44 Suppl 1: p. S121-S130.
25. Nogueira-Rodrigues A, Bukowski A, Paulino E, St. Luis J, Barrichello A, Sternberg C, et al. An alert to Latin America: current human papillomavirus vaccination trends highlight key barriers to successful implementation. *Cancer*. 2017 April;1097-142.
26. Murillo, R., et al., Cervical cancer screening programs in Latin America and the Caribbean. *Vaccine*. 2008. 26 Suppl 11: p. L37-48.

27. Rodríguez AC, Ávila C, Herrero R, Hildesheim A, Sherman ME, Burk RD, , et al. Cervical cancer incidence after screening with HPV, cytology, and visual methods: 18-year follow-up of the Guanacaste cohort. *Int J Cancer*. 2017 Apr 15;140(8):1926-1934.
28. Maza M, Alfaro K, Garai J, Velado MM, Gage JC, Castle PE, et al. Cervical cancer prevention in El Salvador (CAPE): an HPV testing-based demonstration project; changing the secondary prevention paradigm in a lower middle-income country. *Gynecol Oncol Rep*. 2017 Mar 3;20:58-61.
29. Cremer ML., Maza M, Alfaro K, Morales Velado M, Felix J, et al. Scale-up of an human papillomavirus testing implementation program in El Salvador. *J Low Genit Tract Dis*. 2016;21(1):26–32.
30. Arrossi S, Thouyaret L, Laudi R, Marin O, Ramirez J, Paolino M, et al. Implementation of HPV-testing for cervical cancer screening in programmatic contexts: the Jujuy demonstration project in Argentina *Int J Cancer*. 2015: 137, 1709–1718.
31. Jeronimo J, Bansil P, Lim J, Peck R, Paul P, Amador JJ. A multicountry evaluation of care HPV testing, visual inspection with acetic acid, and Papanicolaou testing for the detection of cervical cancer. *Int J Gynecol Cancer*. 2014;24(3):576–585.
32. Jeronimo J, Holme F, Slavkovsky R, Camel C. Implementation of HPV testing in Latin America. *J Clin Virol*. 2016 Mar;76 Suppl 1:S69-73.
33. Arrossi S, Thouyaret L, Herrero R, Campanera A, Magdaleno A, Cuberli M, et al. Effect of self-collection of HPV DNA offered by community health workers at home visits on uptake of screening for cervical cancer (the EMA study): a population-based cluster-randomised trial. *Lancet Glob Health*. 2015 Feb;3(2):85-94.
34. Goss PE, et al., Planning cancer control in Latin America and the Caribbean. *Lancet Oncol*. 2013. 14(5): p. 391-436.
35. Soneji S, Fukui N. Socioeconomic determinants of cervical cancer screening in Latin America. *Rev Panam Salud Publica*. 2013; 33(3): 174-82.
36. Bychkovsky BL, et al. Cervical cancer control in Latin America: a call to action. *Cancer*. 2016; 122(4):502-14.
37. Paolino M, Arrossi S. Analysis of the reasons for abandoning the follow-up and treatment process in women with pre-cancerous cervical lesions in the province of Jujuy: implications for health management. *Salud Colect*. 2012; 8(3): 247-61.

38. Report of the International Narcotics Control Board for 2016. New York: United Nations: International Narcotics Control Board, 2017. [cited 2017 Feb 28]. Available from:
http://www.incb.org/documents/Publications/AnnualReports/AR2016/English/AR2016_E_ebook.pdf.

39. Redes de Institutos e Instituciones Nacionales de Cáncer. Plan Regional de Acciones Integradas: Plataforma de intercambio de experiencias y asistencia técnica para prevención y control del cáncer de cuello uterino en Suramérica. 2016, RINC/UNASUR [Internet]. [cited 2018 Jan 19]. Available in Spanish from:
http://www2.rinc-unasur.org/wps/wcm/connect/e8ebd10040bb3abbaed1be6d5dab20b5/Plan+RINC-UNASUR+Cuello+%C3%A9tero_ES.pdf?MOD=AJPERES&CACHEID=e8ebd10040bb3abbaed1be6d5dab20b5.

Annex A

**Overview of the Situation and Capacity for Cervical Cancer Prevention and Control
in Countries and Territories in the Region of the Americas**

Country/ territory	Cervical cancer burden (a,b)			HPV vaccination (c, d)			Screening (e)			Cancer treatment and palliative care (f,g)			Cancer registration (f)	
	Incidence rate (ASR per 100,000)	Mortality rate (ASR per 100,000)	5-year survival rate (%) 2005- 2009	Year of introduction	Target age group	Coverage 2nd dose/3rd dose - 2016	Screening test used	Target age group	Screening coverage (%) (latest year)	Cancer treatment available	Radiotherapy – number of centers	Palliative care services available in primary care	Cancer registry exists	Hospital or population-based registry
Anguilla	--	--	--	5/2016	9-13 year-olds females	35%	--	--	--	No	NA	No	No	NA
Antigua & Barbuda	--	--	--	NI	NA	NA	Cytology	21-65 year- olds	--	Yes	1	Yes	No	NA
Argentina	20.8	8.3	50.6	10/2011	11 year-olds, both sexes (males 2017)	57%	Cytology/HPV test	30-64 year- olds	72 (2013)	Yes	81	No	Yes	Hospital- based
Aruba	--	--	--	11/2014	11 year-olds females	47%	--	--	--	Yes	--	Yes	No	NA
Bahamas	20.6	7.0	--	5/2015	9-10 year-olds, females	ND	Cytology	21-59 year- olds	--	Yes	1	No	Yes	Population- based
Barbados	25.4	7.2	--	2014	10-11 year-olds, both sexes	12%	Cytology	21-65 year- olds	--	Yes	1	No	Yes	Population- based
Belize	32.7	14.9	--	11/2016	9-13 year-olds, females	NA	Cytology/VIA	21-55 year- olds	37 (1999)	No	NA	No	No	NA
Bermuda	--	--	--	4/2007	9-15 year-olds, both sexes	30%	--	--	--	Yes	--	Yes	Yes	Population- based
Bolivia	47.7	21.0	--	4/2017	10-12 year-olds, females	NA	Cytology	25-64 year- olds	33 (2008)	Yes	6	No	Yes	Population- based
Brazil	16.3	7.3	61.1	3/2014	9-14 year-olds, both sexes (males 2017)	10%	Cytology	25-64 year- olds	82 (2014)	Yes	212	Yes	Yes	Population- based

CD56/9 - ANNEX A

Country/ territory	Cervical cancer burden (a,b)			HPV vaccination (c, d)			Screening (e)			Cancer treatment and palliative care (f,g)			Cancer registration (f)	
	Incidence rate (ASR per 100,000)	Mortality rate (ASR per 100,000)	5-year survival rate (%) 2005- 2009	Year of introduction	Target age group	Coverage 2nd dose/3rd dose - 2016	Screening test used	Target age group	Screening coverage (%) (latest year)	Cancer treatment available	Radiotherapy – number of centers	Palliative care services available in primary care	Cancer registry exists	Hospital or population-based registry
Canada	6.3	1.7	66.8	2007- 2009	9-13 year-olds (target age and sex vary by province)	73%	Cytology	21-69 year- olds	73 (2011)	Yes	54	Yes	Yes	Population- based
Cayman Islands	--	--	--	11/2012	9-15 year-olds, females	NR	--	--	--	Yes	--	Yes	Yes	Population- based
Chile	12.8	6.0	50.9	9/2014	9 year-olds females	78%	Cytology	25-64 year- olds	71 (2013)	Yes	26	No	Yes	other
Colombia	18.7	8.0	59.3	8/2012	9 -17 year-olds, females	NR	Cytology/VIA/H PV test	25-69 year- olds	67 (2005)	Yes	51	No	Yes	Hospital- based
Costa Rica	11.4	4.4	--	NI	NA	NA	Cytology	20 years and older	35 (2013)	Yes	4	Yes	Yes	Population- based
Cuba	17.1	6.7	64.0	NI	NA	NA	Cytology	25-64 year- olds	70 (1994)	Yes	9	Yes	Yes	Population- based
Dominica	--	--	--	NI	NA	NA	Cytology	18-65 year- olds	--	No	NA	No	No	NA
Dominican Republic	30.7	12.3	--	4/2017	9-10 year-olds, females	NA	Cytology	25-64 year- olds	66 (2003)	Yes	12	No	Yes	Hospital- based
Ecuador	29.0	14.0	61.7	2/2014	9-11 year-olds, females	86%	Cytology	21-65 year- olds	47 (2003)	Yes	12	Yes	Yes	Population- based
El Salvador	24.8	11.9	--	NI	NA	NA	Cytology /HPV test	30-59 year- olds	70 (2008)	Yes	4	No	Yes	Hospital- based
Grenada	--	--	--	NI	NA	NA	Cytology	21 years and older	--	No	NA	No	Yes	Hospital- based
Guatemala	22.3	12.2	--	NI	NA	NA	Cytology/VIA/H PV test	25-54 year- olds	40 (2003)	Yes	4	No	Yes	Population- based
Guyana	46.9	21.9	--	2011	9-13 year-olds, females	NR	Cytology/VIA	30-49 year- olds	17 (2012)	No	1	No	Yes	Population- based

CD56/9 - ANNEX A

Country/ territory	Cervical cancer burden (a,b)			HPV vaccination (c, d)			Screening (e)			Cancer treatment and palliative care (f,g)			Cancer registration (f)	
	Incidence rate (ASR per 100,000)	Mortality rate (ASR per 100,000)	5-year survival rate (%) 2005- 2009	Year of introduction	Target age group	Coverage 2nd dose/3rd dose - 2016	Screening test used	Target age group	Screening coverage (%) (latest year)	Cancer treatment available	Radiotherapy – number of centers	Palliative care services available in primary care	Cancer registry exists	Hospital or population-based registry
Haiti	24.9	14.6	--	Pilot	NA	NA	Cytology/VIA	30 years and older	--	No	NA	No	Yes	Hospital- based
Honduras	29.4	14.1	--	5/2016	11 year-olds, females	55%	Cytology/HPV test	30-59 year- olds	31 (2002)	Yes	5	No	Yes	Hospital- based
Jamaica	26.3	11.9	--	10/2017	10-11 year-olds, females	NA	Cytology	25-54 year- olds	25 (2008)	Yes	3	No	Yes	Population- based
Mexico	23.3	8.0	--	10/2012	10-11 year-olds, females	96%	Cytology/HPV test	25-64 year- olds	64 (2003)	Yes	91	No	Yes	Population- based
Nicaragua	36.2	18.3	--	NI	NA	NA	Cytology/HPV test	25-64 year- olds	35 (2007)	Yes	1	No	No	
Panama	18.7	7.1	--	10/2008	10 year-olds, both sexes	56%	Cytology	25-59 year- olds	13 (2014)	Yes	4	Yes	Yes	Population- based
Paraguay	34.2	15.7	--	3/2013	10 year-olds, females	60%	Cytology/HPV test	25-49 year- olds	51 (2003)	Yes	4	No	No	
Peru	32.7	12.0	--	2/2015	9-12 year-olds, females	NR	Cytology/VIA	30-49 year- olds	54 (2013)	Yes	18	No	Yes	Hospital- based
Sint Maarten	--	--	--	9/2013	9-11 year-olds females	NR	--	--	NA	No	NA	No	No	NA
Saint Kitts and Nevis	--	--	--	NI	NA	NA	Cytology	18-55 year- olds	--	No	NA	No	No	NA
Saint Lucia	--	--	--	NI	NA	NA	Cytology	18-55 year- olds	--	No	NA	No	Yes	Hospital- based
Saint Vincent and the Grenadines	--	--	--	NI	NA	NA	Cytology	20-65 year- olds	--	No	NA	No	No	NA
Suriname	38.0	15.7	--	11/2013	9-13 year-olds, females	32%	Cytology/VIA	23-55 year- olds	--	Yes	1	Yes	Yes	Hospital- based

CD56/9 - ANNEX A

Country/ territory	Cervical cancer burden (a,b)			HPV vaccination (c, d)			Screening (e)			Cancer treatment and palliative care (f,g)			Cancer registration (f)	
	Incidence rate (ASR per 100,000)	Mortality rate (ASR per 100,000)	5-year survival rate (%) 2005- 2009	Year of introduction	Target age group	Coverage 2nd dose/3rd dose - 2016	Screening test used	Target age group	Screening coverage (%) (latest year)	Cancer treatment available	Radiotherapy – number of centers	Palliative care services available in primary care	Cancer registry exists	Hospital or population-based registry
Trinidad and Tobago	24.5	12.0	--	2/2013	11-12 year-olds, both sexes	22%	Cytology	25-65 year- olds	--	Yes	3	No	Yes	Population- based
United States of America	6.6	2.7	62.8	6/2006	11-12 year-olds, both sexes	63% girls 50% boys	Cytology/HPV test	21-64 year- olds	81 (2013)	Yes	2,121	Yes	Yes	Population- based
Uruguay	18.9	7.1	--	4/2013	12 year-olds, females	41%	Cytology	21-69 year- olds	40 (2014)	Yes	10	Yes	Yes	Population- based
Venezuela	32.8	12.3	--	NI	NA	NA	Cytology	25-64 year- olds	35 (1994)	Yes	38	No	No	Hospital- based

Legend: ASR=age-standardized rate; -- = No data available; NI = No introduction; NA = Not applicable; NR = No report; VIA = Visual inspection with acetic acid.

Sources:

a. Globocan, 2012, <http://globocan.iarc.fr/Default.aspx>

b. Lancet. 2015, Mar 14; 385(9972):977-1010.

c. WHO/Joint Reporting Form (JRF), July 2017 and additional information provided to PAHO from the countries (with introduction at the end 2016 or 2017). Three territories have information as of year of introduction but no coverage data in JRF: Puerto Rico (6/2006); Saba (2013 = 1/3 of the Dutch municipalities) and Sint Eustatius (1/2013).

d. WHO/JRF, July 2017 and additional information provided to PAHO by the countries (with introduction at the end 2016 or 2017).

e. ICO HPV Information Center, 2017. <http://www.hpvcentre.net/>

f. PAHO, 2017. NCD Country Capacity Survey.

g. IAEA, 2017. Directory of Radiotherapy Centers. <https://dirac.iaea.org/Query/Map2?mapId=0>

Annex B

PAHO/WHO Tools for Cervical Cancer Prevention and Control

Comprehensive cervical cancer control: a guide to essential practice. WHO; 2014.

Available in English, Spanish, and Portuguese on the PAHO website:

http://apps.who.int/iris/bitstream/handle/10665/144785/9789241548953_eng.pdf;jsessionid=A5E7480B867101AEBC6C5B1C35068450?sequence=1

Guidelines for screening and treatment of precancerous lesions for cervical cancer prevention. WHO, 2013

Available in English and Spanish on the WHO website:

http://apps.who.int/iris/bitstream/handle/10665/94830/9789241548694_eng.pdf?sequence=1

Monitoring national cervical cancer prevention and control programmes. WHO, 2013

Available in English and Spanish on the WHO website:

http://apps.who.int/iris/bitstream/handle/10665/79316/9789241505260_eng.pdf?sequence=1

Series of factsheets on HPV and cervical cancer. PAHO, 2015

Available in English, Spanish, and Portuguese on the PAHO website:

https://www.paho.org/hq/index.php?option=com_content&view=article&id=11568&Itemid=40592&lang=en

Integrating HPV testing in cervical cancer screening programs: a manual for program managers. PAHO, 2016

Available in English and Spanish on the PAHO website:

http://www.paho.org/hq/index.php?option=com_content&view=article&id=12428&Itemid=40602&lang=en

PAHO Virtual Public Health Campus. Course on comprehensive cancer control. PAHO, 2018

Available in English and in Spanish on the campus website:

<https://mooc.campusvirtualsp.org/course/view.php?id=32>

Annex C
Synopsis of Relevant Partner Initiatives on Cervical Cancer Prevention and Control

Initiative	Overview	Reference
Global initiatives		
UN Global Joint Program on Comprehensive Cervical Cancer	A global initiative of 7 United Nations agencies/programs to lead and coordinate technical assistance to governments with a view to building and sustaining high-quality national comprehensive cervical cancer control programs	http://www.who.int/ncds/un-task-force/un-joint-action-cervical-cancer-leaflet.pdf
Cervical Cancer Action	An international coalition of nongovernmental organizations that coordinates initiatives and leads global strategic advocacy efforts to inform policies, strengthen programs, and increase global funding for cervical cancer prevention and control	http://www.cervicalcanceraction.org/home/home.php
Cervical Cancer Prevention Initiative	A global initiative launched by Cervical Cancer Action in 2015 to promote multisectoral partnerships, spur investments in the health of adolescent girls and women, and build momentum for action on global cervical cancer prevention over five years (2015–2020)	http://www.cervicalcanceraction.org/initiative/
Pink Ribbon Red Ribbon	A global partnership of national governments, nongovernmental and multilateral organizations, foundations, and corporations with a shared goal of reducing deaths from cervical cancer and breast cancer in low- and middle-income countries	http://pinkribbonredribbon.org/about-cervical-breast-cancer/
International Cancer Control Planning Partnership	A group of international organizations engaged in cancer control planning efforts to support the development, implementation, and evaluation of national cancer control plans around the world	http://www.iccp-portal.org/
Regional initiatives		
RINC Cervical Cancer Plan Prevention and Control Plan for South America	Plan for cervical cancer developed under the aegis of the Network of South America National Cancer Institutes and Institutions (<i>Red de Instituciones Nacionales de Cáncer</i> – RINC), which includes cooperation in research and other areas	http://www2.rinc-unasur.org/wps/wcm/connect/rinc/site/home
IARC ESTAMPA project	A Latin American multicenter study on cervical cancer screening with HPV tests reaching out to 50,000 women in 10 Latin American countries	http://www.who.int/reproductivehealth/projects/HRX17_ESTAMPA.pdf
MD Anderson ECHO project for cervical cancer	A telementoring model used by MD Anderson with providers in Latin America to build capacity for the clinical management of cervical dysplasia	https://www.mdanderson.org/education-training/global-outreach/project-echo.html

56th DIRECTING COUNCIL

70th SESSION OF THE REGIONAL COMMITTEE OF WHO FOR THE AMERICAS

Washington, D.C., USA, 23-27 September 2018

CD56/9
Annex D
Original: English

PROPOSED RESOLUTION

PLAN OF ACTION FOR CERVICAL CANCER PREVENTION AND CONTROL 2018-2030

THE 56th DIRECTING COUNCIL,

(PP1) Having examined the *Plan of Action for Cervical Cancer Prevention and Control 2018-2030* (Document CD56/9);

(PP2) Considering that the Plan is aligned with World Health Organization Resolution WHA70.12, Cancer Prevention and Control in the Context of an Integrated Approach, the WHO Global Health Sector Strategy on Sexually Transmitted Infections, the UN Joint Global Programme on Cervical Cancer Prevention and Control, the new WHO Global Strategy to Eliminate Cervical Cancer, and the Sustainable Development Goals (SDGs), and that this plan of action provides a clear long-term plan to reduce the cervical cancer burden in the Americas by 2030;

(PP3) Cognizant of the impact that this disease has on women, their families, and their communities throughout the Americas, especially among priority populations in situations of vulnerability;

(PP4) Acknowledging the need to decrease and eliminate the scourge of this disease, which is preventable through HPV vaccination, screening, and precancer treatment, and curable if detected at early stages of disease;

(PP5) Aware of the cost-effective and affordable interventions that are available to reduce cervical cancer incidence and mortality and the urgent action that is required to implement these interventions on a population-based scale, seeking to ensure equitable access to cervical cancer primary, secondary, and tertiary prevention,

RESOLVES:

(OP)1. To approve the *Plan of Action for Cervical Cancer Prevention and Control 2018-2030* (Document CD56/9).

(OP)2. To urge Member States, as appropriate and taking into account their national context and needs, to:

- a) prioritize the prevention and control of cervical cancer in the national public health agenda;
- b) formulate, review, and align national comprehensive cervical cancer strategies and plans with related global and regional strategies, plans, and targets, and regularly report on progress in this area;
- c) strengthen governance, organization, and access to health services to ensure that comprehensive cervical cancer services are integrated across the relevant levels of care and that high coverage of HPV vaccination, screening, precancer treatment, and invasive cancer treatment is achieved;
- d) strengthen cancer registries and information systems to monitor the coverage of HPV vaccination, coverage of screening, and treatment rates, and report regularly on these indicators;
- e) implement high-impact interventions on a population-based scale along the continuum of health education and promotion, HPV vaccination, cervical cancer screening and diagnosis, and treatment for precancer and invasive cancer, with interventions tailored to the needs of priority populations in situations of vulnerability;
- f) facilitate the empowerment and engagement of civil society organizations to provide a multisectoral approach to comprehensive cervical cancer prevention and control;
- g) increase and optimize public financing with equity and efficiency for a sustainable response to cervical cancer, and progressively integrate prevention, screening, and treatment interventions into comprehensive, quality, and universal health services;
- h) expand health services according to need and with a people-centered approach, noting that in most cases public expenditure of 6% of GDP for the health sector is a useful benchmark;
- i) secure the uninterrupted supply of quality-assured and affordable HPV vaccines, screening tests, and evidence-based technologies for precancer and invasive cancer treatment, as well as palliative care medicines and other strategic commodities related to cervical cancer, while strengthening supply chain management structures and processes, including forecasting, procurement, warehousing, and distribution;
- j) strengthen the technical capacity and competencies of the national health workforce, particularly at the primary level of care, to address cervical cancer prevention.

(OP)3. To request the Director to:

- a) support implementation of this Plan of Action through a coordinated and interprogrammatic approach to technical cooperation for comprehensive cervical cancer prevention and control;
- b) provide technical support to Member States to strengthen cervical cancer program coverage, quality, and effectiveness in coordination with the Network of National Cancer Institutes and Institutions (RINC)/UNASUR cervical cancer prevention and control plan for South America;
- c) provide support for cancer registration and information systems in order to build country capacity to generate quality, complete, and up-to-date information, and regularly report on HPV vaccination coverage, screening coverage, treatment rates, and cervical cancer incidence and mortality;
- d) provide technical support to Member States for the development and review of policies, norms, and guidelines for high-impact interventions along the continuum of cervical cancer prevention, screening, and diagnosis and treatment of precancer and invasive cancer, based on the latest WHO recommendations, while seeking to ensure quality and equity;
- e) advocate for the empowerment of people and communities and their meaningful, effective, and sustainable engagement in the development and delivery of services for HPV vaccination and cervical cancer screening, treatment, and palliative care;
- f) support capacity-building in the national health workforce, particularly at the primary care level, to provide good quality, accessible, equitable, and people-centered care in the health services;
- g) provide support to Member States through the PAHO Regional Revolving Fund for Strategic Public Health Supplies or the PAHO Revolving Fund for Vaccine Procurement to improve the processes of procurement and supply management and distribution in order to ensure uninterrupted access to quality-assured and affordable HPV vaccines, HPV tests, and essential medicines for cancer and for palliative care in alignment with WHO prequalification;
- h) mobilize resources, adhering to the rules and procedures of the Framework for Engagement with non-State Actors, to support Member States to increase investments in comprehensive cervical cancer prevention and control.

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

1. Agenda item: 4.5 - Plan of Action for Cervical Cancer Prevention and Control 2018-2030

2. Linkage to PAHO [Program and Budget 2018-2019](#):

a) Categories:

Category 1- Communicable Diseases

Category 2- Noncommunicable Diseases and Risk Factors

Category 4- Health Systems

b) Program areas and outcomes:

Program area 1.1: HIV/AIDS, STIs, and viral hepatitis (Outcome 1.1 - Increased access to key interventions for HIV and STI prevention and treatment)

Program area 1.5: Vaccine-preventable Diseases (Outcome 1.5 - Increased vaccination coverage for hard-to-reach populations and communities and maintenance of control, eradication, and elimination of vaccine-preventable diseases)

Program area 2.1: Noncommunicable Diseases and Risk Factors (Outcome 2.1 – Increased access to interventions to prevent and manage NCDs)

Program area 4.2: People-centered, Integrated, Quality Health Services (Outcome 4.2 – Increased access to people-centered, integrated, quality health services)

3. 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\$ 3,000,000 per year. For the period 2018-2030, the total cost is US\$ 36,000,000.

Areas	Estimated cost (US\$)
Human resources	7,500,000
Training	10,500,000
Consultants/service contracts	5,500,000
Travel and meetings for program managers	5,000,000
Publications and communication materials	1,500,000
Supplies (e.g., HPV tests) and other expenses	6,000,000
Total	36,000,000

b) Estimated cost for the 2018-2019 biennium (including staff and activities):

The estimated cost for the biennium is US\$ 3,000,000.

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

Staff currently funded through the PAHO Regular Budget, who will contribute between 25% and 50% of their time to implementation of this plan, will already be subsumed under existing programmed activities. Technical cooperation activities already included and budgeted in this biennial period will also be covered by the PAHO Regular Budget, as well as the PAHO-CDC cooperative agreement on NCDs and the OPEC Fund for International Development grant for NCDs. It is estimated that the total staff time and activity budget already covered for this Plan of Action in the current biennium is approximately US\$ 750,000.

4. 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 implementation of this Plan, it will be crucial to guarantee current technical staff strength at regional and subregional levels, as well as to ensure that NMH country office focal points set aside sufficient time for this Plan of Action in high-impact and priority countries.

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

The proposed plan will cover the time period 2018-2030 and require support from the Pan American Sanitary Bureau, Member States, and partner organizations. A series of progress reports will be submitted to the PAHO Governing Bodies: the first in 2022, the second in 2026, and a final report in 2031.

ANALYTICAL FORM TO LINK AGENDA ITEM WITH ORGANIZATIONAL MANDATES

1. **Agenda item:** 4.5 - Plan of Action for Cervical Cancer Prevention and Control 2018-2030
2. **Responsible unit:** Noncommunicable Diseases and Mental Health, Violence, and Injury Prevention (NMH/NV)
3. **Preparing officer:** Silvana Luciani, Adviser, Cancer Prevention and Control, NMH/NV
4. **Link between Agenda item and [Sustainable Health Agenda for the Americas 2018-2030](#):**
Goal 9: Reduce morbidity, disabilities, and mortality from noncommunicable diseases, injuries, violence, and mental health disorders
5. **Link between Agenda item and the [Strategic Plan of the Pan American Health Organization 2014-2019 \(Amended\)](#):**
 - a) **Categories:**
 - Category 1 - Communicable Diseases
 - Category 2 - Noncommunicable Diseases and Mental Health
 - Category 4 - Health Systems
 - b) **Program areas and outcomes:**
 - Program area 1.1:* HIV/AIDS and STIs (Outcome 1.1 - Increased access to key interventions for HIV and STI prevention and treatment)
 - Program area 1.5:* Vaccine-preventable Diseases (Outcome 1.5 - Increased vaccination coverage for hard-to-reach populations and communities and maintenance of control, eradication, and elimination of vaccine-preventable diseases)
 - Program area 2.1:* Noncommunicable Diseases and Risk Factors (Outcome 2.1 – Increased access to interventions to prevent and manage NCDs)
 - Program area 4.2:* People-centered, Integrated, Quality Health Services (Outcome 4.2 – Increased access to people-centered, integrated, quality health services)
6. **List of collaborating centers and national institutions linked to this Agenda item:**
Key partners with whom we will collaborate on the implementation of this Plan include but are not limited to the following:
 - World Health Organization
 - United Nations Population Fund
 - International Atomic Energy Agency

- International Agency for Research on Cancer
- South American Network of Cancer Institutes (RINC/UNASUR)
- United States National Cancer Institute
- United States Centers for Disease Control and Prevention
- American Cancer Society
- Union for International Cancer Control
- Cervical Cancer Action

7. Best practices in this area and examples from countries within the Region of the Americas:

- a) National immunization programs, which have integrated HPV vaccines into their programs and are beginning to monitor coverage.
- b) HPV testing, which has been introduced in selected countries to complement or substitute Pap testing and improve the quality and effectiveness of screening programs.
- c) Information systems that permit the registration of women screened, their screening test results, and follow-up diagnosis and treatment in order to ensure complete quality of care.
- d) Education and communication campaigns that have been implemented at the local and subnational level to raise awareness about HPV vaccination and cervical cancer prevention.

8. Financial implications of this Agenda item:

The estimated cost of this plan is US\$ 3,000,000 per year. For the period 2018-2030, the total cost is US\$ 36,000,000.

- - -

