

# **FOLLOW UP TO THE THEMATIC SEGMENT FROM THE 47<sup>TH</sup> PCB MEETING**

**Cervical cancer and HIV –  
addressing linkages and common  
inequalities to save women’s  
lives**

**Additional documents for this item:** N/A

**Action required at this meeting—the Programme Coordinating Board is invited to:**

1. Takes note of the background note ([UNAIDS/PCB \(47\)/20.44](#)) and the summary report (UNAIDS/PCB (48)/21.17) of the Programme Coordinating Board thematic segment on cervical cancer and HIV—addressing linkages and common inequalities to save women's lives;
2. Recalls the Global strategy to accelerate the elimination of cervical cancer as a global public health problem adopted by WHA resolution 73.2 and its associated 90-70-90 HPV vaccination and cervical cancer screening and treatment targets for 2030, and the Global AIDS Strategy's 2025 target for 90% of women living with HIV to have access to cervical cancer screening integrated or linked with HIV services.
3. Calls on Member States to:
  - a. Adequately invest in and scale up HPV vaccination and cervical cancer screening, diagnosis, treatment and care services through integrated and multisectoral delivery platforms and community systems that address health inequalities and other vulnerabilities of girls and women, including those living with HIV and from key populations, to both HIV and cervical cancer;
  - b. Empower, engage and strengthen the capacities of communities and civil society partners to address the interlinkages between HIV and cervical cancer, and to support awareness raising, social mobilization, and demand creation for equitable access to services, new technologies and innovations.
4. Calls on the UNAIDS Joint Programme to:
  - a. Support countries and communities with policy guidance and technical assistance to scale up implementation of HPV vaccination and cervical cancer screening, diagnosis, treatment and care services that are integrated with HIV and sexual and reproductive health services for women and adolescent girls and other population groups living with HIV at risk of cervical cancer;
  - b. Strengthen support to countries and communities to integrate HIV and cervical cancer prevention, treatment and care and to eliminate inequalities, health disparities, stigma and discrimination that increase women's and girls' vulnerability to HIV and cervical cancer.
  - c. Advocate for increased domestic and global investments in HIV and cervical cancer programmes with a focus on increasing access and affordability of key technologies, innovations and commodities and optimizing opportunities for integration where appropriate.
  - d. To report back to a future Programme Coordinating Board meeting on the progress made on integrated approaches to cervical cancer and HIV.

**Cost implications for the implementation of the decisions:** none

## INTRODUCTION

1. Monica Ferro, Director of the UNFPA Geneva Office, acted as moderator for the thematic segment. She opened the thematic segment by introducing a video with Sally Kwenda, an AIDS activist and HIV and cervical cancer survivor.
2. Sally Kwenda shared her story of survival with the PCB. She told the meeting that she had lost two babies and that her husband had also died of AIDS-related causes, after which she had been diagnosed with stage 2 cervical cancer. She called on policymakers to include cervical cancer as part of comprehensive HIV care.

## SHAPING THE DISCUSSION: OPENING DIALOGUE AND KEYNOTE ADDRESSES

3. Keynote speakers shared insights on the importance of focusing on the linkages between HIV and cervical cancer, and on opportunities and challenges for partnerships and for rights-based and people-centred approaches.
4. In her introductory remarks, Ms Ferro provided a brief background on the links between HIV, human papillomavirus (HPV) and cervical cancer. She outlined the purposes of the thematic segment and its format, including its timeliness in the context of the World Health Assembly's adoption of the *Global strategy to accelerate the elimination of cervical cancer as a public health problem*, launched just a month ago. She said that cervical cancer is the top cause of cancer-related deaths among women living with HIV, even though it was an entirely preventable and treatable cancer. For many women and girls, the necessary preventive HPV vaccination, screening and treatment services remain unavailable or inaccessible. Women living with HIV are especially vulnerable, she noted, and are more likely to present with HPV infection than women who are HIV-negative and are up to six times more more likely to develop cervical cancer. The burden of cervical cancer is highest in countries and settings with the highest burden of HIV. Cervical cancer is a disease of inequality, she said, noting that 9 in 10 women who die from cervical cancer live in low- and middle-income countries. Incidence is twice higher in low- and middle-income countries than in high-income countries. She emphasized the importance of gender and socioeconomic inequalities, stigma and discrimination, and poor access to sexual and reproductive health services, which are disparities and underlying injustices that must be addressed.
5. Ms Ferro then briefed the meeting on the thematic segment logistics.
6. The First Lady of Namibia, Her Excellency, Monica Geingos, presented the keynote address. She commended the timeliness of the thematic segment and said Namibia had begun integrating cervical cancer screening into HIV services. As fiscal constraints become more pronounced, the integration of HIV infrastructure and cervical cancer is an obvious way forward. Practical challenges include the frequent clinic or hospital visits that are required for screening and treating cervical cancer, she said, especially during the COVID-19 pandemic when many people are reluctant to visit health facilities. She also emphasized the need to inform both women living with HIV and those who are HIV-negative about HPV and cervical cancer.
7. Ms Geingos stressed that cervical cancer is preventable and treatable, yet remains one of main causes of death in women. This is due to poverty, inequality and weak health systems, she said: inequality drives both HIV and HPV. Health services must be inclusive and nondiscriminatory and they should focus on serving the most vulnerable populations, she insisted. Comprehensive sexuality education is an important opportunity to provide information on HIV and cervical cancer to young women and girls, she said. It is also important to communicate with young people in nonjudgmental language and to provide them with safe spaces.

8. Prevention targets will be difficult to meet without sexual and reproductive health and rights services that reach adolescent girls, but this requires strong commitment from leaders, Ms Geingos told the PCB. Partnerships are vital. The Organization of African First Ladies has a strong partnership with UNAIDS and is active in raising awareness about HIV and cervical cancer. She also emphasized the importance of strong political will and multisectoral work across governments and across health and non-health sectors—bringing together activists, communities and funders such as PEPFAR and the Global Fund. One of the lessons learnt was that legal changes are important but that it requires additional actions, driven by partnerships, to achieve real change. Another lesson is the importance of timely and accurate data, which are effective tools against misinformation.
9. In closing, Ms Geingos said it was unacceptable that the cervical cancer disease burden keeps increasing while cervical cancer is one of the few truly preventable cancers. The tools and infrastructure exist to make strong gains; what is lacking is genuine political commitment and the smart use of funds.
10. Ms Ferro summarized the main themes from the keynote address.
11. Sasha Volgina, Director of Programmes at the Global Network of People Living with HIV (GNP+), described her background as an HIV activist, a woman living with HIV, the mother of two daughters, and cervical cancer survivor. She described the difficulties accessing cervical cancer screening and treatment services in Ukraine and other countries in eastern and central Europe. Some countries do not yet include cervical cancer in their Global Fund proposals, she said, and awareness about the issue is very low among women living with HIV.
12. She told the PCB that she was alive because she had been lucky enough to move a country with a strong health system, and she noted the injustice of this fact – that access to basic health services depends on where you live. Yet the tools for preventing and treating cervical cancer are, in theory, available to all countries. However, the political will and funding to use the tools are missing, she said. The same applies to the HIV and COVID-19 pandemics. Ms Volgina appealed to Unitaid to implement innovative initiatives, to the Global Fund to enable countries to include cervical cancer in their country grant proposals, and to governments to act to save the lives of citizens. She concluded her remarks by emphasizing other additional important lessons, including tackling stigma and discrimination, avoiding the "over-medicalization" of the cervical cancer response, supporting community involvement, and engaging women closely in the response.
13. Winnie Byanyima, UNAIDS Executive Director, told the meeting that UNAIDS is committed to make cervical cancer history and end the AIDS epidemic. More than 50% of cervical cancer cases are among women living with HIV in countries with a high prevalence of HIV infection. The HIV and cervical cancer struggles are connected by the fact that inequalities fuel both epidemics. Access to healthcare depends on where people live, how much they earn, and who they are, she said. It is unacceptable that women's lives can be saved with antiretrovirals only for them to then die of cervical cancer. Criticizing the limited access to HPV vaccines, she insisted that no woman should die of cervical cancer, which is preventable and curable. Integrated services and strong partnerships for HIV and cervical cancer can save millions of women's lives, she said.
14. Ms Byanyima emphasized the need for greater gender equality and said that no woman should need permission from a man to access health care services. Women and men must be involved in planning and decision-making around health services. Citing the very low rates of cervical cancer screening among poor women in countries

such as Malawi, Ms Byanyima said that only about 10% of women and girls in low- and middle-income countries overall have access to screening. Access to radiotherapy, chemotherapy and other treatments is also very low in many countries. The financial and other barriers causing this must to be removed, she urged.

## **OVERVIEW: SYNERGIES AND INTERLINKS BETWEEN HIV AND CERVICAL CANCER, AND EFFECTIVE RESPONSES**

15. This session presented the latest evidence on the links between HIV and cervical cancer and on progress in addressing them across the continuum of HIV and cervical cancer prevention, treatment and care, including through the recently launched Global Strategy to Accelerate the Elimination of Cervical Cancer.
16. Princess Nothemba Simelela, Assistant Director-General and Special Advisor to the Director-General, Strategic Priorities, WHO, paid tribute to survivors of cervical cancer and singled out the Teal Sisters in Africa, who have built a social movement demanding screening, prevention and treatment services for all.
17. She briefed the meeting on the Global strategy to accelerate the elimination of cervical cancer as a public health problem, which WHO had recently launched. Cervical cancer is the unfinished business of the HIV response, she said. The Strategy's targets for 2030 targets are: 90% of girls fully vaccinated with the HPV vaccine by age 15; 70% of women screened with a high-performance test by 35 years of age and again by 45 years; 90% of women identified with cervical disease receive treatment (90% of women with precancer are treated, and 90% of women with invasive cancer are managed).
18. Screening programmes had been introduced in 100 countries, though mostly in high- and higher-middle income countries, Ms Simelela told the PCB. The cost of vaccines is a major barrier for the poorest countries, with screening and treatment a further challenge. As a result, more than 310 000 women die of cervical cancer each year, and it remains a top cause of cancer death among women in low-income countries. While women with cervical cancer in high-income countries have a >70% probability of five-year of survival, those odds were <20% for women in low- and middle-income countries, she said. About 80% of cervical cancers in low-income countries were diagnosed at advanced stage.
19. The return on investment that save women's lives is massive, with the benefits lasting for decades into the future, Ms Simelela said. It makes public health, economic and developmental sense to invest more in preventing and treating cervical cancer. Mobilizing the necessary political will and investments will require reaching government ministers (including ministers of finance) with clear, simple messages to that bring together linked but neglected health priorities such as cervical cancer. This is an additional reason why integrated responses are so attractive.
20. Explaining the links between HIV and cervical cancer, Ms Simelela said the risk of cervical cancer is 6 times higher for women living with HIV than for HIV-negative women, with the burden highest in eastern and southern Africa. She called for greater focus on screening the millions of women who survive HIV and then contract cervical cancer. Care for HIV and screening for cervical cancer can be provided together, she stressed.
21. Ms Simelela mentioned several priorities, including a holistic and multisectoral response to the needs of women and girls; a comprehensive package of care that integrates HIV and cervical cancer services; and strengthened partnerships for community-driven advocacy and action toward elimination. These are all supply-side issues, she explained, but major demand-side issues also have to be addressed, by

making it easier for women to understand and use the health services they need. In closing, Ms Simelela said the narrative has to change from "diseases that affects women" to the social justice dimensions of those diseases. Cervical cancer is about poverty and inequality, and the politics that allow those injustices to occur, she said.

22. In a video message, the Director General of the International Atomic Energy Agency, Rafael Mariano Grossi, said that UNAIDS and the Agency had strengthened their partnership to scale up a campaign on cervical cancer prevention and control. This work is especially critical in Africa, where cervical cancer remains the leading cause of cancer death among women, Mr Grossi said. The partnership can help spread the benefits of nuclear science and aims to reduce cervical cancer deaths by 30% by 2030. The recently launched WHO Global strategy to accelerate the elimination of cervical cancer and other IAEA initiatives to increase access to technologies for diagnosis and treatment of cervical cancer are big opportunities for taking that agenda forward, he said and emphasized that the elimination of cervical cancer is a realistic goal.
23. Alvaro Bermejo, Director General, International Planned Parenthood Federation, described the main elements of the IPPF cervical cancer strategy, which 115 member associations and partners are implementing. In 2019, IPPF had provided 12 million women with cervical cancer services, he told the PCB.
24. Mr Bermejo described visiting cervical cancer services in Vanuatu, which had been rapidly implemented. In other countries, home-based cervical cancer screening is being delivered and collaborations with HIV service providers are creating one-stop-shop arrangements that reduce the need need for multiple visits to health facilities. Family planning services remain an underutilized platform for reaching adolescent girls and young women with HIV and other services, he added. IPPF is ready to partner with UNAIDS and other stakeholders to make an even greater difference, he said.
25. In remarks from the floor, speakers applauded the thematic segment theme and comprehensive report, and thanked the panelists for their powerful messages and calls to action. They noted the continued resistance in some countries to provide equitable sexual and reproductive health services for women and girls, and reiterated the need to recognize women and girls' autonomy over their own bodies and health.
26. Integrated prevention and care for HIV and cervical cancer should be funded adequately and the societal, structural and other barriers preventing access to those services should be removed, speakers insisted. They called on PCB members to ensure that adequate funding is available.
27. Speakers welcomed the emphasis on integration and encouraged further development of a broad view of context-specific integration of services across the life-course. They emphasized the importance of people-centred approaches. Some members updated the meeting on steps they were taking to enhance their cervical cancer programmes, including by integrating cervical cancer screening in primary health care facilities, and through integration with HIV services.
28. Ultimately, prevention is the best long-term strategy, speakers said. They welcomed the emphasis on primary prevention, scaling up access to HPV vaccines, and an integrated approach to HPV and HIV prevention. Speakers highlighted the inequalities in access to HPV vaccination and reminded the meeting that, although more than 85% of new cervical cancer cases are in low- and middle-income countries, less than 1% of vaccinations occur in those countries. Much more equitable responses to HIV and cervical cancer are needed, they insisted. Speakers welcomed the emphasis on community engagement and supported calls for community-led responses to increase the impact of cervical cancer prevention and address barriers such as stigma and

discrimination.

29. The meeting heard that PEPFAR has invested more than USD 93 million in cervical cancer programmes since 2014. It has dramatically increased its contribution through the Go Further public-private partnership with the George W. Bush Institute, UNAIDS and Merck, which has already reached more than 1 million women living with HIV with cervical cancer screening and over 40 000 were treated for detected precancerous lesions. The Go Further partnership supports cervical cancer screening among women living with HIV, as part of PEPFAR's support for HIV treatment and care activities.

#### **PANEL 1: WHAT DOES IT TAKE TO END AIDS AND CERVICAL CANCER AS A PUBLIC HEALTH ISSUE FOR WOMEN AND GIRLS LIVING WITH AND AT RISK OF HIV?**

30. Four panelists from different backgrounds and contexts shared examples of successes and challenges in responding to HIV, HPV and cervical cancer, and in addressing socioeconomic and other inequalities as underlying factors. They discussed the importance of political leadership and the roles of health-care providers, civil society and communities, highlighting successful approaches and practices, and the gaps still to be addressed.
31. Deborah Bateson, Medical Director, Family Planning New South Wales and Adjunct Professor, Centre for Social Research in Health, UNSW, Australia, said the life-course approach used in her country had proved to be highly successful. National screening programmes, based on a 2-yearly pap smear, had contributed to a 50% reduction in cervical cancer incidence and mortality rates. However, those gains had stalled, which led to a review of the screening programme, Ms Bateson explained. Free HPV vaccination was provided to girls through national school-based programmes (since 2007) and to boys (since 2013), and HPV testing had been introduced as screening method. Community acceptance and uptake were high, and the provision of comprehensive sexuality education was an important component.
32. The switch from pap smear tests to HPV testing in the context of a vaccine programme could reduce HPV incidence even further. Ms Bateson described additional components, which were added to the programmes, including a universal screening database, which had proved very important in increasing coverage. In addition, the specific needs of certain groups, including women living with HIV, had been factored into the programmes. The overall results were excellent, Ms Bateson said, but screening rates were notably lower among indigenous women and refugees, people in low-income groups and rural areas. An important recent innovation was the self-collection of vaginal samples for HPV DNA testing, which should further increase programme coverage.
33. Sharon Kapambwe, Assistant Director for Cancer Control in the Ministry of Health, Zambia, described how Zambia had introduced national HPV vaccination and screening programmes, and said strong political will had made a huge difference. The First Lady's Office had also been highly active in moving the programmes forward, including by engaging the private sector. Also important was the involvement of traditional chieftaincy structures and religious leaders, she added.
34. The programmes leverage existing service facilities, she said, and are linked with HIV and noncommunicable diseases programmes. Support provided by PEPFAR, the Global Fund and the World Bank was vital, as was the Ministry of Health's support for policy guidance. HPV testing is now included in HIV testing and treatment protocols. Ms Kapambwe also highlighted the Go Further partnership, which is helping to increase awareness, expand services for women living with HIV and improve civil society involvement in the screening programme. However, civil society engagement

can be stronger, she noted.

35. HPV vaccination started in 2013 with a pilot programme and is now nationally available. It is important to integrate HPV vaccination and screening further into adolescent health services, Ms Kapambwe said. Repeat test requirements are also a hurdle, and women do not always return for their full range of tests. A holistic approach is important, she said and urged that programmes address the entire of cervical cancer-related needs.
36. Bingo M'Bortche, Chief Medical Officer for the Association Togolaise pour le Bien-Entre Familial in Togo, said his association, which partners with the national government, had facilitated the screening of 13 000 women (including 5000 women living with HIV) in recent years. This led to the diagnosis of many cervical cancer cases, especially among marginalized populations such as sex workers. Mobile strategies had increased uptake of screening in underserved and rural areas. Partnerships had also been strengthened with the media, and the association was working closely with organizations of women living with HIV and other nongovernmental organizations.
37. Ana Garcés, Programme Manager of the Scale-up Cervical Cancer Elimination with Secondary Prevention Strategy in Guatemala, provided insights from cervical cancer programmes in Latin America, where cervical cancer is the one of the top causes of cancer death among women. Due to inequalities there are big differences in access to sexual and reproductive health services and cervical cancer services, she explained. Most-affected are women from low-income and marginalized or minority groups, particularly women of African descent and indigenous women. An integrated service approach would bring major improvements, especially for women living with HIV who are often those falling through the cracks of screening programmes, she said.
38. In discussion, Ms Bateson said it is important to make a strong case for investing in HPV vaccination, cervical cancer screening and in treatment of invasive cervical cancer. She credited the national registry with taking Australia's cervical cancer programme to the next level, and urged stronger efforts to improve social justice and equity in access to services. Ms Kapambwe said it is crucial to focus attention on the impact that communities and societies suffer when women and girls lose their lives. A priority is to find ways to get screening and testing results back to people more quickly, and to strengthen the systems that underpin health programmes, including data systems. Mr M'Bortche stressed the importance of social inclusion, integrating cervical cancer screening and HPV vaccination with other health programmes, and working with civil society to build networks that can support those programmes. Ms Garcés emphasized the value of a human rights-based approach and said cervical cancer programmes should be strengthened as part of UHC.

## **PANEL 2: INNOVATIONS AND INTEGRATED ACTIONS ON HIV AND CERVICAL CANCER THAT SAVE WOMEN'S AND GIRL'S LIVES**

39. Irene Ogeta, a community activist and Associate Program Officer, Young Women's Advocacy for the Athena Network in Kenya, emphasized that screening success depends on linkages to treatment and referrals, and highlighted the important roles of community-based healthcare for HIV and sexual and reproductive health, as shown in Kenya. Education and awareness building in communities are vital, she told the PCB. Unfortunately, antivaccine rhetoric is a problem, along with skepticism about cervical cancer prevention among some religious groups. Access to screening outside of clinic settings is also important.
40. Ophira Ginsburg, Director of the High-Risk Cancer Genetics Program at the Perlmutter



Cancer Center, NYU Langone Health and Associate Professor in the Department of Population Health, New York University Grossman School of Medicine, said data for 2020 showed that cervical cancer remained the most common cause of cancer death among women in 36 countries, mostly in sub-Saharan Africa. She said that every 2 minutes a woman dies of cervical cancer and described it as a disease of inequality—including in high-income countries, where indigenous women, women living in poverty and women of colour are much more likely to develop and die of cervical cancer.

41. Affordability of vaccines and other technologies is one of the factors holding back accelerated progress. For example, thermal ablation is a powerful tool but it is too expensive in many settings. Costs must come down, Ms Ginsburg insisted. Adherence and completion of care are other challenges: up to 50% of women who test positive do not return for treatment. Improvements can be achieved through stronger community engagement; stronger integration with other health services; scaling up self-sampling options; and supporting women along the treatment and care pathways (e.g. with m-health innovations).
42. Woo Yin Ling, Professor at the Department of Obstetrics and Gynecology, Faculty of Medicine, University of Malaya, Malaysia, said her country had introduced a national school-based HPV vaccination programme, achieving more than 80% coverage, but cervical cancer screening is a major challenge (less than 15% of eligible women had ever received screening services). She hoped that new screening tools would lead to improvements. For example, self-sampling for HPV DNA testing enables women to use a simple swab in nonthreatening environments, and the samples can be kept for up to 2 weeks before being tested for HPV. Mobile phone technology can be used to help women navigate the treatment and care pathway, Ms Woo said. She mentioned Programme Rose as a good example of combining self-sampling, strong referrals and linkages, and using mobile phone technology. Solutions should fit women's social and cultural realities, she added. Women should not feel stigmatized for having a positive test or feel trapped in a cycle of endless clinics visits; a balance must be struck between medical best-practice and what is most helpful and meaningful to women, Ms Woo advised.
43. Smiljka de Lussigny, Programme Manager at Unitaïd, who spoke for the Unitaïd Executive Director Philippe Duneton, said Unitaïd had invested significant amounts in innovative technologies for cervical cancer screening and treatment and had become one of the largest funders of innovative tools for identifying precancerous lesions in women living in low-resource settings, including women living with HIV. Self-sampling and digital technologies can help bridge the gaps between the successes seen in high-income countries and current realities in low- and middle-income countries. Artificial intelligence-based screening tools can revolutionize screening and detection, she foresaw, and eventually it should be possible everywhere to screen women for USD 1 or less. Affordability is a major issue, she told the meeting, although thermal ablation devices are already 50% cheaper than a few years ago (approximately USD 900) and are quick and easy to operate.
44. Ms de Lussigny highlighted three major challenges. Firstly, making the response more affordable (by lowering the prices of key products and commodities) and increasing efficiencies across disease programmes. Secondly, strengthening health financing for cervical cancer, which may be difficult in the context of the COVID-19 pandemic and therefore requires new messages that combine different disease needs and responses. Overcoming demand-side challenges is a third challenge, which could be overcome by looking to the HIV response and its successful models for community engagement, demand-creation and linkage to care.
45. In discussion, Ms Ogeta said it is important to engage meaningfully with women and

young girls as active members of society, not just as recipients of services. Ms Ginsburg agreed and noted the power of activism in the HIV response. The cervical cancer response has to be built from the ground up, she said, and it has to engage women living with and survivors of cervical cancer. The principle of "Nothing about us, without us" applies also to the cervical cancer struggle. Ms Woo said the new technologies are exciting but that not all health practitioners are keen to use them. Resources should be channeled towards agile tools such as cloud computing and e-health, not only expensive physical resources, she suggested. Ms de Lussigny pointed to rapid and massive scale-up of the COVID-19 response as proof that it is possible to "do the impossible", if sufficient political will and financing is mobilized.

46. In a video message, Princess Dina of Jordan said the thematic segment was highly opportune and she congratulated UNAIDS for taking the lead on integrating cervical cancer and HIV services and she committed to the engagement and collaboration of the cancer community. Joanne Lindsay, of Unity Health Toronto, described her organization's work in the prevention and treatment of cervical cancer. She said encounters with women seeking support showed that schools and health-care services were providing too little information about HPV and cervical cancer. Education around HPV and HIV must start at school, she insisted. Women's experiences of pain, discomfort and embarrassment during pap smears remains a problem, as well. Free and accessible HPV vaccination should be a standard part of HIV care, she told the PCB.
47. Some PCB members described actions taken in their countries, including strengthened access to screening (by extending those skills to nurses and midwives) and the development of culturally appropriate information to increase demand and acceptability. Others highlighted high HPV vaccine costs (as much as USD 100 in some contexts) and called for a campaign for equitable access to HPV vaccines, along the lines of the campaign for COVID-19 vaccine access.
48. Siobhan Crowley, head of HIV at the Global Fund, told the meeting that the Global Fund recognizes the need to improve linkages between HIV and cervical cancer prevention, treatment and care. Countries are now able to prioritize interventions for cervical cancer prevention and control, she said, and the Global Fund supports integrated services that address broader health needs, especially those of women. But she added that strong partnerships are needed to ensure that necessary resources are available to invest at the levels required. Susan Brown, Director of Public Policy Engagement at Gavi, the Vaccine Alliance, alerted the meeting to shortages of HPV vaccine supplies and called for steps to prioritize the most vulnerable populations first.

## CONCLUSION

49. Tedros Adhanom Ghebreyesus, Director-General of WHO, in a video message, told the meeting that cervical cancer is a major but solvable public health challenge. Noting that HIV increases the risk of cervical cancer, and that both diseases disproportionately affect women and girls, he emphasized that the world has the tools and capacities to make cervical cancer history. The recently launched by WHO the Global Strategy to Accelerate the Elimination of Cervical Cancer is an important milestone in the global effort to eliminate cervical cancer as a public health problem.
50. Shannon Hader, Deputy Executive Director at UNAIDS, thanked the participants and organizers of the thematic segment for their inspiring commitment and insights. The world has the tools and technologies to prevent and treat HIV and cervical cancer, and the two issues are perfectly positioned for integration, she said.
51. The Thematic Segment Chair noted the emphasis placed on partnerships and

integration. The PCB Chair thanked the Bureau for recommending that the thematic segment be retained on the agenda of the virtual PCB meeting.

**Draft Decision Points:**

52. Takes note of the background note ([UNAIDS/PCB \(47\)/20.44](#)) and the summary report (UNAIDS/PCB (48)/21.17) of the Programme Coordinating Board thematic segment on cervical cancer and HIV—addressing linkages and common inequalities to save women's lives;
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