Accelerate progress towards the elimination of cervical cancer as a public health problem

Date: 15 September 2021
Time: 12:30 to 15:00 (IST)
No of participants: 293

This Webinar was organized by MCA Unit of WHO SEARO in collaboration with IVD, WHO headquarters.

The participants included WCO focal points, regional and HQ staff from MCA, IVD and all relevant external stakeholders.

Objectives:

- To advocate the global strategy to eliminate cervical cancer as a PH problem.
- Disseminate the WHO screening guideline and other related guidelines
- To update the knowledge on current global guidelines on elimination process Member states and all relevant stakeholders.

Agenda:

1. Dr. Neena Raina SA/MCA welcomed the participants and shared the objectives of the webinar. She highlighted that the SEARO gives high importance to the Cervical cancer prevention and it focuses under regional director’s flagship priority of prevention of NCDs focusing on the best buys for disease prevention. She mentioned about the launch of the global strategy on the elimination of Cervical Cancer as a public health problem, aiming to achieve an age standardized incidence rate of less than 4 /100,000 population. She informed about 100 participants being trained on Colposcopy from SEAR despite the pandemic.

2. Dr Anoma Jayathilaka, Medical Officer, Maternal and Reproductive Health talked about the “Current status of cervical cancer elimination in WHO SEARWHO SEAR”. She shared that no country of the SEAR is below the global elimination target of 4 cases/100,000 population. Most of the countries are having opportunistic screening with either VIA or Pap smear with only Thailand doing screening by HPV DNA test. The country-specific context is crucial for diagnosis and treatment services based on existing capacities and each country should develop solutions based on individual context for
strengthening of referral pathways, especially for potentially curable cervical cancers; and for researching and understanding barriers to care (patient and health-care system perspective). She mentioned that Cancer cervix is given a high priority by WHO TAG and have given various recommendations for the elimination of the disease. The key is implementation at scale rather than at incremental approaches.

3. Dr. Cherian V. Varghese Crosscutting lead, WHO HQ talked about “Overview of Global strategy to accelerate the elimination of cervical cancer as a public health problem”. He said that regarding cervical cancer screening, there is inequality at every level globally and within country and if this is addressed, we will be addressing the issue of inequality and gender imbalance. He also talked about the architecture to eliminate cervical cancer with 2030 control targets of 90-70-90. He said that elimination is different from eradication in which we eliminate Cancer cervix as a public health problem. For this we need to achieve a priorly set threshold which is 4/100,000 which might take few decades but some interim milestone targets are needed which is 90-70-90. He shared the link of WHO cceirepository. WHO recommends monitoring the following key indicators: Performance indicators, Result indicator, Impact indicators. To Increase Access to S&T We Need to Move Toward High Performance Test. Coverage, quality and outcomes are important. Elimination is feasible. Status quo is not an option. Now is the time to act.

4. Dr. Emanuel Tondo Opute Technical Officer, Immunization and Vaccine Development, WHO SEARO talked about “Current status of HPV vaccination and future plans for achieving 90 % coverage in 2030 in SEA region”. He talked about overview of global HPV vaccination coverage, HPV vaccine introduction status in SEA region, HPV vaccination strategies and coverages at regional and country levels, the challenges and the opportunity and also about the plans of scale up. He mentioned that global HPV vaccination coverage for 2020 was affected by COVID 19 pandemic and only 13% of girls are fully protected. Bhutan attained >90 % coverage since 2017 for HPV1 and HPV 2. Myanmar reached 90% HPV1 at introduction in 2020 which was done during the pandemic. The challenges for HPV vaccination include high cost of vaccine, supply shortage, resources available for implementation, COVID 19 response activity (delayed introduction, application development and challenges in using school-based delivery platforms) etc. GAVI support the new HPV vaccine with relatively lower price expected soon is being seen as a good opportunity for HPV vaccination coverage.
5. Dr Nathalie Broutet, Medical Officer, Reproductive Health and Research, WHO HQ talked about “WHO screening & treatment Recommendations to prevent Cervical Cancer”. She mentioned about strategies suggested by WHO for cervical cancer prevention that include screen and treat OR screen, triage and treat FOR GENERAL POPULATION OF WOMEN and screen, triage and treat ONLY FOR WOMEN LIVING WITH HIV. Once a decision to treat a woman is made, it is good practice to Treat as soon as possible within six months to reduce the risk of loss to follow-up. The age priority for general population of women is 30 to 49 yrs and 25 to 49 yrs for women living with HIV. She concluded that for general population HPV WITH OR WITHOUT triage was recommended over VIA or cytology.

6. Algorithms for screen and treat strategies was shared by Dr Neerja Bhatla, Professor & Head, Department of Obstetrics & Gynaecology, All India Institute of Medical Sciences. For VIA testing strategy, in case the women have tested negative they are rescreened in 3 years with VIA test. For women who have tested positive and are eligible for ablation try and treat them the same day with ablative treatment else they should be sent for the LLETZ procedure. For HPV DNA testing the women who test negative can be sent for rescreening in 5 to 10 years later with HPV DNA test. As for the women who test positive and are eligible for ablation should be sent for ablative treatment and if not they can go for LLETZ. She also talked about the algorithms for primary HPV DNA screening and VIA triage, Colposcopy triage, and cytology triage followed by Colposcopy. Further she talked about follow up tests at 12 months post treatment for the general population. If negative rescreening at 5 years and if positive then treatment with LLETZ is recommended.

7. Dr Elena Fidarova, Technical Officer, Non-Communicable Diseases, WHO HQ talked about the “Management of invasive cervical cancer.” She mentioned about the cost-effective interventions which could be further classified on the basis of cost effectiveness analysis. For CEA<=1$100 per DALY averted in LMICs includes vaccination against HPV of 9 to 13 yrs of girls and prevention of cervical cancer by screening women aged 30 to 49 yrs. For CEA>1$100 per DALY averted in LMICs includes screening with mammography once every 2 yrs for women aged 50 to 69 yrs linked with timely diagnosis and treatment of breast cancer, treatment of cervical, breast, colorectal cancer stages I and II with surgery +/- chemotherapy and
radiotherapy. She further mentioned the cervical cancer care pathway that includes: early detection followed by diagnosis and staging followed by treatment and care.

8. “Capacity building for cervical cancer prevention” was discussed by Dr. Groesbeck Parham, Co-Chair, DG Expert Group on Cervical Cancer Elimination from university of Zambia. Clarification of the objective, performing situational assessment and building and improving system is needed for capacity building. System should operate in the way the disease presents in one’s society. Myths & misconception in the society need to be understood. Strength & weakness of healthcare systems needs to be understood.

A short video on Elimination of Cervical Cancer which gave message on importance of cervical cancer vaccination & screening was played before concluding the webinar.

Questions from the audience were answered by the respective faculties.

Dr. Neena Riana extended a vote of thanks to all presenters and WCOs, HQ and SEARO colleagues and the audience.