

# Framework for Monitoring the Implementation of the WHO Global Strategy to Accelerate the Elimination of Cervical Cancer as a Public Health Problem

Including indicator metadata



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## INTRODUCTION:

Cervical cancer is preventable and curable, as long as it is detected early and managed effectively. Yet it is the fourth most common form of cancer among women worldwide, with the disease claiming the lives of more than 300 000 women in 2018. Few diseases reflect global inequities as much as cancer of the cervix. Nearly 90% of the deaths in 2018 occurred in low-and middle-income countries. This is where the burden of cervical cancer is greatest, because access to public health services is limited and screening and treatment for the disease have not been widely implemented.

In August 2020 the World Health Assembly adopted the Global Strategy for Cervical Cancer Elimination. The Strategy is ambitious, concerted and inclusive and

has been developed to guide the elimination of cervical cancer as a public health problem. The strategy outlines a comprehensive approach that includes prevention, effective screening and treatment of pre-cancerous lesions, early cancer diagnosis and programmes for the management of invasive cervical cancer.

This Global Strategy for Elimination of Cervical Cancer proposes the following:

- a vision of a world where cervical cancer is eliminated as a public health problem;
- a threshold of 4 per 100 000 women-years for elimination as a public health problem;
- three targets that must be met by 2030 for countries to be on the path towards cervical cancer elimination

## GLOBAL TARGETS FOR CERVICAL CANCER ELIMINATION:

To eliminate cervical cancer, all countries must reach and maintain an incidence rate of below four per 100.000 women. Achieving that goal rests on three key pillars and their corresponding targets:

- Vaccination: 90% of girls fully vaccinated with the HPV vaccine by the age of 15;
- Screening: 70% of women screened using a

high-performance test by the age of 35, and again by the age of 45;

- Treatment: 90% of women with pre-cancer treated and 90% of women with invasive cancer managed.

Each country should meet the 90-70-90 targets by 2030 to get on the path to eliminate cervical cancer within the next century.

**90%**

of girls fully vaccinated with HPV vaccine by 15 years of age.

**70%**

of women are screened using a high-performance test by 35 and again by 45 years of age.

**90%**

of women identified with cervical disease receive treatment (90% of women with precancer treated, and 90% of women with invasive cancer managed).

# FRAMEWORK FOR MONITORING THE IMPLEMENTATION OF CERVICAL CANCER ELIMINATION STRATEGY:

The Framework for Monitoring the Cervical Cancer Elimination Strategy presented in this document reflects the key domains of the strategy. The pillars include primary prevention with a focus on HPV vaccination and health promotion; secondary prevention with a focus on cervical cancer screening and pre-cancer treatment; and tertiary prevention with a focus on treatment and supportive care for those with cervical cancer. The Framework highlights specific indicators related to these domains and identifies the most important indicators in these areas to help track progress and achievement and to drive programmatic improvements and adjustments.

Actions to eliminate cervical cancer cannot proceed without a robust framework and tools to assess and evaluate progress. It is fundamental that robust surveillance and monitoring systems are developed and implemented within countries at the national or subnational level, both to determine the baseline

and to monitor and evaluate the impact of the broad interventions and activities implemented as part of the cervical cancer elimination strategy.

Monitoring implementation of the elimination strategy requires close assessment of the quality and coverage of the different preventive interventions. Vaccination coverage, screening coverage, quality of screening and diagnostic services, and the extent of timely and effective treatment modalities will help to monitor the effectiveness of programmes in achieving a reduction in the disease burden and will also enable programme managers to identify gaps and take specific actions to improve coverage, quality and outcomes.

Information systems need to span primary through to tertiary prevention measures, requiring the recording and tracking of data on individual women across multiple touchpoints in the continuum of care.

Figure 1:

	Primary prevention	Secondary prevention	Tertiary prevention
<b>2030 targets</b>	<b>HPV vaccination and health promotion</b> <b>90%</b> of girls fully vaccinated with HPV vaccine by 15 years of age	<b>Screening and pre-cancer treatment</b> <b>70%</b> of women screened using a high-performance test by 35 and again by 45 years of age	<b>Treatment and supportive care</b> <b>90%</b> of women identified with a cervical disease are treated (90% of women with precancer treated and 90% of women with invasive cancer managed)
<b>Population-based data</b>	<ul style="list-style-type: none"> <li>HPV prevalence</li> <li>HIV prevalence</li> <li>Tobacco use prevalence</li> <li>Condom use at last high-risk sex prevalence</li> </ul>	<ul style="list-style-type: none"> <li>Screening coverage, including with a high-performance test</li> <li>Cervical pre-cancer incidence</li> </ul>	<ul style="list-style-type: none"> <li>Cervical cancer survival</li> <li>Cervical cancer mortality-to-incidence ratio</li> </ul>
<b>Programme monitoring</b>	<ul style="list-style-type: none"> <li>HPV vaccination coverage</li> </ul>	<ul style="list-style-type: none"> <li>Screening test positivity rate*</li> <li>Cervical pre-cancer treatment coverage*</li> <li>Ablative and excision treatment rate</li> </ul>	<ul style="list-style-type: none"> <li>Guideline-based management of women with cervical disease</li> <li>Stage at diagnosis</li> <li>Invasive cervical cancer treatment coverage*</li> <li>Palliative care</li> </ul>
<b>Policies/ Programmes and health system capacity</b>	<ul style="list-style-type: none"> <li>HPV vaccine in National Immunization Programme</li> <li>HPV vaccine supply and availability</li> <li>HPV vaccine cost</li> </ul>	<ul style="list-style-type: none"> <li>Availability of national cervical cancer screening program</li> <li>Availability of pre-cancer treatment</li> <li>HPV test availability in PHC</li> </ul>	<ul style="list-style-type: none"> <li>Availability of guidelines for the management of women with cervical disease, including high-risk groups</li> <li>Availability of treatment – pathology/ surgery/ chemotherapy/radiotherapy</li> <li>Availability of specialized medical staff</li> <li>Availability of palliative care medications</li> </ul>
<b>Cross cutting Incidence and mortality</b>	<b>Cumulative risk of cervical cancer</b>	<b>Cervical cancer incidence</b>	<b>Cervical cancer mortality</b>
			<b>Premature mortality from cervical cancer</b>

\*Stratify by HPV status

## SETTING NATIONAL TARGETS:

Countries are strongly encouraged to consider adopting the three global targets as national targets. Setting targets is a way to draw attention to cervical cancer and help mobilize resources to address cervical cancer. National targets may need to be adapted from the global targets if a country has already achieved a target or if the global target is too low given the progress already achieved within the country.

As a starting point, Member States interested in adopting or adapting national cervical cancer elimination targets are encouraged to consider the following:

- Are the targets and indicators included in the Framework all suitable in the national context?
- Are there additional targets and indicators needed for the country?
- Are the systems in place to track these indicators and report on the three targets? And systems which track any new proposed ones?
- What are the current levels of vaccination, screening, incidence, mortality, service provision?

## TRACKING AND REPORTING ON THE GLOBAL CERVICAL CANCER ELIMINATION TARGETS:

WHO is mandated to prepare regular updates on the progress towards achieving the three global cervical cancer elimination targets. WHO will report on progress in implementation of the efforts to eliminate cervical cancer in 2022 and 2025 and will submit a final report in 2030 with lessons learned, best practices and recommendations for further acceleration towards elimination of cervical cancer as a public health problem.

In addition, WHO will generate and publish periodic cervical cancer country profiles to support monitoring of key targets and indicators aligned to the global strategy and showcase the extent of implementation of key cervical cancer policies and strategies. The profiles provide a snapshot of a country's status of their national cervical cancer control plans. The profiles will be aligned with the key indicators within the Framework, reflecting the specific indicators and priorities outlined in the Global Strategy for Elimination of Cervical Cancer. The country profiles will be based on available data, drawn from multiple sources on cervical cancer mortality, incidence, HPV vaccine coverage,

and other country actions to prevent and control cervical cancer, aligned with the strategies outlined in the global strategy.

To enable reporting on these targets and indicators, and generation of regular country profiles, Member States are encouraged to share data with WHO on a regular basis to enable analysis of the global status of these three targets and associated indicators. For ease of data submission, WHO has prepared a template for reporting against these indicators. This template is available upon request from WHO by contacting: [ncdmonitoring@who.int](mailto:ncdmonitoring@who.int).

It is important to note that WHO will continue to produce figures for each country that are comparable across all Member States. While these comparable figures will be based on the data submitted by Member States, they will also take into consideration differences across countries in data availability, data type, population structure and other data characteristics that reduce comparability across countries. Thus, the figures produced by WHO may differ from those reported by each individual Member State.

## INDICATOR METADATA:

For each indicator included in the Framework, the following guidance provides a complete definition, provides a detailed method of calculation, identifies

appropriate data sources, outlines expected frequency of data collection, any data limitations, and provides links to further information.

# HUMAN PAPILLOMAVIRUS (HPV) PREVALENCE

<b>Abbreviated name</b>	HPV prevalence
<b>Indicator name</b>	Prevalence of HPV infection in women
<b>Domain</b>	Primary prevention
<b>Subdomain</b>	HPV vaccination
<b>Definition</b>	Proportion of women infected by the HPV according to an HPV DNA test at a specific time point
<b>Numerator</b>	Number of women infected by PV according to an HPV test at a specific time point
<b>Denominator</b>	Total number of women
<b>Method of estimation/ Calculation</b>	Numerator/denominator x 100
<b>Data type</b>	Percent
<b>Disaggregation</b>	Age, HIV status, other socioeconomic status, residence type (rural/urban), surveillance site
<b>Preferred data sources</b>	Sentinel site surveillance, special studies
<b>Other data sources</b>	
<b>Frequency of data collection</b>	Ad hoc (routine surveillance is not recommended)
<b>Limitations</b>	Potential limitations include: <ul style="list-style-type: none"><li>• bias due to limitations of HPV DNA detection techniques</li><li>• representativeness of sentinel sites</li></ul>
<b>Related links</b>	<a href="https://www.who.int/immunization/monitoring_surveillance/burden/vpd/WHO_SurveillanceVaccinePreventable_08_HumanPapillomavirus_R1.pdf">https://www.who.int/immunization/monitoring_surveillance/burden/vpd/WHO_SurveillanceVaccinePreventable_08_HumanPapillomavirus_R1.pdf</a> <a href="https://hpvcentre.net/link_media/methodologies.pdf">https://hpvcentre.net/link_media/methodologies.pdf</a>

# HUMAN IMMUNODEFICIENCY VIRUS (HIV) INCIDENCE

<b>Abbreviated name</b>	HIV incidence
<b>Indicator name</b>	IV incidence per 1000 women
<b>Domain</b>	Primary prevention
<b>Subdomain</b>	Health promotion
<b>Definition</b>	Number of new HIV infections per 1000 uninfected women aged 15+ years. The incidence rate is the number of new cases per women at risk in a given time period
<b>Numerator</b>	Number of new HIV infections in women aged 15+ years.
<b>Denominator</b>	Uninfected women aged 15+ years (which is the total number of women aged 15+ years minus women living with HIV)
<b>Method of estimation/ Calculation</b>	Numerator/denominator x 1,000 Longitudinal data on uninfected individuals are the best source of data but are rarely available for large populations. Special diagnostic tests in population-based surveys or from health facilities can be used to obtain data on HIV incidence but results must be nationally-representative and adjusted for performance of the diagnostic tests. Most countries will rely on modelled estimates using Spectrum, a UNAIDS-supported software tool. To calculate the uninfected population per 1000, the estimate of the number of people living with HIV is subtracted from the previous year's population estimates produced by the United Nations Population Division.
<b>Data type</b>	Count and rate
<b>Disaggregation</b>	Age, HPV status, residence type (rural/urban), other socioeconomic status, sites
<b>Preferred data sources</b>	National population-based survey or key population survey with HIV incidence-testing, Spectrum modelling
<b>Other data sources</b>	Regular surveillance system among key populations
<b>Frequency of data collection</b>	Annual
<b>Limitations</b>	Potential limitations include: <ul style="list-style-type: none"><li>▪ bias using sero-surveillance data from studies among key populations/stigmatized populations</li><li>▪ representativeness of the sample /sentinel sites</li></ul>
<b>Related links</b>	<a href="https://www.who.int/data/gho/data/indicators/indicator-details/GHO/prevalence-of-hiv-among-adults-aged-15-to-49-(-)">https://www.who.int/data/gho/data/indicators/indicator-details/GHO/prevalence-of-hiv-among-adults-aged-15-to-49-(-)</a> <a href="https://www.who.int/teams/global-hiv-hepatitis-and-stis-programmes/data-use/hiv-data-and-statistics">https://www.who.int/teams/global-hiv-hepatitis-and-stis-programmes/data-use/hiv-data-and-statistics</a> <a href="https://www.who.int/publications/i/item/9789240000735">https://www.who.int/publications/i/item/9789240000735</a>

# TOBACCO USE PREVALENCE

<b>Abbreviated name</b>	Tobacco use prevalence
<b>Indicator name</b>	Age-standardized prevalence of current tobacco use among adult women
<b>Domain</b>	Primary prevention
<b>Subdomain</b>	Health promotion
<b>Definition</b>	<p>Age-standardized prevalence of current tobacco use among women aged 15+ years.</p> <ul style="list-style-type: none"><li>▪ Smoked tobacco products includes the consumption of cigarettes, bidis, cigars, cheroots, pipes, shisha (water pipes), fine-cut smoking articles (roll-your-own), krekets, and any other form of smoked tobacco.</li><li>▪ Smokeless tobacco includes moist snuff, plug, creamy snuff, dissolvables, dry snuff, gul, loose leaf, red tooth powder, snus, chimo, gutkha, khaini, gudakhu, zarda, quiwam, dohra, tuibur, nasway, naas/naswar, shammah, betel quid, toombak, pan (betel quid), iq'mik, mi-shri, tapkeer, tombol and any other tobacco product that is sniffed, held in the mouth, or chewed.</li></ul>
<b>Numerator</b>	Number of women aged 15+ years currently using any tobacco product (smoked or smokeless)
<b>Denominator</b>	All women in the survey aged 15+ years.
<b>Method of estimation/ Calculation</b>	Numerator/denominator x 100
<b>Data type</b>	Percent
<b>Disaggregation</b>	Age, residence type (rural/urban), other socioeconomic status
<b>Preferred data sources</b>	Population-based (preferably nationally representative) survey
<b>Other data sources</b>	
<b>Frequency of data collection</b>	At least every 5 years
<b>Limitations</b>	<p>Potential limitations include:</p> <ul style="list-style-type: none"><li>▪ bias through self-report, including under-reporting of tobacco use</li><li>▪ misunderstanding/ misinterpretation of questions</li><li>▪ limited validity of survey instruments</li><li>▪ representativeness of the sample</li></ul>
<b>Related links</b>	<p><a href="https://www.who.int/teams/noncommunicable-diseases/surveillance/systems-tools/global-adult-tobacco-survey">https://www.who.int/teams/noncommunicable-diseases/surveillance/systems-tools/global-adult-tobacco-survey</a> <a href="https://www.who.int/teams/noncommunicable-diseases/surveillance/systems-tools/steps">https://www.who.int/teams/noncommunicable-diseases/surveillance/systems-tools/steps</a></p>

# CONDOM USE AT LAST HIGH-RISK SEX PREVALENCE

<b>Abbreviated name</b>	Condom use at last high-risk sex prevalence
<b>Indicator name</b>	Prevalence of condom use at last high-risk sex among people aged 15-49 years
<b>Domain</b>	Primary prevention
<b>Subdomain</b>	Health promotion
<b>Definition</b>	Proportion of people aged 15-49 years who reported using a condom the last time they had sex with a non-marital, non-cohabiting partner, among those who have had sex with such a partner in the last 12 months
<b>Numerator</b>	Number of respondents aged 15-49 years who reported using a condom the last time they had sex with a non-marital, non-cohabiting partner
<b>Denominator</b>	Number of respondents aged 15-49 years who reported they had sex with a non-marital, non-cohabiting partner in the last 12 months
<b>Method of estimation/ Calculation</b>	Numerator/denominator x 100 Respondents' sexual histories are obtained. Analysis of sexual history is used to determine whether the respondent had sex with a non-marital, non-cohabiting partner in the past 12 months and, if so, whether the respondent used a condom the last time the respondent had sexual intercourse with such a partner
<b>Data type</b>	Percent
<b>Disaggregation</b>	Age, HIV status, residence type (rural/urban), other socioeconomic status
<b>Preferred data sources</b>	Population-based (preferably nationally representative) survey
<b>Other data sources</b>	
<b>Frequency of data collection</b>	At least every 5 years
<b>Limitations</b>	Potential limitations include: <ul style="list-style-type: none"><li>▪ bias through self-report</li><li>▪ misunderstanding/ misinterpretation of questions</li><li>▪ limited validity of survey instruments</li><li>▪ representativeness of the sample</li></ul>
<b>Related links</b>	<a href="https://indicatorregistry.unaids.org/indicator/condom-use-last-high-risk-sex">https://indicatorregistry.unaids.org/indicator/condom-use-last-high-risk-sex</a>

# HPV VACCINATION COVERAGE

<b>Abbreviated name</b>	HPV vaccination coverage
<b>Indicator name</b>	HPV vaccination coverage among girls before age 15 years
<b>Domain</b>	Primary prevention
<b>Subdomain</b>	HPV vaccination
<b>Definition</b>	Proportion of girls that started vaccination before age 15 years and received first or final dose of HPV vaccine in the current reporting year
<b>Numerator</b>	Number of girls that started vaccination before age 15 years and received first or final dose of HPV vaccine in the current reporting year
<b>Denominator</b>	Number of girls in the national target cohort(s) (below age 15 years) in the current reporting year
<b>Method of estimation/ Calculation</b>	Numerator/denominator x 100
<b>Data type</b>	Percent
<b>Disaggregation</b>	Age, number of dose, residence type (rural/urban), other socioeconomic status
<b>Preferred data sources</b>	Immunization registries, vaccine monitoring system, surveys, Population census data
<b>Other data sources</b>	UN Population Division population annual estimated and forecasted populations
<b>Frequency of data collection</b>	Annual
<b>Limitations</b>	Potential limitations include: <ul style="list-style-type: none"><li>▪ correctness of reporting of doses and age</li><li>▪ correct definition and quality of the denominator data</li></ul>
<b>Related links</b>	<a href="https://apps.who.int/iris/bitstream/handle/10665/331807/9789240002746-eng.pdf">https://apps.who.int/iris/bitstream/handle/10665/331807/9789240002746-eng.pdf</a> <a href="https://www.who.int/immunization/hpv/monitor/en/">https://www.who.int/immunization/hpv/monitor/en/</a> <a href="http://esa.un.org/wpp/Excel-Data/Interpolated.htm">http://esa.un.org/wpp/Excel-Data/Interpolated.htm</a>

# HPV VACCINE IN NATIONAL IMMUNIZATION PROGRAMME

<b>Abbreviated name</b>	HPV vaccine in National Immunization Programme
<b>Indicator name</b>	Vaccine against HPV included in the national immunization programme
<b>Domain</b>	Primary prevention
<b>Subdomain</b>	HPV vaccination
<b>Definition</b>	HPV vaccine included in National Immunization Programme, either sub-nationally or in the whole country, to females or both sexes.
<b>Numerator</b>	Not applicable
<b>Denominator</b>	Not applicable
<b>Method of estimation/ Calculation</b>	Country can report introduction status of HPV vaccine in the national immunization programme in the WHO-UNICEF Joint Reporting Form on Immunization
<b>Data type</b>	Categorical
<b>Disaggregation</b>	
<b>Preferred data sources</b>	WHO-UNICEF Joint Reporting Form on Immunization
<b>Other data sources</b>	
<b>Frequency of data collection</b>	Annual
<b>Limitations</b>	Potential limitation include: <ul style="list-style-type: none"><li>on data misinterpretation, introduction of the vaccine in national immunization schedule does not imply that children are vaccinated</li></ul>
<b>Related links</b>	<a href="https://immunizationdata.who.int/pages/vaccine-intro-by-antigen/hpv.html?ISO_3_CODE=&amp;YEAR=">https://immunizationdata.who.int/pages/vaccine-intro-by-antigen/hpv.html?ISO_3_CODE=&amp;YEAR=</a>

# HPV VACCINE AVAILABILITY

<b>Abbreviated name</b>	HPV vaccine availability
<b>Indicator name</b>	HPV vaccine availability
<b>Domain</b>	Primary prevention
<b>Subdomain</b>	HPV vaccination
<b>Definition</b>	Country has not experienced a stock-out of HPV vaccine in the reporting year
<b>Numerator</b>	Not applicable
<b>Denominator</b>	Not applicable
<b>Method of estimation/ Calculation</b>	Country can report not having a stock-out of HPV vaccine at national level in the reporting year. Having at least one event in the reporting year where the stock-levels of the vaccine at the national level reached zero (including the recommended 3-month buffer stock)
<b>Data type</b>	Categorical
<b>Disaggregation</b>	Age, HIV status, other socioeconomic status, residence type (rural/urban), surveillance site
<b>Preferred data sources</b>	Routine facility reporting system or routine services data reported annually through the WHO/UNICEF Joint Reporting Form on Immunization
<b>Other data sources</b>	
<b>Frequency of data collection</b>	Annual
<b>Limitations</b>	Potential limitations include: <ul style="list-style-type: none"><li>▪ bias through self-report</li><li>▪ misunderstanding / misinterpretation of questions</li><li>▪ representativeness of routine services data</li></ul>
<b>Related links</b>	<a href="https://immunizationdata.who.int/pages/indicators-by-category/vaccine_supply.html?ISO_3_CODE=&amp;YEAR=">https://immunizationdata.who.int/pages/indicators-by-category/vaccine_supply.html?ISO_3_CODE=&amp;YEAR=</a>

# HPV VACCINE COST

<b>Abbreviated name</b>	HPV vaccine cost
<b>Indicator name</b>	Cost of HPV vaccine to country
<b>Domain</b>	Primary prevention
<b>Subdomain</b>	HPV vaccination
<b>Definition</b>	Cost of HPV vaccine to country
<b>Numerator</b>	Not applicable
<b>Denominator</b>	Not applicable
<b>Method of estimation/ Calculation</b>	Reported vaccine price per dose for HPV vaccine in countries that have included HPV in the national immunization schedule
<b>Data type</b>	Money
<b>Disaggregation</b>	
<b>Preferred data sources</b>	WHO-UNICEF Joint Reporting Form on Immunization
<b>Other data sources</b>	PAHO Revolving Fund, GAVI
<b>Frequency of data collection</b>	Annual
<b>Limitations</b>	Vaccine price data may not change on an annual basis and can be linked to duration of procurement contacts. Vaccine price data are market sensitive data and may therefore not in all cases be freely shared. At the global level data is reported anonymously, either through aggregation or with country code reflecting World Bank income level of respective country
<b>Related links</b>	<a href="https://www.who.int/teams/immunization-vaccines-and-biologicals/vaccine-access/mi4a/mi4a-vaccine-purchase-data">https://www.who.int/teams/immunization-vaccines-and-biologicals/vaccine-access/mi4a/mi4a-vaccine-purchase-data</a> <a href="https://www.who.int/immunization/programmes_systems/procurement/mi4a/platform/module1/MI4A_Public_Database.xlsx?ua=1">https://www.who.int/immunization/programmes_systems/procurement/mi4a/platform/module1/MI4A_Public_Database.xlsx?ua=1</a>

# CERVICAL CANCER SCREENING COVERAGE

<b>Abbreviated name</b>	Cervical cancer screening coverage
<b>Indicator name</b>	Cervical cancer screening coverage among women aged 30-49 years (or for lower or higher age groups according to national programmes)
<b>Domain</b>	Secondary prevention
<b>Subdomain</b>	Screening
<b>Definition</b>	Proportion of women aged 30–49 years who have been screened at least once with a cervical cancer screening test
<b>Numerator</b>	Number of women aged 30–49 years who have been screened with a cervical cancer screening test at least once between the ages of 30 and 49 years, using any of these methods: Visual Inspection with Acetic Acid/vinegar (VIA), pap smear and Human Papillomavirus (HPV) test
<b>Denominator</b>	Total number of women aged 30–49 years in the population
<b>Method of estimation/ Calculation</b>	Numerator/denominator x100 IF HIV positive, use the target age group 25-49 Respondents are asked "Has a health-care worker ever tested you for cervical cancer?"
<b>Data type</b>	Percent
<b>Disaggregation</b>	Age, HIV status, screening method, residence type (rural/urban), other socioeconomic status
<b>Preferred data sources</b>	Cervical cancer service delivery data (including any screening registry) and population-based surveys
<b>Other data sources</b>	
<b>Frequency of data collection</b>	Annual
<b>Limitations</b>	Potential limitations include: <ul style="list-style-type: none"><li>• bias through self-report from surveys</li><li>• misunderstanding/ misinterpretation of questions</li><li>• limited validity of survey instruments</li><li>• representativeness of the sample</li><li>• quality and representativeness of facility-based data</li><li>• correct definition and quality of the denominator data</li></ul>
<b>Related links</b>	<a href="https://www.who.int/publications/i/item/9789241514255">https://www.who.int/publications/i/item/9789241514255</a>

# CERVICAL CANCER SCREENING COVERAGE WITH A HIGH PERFORMANCE TEST

<b>Abbreviated name</b>	Cervical cancer screening coverage
<b>Indicator name</b>	Cervical cancer screening coverage among women aged 30-49 years (or for lower or higher age groups according to national programmes or policies) using a high-performance test
<b>Domain</b>	Secondary prevention
<b>Subdomain</b>	Screening
<b>Definition</b>	Proportion of women aged 30–49 years who been screened for cervical cancer with a high-performance test (a test which would have performance characteristics similar to or better than a HPV DNA test) at least once between the ages of 30 and 49 years.
<b>Numerator</b>	Number of women aged 30-49 years screened using a high-performance test
<b>Denominator</b>	Total number of women aged 30–49 years
<b>Method of estimation/ Calculation</b>	Numerator/denominator x100 If respondents are HIV positive, use the target age group 25-49 Respondents are asked "Has a health-care worker ever tested you for cervical cancer?"
<b>Data type</b>	Percent
<b>Disaggregation</b>	Age, HIV status, screening method, residence type (rural/urban), other socioeconomic status
<b>Preferred data sources</b>	Cervical cancer service delivery data (including any screening registry) and population-based surveys
<b>Other data sources</b>	
<b>Frequency of data collection</b>	Annual
<b>Limitations</b>	Potential limitations include: <ul style="list-style-type: none"><li>• quality and representativeness of facility-based data</li><li>• bias through self-report</li><li>• misunderstanding/ misinterpretation of questions</li><li>• limited validity of survey instruments</li><li>• representativeness of the sample- correct definition and quality of the denominator data</li></ul>
<b>Related links</b>	<a href="https://www.who.int/publications/i/item/9789241514255">https://www.who.int/publications/i/item/9789241514255</a>

# CERVICAL PRE-CANCER INCIDENCE

<b>Abbreviated name</b>	Cervical pre-cancer incidence
<b>Indicator name</b>	Incidence/incident case (numbers and rates) of new cervical high-grade squamous intraepithelial lesions grade 2/3 (CIN II/III)
<b>Domain</b>	Secondary prevention
<b>Subdomain</b>	Screening
<b>Definition</b>	Recorded numbers and rates (age-specific, crude, age-standardized) of new cervical high-grade squamous intraepithelial lesions grade 2/3 (CIN II/III) in a defined geographic area and specified period
<b>Numerator</b>	Recorded numbers of new high-grade squamous intraepithelial lesions grade 2/3 (CIN II/III) include the following morphology and behavior codes (International Classification of Diseases for Oncology 3rd edition): 8077/2; 8070/2
<b>Denominator</b>	Population-at-risk: women in corresponding geographic area and specified period
<b>Method of estimation/ Calculation</b>	Numerator/denominator x 100,000 Rates need to be age-standardized.
<b>Data type</b>	Count and rate
<b>Disaggregation</b>	Age, HIV status, residence type (rural/urban), other socioeconomic status
<b>Preferred data sources</b>	Population-based cancer registries, official population statistics from census
<b>Other data sources</b>	
<b>Frequency of data collection</b>	Annual
<b>Limitations</b>	Possible limitations include: <ul style="list-style-type: none"><li>• quality and representativeness of cancer screening registry</li><li>• correct definition and quality of the denominator data</li></ul>
<b>Related links</b>	<a href="https://apps.who.int/iris/handle/10665/42344">https://apps.who.int/iris/handle/10665/42344</a> <a href="https://www.who.int/standards/classifications/other-classifications/international-classification-of-diseases-for-oncology">https://www.who.int/standards/classifications/other-classifications/international-classification-of-diseases-for-oncology</a>

# CERVICAL CANCER SCREENING TEST POSITIVITY RATE

<b>Abbreviated name</b>	Screening test positivity rate
<b>Indicator name</b>	Cervical cancer screening test positive rate among women aged 30-49 years (or for lower or higher age groups according to national programmes or policies)
<b>Domain</b>	Secondary prevention
<b>Subdomain</b>	Screening
<b>Definition</b>	Proportion of screened women aged 30–49 years with a positive screening result in the previous 12-month period
<b>Numerator</b>	Number of screened women aged 30-49 years with a positive screening result in the previous 12-month period using any of these methods: Visual Inspection with Acetic Acid/vinegar (VIA), pap smear and Human Papillomavirus (HPV) test.
<b>Denominator</b>	Number of women aged 30-49 years screened in the previous 12-month period
<b>Method of estimation/ Calculation</b>	Numerator/denominator x 100
<b>Data type</b>	Rate
<b>Disaggregation</b>	Age, HPV status, HIV status, screening method, residence type (rural/urban) other socioeconomic status
<b>Preferred data sources</b>	Cervical cancer service delivery data (screening facility)
<b>Other data sources</b>	Cervical cancer service delivery data (including any screening registry) and population-based surveys
<b>Frequency of data collection</b>	Annual
<b>Limitations</b>	Potential limitations include: <ul style="list-style-type: none"><li>• quality and representativeness of cancer screening registry</li><li>• quality and representativeness of facility-based data</li></ul>
<b>Related links</b>	<a href="https://www.who.int/publications/i/item/9789241514255">https://www.who.int/publications/i/item/9789241514255</a>

# CERVICAL PRE-CANCER TREATMENT RATE

<b>Abbreviated name</b>	Cervical pre-cancer treatment rate
<b>Indicator name</b>	Cervical pre-cancer treatment rate
<b>Domain</b>	Secondary prevention
<b>Subdomain</b>	Pre-cancer treatment
<b>Definition</b>	Proportion of screen-positive women with lesions eligible for ablative or excision treatment who received that treatment in the previous 12-month period. Treatment options include thermal ablation, cryotherapy and excision treatment including Large Loop Excision of the Transformation Zone therapy
<b>Numerator</b>	Number of screen-positive women with lesions eligible for ablative or excision treatment who received that treatment in the previous 12-month period
<b>Denominator</b>	Number of screen-positive women with lesions eligible for ablative or excision treatment in the previous 12-month period
<b>Method of estimation/ Calculation</b>	Numerator/denominator x 100 For strategies where the decision to treat is determined by triage examination, only women who tested positive on both the primary screening test and the triage examination will require treatment, and should be counted in the numerator – programmes may adjust the wording of these indicators to better suit the context (e.g. replace screen-positive with triage-positive). In countries where both screen-treat and screen-triage-treat strategies are in use, the indicator wording can be adapted to better suit the context, but must still measure the number of women who required treatment and received treatment in the numerator and the number of women who required treatment in the denominator.
<b>Data type</b>	Rate
<b>Disaggregation</b>	Age group, HIV status, treatment type, residence type (rural/urban) other socioeconomic status
<b>Preferred data sources</b>	Cervical cancer service delivery data (screening or triage facility); Screening registries
<b>Other data sources</b>	
<b>Frequency of data collection</b>	Annual
<b>Limitations</b>	Potential limitations include: <ul style="list-style-type: none"><li>▪ quality and representativeness of cancer screening registry</li><li>▪ quality and representativeness of facility-based</li></ul>
<b>Related links</b>	<a href="https://www.who.int/publications/i/item/9789241514255">https://www.who.int/publications/i/item/9789241514255</a>

# AVAILABILITY OF NATIONAL CERVICAL CANCER SCREENING PROGRAMME

<b>Abbreviated name</b>	National cervical cancer screening programme
<b>Indicator name</b>	Availability of a national cervical cancer screening programme
<b>Domain</b>	Secondary prevention
<b>Subdomain</b>	Screening
<b>Definition</b>	Availability of a national screening program for cervical cancer targeting women aged 30-49 years or for lower or higher age groups according to national programmes or policies
<b>Numerator</b>	Not applicable
<b>Denominator</b>	Not applicable
<b>Method of estimation/ Calculation</b>	Countries can respond “yes” to the question “Please indicate if there is a national screening program targeting the general population for the following cancers: cervical cancer”. Countries are also requested to submit a copy of the screening program strategy and/or the last report on the screening program to support their response.
<b>Data type</b>	Categorical
<b>Disaggregation</b>	
<b>Preferred data sources</b>	WHO NCD Country Capacity Survey
<b>Other data sources</b>	
<b>Frequency of data collection</b>	Every 2 years
<b>Limitations</b>	Potential limitations include: <ul style="list-style-type: none"><li>• bias through self-report</li><li>• misunderstanding / misinterpretation of questions</li></ul>
<b>Related links</b>	<a href="https://www.who.int/teams/ncds/surveillance/monitoring-capacity/ncdccs">https://www.who.int/teams/ncds/surveillance/monitoring-capacity/ncdccs</a>

# AVAILABILITY OF PRE-CANCER TREATMENT

<b>Abbreviated name</b>	Availability of pre-cancer treatment
<b>Indicator name</b>	Availability of pre-cancer treatment
<b>Domain</b>	Secondary prevention
<b>Subdomain</b>	Pre-cancer treatment
<b>Definition</b>	Availability of ablative and excisions treatments
<b>Numerator</b>	Not applicable
<b>Denominator</b>	Not applicable
<b>Method of estimation/ Calculation</b>	<p>Precancer treatment is generally available if at least 50% of the facilities provide cervical precancer treatment services based on health facility survey conducted in the last 5 years</p> <p>Country can respond “generally available” to the question “Detail the availability of cancer diagnosis and treatment services in the public sector: cervical precancer treatment such as ablative and excision treatment” if cervical precancer treatment is generally available in 50% or more health care facilities.</p>
<b>Data type</b>	Categorical
<b>Disaggregation</b>	Age, HIV status, other socioeconomic status, residence type (rural/urban), surveillance site
<b>Preferred data sources</b>	Health facility survey; WHO NCD Country Capacity Survey
<b>Other data sources</b>	
<b>Frequency of data collection</b>	Every 2 years
<b>Limitations</b>	<p>Potential limitations include:</p> <ul style="list-style-type: none"><li>▪ bias through self-report</li><li>▪ misunderstanding / misinterpretation of questions</li></ul>
<b>Related links</b>	<a href="https://www.who.int/teams/ncds/surveillance/monitoring-capacity/ncdcss">https://www.who.int/teams/ncds/surveillance/monitoring-capacity/ncdcss</a>

# HPV TEST AVAILABILITY IN PRIMARY HEALTH CARE (PHC)

<b>Abbreviated name</b>	HPV test availability in PHC
<b>Indicator name</b>	Availability of HPV test in primary health care
<b>Domain</b>	Secondary prevention
<b>Subdomain</b>	Screening
<b>Definition</b>	Availability of HPV test in the primary care facilities of the public sector
<b>Numerator</b>	Not applicable
<b>Denominator</b>	Not applicable
<b>Method of estimation/ Calculation</b>	<p>HPV test is generally available if at least 50% of the primary care facilities of the public sector provide HPV test services based on health facility survey conducted in the last 5 years</p> <p>Country can respond “generally available” to the question “Indicate the availability of the following basic technologies for early detection, diagnosis and monitoring of NCDs in the primary care facilities of the public and private health sector: HPV test” if HPV test is generally available in 50% or more health care facilities.</p>
<b>Data type</b>	Categorical
<b>Disaggregation</b>	
<b>Preferred data sources</b>	Health facility survey, WHO NCD Country Capacity Survey
<b>Other data sources</b>	
<b>Frequency of data collection</b>	Every 2 years
<b>Limitations</b>	<p>Potential limitations include:</p> <ul style="list-style-type: none"><li>▪ representativeness of the sample (health facility survey)</li><li>▪ misunderstanding / misinterpretation of questions</li><li>▪ bias through self-report (WHO NCD Country Capacity Survey)</li></ul>
<b>Related links</b>	<p><a href="https://www.who.int/teams/ncds/surveillance/monitoring-capacity/ncdccs">https://www.who.int/teams/ncds/surveillance/monitoring-capacity/ncdccs</a></p> <p><a href="https://www.who.int/publications/i/item/harmonized-health-facility-assessment-(hhfa)_core_additional">https://www.who.int/publications/i/item/harmonized-health-facility-assessment-(hhfa)_core_additional</a></p> <p><a href="https://www.who.int/data/data-collection-tools/service-availability-and-readiness-assessment-(sara)?ua=1">https://www.who.int/data/data-collection-tools/service-availability-and-readiness-assessment-(sara)?ua=1</a></p>

# REFERRAL PATHWAY FOR SCREEN-POSITIVE WOMEN (LINKAGE TO TREATMENT)

<b>Abbreviated name</b>	Referral pathway for screen-positive women
<b>Indicator name</b>	Referral pathway for screen-positive women (linkage to treatment)
<b>Domain</b>	Secondary and tertiary prevention
<b>Subdomain</b>	Pre-cancer Treatment and Treatment
<b>Definition</b>	Existence of early detection of the cervical cancer by means of rapid identification of the first symptoms is integrated into primary health care services and a clearly defined referral system from primary to secondary /tertiary care for suspect cases if early detection of the cervical cancer by means of rapid identification of the first symptoms is integrated into primary health care services
<b>Numerator</b>	Not applicable
<b>Denominator</b>	Not applicable
<b>Method of estimation/ Calculation</b>	Country can respond "yes" to the question "Please indicate if early detection of the cervical cancer by means of rapid identification of the first symptoms is integrated into primary health care services and if there is a clearly defined referral system from primary care to secondary / tertiary care for suspect cases." Countries are also requested to submit a copy of the program/guideline to support their response.
<b>Data type</b>	Categorical
<b>Disaggregation</b>	
<b>Preferred data sources</b>	WHO NCD Country Capacity Survey
<b>Other data sources</b>	
<b>Frequency of data collection</b>	Every 2 years
<b>Limitations</b>	Potential limitations include: <ul style="list-style-type: none"><li>• bias through self-report</li><li>• misunderstanding / misinterpretation of questions</li></ul>
<b>Related links</b>	<a href="https://www.who.int/teams/ncds/surveillance/monitoring-capacity/ncdcss">https://www.who.int/teams/ncds/surveillance/monitoring-capacity/ncdcss</a>

# CERVICAL CANCER SURVIVAL

<b>Abbreviated name</b>	Cervical cancer survival
<b>Indicator name</b>	Cervical cancer survival rate
<b>Domain</b>	Tertiary prevention
<b>Subdomain</b>	Treatment
<b>Definition</b>	Probability that a cervical cancer patient will be alive some years (typically one, three, five or ten years) after diagnosis. Relative survival is commonly used as a way of comparing the survival of those women with cervical cancer versus those who do not, over a defined period of time e.g. five years from the date of diagnosis.
<b>Numerator</b>	Proportion of cervical cancer patients who are still alive at the end of the defined period
<b>Denominator</b>	Proportion of people in the general population of the same sex and age who are alive at the end of the same period
<b>Method of estimation/ Calculation</b>	Numerator/denominator Calculations of relative survival can use different methodologies
<b>Data type</b>	Rate
<b>Disaggregation</b>	Age, stage at diagnosis (TNM/FIGO stage or SEER Summary Stage), HIV status, residence type (rural/urban), other socioeconomic status
<b>Preferred data sources</b>	Rates provided by population-based cancer registry from reports, benchmarking studies etc. (EUROCARE, SURVMARK, SURVCAN, CONCORD)
<b>Other data sources</b>	
<b>Frequency of data collection</b>	Every 1-3 years
<b>Limitations</b>	Potential limitations include: <ul style="list-style-type: none"><li>• quality and representativeness of population-based cancer registry</li><li>• requirement of population-based cancer registry to actively or passively follow-up the vital status of all cancer cases under consideration</li><li>• correct definition and quality of the denominator data</li></ul>
<b>Related links</b>	<a href="https://gco.iarc.fr/survival/survmark/">https://gco.iarc.fr/survival/survmark/</a> <a href="https://survival.iarc.fr/Survcan/en/">https://survival.iarc.fr/Survcan/en/</a> <a href="https://csg.lshtm.ac.uk/research/themes/concord-programme/">https://csg.lshtm.ac.uk/research/themes/concord-programme/</a> <a href="http://www.eurocare.it/">http://www.eurocare.it/</a>

# CERVICAL CANCER MORTALITY-TO-INCIDENCE RATIO

<b>Abbreviated name</b>	Cervical cancer MIR
<b>Indicator name</b>	Cervical cancer mortality-to-incidence ratio
<b>Domain</b>	Tertiary prevention
<b>Subdomain</b>	Treatment
<b>Definition</b>	Mortality rate due to cervical cancer divided by incidence rate for a specified geographical areas and year
<b>Numerator</b>	Mortality rate of cervical cancer for a specific geographical area and a specific year
<b>Denominator</b>	Incidence rate of cervical cancer for the same geographical and year specified in the numerator
<b>Method of estimation/ Calculation</b>	Numerator/denominator
<b>Data type</b>	Ratio
<b>Disaggregation</b>	Age, residence type (rural/urban), other socioeconomic status
<b>Preferred data sources</b>	National vital registries, population-based cancer registry
<b>Other data sources</b>	
<b>Frequency of data collection</b>	Annual
<b>Limitations</b>	Potential limitations include: <ul style="list-style-type: none"><li>▪ availability and quality of civil registration and vital statistics system</li><li>▪ availability of standardized medical cause-of-death certification and coding</li><li>▪ reallocation of deaths</li><li>▪ availability of reliable population estimates/census data disaggregated by age group</li></ul>
<b>Related links</b>	<a href="https://gco.iarc.fr/">https://gco.iarc.fr/</a>

# GUIDELINE-BASED MANAGEMENT OF WOMEN WITH CERVICAL DISEASE

<b>Abbreviated name</b>	Guideline-based management
<b>Indicator name</b>	Guideline-based management of women with cervical disease
<b>Domain</b>	Tertiary prevention
<b>Subdomain</b>	Treatment
<b>Definition</b>	Number of patients in each stage of cervical cancer who have been treated based on guideline (WHO guideline or national guideline) among those diagnosed with cervical cancer in each stage
<b>Numerator</b>	Number of patients in each stage of cervical cancer who have been treated based on guideline (WHO guideline or national guideline)
<b>Denominator</b>	Those diagnosed with cervical cancer in each stage
<b>Method of estimation/ Calculation</b>	Numerator/denominator *100
<b>Data type</b>	Percent
<b>Disaggregation</b>	Age, HIV status, HPV status, residence type (rural/urban), other socioeconomic status
<b>Preferred data sources</b>	Routine facility reporting system
<b>Other data sources</b>	
<b>Frequency of data collection</b>	Annual
<b>Limitations</b>	Potential limitation includes: Quality and representativeness of facility-based data
<b>Related links</b>	<a href="https://www.who.int/publications/i/item/9789240030824">https://www.who.int/publications/i/item/9789240030824</a>

# STAGE AT DIAGNOSIS

<b>Abbreviated name</b>	Stage at Diagnosis
<b>Indicator name</b>	Percentage of different stages of cancer at the time of diagnosis
<b>Domain</b>	Tertiary prevention
<b>Subdomain</b>	Treatment
<b>Definition</b>	Percentage of each stage ((TNM/FIGO stage or SEER Summary Stage)) of cervical cancer at the time of diagnosis in a calendar year
<b>Numerator</b>	Number of cases with a specific stage of cervical cancer at diagnosis in a calendar year
<b>Denominator</b>	Number of cases diagnosed with cervical cancer
<b>Method of estimation/ Calculation</b>	Numerator/denominator x 100
<b>Data type</b>	Percent
<b>Disaggregation</b>	Age, HIV status, residence type (rural/urban), other socioeconomic status
<b>Preferred data sources</b>	Population-based cancer registries
<b>Other data sources</b>	
<b>Frequency of data collection</b>	Annual
<b>Limitations</b>	Potential limitations include: <ul style="list-style-type: none"><li>quality and representativeness of high-quality population-based cancer registry</li></ul>
<b>Related links</b>	<a href="https://www.who.int/publications/i/item/9789241514255">https://www.who.int/publications/i/item/9789241514255</a> <a href="https://www.who.int/standards/classifications/other-classifications/international-classification-of-diseases-for-oncology">https://www.who.int/standards/classifications/other-classifications/international-classification-of-diseases-for-oncology</a> <a href="https://www.uicc.org/resources/tnm">https://www.uicc.org/resources/tnm</a> <a href="https://seer.cancer.gov/tools/ssm/">https://seer.cancer.gov/tools/ssm/</a>

# INVASIVE CERVICAL CANCER TREATMENT RATE

<b>Abbreviated name</b>	Invasive cervical cancer treatment rate
<b>Indicator name</b>	Invasive cervical cancer treatment rate
<b>Domain</b>	Tertiary prevention
<b>Subdomain</b>	Treatment
<b>Definition</b>	Proportion of women with invasive cervical cancer who have received treatment in a given time period
<b>Numerator</b>	Number of women treated with cervical cancer
<b>Denominator</b>	Number of women diagnosed with invasive cervical cancer
<b>Method of estimation/ Calculation</b>	Numerator/denominator x 100 Population-based cancer registries and CRVS will identify all women who are identified with a diagnosis of cervical cancer including as a cause of death
<b>Data type</b>	Percent
<b>Disaggregation</b>	Age, stage at diagnosis (TNM/FIGO stage or SEER Summary Stage), HIV status, HPV status residence type (rural/urban), other socioeconomic status
<b>Preferred data sources</b>	Population-based cancer registry
<b>Other data sources</b>	Special studies Hospital-based cancer registry/hospital records (hospital records and/or hospital-based cancer registries can be used to identify women treated for cervical cancer). Screening registry (Cancer screening registries can be used to identify women with cervical cancer captured through a screening programme). IARC Global cancer observatory (for those without PBCRs/HBCRs). Modelled effective coverage using methodology from UHC indicator (including consideration for mortality to incidence ratio, only if necessary)
<b>Frequency of data collection</b>	Every 2 years
<b>Limitations</b>	Potential limitations include: <ul style="list-style-type: none"><li>quality and representativeness of high-quality population-based cancer registry</li></ul>
<b>Related links</b>	<a href="https://www.who.int/publications/i/item/9789241514255">https://www.who.int/publications/i/item/9789241514255</a>

# PALLIATIVE CARE MEDICATION

<b>Abbreviated name</b>	Palliative care medication
<b>Indicator name</b>	Reported annual opioid consumption -excluding methadone- in oral morphine equivalence per capita
<b>Domain</b>	Tertiary prevention
<b>Subdomain</b>	Supportive care
<b>Definition</b>	Opioid consumption is based on the amount of opioids (in milligrams/capita/year in oral morphine equivalence or OME), excluding methadone, distributed legally in a country for medical use to health care institutions and programmes that are licensed to dispense to patients, such as hospitals, nursing homes, pharmacies, hospices and palliative care programmes.
<b>Numerator</b>	Opioid consumption milligrams in a specified year, excluding methadone in OME
<b>Denominator</b>	Estimated population in the specified year
<b>Method of estimation/ Calculation</b>	Data on opioid consumption are obtained from the latest available reported consumption to the International Narcotics Control Board
<b>Data type</b>	Rate
<b>Disaggregation</b>	Opioids (morphine, fentanyl, hydromorphone, codeine, oxycodone and pethidine)
<b>Preferred data sources</b>	International Narcotics Control Board
<b>Other data sources</b>	
<b>Frequency of data collection</b>	Annual
<b>Limitations</b>	Potential limitations include: <ul style="list-style-type: none"><li>• delayed and/or incomplete reporting of opioid consumption by countries to INCB</li></ul>
<b>Related links</b>	<a href="https://www.who.int/publications/i/item/9789240033351">https://www.who.int/publications/i/item/9789240033351</a>

# AVAILABILITY OF GUIDELINES FOR THE MANAGEMENT OF WOMEN WITH CERVICAL DISEASE

<b>Abbreviated name</b>	Guidelines for the management of women with cervical disease
<b>Indicator name</b>	Availability of guidelines for appropriate management of screen positive women & women diagnosed with cervical cancer
<b>Domain</b>	Tertiary prevention
<b>Subdomain</b>	Treatment
<b>Definition</b>	Nationally reported guideline and/or standard of care for the management of cervical cancer disease (both pre-invasive and invasive lesions)
<b>Numerator</b>	Not applicable
<b>Denominator</b>	Not applicable
<b>Method of estimation/ Calculation</b>	Country can respond “yes” to the question “Please indicate whether evidence-based national guidelines/protocols/standards are available for the management (diagnosis and treatment) of each of the major NCDs through a primary care approach recognized/ approved by government or competent authorities. : Cancer” and indicate specifically that cervical cancer management guidelines are available. The country must provide a copy of the guidelines, which are evaluated for the inclusion of management of pre-invasive and invasive lesions.
<b>Data type</b>	Categorical
<b>Disaggregation</b>	
<b>Preferred data sources</b>	WHO NCD Country Capacity Survey
<b>Other data sources</b>	
<b>Frequency of data collection</b>	Every 2 yers
<b>Limitations</b>	Potential limitations include: <ul style="list-style-type: none"><li>▪ bias through self-report</li><li>▪ misunderstanding / misinterpretation of questions</li></ul>
<b>Related links</b>	<a href="https://www.who.int/teams/ncds/surveillance/monitoring-capacity/ncdccc">https://www.who.int/teams/ncds/surveillance/monitoring-capacity/ncdccc</a>

# AVAILABILITY OF PATHOLOGY SERVICES

<b>Abbreviated name</b>	Availability of pathology services
<b>Indicator name</b>	Availability of pathology services in the public health system
<b>Domain</b>	Tertiary prevention
<b>Subdomain</b>	Treatment
<b>Definition</b>	Country reported availability of pathology services in the public health system for at least 50% of patients with NCD
<b>Numerator</b>	Not applicable
<b>Denominator</b>	Not applicable
<b>Method of estimation/ Calculation</b>	Country can respond “generally available” to the question “Detail the availability of cancer diagnosis and treatment services in the public sector: pathology services (laboratories).” Generally available means the service reaches 50% or more patients in need.
<b>Data type</b>	Categorical
<b>Disaggregation</b>	
<b>Preferred data sources</b>	WHO NCD Country Capacity Survey
<b>Other data sources</b>	
<b>Frequency of data collection</b>	Every 2 years
<b>Limitations</b>	Potential limitations include: <ul style="list-style-type: none"><li>• bias through self-report</li><li>• misunderstanding / misinterpretation of questions</li></ul>
<b>Related links</b>	<a href="https://www.who.int/teams/ncds/surveillance/monitoring-capacity/ncdccs">https://www.who.int/teams/ncds/surveillance/monitoring-capacity/ncdccs</a>

# AVAILABILITY OF CANCER SURGERY

<b>Abbreviated name</b>	Availability of cancer surgery
<b>Indicator name</b>	Availability of cancer surgery in the public health system
<b>Domain</b>	Tertiary prevention
<b>Subdomain</b>	Treatment
<b>Definition</b>	Country reported availability of cancer surgery in the public health system for at least 50% of patients with NCD
<b>Numerator</b>	Not applicable
<b>Denominator</b>	Not applicable
<b>Method of estimation/ Calculation</b>	Country can respond “generally available” to the question “Detail the availability of cancer diagnosis and treatment services in the public sector: cancer surgery.” Generally available means the service reaches 50% or more patients in need.
<b>Data type</b>	Categorical
<b>Disaggregation</b>	Age, HIV status, other socioeconomic status, residence type (rural/urban), surveillance site
<b>Preferred data sources</b>	WHO NCD Country Capacity Survey
<b>Other data sources</b>	
<b>Frequency of data collection</b>	Every 2 years
<b>Limitations</b>	Potential limitations include: <ul style="list-style-type: none"><li>• bias through self-report</li><li>• misunderstanding / misinterpretation of questions</li></ul>
<b>Related links</b>	<a href="https://www.who.int/teams/ncds/surveillance/monitoring-capacity/ncdccs">https://www.who.int/teams/ncds/surveillance/monitoring-capacity/ncdccs</a>

# AVAILABILITY OF CHEMOTHERAPY

<b>Abbreviated name</b>	Availability of chemotherapy
<b>Indicator name</b>	Availability of chemotherapy in the public health system
<b>Domain</b>	Tertiary prevention
<b>Subdomain</b>	Treatment
<b>Definition</b>	Country reported availability of chemotherapy in the public health system for at least 50% of patients with NCD
<b>Numerator</b>	Not applicable
<b>Denominator</b>	Not applicable
<b>Method of estimation/ Calculation</b>	Country can respond “generally available” to the question “Detail the availability of cancer diagnosis and treatment services in the public sector: chemotherapy.” Generally available means the service reaches 50% or more patients in need.
<b>Data type</b>	Categorical
<b>Disaggregation</b>	
<b>Preferred data sources</b>	WHO NCD Country Capacity Survey
<b>Other data sources</b>	
<b>Frequency of data collection</b>	Every 2 years
<b>Limitations</b>	Potential limitations include: <ul style="list-style-type: none"><li>• bias through self-report</li><li>• misunderstanding / misinterpretation of questions</li></ul>
<b>Related links</b>	<a href="https://www.who.int/teams/ncds/surveillance/monitoring-capacity/ncdccs">https://www.who.int/teams/ncds/surveillance/monitoring-capacity/ncdccs</a>

# AVAILABILITY OF RADIOTHERAPY

<b>Abbreviated name</b>	Availability of radiotherapy
<b>Indicator name</b>	Availability of radiotherapy in the public health system
<b>Domain</b>	Tertiary prevention
<b>Subdomain</b>	Treatment
<b>Definition</b>	Country reported availability of radiotherapy (including brachytherapy) in the public health system for at least 50% of patients with NCD
<b>Numerator</b>	Not applicable
<b>Denominator</b>	Not applicable
<b>Method of estimation/ Calculation</b>	Country can respond “generally available” to the question “Detail the availability of cancer diagnosis and treatment services in the public sector: radiotherapy.” Generally available means the service reaches 50% or more patients in need.
<b>Data type</b>	Categorical
<b>Disaggregation</b>	
<b>Preferred data sources</b>	WHO NCD Country Capacity Survey
<b>Other data sources</b>	
<b>Frequency of data collection</b>	Every 2 years
<b>Limitations</b>	Potential limitations include: <ul style="list-style-type: none"><li>• bias through self-report</li><li>• misunderstanding / misinterpretation of questions</li></ul>
<b>Related links</b>	<a href="https://www.who.int/teams/ncds/surveillance/monitoring-capacity/ncdcss">https://www.who.int/teams/ncds/surveillance/monitoring-capacity/ncdcss</a>

# AVAILABILITY OF SPECIALIZED MEDICAL STAFF

<b>Abbreviated name</b>	Availability of specialized medical staff
<b>Indicator name</b>	Availability of specialized medical staff
<b>Domain</b>	Tertiary prevention
<b>Subdomain</b>	Treatment
<b>Definition</b>	Country reported number of specialized medical staff (radiation oncologists, medical physicists, nuclear medicine physicians, radiologists, surgeons, medical & pathology lab scientists) in the health system
<b>Numerator</b>	number of specialized medical staff (radiation oncologists, medical physicists, nuclear medicine physicians, radiologists, surgeons, medical & pathology lab scientists) in the health system
<b>Denominator</b>	Cancer patients
<b>Method of estimation/ Calculation</b>	Numerator/denominator*100000
<b>Data type</b>	Rate
<b>Disaggregation</b>	
<b>Preferred data sources</b>	Data on the number of radiation oncologists, medical physicists, nuclear medicine physicians, and radiologists are available from the International Atomic Energy Agency (IAEA) IMAGINE database (IAEA Medical imaging and Nuclear mEdicine global resources database). Data on the number of surgeons and medical & pathology lab scientists are available from the WHO Global Health Observatory. For the number of cancer patients, the estimated number of new cases for all cancer types for both sexes are used. These data can be extracted from IARC's Global Cancer Observatory.
<b>Other data sources</b>	
<b>Frequency of data collection</b>	Every 2 years
<b>Limitations</b>	
<b>Related links</b>	<a href="https://humanhealth.iaea.org/HHW/DBStatistics/IMAGINE.html">https://humanhealth.iaea.org/HHW/DBStatistics/IMAGINE.html</a> <a href="https://www.who.int/data/gho/indicator-metadata-registry">https://www.who.int/data/gho/indicator-metadata-registry</a> <a href="https://gco.iarc.fr/">https://gco.iarc.fr/</a>

# AVAILABILITY OF PALLIATIVE CARE

<b>Abbreviated name</b>	Palliative care
<b>Indicator name</b>	Availability of palliative care for patients with noncommunicable diseases in the public health system, in primary care facilities and in community or home-based care
<b>Domain</b>	Tertiary prevention
<b>Subdomain</b>	Supportive care
<b>Definition</b>	Country reported availability of palliative care in the public health system for at least 50% of patients with NCD in primary care facilities and in community or home-based care
<b>Numerator</b>	Not applicable
<b>Denominator</b>	Not applicable
<b>Method of estimation/ Calculation</b>	Country can respond “generally available” to the questions “Please indicate the availability of palliative care for patients with NCD in the public health system in (1) primary care facilities and (2) community- or home-based care”. Generally available means the service reaches 50% or more patients in need.
<b>Data type</b>	Categorical
<b>Disaggregation</b>	
<b>Preferred data sources</b>	WHO NCD Country Capacity Survey
<b>Other data sources</b>	
<b>Frequency of data collection</b>	Every 2 years
<b>Limitations</b>	Potential limitations include: <ul style="list-style-type: none"><li>▪ bias due to self-reporting</li><li>▪ misunderstanding/misinterpretation of question</li></ul>
<b>Related links</b>	<a href="https://www.who.int/teams/ncds/surveillance/monitoring-capacity/ncdccs">https://www.who.int/teams/ncds/surveillance/monitoring-capacity/ncdccs</a>

# AVAILABILITY AND QUALITY OF PERIODIC POPULATION-BASED SURVEYS

<b>Abbreviated name</b>	Periodic population-based surveys
<b>Indicator name</b>	Availability and quality of periodic population-based surveys that include cervical cancer risk factors and screening coverage
<b>Domain</b>	Cross-cutting surveillance
<b>Subdomain</b>	
<b>Definition</b>	Country has conducted population-based survey(s) that includes cervical cancer risk factors and screening coverage every 3-5 years.
<b>Numerator</b>	Not applicable
<b>Denominator</b>	Not applicable
<b>Method of estimation/ Calculation</b>	<p>Country can respond “yes” to the question “Have population-based surveys of risk factors (may be a single RF or multiple) been conducted in your country for any of the following? : tobacco use” The country must indicate also that the last survey was conducted in the past 5 years and must respond “Every 3 to 5 years” to the sub-question “How often is the survey conducted?”</p> <p>Additionally, statistics from other standardized surveys on tobacco use, condom use, screening coverage can support the availability of periodic population-based surveys.</p>
<b>Data type</b>	Categorical
<b>Disaggregation</b>	
<b>Preferred data sources</b>	WHO NCD Country Capacity Survey
<b>Other data sources</b>	UNAIDS
<b>Frequency of data collection</b>	Every 2 years
<b>Limitations</b>	<p>Potential limitations include:</p> <ul style="list-style-type: none"><li>• bias through self-report</li><li>• misunderstanding / misinterpretation of questions</li></ul>
<b>Related links</b>	<p><a href="https://www.who.int/teams/ncds/surveillance/monitoring-capacity/ncdcss">https://www.who.int/teams/ncds/surveillance/monitoring-capacity/ncdcss</a> <a href="https://indicatorregistry.unaids.org/indicator/condom-use-last-high-risk-sex">https://indicatorregistry.unaids.org/indicator/condom-use-last-high-risk-sex</a></p>

# AVAILABILITY AND QUALITY OF PERIODIC HEALTH FACILITY SURVEYS

<b>Abbreviated name</b>	Periodic health facility survey
<b>Indicator name</b>	Conduct of periodic standardized health facility surveys on availability, quality and effectiveness of services including cervical cancer services
<b>Domain</b>	Cross-cutting surveillance
<b>Subdomain</b>	
<b>Definition</b>	Country has conducted periodic standardized health facility survey(s) that allows review of availability of health facility services, systems in place to deliver standard quality services, and effectiveness of the services, including cervical cancer services, every 2 years.
<b>Numerator</b>	Not applicable
<b>Denominator</b>	Not applicable
<b>Method of estimation/ Calculation</b>	<p>Country can respond “yes” to the question “Has your country conducted a survey of facilities to assess service availability and readiness for NCDs?”, indicate the year of last survey and the coverage of the survey</p> <p>The country is considered to have conducted a health facility survey if there are published surveys or survey statistics on availability, quality and effectiveness of cervical cancer services. Surveys will only be considered for the purpose of this indicator if data have been published on cervical cancer services.</p>
<b>Data type</b>	Categorical
<b>Disaggregation</b>	
<b>Preferred data sources</b>	WHO NCD Country Capacity Survey.
<b>Other data sources</b>	
<b>Frequency of data collection</b>	Every 2 years
<b>Limitations</b>	<p>Potential limitations include:</p> <ul style="list-style-type: none"><li>• bias through self-report</li><li>• misunderstanding / misinterpretation of questions</li></ul>
<b>Related links</b>	<p><a href="https://score.tools.who.int/tools/optimize-health-service-data/tool/standardized-health-facility-survey-modules-36/?L=">https://score.tools.who.int/tools/optimize-health-service-data/tool/standardized-health-facility-survey-modules-36/?L=</a> <a href="https://www.who.int/publications/i/item/harmonized-health-facility-assessment-(hhfa)_core_additional">https://www.who.int/publications/i/item/harmonized-health-facility-assessment-(hhfa)_core_additional</a> <a href="https://www.who.int/data/data-collection-tools/service-availability-and-readiness-assessment-(sara)?ua=1">https://www.who.int/data/data-collection-tools/service-availability-and-readiness-assessment-(sara)?ua=1</a> <a href="https://cdn.who.int/media/docs/default-source/world-health-data-platform/hhfa/hhfa_questionnaire_combined_core_additional_2021.03.07.pdf?sfvrsn=9caf7723_5&amp;download=true">https://cdn.who.int/media/docs/default-source/world-health-data-platform/hhfa/hhfa_questionnaire_combined_core_additional_2021.03.07.pdf?sfvrsn=9caf7723_5&amp;download=true</a></p>

# AVAILABILITY AND QUALITY OF CANCER SCREENING REGISTRY

<b>Abbreviated name</b>	Screening registry
<b>Indicator name</b>	Availability and quality of a cervical pre-cancer or screening registry
<b>Domain</b>	Cross-cutting surveillance
<b>Subdomain</b>	
<b>Definition</b>	Country has a cancer screening registry that includes cervical cancer
<b>Numerator</b>	Not applicable
<b>Denominator</b>	Not applicable
<b>Method of estimation/ Calculation</b>	Country can respond yes to “Please indicate if there is a national screening program targeting the general population for the following cancers: cervix” and respond yes to “Are there any other registries that can provide information on NCDs?” and indicate cervical cancer screening registry
<b>Data type</b>	Categorical
<b>Disaggregation</b>	
<b>Preferred data sources</b>	WHO NCD Country Capacity Survey
<b>Other data sources</b>	
<b>Frequency of data collection</b>	Every 2 years
<b>Limitations</b>	Potential limitations include: <ul style="list-style-type: none"><li>• bias through self-report</li><li>• misunderstanding / misinterpretation of questions</li></ul>
<b>Related links</b>	<a href="https://www.who.int/teams/ncds/surveillance/monitoring-capacity/ncdccs">https://www.who.int/teams/ncds/surveillance/monitoring-capacity/ncdccs</a>

# AVAILABILITY AND QUALITY OF POPULATION-BASED CANCER REGISTRY

<b>Abbreviated name</b>	Population-based cancer registry
<b>Indicator name</b>	Availability and quality of population-based cancer registry
<b>Domain</b>	Cross-cutting surveillance
<b>Subdomain</b>	
<b>Definition</b>	Country has a population-based cancer registry that covers its whole population.
<b>Numerator</b>	Not applicable
<b>Denominator</b>	Not applicable
<b>Method of estimation/ Calculation</b>	Country can respond "Yes" to the question: "Does your country have a disease registry for cancer?" and indicates that it is population-based.
<b>Data type</b>	Categorical
<b>Disaggregation</b>	
<b>Preferred data sources</b>	WHO NCD Country Capacity Survey
<b>Other data sources</b>	IARC
<b>Frequency of data collection</b>	Every 2 years
<b>Limitations</b>	Potential limitations include: <ul style="list-style-type: none"><li>▪ bias through self-report</li><li>▪ misunderstanding / misinterpretation of questions</li></ul>
<b>Related links</b>	<a href="https://www.who.int/teams/ncds/surveillance/monitoring-capacity/ncdccs">https://www.who.int/teams/ncds/surveillance/monitoring-capacity/ncdccs</a>

# AVAILABILITY AND QUALITY OF ROUTINE FACILITY REPORTING SYSTEM

<b>Abbreviated name</b>	Routine facility reporting system
<b>Indicator name</b>	Availability and quality of routine facility reporting system
<b>Domain</b>	Cross-cutting surveillance
<b>Subdomain</b>	
<b>Definition</b>	Country has a national, electronic, standardized system for recording patient level data that includes NCD status and risk factors in the majority of public health facilities
<b>Numerator</b>	Not applicable
<b>Denominator</b>	Not applicable
<b>Method of estimation/ Calculation</b>	Country can respond yes to “Does a standardized system for recording patient level data that includes NCD status and risk factors exist, in primary health care centres and hospitals?”, indicate the scope of the system is “national”, indicate type of the system is “electronic”, and indicate the coverage of the system is “more than 75% facilities of facilities.”
<b>Data type</b>	Categorical
<b>Disaggregation</b>	
<b>Preferred data sources</b>	WHO NCD Country Capacity Survey
<b>Other data sources</b>	
<b>Frequency of data collection</b>	Every 2 years
<b>Limitations</b>	Potential limitations include: <ul style="list-style-type: none"><li>▪ bias through self-report</li><li>▪ misunderstanding / misinterpretation of questions</li></ul>
<b>Related links</b>	<a href="https://www.who.int/teams/ncds/surveillance/monitoring-capacity/ncdcs">https://www.who.int/teams/ncds/surveillance/monitoring-capacity/ncdcs</a> <a href="https://score.tools.who.int/tools/optimize-health-service-data/tool/standardized-health-facility-survey-modules-36/?L=">https://score.tools.who.int/tools/optimize-health-service-data/tool/standardized-health-facility-survey-modules-36/?L=</a>

# AVAILABILITY AND QUALITY OF CIVIL REGISTRATION AND VITAL STATISTICS SYSTEM

<b>Abbreviated name</b>	Civil registration and vital statistics system
<b>Indicator name</b>	Availability and quality of civil registration and vital statistics system
<b>Domain</b>	Cross-cutting surveillance
<b>Subdomain</b>	
<b>Definition</b>	Country has a well-functioning civil registration and vital statistics system for generating reliable cause-specific mortality data on a routine basis. The International Form of Medical Certificate of the Cause of Death is completed by certifiers. The International Classification of Diseases (ICD) is used to code the causes of death. The data compiled are made available to policy-makers and researchers
<b>Numerator</b>	Not applicable
<b>Denominator</b>	Not applicable
<b>Method of estimation/ Calculation</b>	Availability and quality of national civil registration and vital statistic systems is assessed through submissions to the WHO mortality database. The WHO collects mortality data, including cause of death, from civil registration systems in the WHO mortality database through a routine annual call for data. Data are considered to generate reliable cause-specific mortality data on a routine basis if: <ul style="list-style-type: none"><li>▪ Data from the five most recent reporting years are, on average, at least 70% usable. Usability is calculated as: (Completeness (%))*(1- Proportion Garbage)</li><li>▪ At least five years of cause-of-death data have been reported to the WHO in the last 10 years.</li></ul> The most recent year of data reported to the WHO is no more than five years old.
<b>Data type</b>	Categorical
<b>Disaggregation</b>	
<b>Preferred data sources</b>	WHO Mortality Database
<b>Other data sources</b>	
<b>Frequency of data collection</b>	Annual
<b>Limitations</b>	Possible limitation include: <ul style="list-style-type: none"><li>▪ misunderstanding / misinterpretation of questions</li></ul>
<b>Related links</b>	<a href="https://score.tools.who.int/tools/count-births-deaths-and-causes-of-death/">https://score.tools.who.int/tools/count-births-deaths-and-causes-of-death/</a> <a href="https://www.who.int/data/data-collection-tools/who-mortality-database">https://www.who.int/data/data-collection-tools/who-mortality-database</a> <a href="http://www.who.int/healthinfo/tool_cod_2010.pdf">http://www.who.int/healthinfo/tool_cod_2010.pdf</a>

# CERVICAL CANCER INCIDENCE

<b>Abbreviated name</b>	Cervical cancer incidence
<b>Indicator name</b>	Incident cases/incidence (numbers of new cases and rates) of cervical cancer
<b>Domain</b>	Cross-cutting incidence and mortality
<b>Subdomain</b>	
<b>Definition</b>	Recorded or estimated numbers and rates (age-specific, crude, age-standardized) of new cervical cancer in a defined geographic area and in a year
<b>Numerator</b>	Recorded or estimated numbers of new cervical cancer in a defined geographic area and in a year
<b>Denominator</b>	Population-at-risk: women in corresponding geographic area and year
<b>Method of estimation/ Calculation</b>	Numerator/denominator x 100,000 The numerator represents number of incident cases
<b>Data type</b>	Count and rate
<b>Disaggregation</b>	Age, stage at diagnosis (TNM/FIGO stage or SEER Summary Stage), HIV status, residence type (rural/urban), other socioeconomic status
<b>Preferred data sources</b>	Recorded numbers and rates come from population-based cancer registries (PBCR), including those considered of high quality, compiled by IARC in the Cancer Incidence in Five Continents series; estimated numbers and rates are compiled by IARC in the GLOBOCAN database; official population statistics for denominator
<b>Other data sources</b>	
<b>Frequency of data collection</b>	Annual
<b>Limitations</b>	Potential limitations include: <ul style="list-style-type: none"><li>• quality and representativeness of high-quality population-based cancer registry</li><li>• correct definition and quality of the denominator data</li></ul>
<b>Related links</b>	<a href="https://www.who.int/standards/classifications/other-classifications/international-classification-of-diseases-for-oncology">https://www.who.int/standards/classifications/other-classifications/international-classification-of-diseases-for-oncology</a> <a href="https://ci5.iarc.fr/Default.aspx">https://ci5.iarc.fr/Default.aspx</a> <a href="https://gco.iarc.fr/today/home">https://gco.iarc.fr/today/home</a>

# CUMULATIVE RISK OF CANCER

<b>Abbreviated name</b>	Cumulative risk of cancer
<b>Indicator name</b>	Lifetime cumulative risk of cervical cancer
<b>Domain</b>	Cross-cutting incidence and mortality
<b>Subdomain</b>	
<b>Definition</b>	The probability that an individual will develop cervical cancer in her lifetime (defined for the age range 0-74 years), in the absence of competing causes of death.
<b>Numerator</b>	Not applicable
<b>Denominator</b>	Not applicable
<b>Method of estimation/ Calculation</b>	Cumulative risk = $1 - \exp(-\text{cumulative rate})$ Cumulative rate is the sum of the age-specific incidence rates over each year of age from birth to age 74.
<b>Data type</b>	Proportion
<b>Disaggregation</b>	Age, stage at diagnosis (TNM/FIGO stage or SEER Summary Stage), HIV status, residence type (rural/urban), other socioeconomic status
<b>Preferred data sources</b>	Recorded numbers come from population-based cancer registries (PBCR), including those considered of high quality, compiled by IARC in the Cancer Incidence in Five Continents series; estimated numbers are compiled by IARC in the GLOBOCAN database; official population statistics for denominator
<b>Other data sources</b>	
<b>Frequency of data collection</b>	Annual
<b>Limitations</b>	Potential limitations include: <ul style="list-style-type: none"><li>• quality and representativeness of high-quality population-based cancer registry</li><li>• correct definition and quality of the denominator data</li></ul>
<b>Related links</b>	<a href="https://ci5.iarc.fr/Default.aspx">https://ci5.iarc.fr/Default.aspx</a> <a href="https://gco.iarc.fr/today/home">https://gco.iarc.fr/today/home</a>

# CERVICAL CANCER MORTALITY

<b>Abbreviated name</b>	Cervical cancer mortality
<b>Indicator name</b>	Numbers and rates of cervical cancer deaths for the year indicated
<b>Domain</b>	Cross-cutting incidence and mortality
<b>Subdomain</b>	
<b>Definition</b>	Recorded or estimated numbers and rates (age-specific, crude, age-standardized) of cervical cancer deaths for the year indicated
<b>Numerator</b>	Recorded or estimated numbers of cervical cancer (ICD-11 2C77/ ICD-10 C53) deaths
<b>Denominator</b>	Population-at-risk: women
<b>Method of estimation/ Calculation</b>	<p>Numerator/denominator x100,000  Rates need to be age-standardized  The calculation of cervical cancer mortality rates requires additional processing due to the deaths that are coded as malignant neoplasm of uterus, part unspecified (ICD-11 2C78/ICD-10 C55). This can be a considerable proportion of all deaths due to uterine cancers (Cervix ICD-11 2C77/ICD-10 C53 Endometrium ICD-11 2C76/ ICD-10 C54 and Uterus, part unspecified ICD-11 2C78/ICD-10 C55).  Provide the proportion of deaths for each uterus subsite</p> <ul style="list-style-type: none"> <li>▪ No. of cervical cancer deaths (ICD-11 2C77/ICD-10 C53)/ All uterine cancer deaths (ICD-11 2C77+2C76+2C78/ICD-10 C53+C54+C55)</li> <li>▪ No. of endometrium cancer deaths (ICD-11 2C76/ ICD-10 C54)/ All uterine cancer deaths (ICD-11 2C77+2C76+2C78/ICD-10 C53+C54+C55)</li> <li>▪ No. of non-specified uterus cancer deaths (ICD-11 2C78/ICD-10 C55C55)/All uterine cancer deaths (ICD-11 2C77+2C76+2C78/ ICD-10 C53+C54+C55)</li> </ul> <p>Reallocation methods based on age- and time-specific distributions of cervix and corpus uteri cancer are applied to the unspecified death. See example from Pilleron S et al. Int J Cancer 2020;147 (6):1638-1648. doi: 10.1002/ijc.32956.</p>
<b>Data type</b>	Count and rate
<b>Disaggregation</b>	Age, stage at diagnosis (TNM/FIGO stage or SEER Summary Stage), HIV status, residence type (rural/urban), other socioeconomic status
<b>Preferred data sources</b>	Official cause-of-death statistics and official population statistics
<b>Other data sources</b>	
<b>Frequency of data collection</b>	Annual

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**Limitations**

Potential limitations include:

- availability and quality of civil registration and vital statistics system
- availability of standardized medical cause-of-death certification and coding
- reallocation of deaths
- availability of reliable population estimates/census data

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**Related links**

<https://www.who.int/data/global-health-estimates>

<https://www.who.int/data/gho/data/indicators/indicator-details/GHO/number-of-deaths-attributed-to-non-communicable-diseases-by-type-of-disease-and-sex>

<https://www.who.int/standards/classifications/classification-of-diseases>

<https://gco.iarc.fr/today/home>

# PREMATURE MORTALITY FROM CERVICAL CANCER

<b>Abbreviated name</b>	Premature mortality from cervical cancer
<b>Indicator name</b>	Premature mortality from cervical cancer
<b>Domain</b>	Cross-cutting incidence and mortality
<b>Subdomain</b>	
<b>Definition</b>	Probability of dying between exact ages 30 and 70 years from cervical cancer
<b>Numerator</b>	Number of 30-year-old women who die before their 70th birthday from cervical cancer, assuming that they would experience current mortality rates at every age and they would not die from any other cause of death
<b>Denominator</b>	Number of 30–70-year-old women
<b>Method of estimation/ Calculation</b>	<p>Numerator/denominator x 100</p> <p>The probability of death between exact age 30 and exact age 70 can be calculated using cause-specific mortality rates in each 5-year age group and standard life table methods. Estimates can be derived from the WHO Global Health Estimates (GHE), which represent the best estimates of WHO, computed using standard categories, definitions and methods to ensure cross-country comparability, and may not be the same as official national estimates.</p>
<b>Data type</b>	Percent
<b>Disaggregation</b>	Age, residence type (rural/urban), other socioeconomic status
<b>Preferred data sources</b>	Sample, sentinel, national vital registries
<b>Other data sources</b>	
<b>Frequency of data collection</b>	Annual
<b>Limitations</b>	<p>Potential limitations include:</p> <ul style="list-style-type: none"><li>▪ availability and quality of civil registration and vital statistics system</li><li>▪ availability of standardized medical cause-of-death certification and coding</li><li>▪ reallocation of deaths</li><li>▪ availability of reliable population estimates/census data disaggregated by age group.</li></ul>
<b>Related links</b>	<a href="https://www.who.int/data/gho/indicator-metadata-registry/imr-details/3354">https://www.who.int/data/gho/indicator-metadata-registry/imr-details/3354</a>

# FREQUENTLY ASKED QUESTIONS:

## 1. What is Framework for Monitoring the Cervical Cancer Elimination Strategy?

The Framework for Monitoring the Cervical Cancer Elimination Strategy provides a structure and suggested indicators for guiding the tracking of progress and achievement towards the elimination of cervical cancer as a public health challenge. The Framework highlights specific indicators related to these domains and identifies the most important indicators in these areas to help track progress and achievement and to drive programmatic improvements and adjustments.

## 2. What are the global cervical cancer targets for 2030?

To eliminate cervical cancer, all countries must reach and maintain an incidence rate of below four per 100,000 women. Achieving that goal rests on three key pillars and their corresponding targets:

- Vaccination: 90% of girls fully vaccinated with the HPV vaccine by the age of 15
- Screening: 70% of women screened using a high-performance test by the age of 35, and again by the age of 45
- Treatment: 90% of women with pre-cancer treated and 90% of women with invasive cancer managed

## 3. What can countries do to strengthen monitoring and surveillance for cervical cancer elimination?

- strengthen governance and accountability of programmes related to cervical cancer and conduct regular reviews to help ensure that national strategies, plans and resource allocations reflect actual country needs;
- set country-specific targets, milestones and indicators for monitoring and evaluating the national cervical cancer elimination programme – data on progress towards these objectives should be used to regularly report on the impact of the various interventions being carried out in a country and adjust programme interventions as necessary;
- develop or improve population-based cancer registries so as to inform national cervical cancer elimination programmes and help to track progress towards the goal of elimination;
- track patients throughout the continuum of services to ensure that women and girls in need are being successfully treated;
- work towards disaggregation of data by equity stratifiers to enable detection of differences

across population segments and set equity-oriented targets.

## 4. How should countries set national targets?

Countries are strongly encouraged to adopt the three targets as national targets. Adopting targets is a way to draw attention to cervical cancer and help mobilize resources to address cervical cancer. National targets may need to be adapted from the global targets if a country has already achieved a target or if the global target is too low given the progress already achieved within the country.

## 5. What is the timeframe for the global targets?

Each country should meet the 90-70-90 targets by 2030 to get on the path to eliminate cervical cancer within the next century.

## 6. What is the reporting cycle? When should countries report, to whom and how?

WHO is mandated to prepare regular updates on the progress towards achieving the three global cervical cancer elimination targets. WHO will report on progress in implementation of the efforts to eliminate cervical cancer in 2022 and 2025 and will submit a final report in 2030 with lessons learned, best practices and recommendations for further acceleration towards elimination of cervical cancer as a public health problem.

To enable these reports to be as comprehensive as possible, Member States are strongly encouraged to submit data to WHO on a regular basis, as data becomes available. For ease of data submission, WHO has prepared a template for reporting against the NCD indicators. This template is available upon request from WHO by contacting: [ncdmonitoring@who.int](mailto:ncdmonitoring@who.int).

## 7. Should countries provide raw data or the summary estimate?

WHO would be pleased to receive either raw data to enable the age-standardized indicators to be calculated or aggregate data for the relevant variables. Further guidance on this is provided in the reporting template available from WHO.

## 8. What is the approach for estimating global status if countries are not able to report?

If countries do not have recent data to report against specific indicators, country comparable estimates generated by WHO will be used to inform global values.

