

**THEMATIC SEGMENT:  
CERVICAL CANCER AND HIV -  
ADDRESSING LINKAGES AND  
COMMON INEQUALITIES TO SAVE  
WOMEN'S LIVES**

**Country submissions**

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**Table of contents**

<b>INTRODUCTION .....</b>	<b>4</b>
<b>AFRICAN STATES.....</b>	<b>5</b>
1. Côte d'Ivoire.....	6
2. Guinée Bissau .....	8
3. Kenya .....	10
4. Malawi .....	13
5. Morocco.....	16
6. Namibia .....	19
7. Nigeria .....	21
8. Uganda.....	25
9. Uganda.....	29
10. Zimbabwe.....	32
11. Zimbabwe.....	36
<b>Asian States .....</b>	<b>40</b>
12. Islamic Republic of Iran .....	41
<b>Eastern European States.....</b>	<b>44</b>
13. Ukraine.....	45
14. Ukraine.....	47

## INTRODUCTION

The Thematic Segment of the 47th UNAIDS Programme Coordinating Board (PCB) meeting will be held on the 18th of December 2020 and will focus on “cervical cancer and HIV - addressing linkages and common inequalities to save women’s lives”.

In the preparation for the Thematic Segment, UNAIDS issued a call for submission of examples of best practices to inform the development of the background note to the thematic as well as the discussions during the day.

A total of fourteen submissions were received. The submissions reflect the work of governments and civil society, as well as collaborative efforts. The case studies highlight different approaches in addressing linkages and common inequalities faced by women in the context of HIV and cervical cancer.

## **AFRICAN STATES**

## 1. Côte d'Ivoire

**TITLE OF THE PROGRAMME: AIMA-CC ANRS 12375 (Evaluation of screening algorithms based on self-collection and HPV testing with partial genotyping for the prevention of cervical cancer among HIV-infected women in resource-limited countries)**

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- **Date de début du programme** : 2019 – fin : Fin du dépistage en 2021 mais les femmes traitées seront suivies pendant encore un an
- **Responsable(s)** : Institution universitaire, agence publique française (ANRS), société civile, gouvernement
- **Groupe de population atteint** : Personnes vivant avec le VIH
- **Le programme a-t-il été évalué/analysé ?** Oui
- **Si oui, comment et par qui ?** Evaluation en cours: première recherche d'acceptabilité conduite au début du programme par une chercheuse; une seconde évaluation portant sur l'acceptabilité et la faisabilité devrait être conduite ainsi qu'une évaluation d'impact budgétaire (mais l'épidémie de COVID-19 a bouleversé les calendriers).
- **Le programme fait-il partie de la stratégie nationale de VIH ?** Non
- **Le programme fait-il partie d'un plan national autre que la stratégie nationale ?** Non

### **RESULTATS, REPERCUSSIONS ET IMPACT DU PROGRAMME :**

Approximativement 1200 femmes ont été dépistées jusqu'à présent. Le dépistage est globalement bien accepté par les patientes. Une des principales difficultés est de maintenir l'approche en une visite car cela met beaucoup de pression sur l'équipe soignante et fait attendre les femmes plusieurs heures (quand elles sont HPV+). Il est intéressant de noter que la demande des femmes plus âgées (40 ans ou plus) pour le dépistage était très élevée.

Nous prévoyons d'examiner l'impact du dépistage sur l'anxiété des femmes quand il a été positif (et qu'elles ont reçu un traitement par ablation thermique). La seule référence disponible à ce jour concerne l'évaluation initiale de l'acceptabilité (Mensah K et al. Acceptability of HPV screening among HIV-infected women attending an HIV-dedicated clinic in Abidjan, Côte d'Ivoire BMC Womens Health. 2020).

### **ENSEIGNEMENTS TIRES ET RECOMMANDATIONS :**

Ce projet a été réalisé dans un centre où le dépistage du cancer du col était déjà en place (VIA avec traitement sporadique par cryothérapie). Il s'agit d'un centre d'excellence où de nombreuses recherches ont été conduites dans le passé, ce qui en fait un site "idéal". Le projet a également bénéficié des collaborations nationales (PACCI / CEPRED / CHU de Yopougon / PNLCa) et internationales. Comme le montre l'article de Mensah et al. les associations de femmes ont un effet positif sur le dépistage dans la mesure où elles améliorent la "littéracie" des femmes dans le domaine du cancer du col.

Les difficultés les plus importantes sont les suivantes :

- logistique +++: l'introduction du test HPV est complexe car cela nécessite de réaliser des commandes internationales et d'avoir des installations électriques de bonne qualité. Même si les plateformes genexpert permettent d'obtenir des résultats rapidement, l'organisation hospitalière fait qu'il faut plusieurs heures pour obtenir les résultats des tests et, par conséquent, les femmes attendent parfois une demi journée pour le dépistage complet, ce qui peut être problématique.
- contrôle qualité : nous avons un suivi par cervicographie des VIA réalisées mais cela prend beaucoup de temps et semble difficile à mettre à l'échelle.
- suivi des femmes traitées : jusqu'à ce jour, il a été difficile de suivre toutes les femmes. Nous sommes en train d'investiguer sur les raisons à cela.
- prise en charge des lésions non éligibles à l'ablation thermique : les délais d'attente sont très longs et les sites disposant de la LEEP (ou autre méthode) peu nombreux.

**ANNEXES : N/A**

## 2. Guinée Bissau

### TITLE OF THE PROGRAMME: CASAMANCE RESEARCH PROGRAM ON HIV-RESISTANCE AND SEXUAL HEALTH

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- **Date de début du programme :** Juillet 2018 – **fin:** Juillet 2022
- **Responsable(s):** Société civile, institution universitaire, hôpitaux
- **Groupe(s) de population(s) atteint(s) :** Personnes vivant avec le VIH, femmes et filles des populations clefs, adolescentes et jeunes femmes, femmes et filles
- **Le programme a-t-il été évalué/analysé ?** Non
- **Le programme fait-il partie de la stratégie nationale de VIH ?** Oui
- **Le programme fait-il partie d'un plan national autre que la stratégie nationale ?** Oui
- **Si oui, lequel ?** Stratégie nationale de lutte le VIH à travers le 3eme 90 au Sénégal et en Guinée Bissau Plan nation de lutte le cancer du col de l'utérus Sénégal

#### RÉSULTATS, RÉPERCUSSIONS ET IMPACT DU PROGRAMME :

- Au Sénégal et en Guinée Bissau : 04 sites de prise en charge des personnes vivant avec le VIH et 04 structures sanitaires et communautaires de prise en charge des populations clés offrent des services intégrés de dépistages et traitement du VIH et du cancer du col.

- 2 588 femmes d'avoir accès aux services de dépistages du cancer du col et du VIH

- 178 femmes vivant avec le VIH et professionnelles de sexe ont bénéficié des services de dépistage cancer du col dans ces sites.

- Un total de 117 professionnels de santé (médecins et sages-femmes) ont reçu une formation conduite par des experts du Luxembourg et du Sénégal sur différentes techniques de dépistage et traitement du cancer du col de l'utérus (IVA-L, la cryothérapie et les CAD, cytologie gynécologique sur la coloration et l'interprétation de frottis cervicaux conventionnels.)



## **ENSEIGNEMENTS TIRÉS ET RECOMMANDATIONS :**

L'intégration de service de santé sexuelle et reproductive notamment Cancer du col de l'utérus, dans un programme VIH offre une opportunité d'élargir les services qui prennent en compte les besoins des femmes et populations vulnérables. Elle améliore la qualité de vie des personnes vivant avec les VIH et les populations, augmente la fréquentation et l'utilisation des services et enfin une optimisation des ressources.

**ANNEXES: N/A**

### 3. [Kenya](#)

**TITLE OF THE PROGRAMME: Towards cervical cancer elimination: Utilization of excess capacity in GeneXpert infrastructure for HIV/Tuberculosis control in implementing HPV-based cervical cancer screening programme in primary care settings in Kenya**

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- **Programme is being implemented since:** 2019 - **End** 2022
- **Responsible party/parties:** Government, International Global Health Organizations
- **Population group(s) reached:** People living with HIV, women and girls, women and girls among key populations
- **Has the programme been evaluated/assessed:** No
- **Is the programme part of the national AIDS strategy or national HPV/cervical cancer elimination strategy?** Yes
- **Is the programme part of a national plan other than the national aids strategy?**  
No

#### **BACKGROUND**

Kenya has a population of 48 million people, with a median age of 20 years. In 2018, Kenya had an estimated 5,250 cases of cervical cancer (11 % of all cancer cases), which is, with over 3,000 annual deaths, the second leading cause of all cancer deaths [1]. Unfortunately, the uptake of screening for cervical cancer is low, at 16% in 2015 [2]. HPV infection is necessary (but not sufficient) for the development of cervical cancer and causes 99.7% of all cervical cancers [3]. Kenya is implementing strategies to move towards this global goal of cervical cancer elimination. About 30% of all cancers in Kenya is due to infectious agents and as such, the National Cancer Control Strategy (NCCS 2017-2022) identifies increase in detection and treatment of cancers due to infectious agents as a key strategy for reducing cancer burden in Kenya. Along the lines of the WHO global guidelines, comprehensive National Cancer Screening Guidelines have been formulated and disseminated to all the 47 counties in Kenya [4,5]. The guidelines recommend programmatic screening for all women 30-49 years of age using HPV DNA testing as the gold standard method, or VIA where HPV testing is unavailable or as a follow-up test for a positive HPV test. The Government of Kenya is implementing the Big Four Agenda with Universal Health Coverage as one of its

main focus areas. The Universal Health Agenda has prioritized primary health care with a focus on strengthening the community health strategy including through creation of community health units. In this regard, the National Cancer Control Program has identified strengthening of primary care settings as a pragmatic approach towards increasing cervical cancer screening in Kenya.

## References

1. Ferlay J, Ervik M, Lam F, et al. Global cancer observatory: cancer today. Lyon, Fr Int Agency Res Cancer. 2018.
2. Ng'Ang'A A, Nyangasi M, Nkonge NG, et al. Predictors of cervical cancer screening among Kenyan women: Results of a nested case-control study in a nationally representative survey. BMC Public Health. 2018;18(3):1-10. doi:10.1186/s12889-018-6054-9
3. Ngoma M, Autier P. Cancer prevention: Cervical cancer. Ecancermedicalscience. 2019;13. doi:10.3332/ecancer.2019.952
4. Ministry of Health Kenya. National Cancer Screening Guidelines. <http://www.health.go.ke/wp-content/uploads/2019/02/National-Cancer-Screening-Guidelines-2018.pdf>. Accessed April 10, 2020.
5. WHO. Guidelines for screening and treatment of precancerous lesions for cervical cancer prevention. WHO Guidel. 2013:60.

## DESCRIPTION

In many settings, point of care HPV testing including use of the self-sampling method has been shown to increase screening coverage for cervical cancer. In addition, it is less resource intensive and does not require highly skilled personnel to perform the test. In the Guidelines for Screening and Treatment of Precancerous Lesions for Cervical Cancer Prevention, the World Health Organization recommends that, where resources allow, a strategy of screen with an HPV test followed by VIA and treat is superior to a screen-with-VIA-and-treat strategy. This project aims to introduce HPV-based cervical cancer screening through use of GeneXpert machines that are already available through the TB and HIV programs. Objectives The main objective of this programme is to increase the early detection of HPV infection with a longer-term goal of reducing the incidence of advanced cervical cancer and mortality through an integrated HPV testing model.

The specific objectives are:

1. To demonstrate the effectiveness of an integrated HPV testing system leveraging on pre-existing GeneXpert machines
2. To determine the HPV burden in the selected facilities
3. To evaluate the direct medical cost of screening per client using the approach of the project
4. To improve by 50% cervical cancer screening coverage and treatment of precancerous lesions in the pilot facilities
5. To evaluate the yield and acceptability from self-collected vs health care worker-collected samples.

Implementation framework:

The pilot project is being implemented in six counties in Kenya. It is utilizing both a health-facility and community-based, self-sample collection approaches. The target population is women between the ages of 30-49 years, both HIV positive and negative. If HIV status is unknown, the service is also offered to the screened women. Awareness creation and demand mobilization was conducted through the community strategy in the selected counties. Laboratory analysis of samples is conducted at the selected sub-county and county facilities. Women with positive high-risk HPV subtypes undergo VIA, and are linked to treatment as per the national guidelines. Data collection, monitoring and evaluation utilizes the already available surveillance infrastructure and the screening data is uploaded into the Kenya Health Information System (KHIS).

Implementing partners:

- National Cancer Control Programme: training, technical support, monitoring and evaluation, supply chain for commodities.
- National Oncology Reference Lab (NORL): quality assurance, training on sample handling. County governments Departments of Health: human resources, supporting infrastructure, ensure linkage to treatment and follow-up, data entry.
- Clinton Health Access Initiative: financial support (logistics and commodities), technical support, facilitate dissemination of findings.

## **RESULTS OUTCOMES AND IMPACT OF THE PROGRAMME**

This information is currently being processed and will be shared shortly. However, the final evaluation of the project is yet to be carried out, since the project is still ongoing.

## **LESSONS LEARNED AND RECOMMENDATIONS**

Critical success factors so far:

1. Clear guidance from the national cancer control programme at the national level.
2. Utilization of already available structures and resources: human resources already employed by counties, the community strategy, already available Genexpert equipment. The only new ingredients were commodities and training.
3. County ownership, for sustainability.
4. Utilizing the community strategy to drive both awareness and uptake.

Main challenges:

1. Interruption of commodities supply chain due to either local or global constraints.
2. Recall and linkage to care: ensuring all clients receive their results conveniently and those in need are linked to care, minimizing loss to follow-up.

Recommendations:

1. Primary healthcare is the best way to drive cervical cancer screening uptake; however, proper planning of screening programmes is necessary to ensure successful linkage to care.
2. Community-based approaches can give programmes resilience, especially in the context of global health emergencies like the current COVID-19 pandemic.

**ANNEXES: N/A**

#### 4. [Malawi](#)

### TITLE OF THE PROGRAMME: HIV/SRH/SGBV integration program

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- **Programme is being implemented since:** 2017 – **End:** NA
- **Responsible party/parties:** Government, Civil society, Academic institution, UN
- **Population group(s) reached:** People living with HIV, adolescent girls and young women living with HIV, adolescent girls and young women, women and girls among key populations, women prisoners, women and girls
- **Has the programme been evaluated/assessed:** No
- **Is the programme part of the national AIDS strategy or national HPV/cervical cancer elimination strategy?** Yes
- **Is the programme part of a national plan other than the national aids strategy?** Yes
- **If yes, please specify:** The program is part of the National HIV/SRH integration agenda as well as the National Cancer Control Plan 2020-2025

#### BACKGROUND

Malawi is a landlocked country (has no access to the sea) and got its independence from Britain in 1964. The country follows a multiparty system of government and incumbent president was elected in July 2020 following the court nullification of the presidential elections in May 2020. It is classified by the World Bank as a low income country with an average citizen surviving on less than \$1.90 per day. According the Population and Housing census conducted in 2018, there are 17,563,749 people in Malawi and 8,521,460 are Males while 9,042,289 are females (PHC,2018) Cervical cancer is a public health problem in Malawi with age standardized incidence and mortality rates of 72.9 and 49.8 respectively per 100,000 population of women of child - bearing age. In 2018, 4163 women developed cervical cancer and 2,879 of these women died from the disease (IARC, 2018). According to the UNAIDS HIV statistics for Malawi, about 1, 100, 000 people were living with HIV in 2019 and prevalence of HIV among adults aged 15-49 is at 8.9 while HIV prevalence rate among women aged 15-49 is at 10.8. The estimated incidence of HIV in 2018 was 2.28%. and nearly 600,000 women aged 15 and over, were living with HIV in 2019 (UNAIDS Malawi, 2018, 2019). Cervical cancer is an AIDS-defining illness since women living with HIV who become infected with HPV are more likely to develop pre-invasive lesions that can, if left

untreated, quickly progress to invasive cancer. Therefore, combining the approaches to tackling both HIV and cervical cancer holds major benefits and offers hope for the dual control of both epidemics. In this regard, Ministry of Health in Malawi came up with the agenda to integrate the cervical cancer and HIV services to ensure control of both epidemics. In this case study, I describe the joint response implemented by the Malawi government with support from the development partners such as the Global Fund and USAID.

## **DESCRIPTION**

The integration of Cervical cancer and HIV programs falls under the national agenda for HIV/SRH services integration aimed at controlling both cervical cancer and HIV epidemics and other related diseases. Under this program, policies and guidelines aimed at guiding the implementation of the integrated services were developed and operational. As part of the integration agenda for Malawi, joint cervical cancer and HIV programs response was developed and this led to the formulation of the joint National coordination structure, comprising of the Department of HIV and AIDS (DHA), Reproductive Health Directorate, (RHD) and National Aids Commission (NAC). Financial support is also provided by both the Treasury (Malawi Government) as well as USAID and PEPFAR. In addition, the National HIV/cervical Cancer Technical Working group was formulated to oversee the technical aspect of the cervical cancer and HIV implementation. The main objective for this is to reduce operations costs for controlling both epidemics and at the same time reduce cost as a barrier to accessing both services. In 2018, Malawi Ministry of Health in collaboration with development partners and stakeholders recognized the need to jointly respond to these two epidemics which have both negatively affected women.

The joint responses are categorized into 4 levels and these are:

### **1.1 JOINT RESPONSE TO HIV/CERVICAL CANCER AT POLICY LEVEL**

After recognizing the need for Malawi to jointly respond to both HIV and Cervical cancer, Malawi Ministry of Health revised and developed policies to reflect the joint response to the two epidemics. Furthermore, in 2020, Ministry of Health recognized the need to have a joint policy on HIV and SRH services integration and the Integrated services delivery guidelines were developed and the ministry is currently moving towards the revision and review of the SRH /HIV integration strategy. The Ministry also addressed the joint response to HIV and cervical cancer in its newly developed HIV National Strategic Plan and Global Fund NFM III grant application. In this strategic plan and Global Fund grant, joint HIV and Cervical Cancer response is highlighted, and Cervical cancer Logistics and Supply Chain were included as part of the joint response.

### **1.2 JOINT RESPONSE AT THE LEVEL OF COORDINATION AND GOVERNANCE**

To effectively respond jointly to HIV and Cervical Cancer in Malawi, Reproductive Health Directorate (RHA) and the Department of HIV and AIDS (DHA) as well as National AIDS Commission (NAC) came together to coordinate the joint response to Cervical cancer and HIV in Malawi.

### **1.3 JOINT RESPONSE AT THE LEVEL OF SUPPLY CHAIN AND LOGISTICS**

In Malawi, both HIV and Cervical Cancer programs have one supply chain and logistics system. The Forecasting, Procurement, Warehousing and Distribution of both HIV and Cervical cancer Commodities are done jointly with financial support from

**1.4 JOINT RESPONSE AT THE E LEVEL OF SERVICE DELIVERY.** As part of joint response to HIV and Cervical cancer in Malawi, Reproductive Health Directorate (RHD) and Department of HIV and AIDS (DHA) came up with a scale up plan aimed at fully integrating cervical cancer and HIV services delivery in all the 750 ART sites in Malawi. Currently 311 out of 750 ART sites are jointly offering both cervical cancer and HIV services. And of the 311 facilities jointly offering cervical cancer and HIV services, 205 are offering treatment to cervical precancer using Cryotherapy or Thermal Ablation.

## **RESULTS OUTCOMES AND IMPACT OF THE PROGRAMME**

According to the 2019 DHIS2 data, Total number of women (initial, 1 year follow up, and subsequent) screened using VIA were 108,716 and of these, 18,116 women were positive for VIA and only 2,067 women received treated with either Cryotherapy or Cold thermal ablation. However, the figures could be higher since reporting using DHIS2 came into effect in October 2019 and prior to this period the reporting was paper based and there was a lot of missing data in DHIS2 due to non reporting or late reporting. Through HIV and cervical Cancer integration agenda, number of facilities offering both cervical cancer and HIV increased from 81 in 2017 to 311 facilities. While 205 facilities are capable of offering the single visit approach. The cervical cancer statistics are expected to change with full reporting in DHIS2 and joint HIV and Cervical supportive supervision, which is yet to be approved and accepted by both RHD, NAC and DHA. SRH and HIV policies have been revised to ensure synergy across policies as well as leveraging of the financial resources to ensure efficiencies. Detailed HIV/SRH program evaluation has never been conducted in Malawi, as such no reliable data to assess impact of our interventions.

## **LESSONS LEARNED AND RECOMMENDATIONS**

Integration of policies such as SRHR and HIV policies was very helpful in shaping the landscape for the financing and coordination of the program. This had a trickle-down effect to the services delivery level. Interdepartmental collaboration between HIV and Reproductive Health Directorates, offered opportunities for resource mobilization to move the integration agenda. involvement of adolescent girls and young women as well as sex workers and members of the Key populations in the development and revision of HIV and SRH policies was helpful in ensuring that nobody is left behind. Enactment of the HIV prevention and Management Act and its dissemination helped in making sure that the general public is sensitized on their HIV related rights and criminalization of high risk and harmful cultural practices. To fully implement the joint response, the major challenge was the resources to move the agenda on HIV cervical cancer integration. Service uptake is still on the lower side due to the services being available in only 311 sites out of the 750 ART sites in Malawi. Development partners and the Malawi government need to jointly respond by making financial resources available for this joint response to the two epidemics.

**ANNEXES: N/A**

## 5. [Morocco](#)

### TITLE OF THE PROGRAMME: ACTION RESEARCH ON SCREENING FOR HPV AND CERVICAL CANCER FOR WOMEN LIVING WITH HIV- MOROCCO

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- **Programme is implemented from:** 1 September 2019 - **to:** 31 December 2019
- **Responsible party/parties:** Government, civil society, UN or other inter-governmental organization, academic institution
- **Population group(s) reached:** People living with HIV, adolescent girls and young women living with HIV
- **Has the programme been evaluated/assessed:** No
- **Is the programme part of the national aids strategy or national HPV/cervical cancer elimination strategy?** Yes
- **Is the programme part of a national plan other than the national aids strategy?**  
No

#### BACKGROUND:

Morocco is experiencing an epidemiological transition, chronic diseases and cancers are responsible for 56% of the general disease burden. Cancer is a growing burden on the health care system; it was the cause of death in 12% of cases in 2012. In just six years, the number of deaths from cervical cancer has more than doubled in Morocco. It went from 1,076 in 2012 to 2,465 deaths in 2018, according to the latest data from the International Agency for Research on Cancer (IARC), published on New Global Cancer Data (GLOBOCAN 2018). As for the number of cases of cervical cancer, it has risen sharply, from 2,258 new cases per year in 2012 to 3,388 in 2018. Considered for several years as the second leading cause of death related to cancer in women in Morocco, the rates for cervical cancer remain the highest in the Middle East and North Africa (MENA) region. In 2010, Morocco officially launched a National Cancer Prevention and Control Plan (PNPCC) 2010-2019. The early detection of cervical cancer, integrated into the reproductive health activities



package, has been gradually implemented at the national level since 2010. The national program for the early detection of breast and cervical cancer (PNDPCSC) was ratified by circular 1725DP / PF / 12 of 04 December 2012.

## **DESCRIPTION:**

In Morocco, little information is available on the association of HPV, pre-cancerous lesions of the cervix and cervical cancer. In response to the need to conduct a nationwide study on the aforementioned issues and HPV and cervical cancer screening among women living with HIV, the aids CSO OPALS in partnership with the Ministry of Health, the ART reference centers of Agadir and Fès, the Association Sud contre le Sida (ASCS), the WHO collaborating center maternity of Orangers in Rabat and with the support of UNAIDS, WHO conducted an action research aimed at measuring the prevalence of HPV and cervical cancer in women living with HIV.

The main objective of the study was to provide evidence to advocate for better access for women living with HIV to HPV and cervical cancer screening and management. With more specific objective to:

- (i) measure the prevalence of HPV in women living with HIV;
- (ii) describe the demographic and gynaecological characteristics of HIV positive women;
- (iii) determine the proportion of those who have been screened for cervical cancer as part of the medical follow-up for HIV infection;
- (iv) collect the perceptions of participating women with regard to cervical cancer screening; and
- (v) make recommendations for improved recruitment for early screening of HPV positive women.

This was a cross-sectional study scheduled over a 3-month period from October to December 2019 and which aimed to measure the prevalence of HPV in women living with HIV utilising the cervical smear test. Anatomopathological examinations were carried out in the same laboratory responsible for carrying out the assessments (HPV typing and search for pre-cancerous lesions). The method of collecting the cervical smear was done in immersion was identical for all. The training of doctors participating in the study was carried out over 2 days and took place on 30 October 2019 in favour of 5 doctors, 2 from Agadir, 2 from Fez and 1 from Rabat. The objective of the training was to update knowledge about cervical cancer, to know the recruitment criteria, to harmonize the cervical sampling technique (cervical smear) and to know the care system for women. HPV positive and women with cervical lesions. The target population were 100 women living with HIV positive under treatment and who presented for the HIV consultation in the Referral Centers in Rabat, Fez and at the Infectious Diseases Service in Agadir and / or were registered. Although some women were excluded from the study from the outset (women living with HIV under 18, or over 55 and women who did not agree to participate in the study), some at the time of clinical examination, had either cervical infection or were menstruating.

## **RESULTS OUTCOMES AND IMPACT OF THE PROGRAMME:**

The average age of the participants was 38 years from (20 – 55 years). Seventy-five percent

were married and 25% were single. Half of the women were sexually active and three quarters had given birth several times. Contraception usage was at 18%. None of them had been screened for cervical cancer, previously. The women were from a low or medium socio-economic levels and only 1 in 10 had knowledge of cervical cancer screening with almost ½ having had not heard of cervical cancer and 96% have never heard of HPV.

- Out of the 93 samples analysed, 27 samples are HPV positive, ie a positivity rate of 29%; almost 1 in 3 women living with HIV was detected HPV positive, which places this prevalence in the high margin.
- Oncogenic HPV types being HPV 18 in 7.5% of participants and HPV 16 in 26% of participants and 14 other types of High Risk "HR" HPV in 81.5% of participants
- Also, it can be concluded that among the 25 HPV positive women, it was possible to detect. 10.6% of patients with a cellular anomaly in the cervix (these anomalies are ASCUS type in 70% of cases and atypical lesions in 30% of cases).
- Among HPV positive women almost 40% have cell damage (i.e. 1 woman / 4)
- The study found that the cervical cancer screening program must be adapted for women living with HIV.
- The 10 patients with a cell abnormality were given a colposcopy with directed cervical biopsy in order to make the diagnosis of cervical cancer if present. Those women with cervical cancer were referred for their management of cervical cancer.

#### **LESSONS LEARNED AND RECOMMENDATIONS:**

- Establish a specific sensitization program for women living with HIV with regard to cervical cancer and its main risk factors.
- During STI-AIDS awareness and screening campaigns, integrate the awareness component into early detection of cervical cancer, especially for women living with HIV and women from key populations
- Taking into account the particular nature of the evolution of HPV in women living with HIV it is strongly recommended to prepare a cervical cancer screening program specific to this group. This screening should focus more on the cervical smear method with detection of HPV positive women.

#### **ANNEXES: N/A**

## 6. [Namibia](#)

### TITLE OF THE PROGRAMME: CERVICAL CANCER SCREENING PROGRAM

#### CONTACT PERSON

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- **Programme is being implemented since:** 2018 - **End:** N/A
- **Responsible party/parties:** Government, PEPFAR
- **Population group reached:** Women living with HIV
- **Has the programme been evaluated/assessed:** No
- **Is the programme part of the national AIDS strategy or national HPV/cervical cancer elimination strategy?** Yes
- **Is the programme part of a national plan other than the national aids strategy?** Yes
- **If yes, please specify:** Cervical cancer guideline, National ART guideline

#### BACKGROUND

Namibia has high rates of cervical cancer due to a high HIV prevalence among women. Cervical cancer is a leading cause of cancer related deaths in HIV positive women in Namibia. Women with HIV are four to five times more likely than HIV negative women to develop persistent HPV precancerous lesions and progress to cervical cancer, and often with forms that are more aggressive and with higher mortality. The country adopted the Visual Inspection of the cervix using Acetic acid method since 2018 which is cost effective and efficient in the prevention of advanced cervical cancer. Previously, the program was using the PAP smear as a screening method but due to centralized laboratory services, there has been delays in receiving of results and treatment thereof. The program is aimed at early detection and treatment of pre-cancerous lesion to reduce the mortality and morbidity of Women living with HIV in Namibia.

#### DESCRIPTION

The objective of the cervical cancer screening programs is to provide cervical cancer screening and treatment amongst HIV infected women. The program is being implemented

by the Ministry of Health and Social services with technical and financial support from PEPFAR. Since inception, the program primary focus is the screening of women living with HIV with the intention of early detection and treatment of pre-cancerous lesions. The services are being provided at the already existing Ministry of Health and Social Services health facilities making it convenient for the patients as they are collecting their ARV's at the same sites. The program covers all the 14 regions and are equipped to perform on site Large Loop Excision of the Transformation Zone (LLETZ) to avoid referrals. Patients with cancerous lesions are referred for further management at the referral hospital. The Primary focus of the program is screening of women living with HIV as per the eligibility criteria set out in the cervical cancer guideline. In order to ensure program sustainability beyond donor funding, the services are provided at the existing health care care facilities, government health care workers are capacitated with knowledge and skills through trainings and subsequent practical. The Ministry has also made budgetary provision for the cervical cancer program. The major implementing partner is PEPFAR-CDC.

## **RESULTS OUTCOMES AND IMPACT OF THE PROGRAMME**

The overall program strategy is to provide cervical cancer screening and treatment among HIV infected women in the reproductive age. the program intends to increase coverage of cervical cancer diagnosis and treatment, increase uptake of cervical cancer screening among women living with HIV and to reduce cervical cancer related morbidity and mortality. Although the program inception was in 2018, the screening of patients commenced mid 2019. A total of 30 058 patient were screened for cervical cancer using the VIA (25 494) and Pap smear (4 564) method by September 2020. It covers all the 14 regions in the country at approximately 58 sites. The uptake has been gradually increasing although due to COVID-19 pandemic gathering restrictions, the number has been relatively low.

## **LESSONS LEARNED AND RECOMMENDATIONS**

The success of the program came about through extensive community education through media, dissemination of IEC material. The Ministry has also availed space for the set up of the VIA services and contribution of the GRN budget towards the program. The major challenges facing the program is staff shortage especially personnel for data collection (data clerks), as a result health care workers collect data. The other challenges are commodities shortage due to the supply chain disruption by COVID-19 restriction. The recommendations are for the government to increase the budget allocation for the cervical cancer screening program, training of more health care workers and increasing the sites where screening takes place.

**ANNEXES: N/A**

## 7. [Nigeria](#)

**TITLE OF THE PROGRAMME: Preventing deaths from cervical cancer by catalysing the use of optimal screening tests and treatment devices**

### **CONTACT PERSON**

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- **Programme is being implemented since:** 2019 – **End:** 2021
- **Responsible party/parties:** Government, Civil society, UN / other inter-governmental organization
- **Population group(s) reached:** Women and girls, people living with HIV
- **Has the programme been evaluated/assessed:** No
- **Is the programme part of the national AIDS strategy or national HPV/cervical cancer elimination strategy?** No
- **Is the programme part of a national plan other than the national aids strategy?** No

### **BACKGROUND**

Cervical cancer is one of the most preventable types of cancer, but it continues to generate a significant burden of disease and death in low and middle-income countries (LMICs). Globally, more than 300,000 women die of cervical cancer each year, with more than 90% of deaths occurring in LMICs. This inequitable distribution of cervical cancer cases and deaths is directly linked to disparities in access to secondary prevention as countries with robust screening programs have cut cervical cancer deaths by 50%. Nigeria contributes significantly to the global burden of cervical cancer cases. 53 million Nigerian women are estimated to be at risk of cervical cancer and existing screening programs covers less than 9% of the population. Available data also indicates that cervical cancer incidence rate is about 33 per 100,000 women and an estimated 14,943 women are diagnosed every year, with a mortality rate of about 25% – this makes it the second most common in incidence and mortality for all cancers in Nigeria. Cervical cancer is primarily caused by persistent or chronic infection with one or more of the high-risk types of Human Papilloma Virus (HPV), an extremely common virus transmitted through skin to skin contact including sexual contact.

Co-infection with HPV and HIV puts women living with HIV (WLHIV) at risk of progression to cancer. In countries like Nigeria with high HIV prevalence, more than 50% of cervical cancer cases occur in WLHIV as they are six times more likely to develop cervical cancer making it a significant threat to improving health outcomes for WLHIV. There are 1.6 million Nigerian adults (15 and above) living with HIV, 940,000 of these are women, the high prevalence of HIV among Nigerian women and the lack of organized screening programs are substantial contributing factors to the high burden of cervical cancer. There are proven and cost-effective measures to eliminate cervical cancer. Effective programs to screen and treat women for pre-cancerous lesions offer the opportunity to achieve the aim of its elimination as a public health problem. Access to screen and treat has however been constrained by a few challenges: Required tools and technologies not available at scale; the accuracy of visual inspection with acetic acid (VIA) is highly variable and dependent on a provider's skill; HPV testing is expensive and available only at a limited number of sites; treatment with cryotherapy and LEEP is cumbersome, expensive and impractical to use at large scale; lack of routine screening and integrated services for women at health facilities; poor referral linkages and follow-up mechanisms. It is therefore imperative to identify affordable and effective tools to bring screening and treatment to scale in order to effectively fight cervical cancer and improve the health outcomes of WLHIV and women in the general population. References: National Strategic Plan for Prevention and Control of Cancer of the Cervix in Nigeria, 2017 -2021 Vaccarella et al. Preventable fractions of cervical cancer via effective screening in six Baltic, central and eastern European countries 2017-40: a population-based study. *The Lancet Oncology*: Volume 17, Issue 10, 1445-1452. Human papillomavirus and related diseases in Nigeria. In: Summary Report 27 July 2017. ICO/IARC HPV National Strategic Plan for Prevention and Control of Cancer of the Cervix in Nigeria, 2017 -2021 Invasive cervical cancer risk among HIV-infected women: A North American multicohort collaboration prospective study. *JAIDS Journal of Acquired Immune Deficiency Syndromes*. 2013; 62(4):405–413 UNAIDS epidemiological estimates, 2020

## **DESCRIPTION**

In support of the WHO 2030 goal towards the elimination of cervical cancer as a public health problem, UNITAID and the Clinton Health Access Initiative (CHAI) seek to accelerate access and scale up the use of optimal tools through the cervical cancer secondary prevention program in Nigeria. The program is introducing artificial intelligence and scaling affordable treatment and screening to the fight against cervical cancer in three Nigerian states – Lagos, Rivers and Kaduna. The program which is in collaboration with the Ministry of Health targets to reach 430,000 women over the next two years and the goal is to lay the groundwork for the rapid national scale up of high-quality secondary prevention services. The program is being implemented in 177 healthcare facilities in these three states. 136 of which are ART sites to enable a good coverage of WLHIV. The program is leveraging on integrated models for reaching WLHIV through existing health services, such as antiretroviral therapy (ART) clinics while innovative tools such as self-sampling kits will be introduced to ease the burden of HPV testing both for clients and for health workers. CHAI's approach aspires to build robust health systems in-country and provide for equitable cervical cancer screening and treatment services to women across the continuum of care: 1. Expanding access to cervical cancer screening for WLHIV and general population; integrating HPV testing on existing multiplex testing platforms with underutilized capacity that currently provide HIV viral load and/or tuberculosis testing. The program is also working to bring a

promising new screening technology, Automated Visual Evaluation (AVE), to Nigeria. AVE uses AI to overcome the inadequacies of human-based visual inspection of the cervix by analyzing images to detect pre-cancer, potentially offering effective screening at very low cost via a software application on mobile phones and allowing for widespread scale-up 2. Introducing portable thermal ablation and LEEP devices for the treatment of precancerous lesions. The devices are portable, light, battery-powered devices for treatment of precancerous lesions is the essential building block that enables the widespread scale-up of secondary prevention particularly in low resource settings like Nigeria. Women with advanced cancer will be referred for appropriate care. The program is also building the capacity of over 1000 HCWs through training and mentoring because secondary prevention of cervical cancer in countries like Nigeria requires a diverse set of clinical skills 3. Engaging civil society organizations (CSO) to generate demand for cervical cancer services. The program will build on existing structures for demand generation and work with CSOs to increase awareness of and understand women's preferences, barriers, and enablers for screening; leverage key influencers including states' first ladies and professional bodies at high and low levels to drive messaging around timely screening, promote health literacy, and promote active patient counselling and referral; leverage service delivery points where women are already accessing services; support the Federal MOH to review health promotion policies and strategies for cervical cancer; and explore financing mechanisms to reduce cost-related barriers to service update 4. Patient Tracking - The program is working with the FMOH to build a robust patient tracking system for cervical cancer in Nigeria. Secondary prevention and treatment of cervical cancer often involve the full continuum of care including multiple touchpoints across time and service provision points. The ability to track individual women linking patient records over multiple touchpoints is essential for service provision, as healthcare providers can work to ensure that women receive the treatment and follow-up care that they need, and put in place efforts to reduce loss-to-follow-up

## **RESULTS OUTCOMES AND IMPACT OF THE PROGRAMME**

The main impact anticipated through CHAI's work is the reduction in cases of cervical cancer and related deaths, both in the near-term through CHAI's direct programmatic support to the Nigerian government, and in the medium- to long-term as CHAI's efforts lay the groundwork for scale-up.

This health impact is achieved through improvements to screening accuracy and the rate of treatment of screen-positive women:

- The program is facilitating more accurate screening programs, particularly among WLHIV, reducing the rate of false negative results and catching more women who need treatment in the three program states
- Treatment with thermal ablation is logistically easier to manage and administer than traditional cryotherapy, allowing treatment to be deployed at lower-level health facilities and improving the rate of treatment of screen-positive women
- Once available, screening with AVE is expected to have significantly better test characteristics than VIA, allowing screening programs to catch more women with precancerous lesions and reduce the rate of false positive results Together, these innovations enable scale-up by offering an affordable package of secondary prevention services. Screening with AVE offers improved test characteristics at minimal additional cost relative to

VIA. Treatment with thermal ablation is significantly less expensive than traditional cryotherapy, particularly with the device price reductions.

By demonstrating that effective screen and treat is practical and affordable, CHAI aims to demonstrate to the Nigerian government and to additional donors that this effort represents good value for money, spurring them to invest in scale-up.

## **LESSONS LEARNED AND RECOMMENDATIONS**

The program is currently in the implementation phase but so far, the following have been fundamental in program initiation and implementation:

- Strong ownership and leadership of the program by the government at the federal and state level
- Collaborations with different partners such as the Nigerian government, US Government, WHO, local CSOs, technical experts from the academics and other implementation partners
- Good understanding of the local context of the three different program states through community engagement

Key challenges faced by the program which are being addressed:

- Low awareness and knowledge of cervical cancer among target women i.e WLHIV aged 25 – 49 years and 30-49 in general population
- Increased burden for existing HCWs
- Impact of COVID-19 on program implementation

**ANNEXES: N/A**



## 8. [Uganda](#)

### TITLE OF THE PROGRAMME: Integration of cervical cancer screening in routine HIV/AIDS care services: Lessons from a pilot program in Uganda

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- **Programme is being implemented since:** 2019 - End N/A
- **Responsible party/parties:** Government, non Governmental Organization
- **Population group reached:** People living with HIV
- **Has the programme been evaluated/assessed:** Yes
- **Is the programme part of the national AIDS strategy or national HPV/cervical cancer elimination strategy?** Yes
- **Is the programme part of a national plan other than the national aids strategy?** Yes
- **If yes, please specify:** The programme is part of the national cervical cancer prevention and control strategy

#### BACKGROUND

Cervical cancer is the most common gynecological malignancy among women in Uganda and the leading cause of cancer death. With an incidence of 54.8 cases per 100,000 women, Uganda is one of the highest burdened countries in the world. Similar to the context in other resource-limited settings, cervical cancer in Uganda is characterized by late presentation with more than 80% of women either reporting or being diagnosed late when the cancer is more difficult to treat. This has resulted in low treatment success and survival rates with most patients often referred for palliation treatment only. Human papillomavirus (HPV) is the primary cause of invasive cervical cancer and affects many women in Uganda. Recent studies exploring HPV genotyping in invasive cervical cancer in Uganda have reported high prevalence (73.5%) of HPV 16 and 18, two high-risk HPV types attributed to 90% of all invasive cervical cancers. Women living with HIV (WLHIV) are 2 – 4 times more likely to be infected with HPV, and 3 times more likely to have persistent HPV progressing to pre-cancerous lesions. In Uganda, the incidence of oncogenic HPV infections among HIV

positive women is more than double that of HIV negative women, 17.3 versus 7.0 per 100 person-years. The prevalence of high-risk HPV (hrHPV) infections is significantly higher among HIV positive adult women ranging from 37% - 77.8% compared to 10.2% - 40% among HIV negative women. Previously in Uganda, the main screening method has been VIA but uptake has been low and mainly supported by health development partners. Consequently, screening coverage is also low with a recent national survey reporting that less than 10% of women aged 30 – 49 years have ever been screened. VIA is a low-resource screening method, however the main challenge with VIA is the training/supervision requirements. In addition, VIA requires physical examination of the cervix, which in some cultures in Uganda is not well accepted.

## **DESCRIPTION**

In Uganda, cervical cancer screening has historically only been available through VIA. The World Health Organization (WHO) has recommended that testing for high-risk HPV (hrHPV) infection be incorporated into cervical cancer screening programs. Molecular nucleic acid tests (NATs) for HPV detection are highly sensitive for the detection of high-grade cervical intraepithelial neoplasia (CIN) and invasive disease, have comparable specificities to cytology, and their potential efficacy for population-based cervical screening has been demonstrated in large-scale randomized trials and prospective studies. Due to the large existing footprint of NAT platforms, including GeneXpert, in Uganda, there is great potential to offer HPV testing as the primary screening modality. Indeed, it is hypothesized that the addition of HPV testing to existing NAT devices will increase the coverage for cervical cancer screening without exceeding the device capacity or hampering service delivery for HIV and TB programs that are currently utilizing the platforms. By leveraging existing GeneXpert devices, which is a simpler near point-of-care (POC)/POC platform, it may be possible to offer decentralized access to screening for the prevention cervical cancer and same day treatment of pre-cancerous lesions. In addition, the alternative option of centralized HPV testing at Uganda National Health Laboratory Services (UNHLS) will be explored. The National Cervical Cancer Control Programme has introduced HPV testing as the primary cervical cancer screening method in Uganda. A pilot program targeting WLHIV attending ART services across 16 high volume hospitals was initiated and a process evaluation performed to assess the feasibility and acceptability of this integration model for offering HPV testing to screen WLHIV for cervical cancer. The aim of the pilot is to promote the uptake of screening, while minimizing loss between testing HPV positive and linkage to treatment services. In addition, this pilot assessed the feasibility of integrating HPV testing into routine health services using existing resources including health facility-based GeneXpert devices and high-throughput platforms at central laboratories.

### **Primary Objectives:**

The primary objective of this pilot was to determine the acceptability and operational feasibility of HPV testing in WLHIV as a primary cervical cancer screening method, specifically through the following:

1. To describe the uptake of HPV testing for WLHIV
2. To describe linkage to VIA and treatment for HPV+ WLHIV and the feasibility of same day test-triage-treat for HPV+ WLHIV with small pre-cancerous lesions (i.e. eligible for on-site cryotherapy)

3. To document patient and HCW opinion on HPV screening and treatment programs across different service delivery models

### Secondary Objectives

The secondary objectives included:

1. Documenting the feasibility of adding HPV testing to existing GeneXpert devices (already testing for TB and EID) by analyzing device utilization and turnaround times
2. Determining the HPV positivity rate among WLHIV accessing ART services at the pilot clinics
3. Describing the timeliness of the patient cascade of care from offering of screening through to linkage to treatment, rates of lost to follow-up, and cost implications (for both facility-based HPV testing using GeneXpert devices and centralized HPV testing at UNHLS using high-throughput platforms)

## RESULTS OUTCOMES AND IMPACT OF THE PROGRAMME

### HPV Testing

- Almost 5,000 HPV tests were conducted across the 15 sites in the first 8 months of implementation.
- Age was evenly distributed, with about 20% of women falling into each 5-year age category from 25-49 years.
- Only 10% of the women had documented records of previous cervical cancer screening.
- Only 2% of all self-collected samples had invalid test results.
- Among valid test results, 37% of women tested positive for a high-risk HPV type (35% with subtypes 16 and/or 18/45). Testing Turnaround Time
- Median turnaround time from sample collection to clinic receipt was 1 day (IQR: 1-3) and 24 days (IQR: 6-53) to patient receipt.
- HPV positive women received their results faster than HPV negative women: median time from sample collection to patient result was 20 days (IQR: 5-42) in comparison to 28 days (IQR: 7-60).
- HPV positive women who were then linked to VIA care had a median turnaround time of 22 days (IQR: 7-41).
- Median time from sample collection to treatment (for HPV positive and VIA positive women) was 24 days (IQR: 7-36). Linkage to VIA (for HPV+) and Treatment (for HPV+ and VIA+)
- 42% of those that tested HPV positive have been linked to VIA, with 61% being linked on the same day of result receipt.
- Among those that received VIA and were VIA positive (n=91), 69% received treatment (either cryotherapy, thermocoagulation, or LEEP) on the same day they received VIA.
- 44% of women were tested less than 30 days before data collection. Accounting for the varying amount of follow-up time, 29% were linked to VIA care within 30 days and 48% by 90 days.

## LESSONS LEARNED AND RECOMMENDATIONS

- Preliminary data from the pilot indicate that HPV testing, with self-collected samples, in

WLHIV is acceptable and feasible with HPV positive women linking to care and receiving VIA and treatment, if needed, on the same day they received their results.

- Integration of cervical cancer in routine HIV care enables access to cervical cancer screening for first time screeners.
- Linkage rates to increase with additional follow-up, and with additional time for newly tested women to return.
- In resource-limited settings, thermal ablation is a practical approach for prompt on-site treatment of VIA positive women and offers a potent solution to the logistical challenges posed by conventional gas cryotherapy
- Targeting pre-service training: Cervical cancer should be integrated into broader Health care worker (HCWs) education and trainings in nursing schools and continuing medical education curricula to sensitize HCWs to core Cervical cancer concepts.

Challenges HR/Training: Staffing levels at screening sites together with indiscriminate staff rotations across departments affect continuity of service delivery. Although hospitals were engaged to minimize withdrawal of trained staff at key service units and at least ten HCWs trained per facility, inadequate staffing remains common.

**ANNEXES: N/A**

## 9. [Uganda](#)

### TITLE OF THE PROGRAMME: LEVERAGING UNFPA COMPARATIVE ADVANTAGE TO ADDRESS CERVICAL CANCER AND SAVE WOMEN'S LIVES IN UGANDA

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- **Programme is being implemented since:** 2016 – **End:** N/A
- **Responsible party/parties:** [UN or other inter-governmental organization, Government, civil society]
- **Population group(s) reached:** People living with HIV, adolescent girls and young women living with HIV, women and girls among key populations, women and girls, adolescent girls and young women
- **Has the programme been evaluated/assessed:** No
- **Is the programme part of the national aids strategy or national HPV/cervical cancer elimination strategy?** Yes
- **Is the programme part of a national plan other than the national aids strategy?** Yes
- **If yes, please specify:** Sexual Reproductive Health and Rights

#### BACKGROUND:

Cervical cancer is one of the most common cancers among women worldwide. Existing evidence shows that women living with HIV are four to five times more likely to develop invasive cervical cancer. HPV infection has been found to significantly increase the risk of HIV transmission for both men and women. As a result, there is a growing awareness of the need to maximize synergies between the AIDS response and efforts to prevent, diagnose and treat cervical cancer through HPV vaccination, education, screening and treatment. In Uganda, where cervical cancer screening services have not been widely available coupled with limited awareness, cervical cancer has become a huge public health problem. Cervical cancer is the number one incident cancer among women in Uganda followed by breast cancer.

**DESCRIPTION:**

During the past five years (2016-2020), United Nations Populations Fund (UNFPA) in Uganda is leveraging on her comparative advantage in the delivery of integrated sexual reproductive health and rights (SRHR) services to increase access to cervical cancer and HIV services to vulnerable women and girls particularly KPs, people living with HIV and adolescent and young people engaged in risky sexual behaviours. UNFPA activities focused on national advocacy for resources mobilization and a focus in embedding cervical cancer in the various SRH/HIV/GBV integration technical guidance tools and supporting integrated service delivery to increase access to cervical cancer screening and referral for treatment in seventeen UNFPA supported districts in Uganda. The approaches are employed through leveraging existing resources in terms of technical expertise and service delivery funds for broader SRHR programs implemented by the country office because the office has no specific budget dedicated to supporting the implementation of the national strategy for cervical cancer prevention and control.

**RESULTS OUTCOMES AND IMPACT OF THE PROGRAMME:**

UNFPA technical support and leveraging of resources through integrated SRHR programming has contributed to enhanced focus on cervical cancer (CaCx) programming in the country. The results include:

- Integration of cervical cancer screening and treatment of precancerous lesions into services delivery guidelines including Family Planning, HIV care and Postnatal care.
- Development of the Implementation Plan for the National CaCx Prevention and Control Program with Full integration of CaCx screening in SRHR service delivery and HIV care, the adoption and roll-out of the Use of HPV test for screening prioritized for the HIV+ as a National Program. The rollout will Cover the Whole Continuum of care with all aspect of prevention levels Including HPV Immunization (Already integrated into the EPI program) and awareness creation under Primary Prevention.
- Integration of CaCx Screening (HPV, VIA, PAP) and Treatment of precancerous lesions (Cryotherapy, Thermocoagulation, LEEP +B, Hysterectomy) under Secondary Prevention.
- Integration of cervical cancer screening and referral for treatment of precancerous lesions into UNFPA CSO IP integrated SRHR service outreaches in UNFPA supported districts focusing on KPs, people living with HIV and adolescent and young people engaged in risky sexual behaviours. Through this contribution, 36,665 (DHIS2) women and girls have been screened in 17 UNFPA supported districts including all the districts in Karamoja region for the period (2016-2020).
- The development of the Monitoring and Evaluation Plan for the cervical cancer prevention and control strategy
- The development of HMIS tools for documentation and reporting on cervical cancer

**LESSONS LEARNED AND RECOMMENDATIONS:**

What factors helped the success of the programme, including institutional set-up, the participation of children and young people, people living with HIV and of key populations, legislative and policy environment, coordination, political mobilisation and support?

- Improving strategic information management including generation of evidence from surveys and management information systems that reflect for example prevalent comorbidities among people living with HIV has informed targeted advocacy for focus on cervical cancer
- The expanding advocacy for integrated SRH/HIV/GBV programming to provide holistic focus on beneficiaries has been a key success factor in focus on cervical cancer on SRH and HIV programming and service delivery platforms
- Existing institutional structures in the health sector and HIV multisectoral programming enhance wider stakeholder engagement including non-public actors and beneficiary groups of women, adolescents and young people as well key population groups to present their voices and help shape resource mobilization and program delivery tools
- Specifically, UNFPA has positioned technical officers at the Ministry of health-supporting SRH/HIV/GBV program design, coordination and monitoring and evaluation aspects that provides opportunities for mapping and exploiting platforms for promoting a focus on integrated actions. This has provided opportunities for leveraging resources from bigger funding streams for example from PEPFAR partners What were the biggest challenges?
- Prevention and treatment of cancers generally and cervical cancer specifically has previously not been prioritized as an essential service and therefore severely underfunded by government. Yet the large donor-driven biomedical HIV response in the country is still largely vertical with missed opportunities for comprehensive programming focusing on HIV co-morbidities.
- Competing priorities within a framework of limited financial and human resources at UNFPA level further curtail expanded focus on cervical cancer programming. What recommendations could be made to further improve the programme or similar programmes in other settings?
- Invest in enhanced integrated SRH, HIV, GBV program delivery as a practical approach for focus on the non-essential services such as cervical cancer services
- Global partners to provide guidance on integrated programming with the country reporting commitments at national and international level through existing peer review mechanisms

**ANNEXES: N/A**

## 10. [Zimbabwe](#)

**TITLE OF THE PROGRAMME: N/A**

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- **Programme is being implemented since:** 2013 - **End:** N/A
- **Responsible party/parties:** Government, UN or other inter-governmental organization
- **Population group(s) reached:** People living with HIV, adolescent girls and young women living with HIV, adolescent girls and young women, women and girls among key populations, women and girls
- **Has the programme been evaluated/assessed:** Yes
- **Is the programme part of the national AIDS strategy or national HPV/cervical cancer elimination strategy?** Yes
- **Is the programme part of a national plan other than the national aids strategy?**  
No

### **BACKGROUND:**

The Government of Zimbabwe has demonstrated a firm commitment to HIV-SRH integration, with cervical cancer screening forming a key component of the core services to be provided. In 2010, the Government of Zimbabwe Ministry of Health and Child Welfare, now Ministry of Health and Child Care (MoHCC), with technical and financial support from UNFPA and development partners, commissioned a Rapid Needs Assessment with the following objectives:

1. To assess the existence of SRH and HIV policies and the extent to which these are in support of SRH and HIV integration.
2. To explore the systems in place to support or hinder integration, including funding, partnerships, planning, human resources and logistics.
3. To understand the extent to which SRH and HIV services are integrated at the service delivery point, the gaps and operational challenges.
4. To uncover the extent of integration and opportunities that exist at the community level.



At the system level, SRH and HIV integration was also found to be weak. At the service delivery level, some degree of integration was found, particularly at Rural Health Clinics, although this was uncoordinated, inconsistent, and uninformed by policies. Community-based stakeholders reported that integration within SRH and HIV programs was weak, and confirmed the lack of coordination, strategy and required capacity.

## **DESCRIPTION:**

The project proposed for presentation is an evaluation (“the evaluation”) of a series of measures implemented by the MoHCC to address the gaps identified by the rapid needs assessment with the goal of improving HIV and SRH integrated service provision, including cervical cancer screening in that basket of key services (“the intervention”). While not focused exclusively on cervical cancer screening, the analysis did specifically assess provision of cervical cancer screening services as part of HIV/SRH service integration. It is also one of the only studies that quantitatively shows the benefits of integration and thus would be an important case study to add to the evidence to present to the PCB.

The intervention: In response to the Rapid Assessment, in 2013 the MoHCC addressed the identified gaps to integration by publishing a set of national service guidelines to promote efficient and effective linkages between SRH and HIV policies and services, and set national standards for high quality integrated services. The integration guidelines focused on strengthening the following integration modalities: (i) intra-provider; (ii) intra-facility; (iii) inter-facility; and (iv) mixed model.

The service guidelines also involved the development of minimum package of services at the community, primary (rural/urban clinics), secondary (district hospitals), tertiary (provincial hospitals), and referral level (central hospitals) to guide the delivery of standardized integrated SRH and HIV services. The guidelines were followed by the development of a training package, which included trainers’ guides for health service managers, service providers and community health workers. As part of the Government nationwide integration efforts, the minimum package of service described in the national guidelines became the standards for all facilities.

Each facility was required to provide training of health-care providers as well as to incorporate a mix of HIV and SRH services. Overall, 311 trainers and senior managers and 4,806 service providers, among which nurses and village health workers, were trained on HIV/SRH integration. Additionally, among the community health workers trained, 1,730 were assigned the role of “Behavior Change Facilitators” and put in charge of community mobilization and demand generation. Through a home visit approach, they reached 410,636 individuals and shared information on HIV, gender-based violence and SRH services available to them.

The evaluation: The evaluation took place in a subsample of provinces with data collected before and after the roll out of the Government nationwide integration efforts. Baseline data collection was conducted between 2013 and 2014, which correspondent to the time when the service guidelines were developed, and endline data was collected in the fall of 2017 on the same facilities – two years after the initial roll out of the integration capacity building efforts. The MoHCC and the research team also decided to design a secondary

experimental intervention to further promote integration in a subsample of districts, entailing four rounds of supportive supervision focusing on HIV-SRH integration and cash prizes awarded to the district with the best performance and to the most improved district in each of the four provinces at every quarter.

For the purpose of the study, two different sets of measures related to HIV and SRH services were constructed, drawing data from different sources. Patient-centered measures were constructed from survey data to capture changes in the volume of additional observed and self-reported services delivered to or received by each patient. Concomitantly, HMIS routine data were used to estimate system-level service counts, which were instead meant to capture changes in the volume of HIV and SRH services and were included in the cost function for the estimation of efficiency gains.

## **RESULTS OUTCOMES AND IMPACT OF THE PROGRAMME:**

As mentioned above, the study presented here specifically assessed an HIV/SRH service integration package including cervical cancer screening and is one of the only studies that quantitatively shows the benefits of integration and thus would be an important case study to add to the evidence to present to the PCB. The description below presents the overall findings.

A set distinct HIV and SRH services were covered, including cervical cancer screening:

- ART
- Support services for PLHIV already enrolled in ART
- HIV testing and counselling
- Condom promotion and distribution
- Family planning for all HIV-positive women
- HIV testing for pregnant women
- Antenatal and postnatal care for all identified HIV-positive women and their infants
- Voluntary medical male circumcision services
- Family planning, excluding condoms
- Antenatal care for all pregnant women
- Cervical cancer screening
- Gender-based violence screening and counselling

Findings: From the Government's launch of the national services guidelines in 2013 to the end of data collection, the health system of Zimbabwe has seen significant changes in the delivery of HIV and SRH services. Overall, the volume of HIV and SRH services delivered increased in both DHs and PHCs, with this increase being proportionately larger in SRH compared to HIV services. Compared to baseline, in 2017 HIV and SRH services were also provided in a more integrated way, either by the same health provider or by different providers within the same facility. This increase in integration can be attributed to the secular efforts of the Government of Zimbabwe, which have led to an increase of the integration measure by about 0.8 standard deviations in PHCs and 1.2 in DHs. The effects driven by the country's dedication and commitment to HIV-SRH integration were complemented by the additional randomized experiment which in turn contributed to increasing the integration measure by an additional 0.2 standard deviations in PHCs and 0.8 in DHs, on top of what had already been achieved.

The assessment also showed that the benefits of integration are not financially burdensome, but, on the contrary, may lead to economic gains. Many more SRH services, including cervical cancer screening, could be delivered for virtually no increase in costs from delivering exclusively HIV services, indicating economies of scope. Additionally, in district hospitals, high levels of integration were found to translate into economies of scale. Higher levels of integration could be achieved at almost no additional cost in 2016 compared to 2013. Before the Government had promoted integration and trained its staff in how to achieve it, the same increase in integration would have led to much higher marginal costs per composite HIV-SRH service. In the context of Zimbabwe, we also found that all of this could be done without sacrificing quality, nor burdening clients with increased financial or time costs. Patient satisfaction may even be marginally increased and some of the costs associated with visiting a facility may decline, although findings vary based on the type of facility and may be mainly associated to increased integration efforts resulting from the supplementary supportive supervision experiment.

#### **LESSONS LEARNED AND RECOMMENDATIONS:**

Measuring integration and its economic gains in scale and scope is a challenging and ambitious task. But it is one that we believe is essential to yield important perspectives. Moreover, as outlined above, the process revealed important insights into the performance of the integration efforts assessed including integration of cervical cancer screening with HIV services as part of an integrated HIV/SRH package.

**ANNEXES: N/A**

## 11. [Zimbabwe](#)

### TITLE OF THE PROGRAMME: INTEGRATED CERVICAL CANCER SCREENING PROJECT IN KWEKWE DISTRICT, ZIMBABWE

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- **Programme is being implemented since:** 2015 - **End:** 2016
- **Responsible party/parties:** Government, Civil society
- **Population group(s) reached:** Adolescent girls and young women, women and girls
- **Has the programme been evaluated/assessed:** Yes
- **Is the programme part of the national aids strategy or national HPV/cervical cancer elimination strategy?** Yes
- **Is the programme part of a national plan other than the national aids strategy?** Yes
- **If yes, please specify:** National Cancer Prevention and Control Strategy for Zimbabwe 2014 - 2018

#### BACKGROUND:

Globally cancer is the third leading cause of death with 12 million new cases and 7.6 million deaths in 2007, projected to increase to 26 million cases and 17 million deaths annually by 2030. In Zimbabwe, the total number of new cases of cancer recorded among Zimbabweans in 2007 was 3 349. Although this was slightly down from the 4 015 new cases recorded in 2005, a greater number of women than men are affected by cancer National Cancer Prevention and Control Strategy For Zimbabwe, 2013 – 2017, Ministry of Health and Child Welfare, Government of Zimbabwe). According to official statistics from the Zimbabwe Ministry of Health and Child Care, cervical cancer kills not less than 2000 women annually and the majority of affected women are HIV Positive. The Centre for Disease Control (CDC) in their 2019 report acknowledged HIV as a risk factor or cervical cancer highlighting that women with HIV are 4-5 times more likely to develop cervical cancer compared to HIV negative women. There is strong evidence that there is a link between cervical cancer and HIV: According to the Zimbabwe National Cancer Registry 2005 Annual Report, 60% of cancers are associated with HIV infections. The impact of HIV is reflected in the high incidence rates of Kaposi sarcoma and other HIV associated cancers which include cervical cancer, squamous cell carcinoma of the conjunctiva and non-Hodgkin's lymphoma (Parkin et

al, 2006). Specifically, the “sexually transmitted human papilloma virus is now recognized as the principal cause of cancer of the uterine cervix. About 35% of women in the general population are estimated to harbor cervical HPV infection at a given time, and 79.6% of invasive cervical cancers in Zimbabwe are attributed to HPVs 16 or 18.” Although the HPV vaccination process has started to roll out for young girls in Zimbabwe, coverage numbers are still fairly low. In the long term this will enhance prevention of cervical cancer, but will not have an effect in the short to medium term for many women in Zimbabwe. STIs, HIV, cervical cancer and gender-based violence are addressed together to ensure that women get the maximum benefit from our health system.”

The provision of integrated health services has had a specific focus of the Government’s SRH strategy. Research has also highlighted additional risk factors for cervical cancer as: “early sexual debut, multiple sexual partners, history of sexually transmitted infections, excessive tobacco smoking, long term use of oral contraceptives, poor nutrition, genetic factors and immunosuppression. HIV positive women who are immunosuppressed are thus at a higher risk for developing precancerous lesions and may have a more rapid progression to invasive cervical cancer. The diagnosis of cancer at earlier stages of disease can enhance the chances of successful treatment outcomes and greatly increases the chances of a successful cure. However the majority of cancer patients (80%) in Zimbabwe present late (3rd and 4th stage), resulting in increased premature deaths from cancer. The challenges associated with late diagnosis are exacerbated in Zimbabwe where there is virtually no capacity within the public health system to treat cancer outside of surgical removal. Over and above the work taking place in hospitals, the Government of Zimbabwe - supported by development partners - is also in the process of trying to decentralize health services in order to make them more accessible to communities living in hard to reach areas. In many cases, this involves development partners supporting ‘outreach visits’, where Ministry of Health and Child Welfare staff members are taken into hard to reach areas using vehicles, and sometimes equipment, provided by development partners. SAT has been at the fore of such outreaches and mobilisations. The need for this change to outreach that offers integrated services is therefore critical.

#### **DESCRIPTION:**

In order to respond to the growing concerns of an increase in cervical cancer prevalence, SAT embarked on a project to address this concern. SAT Zimbabwe was approached by the National AIDS Council (NAC) and requested to complement the support offered by other development partners by providing VIAC equipment and training in the KweKwe District, in the Midlands Province of Zimbabwe. This would involve the provision of support to the VIAC Clinic at KweKwe Hospital to enable them to expand their services, and the establishment of VIAC Clinics at Silobela Hospital and Nyoni Clinic. In addition to the provision of the equipment and the training of staff, SAT Zimbabwe recognised, through its community mapping exercises and the work of one of its partners, Women in Coalition (WICO), in this geographical area, that many rural women were not accessing VIAC due to the distances that they live from clinics. It was therefore agreed to include an outreach element in the programme, in order for these services to be taken into the community. The description of the context provided above illustrates the Government of Zimbabwe’s commitment to both rolling out VIAC within the health system and to offering decentralized, integrated services. The intended objectives for the project were:

- To increase the number of women utilising cervical cancer screening and treatment services and HIV counselling and testing in the hard to reach rural areas.
- To increase the number of facilities providing screening and treatment services for early stage cervical cancer.
- To improve skills and knowledge of health workers in early stage cervical cancer detection and treatment.
- To investigate the correlation that may exist between cervical cancer findings and HIV infection.

Individuals responsible for supporting the implementation the programme from health facilities that were involved in the intervention in Kwekwe, including Kwekwe General Hospital, Nyoni Clinic and Silobela District Hospital were:

- Health workers that were trained as part of the project (from the Ministry of Health and Child Care)
- The Ministry of Health
- Other key role players in the field in Zimbabwe
- Individuals from other key development partners as recommended by SAT Zimbabwe.

The programme was implemented over a period of 2015 -2016. Lessons learnt from the project were derived from an evaluation that was undertaken. In terms of financial sustainability, the programme was conducted in partnership with the Ministry of Health and Child Care who have started to cascade the programme in the country's various districts with support from the Office of the First Lady.

## **RESULTS OUTCOMES AND IMPACT OF THE PROGRAMME:**

A total of 1 391 screens were carried out in the course of the programme, for Cervical Cancer, HIV, and other conditions using the ultrasound equipment, and 435 women received VIAC specifically in this particular programme. Women and girls in Kwekwe district benefited from this programme through the awareness campaigns and managed to be screened for Cervical Cancer, HIV and other conditions where other women were also referred for further medical reviews after the screening process. The programme also indirectly benefitted some men from the district, who also got an opportunity to be screened for prostate cancer.

## **LESSONS LEARNED AND RECOMMENDATIONS:**

Those that attended the cervical cancer screening were also screened for HIV using the Rapid Test and STI screening. A total of 1 391 screens were carried out in the course of the programme, for Cervical Cancer, HIV, and other conditions using the ultrasound equipment, and 435 women received VIAC specifically. It was found that there was keenness on the part of women to be screened for cervical cancer. This was also attributed to the prevalence of cervical cancer in the community and the number of sensitisations that had been done by SAT in conjunction with HIV/AIDS awareness sessions. The awareness was also buttressed by the then Mayor and Mayoress of Kwekwe and the Mayoress who was also screened. The efficacy of the programme was further improved by the outreach services that were an essential part. SAT mobilized the community members in advance and the screening team would follow. Without the outreach, not as many women would have been screened. One partner commented that through the mobile outreach work that they are doing, they support

integrated services including HCT, family planning, ART re-supply, tracing of defaulters, ANC (visits and registration of pregnancy), cervical cancer screening, and health education. They continued to say that initially the services that they supported were integrated, “but not comprehensive, and we added services so they could be more comprehensive”. The SAT Cancer programme was considered a critical ‘gateway’ for building understanding amongst patients around broader sexual and reproductive health issues including HIV. The cervical cancer screening programme was also popularised by the First Lady Auxilia Mnangagwa who managed to mobilise over 60 000 women and girls who were screened over a period of one year.

**Annexes: N/A**

## Asian States



## 12. Islamic Republic of Iran

### TITLE OF THE PROGRAMME: PREVENTION OF HPV AND CERVICAL CANCER AMONG WOMEN AND GIRLS LIVING WITH/AFFECTED BY/ AT RISK OF HIV

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- **Programme is being implemented since:** 2017 – **End:** N/A
- **Responsible party/parties:** Government, civil society, private sector, UN/other inter-governmental organization, academic institution
- **Population group(s) reached:** People living with HIV, adolescent girls and young women living with HIV, women and girls among key populations, women prisoners
- **Has the programme been evaluated/assessed:** No
- **Is the programme part of the national aids strategy or national HPV/cervical cancer elimination strategy?** Yes
- **Is the programme part of a national plan other than the national aids strategy?** No

#### BACKGROUND

There is a long history of Pap smear exercise as a principal element of Primary Health Care system in the country. However, considering requirements of WLHIV and most at risk women, screening of cervical cancer was specifically included in the care and treatment protocol of WLHIV in 2007. Following scientific advancements and expansion of services, HPV prevention was also added to HIV care and treatment protocol in line with STI management strategy of the National Strategic Plan for HIV Control. Complementary to traditional concept of prevention of HPV for elimination of cervical cancer which can be timely diagnosed and addressed through screening, HPV's other consequences which are usually less addressed appeared to be essential to be taken into consideration for an effective programme. Importantly, ano-genital wart (AGW) is a highly stigmatized condition which can affect all aspects of life. These include psychological (depression, anxiety, obsession, sexual intercourse malfunctions and fear of malignancy), familial and legal

consequences and cost of medical care, prolonged treatment, and treatment complications including fistula, stricture and cosmetic consequences. Meanwhile, public and private sector practitioners' observations indicated an increasing trend of HPV which demanded a more comprehensive yet targeted approach. Therefore, this programme is not merely restricted to cervical cancer screening but to effectively address AGW as a cause of impairment of sexual and reproductive well-being of women.

## **DESCRIPTION**

The main objective of the programme is to prevent and address HPV consequences in order to improve women and girls' health condition including sexual and reproductive health. The target populations are WLHIV and vulnerable women. Across the country, screening test is done either in obstetric units of Voluntary Counselling and Testing Centers (VCT) or by referral to out-sourced service delivery points. Supplementing the programme with HPV vaccine is another objective of the programme. Since 2017, HPV vaccine has been included in the national HIV care and treatment protocol. Covering eligible WLHIV with HPV vaccine will become more meaningful as access to vaccine through UN channels and locally produced vaccine (2v-16,18) launched in late 2020 will increase. Considering other consequences of HPV infection, and in order to increase vulnerable population's access to free-of-charge vaccine, priority was given to at-risk adolescents. Other elements of the programme include awareness raising and education of clients including most at risk women, advocacy and sensitization of decision-makers and capacity building of service providers and peers. Reproductive health, safe motherhood, referral system for biopsy and colposcopy are other pillars of the programme. The programme is being implemented through collaboration of medical universities, NGOs, private sectors and academic centers at field level. Started with UN financial contribution, nation-wide expansion of the programme is planned to financially be supported by the government.

## **RESULTS OUTCOMES AND IMPACT OF THE PROGRAMME**

HPV prevention including Co-Test and HPV vaccine has been included in HIV treatment and care guideline after thorough advocacy with decision makers. Although HPV vaccine is not included in the national vaccination programme, but it has been included in the national HIV protocol targeting PLHIV and vulnerable women with at-risk adolescents as a window priority group in selected areas. HPV prevention programme by sensitization and education of target groups has increased demand for screening, vaccine and other related services. Meanwhile, as a window to HIV care programme, it has motivated most at-risk women to seek other HIV services provided by VCTs. Since start of the programme, 2,312 eligible WLHIV and vulnerable women have been screened for cervical cancer through HIV programme. Its impact on quality of life remains to be shown, however it is already clear that by diagnosis at earlier stage, many women have benefited from its secondary prevention values.

## **LESSONS LEARNED AND RECOMMENDATIONS**

HIV/HPV prevention programme is a window to mobilize policy makers for considering HPV vaccine in the national vaccination programme. The main challenge is stigma associated with HPV infection which leads to discrimination in service provision. Other challenges include limited access to HPV vaccine because of its high price and lack of public awareness

about HPV and its consequences. Necessity of psychologic support, capacity building and updating service providers on this novel service for the most marginalized population requires further investment in manpower and infrastructure.

**ANNEXES: N/A**

## Eastern European States

### 13. [Ukraine](#)

**TITLE OF THE PROGRAMME: VACCINATION CAMPAIGN AGAINST HPV FOR 600 HIV POSITIVE GIRLS 9-14 YEARS OLD. THE MAIN MESSAGE: PROTECTED GIRL - HEALTHY WOMAN**

#### **CONTACT PERSON**

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- **Programme is being implemented since:** 2020 – **End:** N/A
- **Responsible party:** AIDS Healthcare Foundation
- **Population group reached:** Adolescent girls and young women living with HIV
- **Has the programme been evaluated/assessed:** No
- **Is the programme part of the national AIDS strategy or national HPV/cervical cancer elimination strategy?** No
- **Is the programme part of a national plan other than the national aids strategy?** No

#### **BACKGROUND**

Cervical cancer ranks one of the first place among cancer and first place in the structure mortality from cancer in women in Ukraine. HIV positive women have a 3-4 times higher risk of cervical cancer. HPV vaccination is currently considered the best method to prevent cervical cancer and precancerous conditions. Ukraine does not provide free access to vaccination against HPV. Development partners are working together to strengthen advocacy to revise the immunization calendar and inclusion of the HPV vaccination in Ukraine.

#### **DESCRIPTION**

Goal: Create a model for providing additional preventive services to preserve the reproductive health of HIV positive women in Ukraine. Objectives 1) To expand the capacity of 24 health care providers in preserving the reproductive health of HIV positive women

Activity: Theoretical and practical training of 24 doctors and 24 nurses working with HIV positive girls about vaccination of HIV positive people (with a focus on HIV vaccination against HIV positive girls) (development training materials, educational brochures) Methodical and technical assistance to medical institutions providing help to HIV positive people to organize services (vaccination cabinets) for vaccination (development local guidelines, purchase cold chain equipment) 2) Protect from HPV (3 doses of HPV vaccine) 600 girls adolescents 9-14 years old from 24 regions of Ukraine and Kyiv. Activity: Communication campaign for 600 parents (legal representatives) and 600 girls HPV vaccine purchase and delivery to 24 regions according to need (600 doses\*3 time schedule = 1800 doses) Support immunization campaign 600 girls \*3 time schedule (Limitations: Usually 10-20% of clients do not reach up to 3 doses) 3) AHF Ukraine become a leader in woman LWH health protection advocacy and also in PLWH vaccination advocacy in Ukraine Activity: To establish cooperation with stakeholders involved in the advocacy of immunization in Ukraine Actively engage in educational, political, mass media events promoting vaccination with our main message: Protected girl - healthy woman. Vaccination project fully funded by AHF. Partners: Public Health Center, Local Department of Health.

## **RESULTS OUTCOMES AND IMPACT OF THE PROGRAMME**

Short Outcomes Vaccination campaign against HPV for HIV positive girls 24 health facilities (at least 1 in each region of Ukraine) have equipment, staff trained and motivated to carry out vaccination against IDPs for HIV-positive girls (24 doctors & 24 nurses) 600 parents of HIV-positive children were given permission to vaccinate their daughters 600 HIV girls are covered with 3 doses of HPV vaccine (vaccination starts in the beginning of 2020 ) 24 health facilities staff (at least 1 in each region of Ukraine) recognize AHF Ukraine in relation to issue of HIV+ girls health protection Participation in at least 1 educational, 1 mass media events promoting HIV+ vaccination and women health protection with a main message: Protected girl - healthy woman

## **LESSONS LEARNED AND RECOMMENDATIONS**

Partnership with the Ministry of Health, Public Health Center and health care workers at local level helped success of the programme and ensured high coverage. Currently, the organization expands the geography of its programs to the whole country. It is recommended to advocate for integration of Cervical Cancer prevention into the National HIV/TB/Hep programme.

**ANNEXES: N/A**

## 14. [Ukraine](#)

### TITLE OF THE PROGRAMME: STRATEGY TO ELIMINATE CERVICAL CANCER WOMEN LIVING WITH HIV IN ODESSA OBLAST, UKRAINE

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- **Programme is being implemented since:** 2018 – **End:** N/A
- **Responsible party:** State Health Institution
- **Population group reached:** Adolescent girls and young women living with HIV
- **Has the programme been evaluated/assessed:** No
- **Is the programme part of the national AIDS strategy or national HPV/cervical cancer elimination strategy?** No
- **Is the programme part of a national plan other than the national aids strategy?**  
No

#### BACKGROUND

About 5,733 new cervical cancer cases are diagnosed annually in Ukraine (estimates for 2018). Cervical cancer ranks as the 4th leading cause of female cancer in Ukraine. Cervical cancer is the 2th most common female cancer in women aged 15 to 44 years in Ukraine. Ref. <https://hpvcentre.net/statistics/reports/UKR.pdf>

#### DESCRIPTION:

The main aim of the project was early detection of cervical cancer among HIV positive women followed by treatment of detected precancerous lesions in Odessa region. The project initiated by administration and health care providers of Odessa Oblast Center for Socially Significant Diseases of Odessa Oblast Government.

#### RESULTS OUTCOMES AND IMPACT OF THE PROGRAMME:

372 women living with HIV of fertile age were examined since 2018. On the basis of the clinic gynecologists have conducted cervical cytology for all women diagnosed with HIV before starting ART therapy. When detecting STIs and changes in the PAP test, patients have received relevant treatment and dispensary follow up. There were two groups of patients: 1. women receiving ART for more than a year and not previously examined by a gynecologist (221, 59.4%) and 2. women, who after cytological examination were linked to HIV care and started receiving ART (151, 40%). A comparative analysis of preliminary results showed that among women receiving ART for more than one year cytological changes were less by 47.9%, grade 1 dysplasia less by 21.7%, grade 2 dysplasia less by 16.5%, dysplasia 3 degree less by 4.5%, and cervical cancer less by 5.2%.

A comparative analysis was also carried out within the second group of examined patients who received ART after cytological examination and six months after the initiation of ART with different baseline CD4 counts and viral load. The preliminary results showed that early initiation of ART is likely to reduce and progression of SIL and CIN and ultimately incidence of invasive cervical cancer.

#### **LESSONS LEARNED AND RECOMMENDATIONS:**

Women and girls living with HIV should be screened as soon as they are diagnosed with HIV. Women and girls who are living with HIV need to receive information and counselling about their greater vulnerability to HPV infection and their increased likelihood of developing cervical cancer at an earlier age. HPV vaccination coverage should be increased. The main challenge was women and girls living with HIV who wanted to visit a gynecologist at a regular antenatal clinic fear they would be discriminated against or judged negatively if their HIV status is revealed.

#### **ANNEXES: N/A**

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