Overview of cervical cancer screening coverage/barriers/opportunities for refugees and other displaced persons

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HPV Prevention and Control Board

Global Meeting on Cervical Cancer Prevention and Control in Displaced Populations
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Disclaimer

World Health Organization

Currently not contracted by WHO, not representing the organization

No conflict of interest

Statements not referenced, bibliography in annex

Overview presentation

01

WHO

Cervical Cancer Elimination Strategy

Screening Guidelines

Integration of cancer in crisis

02

Coverage

Cervical cancer screening coverage overall and in displaced populations

03

Barriers/support

Non exhaustive overview of barriers and support measures to CCS

04

Opportunities

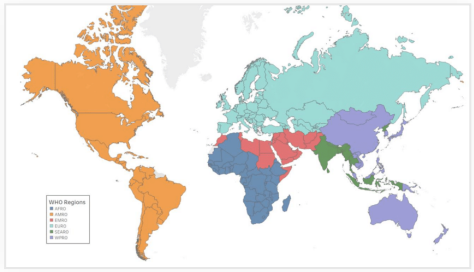
Selected potential opportunities such as point-of-care testing, mobile treatment devices to enhance screening in LMICs

WHO response

Flagship launched by WHO Director-General (2018

"One woman dies of cervical cancer every two minutes…Each one is a tragedy, and we can prevent it."

Partnership, advocacy, and monitoring and evaluation



2020

Adoption & Launch of Global strategy

2021-2022

Guidance updated & expanded

2022

Regional implementation/ action plan

2023-2024

Implementation guidance & support

Strengthened leadership & accelerated impact

The Global Strategy

THRESHOLD: < 4 cases per 100 000 women-years

"Through cost-effective, evidence-based interventions, including human papillomavirus vaccination of girls, screening and treatment of precancerous lesions, and improving access to diagnosis and treatment of invasive cancers, we can eliminate cervical cancer as a public health problem and make it a disease of the past."

Dr Tedros Adhanom Ghebreyesus,

90%

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

70%

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

90%

Of women with pre-cancer treated and 90% of women with invasive cancer managed

LIFE-COURSE APPROACH:

Three pillars provide a comprehensive strategy to ensure lifetime benefits are maximized.

The Global Strategy

70% women screened with a high-performance test

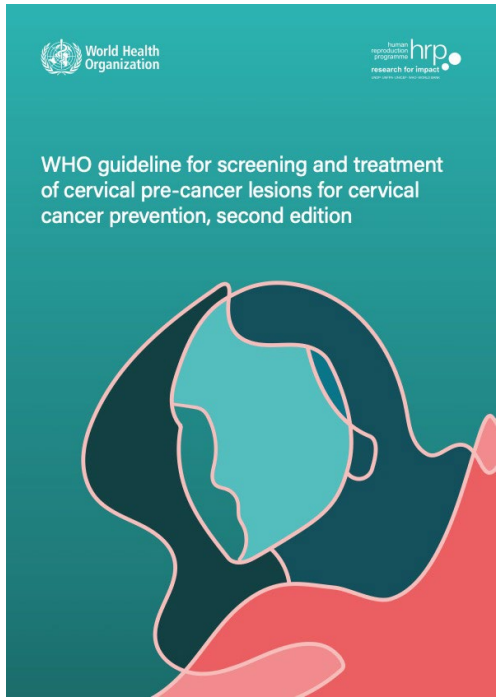
90% of women with identified cervical disease treated

Strategic Actions

- Promote simple screening algorithms to increase retention to the screening continuum and improve programmes' efficiency
- Ensure affordable supply of quality assured, high performance screening tests & treatment devices
- Understand barriers, improve communication/ information to create enabling environment for screening
- Strengthen laboratory and screening services capacity
- Integrate screening and treatment services into primary care, and other health programmes

WHO Guideline

for screening and treatment of cervical pre-cancer lesions for cervical cancer prevention



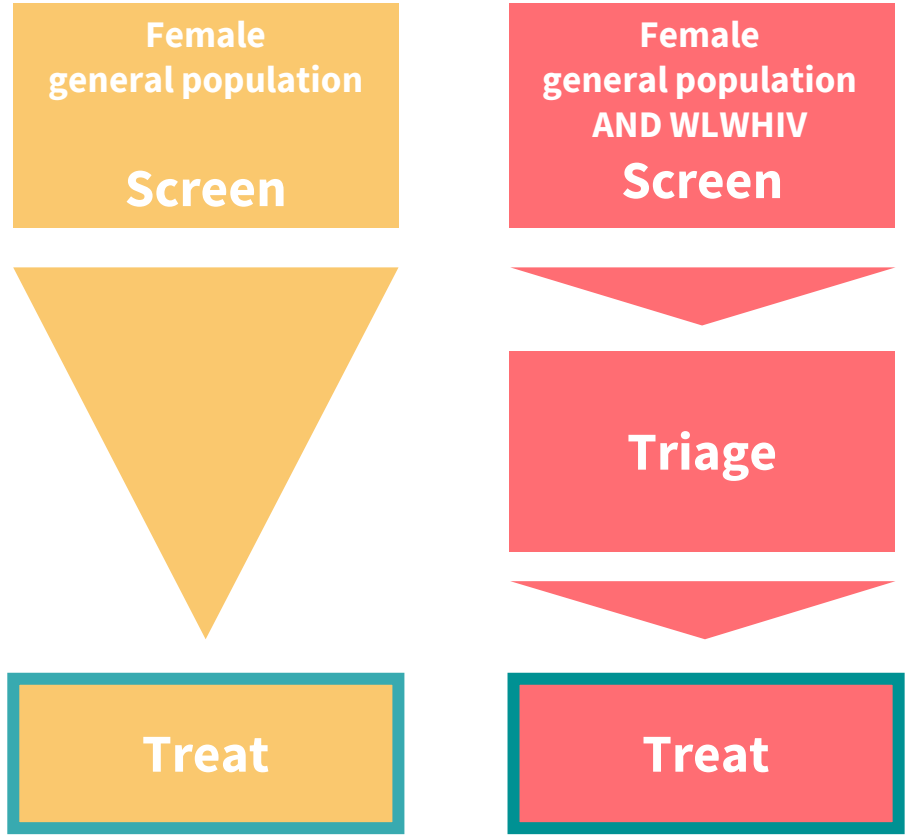
Primary screening test

- High-performance HPV DNA Test
  - Provider-collected or self-collected samples
  - Starting at age 30; WLHIV: at age 25
  - Every 5 to 10 years, WLHIV: 3 to 5 years

- High-performance HPV mRNA Test
  - Only general population
  - Only provider-collected samples
  - Every 5 years

Triage

- Limited genotyping: HPV 16/18
- VIA
- Cytology, Dual-stain cytology (2024)
- Colposcopy



Integration of cancer in crisis

First Global High-Level Technical Meeting on Non-communicable Diseases in Humanitarian Settings, with a focus on cancer

- LMICs bear the highest (cervical) cancer burden and the highest number of humanitarian crises; 76% of refugees are hosted in LMICs
- Additional strain on fragile health-care systems, increase of existing health inequalities
- Substantial gaps in technical and operational guidance, capacity, and resources for cancer in humanitarian crises

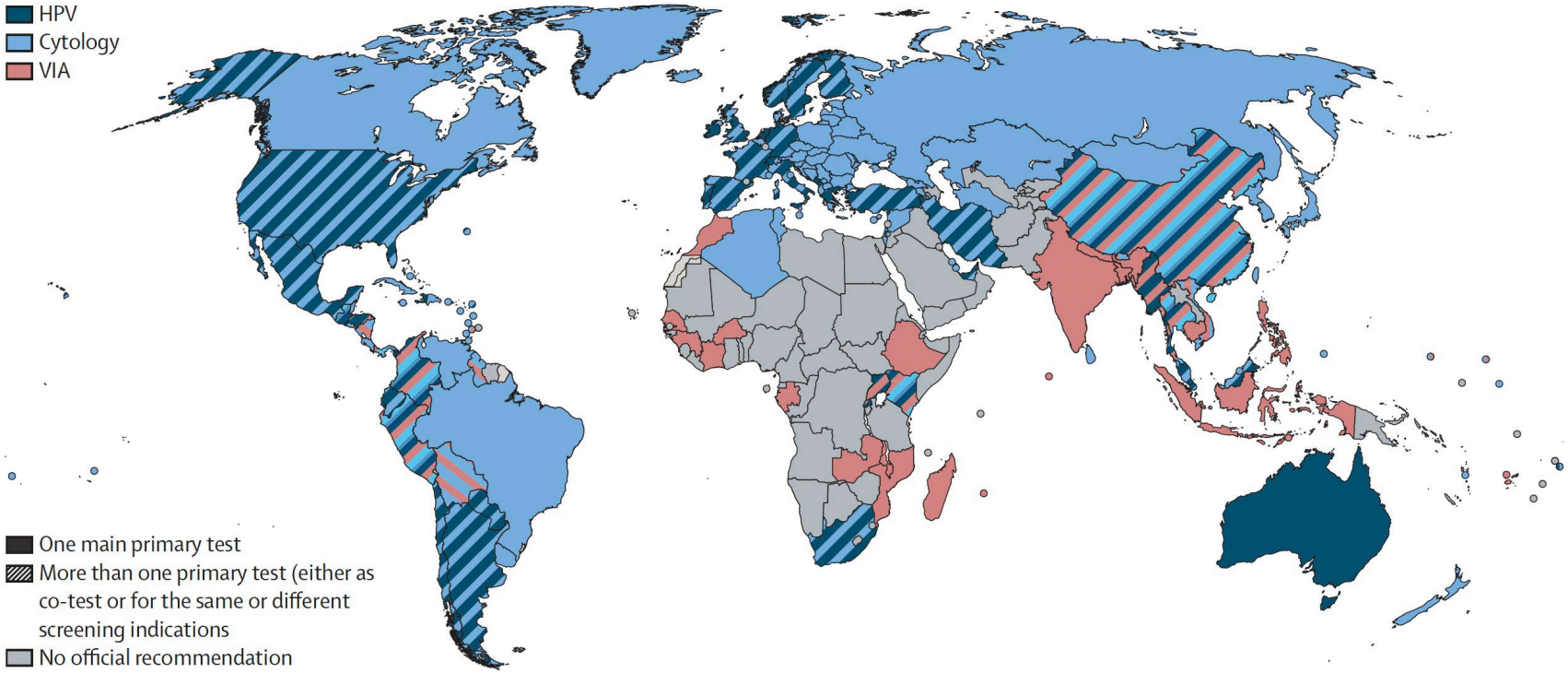
National legislation must ensure that refugees, displaced people, and individuals affected by crises have access to essential health services, including cancer care.

Define a minimum service package for cancer services, across the continuum, to be included in minimum service package for non-communicable diseases (NCDs).

Cervical cancer screening coverage

Officially recommended primary tests for cervical cancer screening

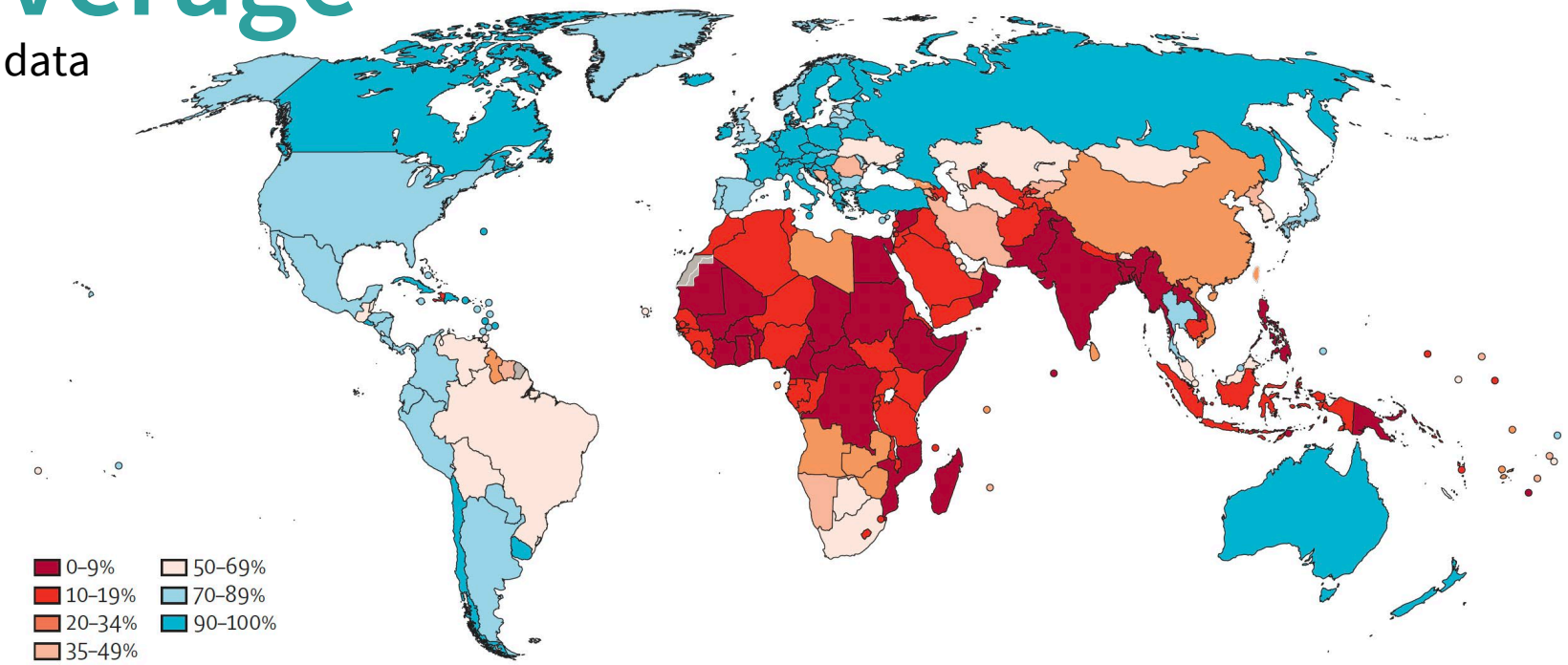
Bruni et al. – 2019 data – update pending



- Cervical screening recommendations were identified in 139/202 (69%) countries
- The 63 countries without screening recommendations are mostly in EMRO and AFRO
- Cytology was still the most used screening test, with 109/139 (78%) countries
- VIA was the most recommended test in resource-limited settings

CCS coverage

Bruni et al. – 2019 data
Update pending



- The coverage and organisation of cervical cancer screening varies widely between countries, leading to wide disparities in access to cervical cancer prevention.
- **Worldwide, two out of three women aged 30-49 have never been screened**, with significant differences across regions and country income levels.
- Screening coverage is very low in low- and lower-middle-income countries, and HPV-based screening is still anecdotal.

CCS coverage displaced persons/migrants

Largely unknown

- Scarce data due to absent or dispersed programmes and interventions
- Disruption of health information systems and insufficient comprehensive cancer registries
- Subgroup of migrants that does reach the services may not be Representable for the whole group
- Refugee and migrant health-related variables are not commonly included in national datasets

Data that is known

- Largely varying depending on geography, ethnicity, length of stay in a country,…
- CCS coverage seems to be generally lower
  - HICs (2002-2012): 25% of asylum seekers had undergone a cervical pap screening test compared with 62% in the host population
  - HIC EURO region: higher incidence rates of cervical cancer among migrant women + more likely to be diagnosed at a later stage in their disease
  - US: immigrant women > 65 triple the chance not having had any CCS
  - Turkey: 86,6% of Syrian refugees (15-49) without CCS

CCS in migrant displaced refugee populations

Barriers

Support

Opportunities

Barriers

- Very heterogenous group
  - Internally displaced, cross-boarder, refugees, asylum seekers, transient migrants, labour migrants,…
- Barriers depend on
  - Health systems and CCS practices country of origin / host country
  - Setting: formal/informal camps, closed/open centers or settled, urban/rural, H/M/LIC
  - …

Earlier negative experiences
Lack of knowledge
No symptoms
Lack of social support (husband/family/friends)
Fear of / discomfort with procedure and/or result
Migration-related stress

Lack of female provider
Lack of gynaecologist
Providers that are not knowledgeable of not friendly
Literacy/Language/Interpretation by family members
Poor quality

No patient navigation
No earlier access to screening
Distrust in the health facility
Lack of confidential spaces
Distance from health facility
Cost of services

CCS linked to national registration number
No public health insurance
No sustainable funding
Configuration host healthcare system
Absence of CSS in Essential Package of Health Services

Link with sexual activity
Link with perceived infertility
Not accustomed to talk about cancer
No support from community leaders
Fatalism/religious beliefs

Barriers

Example Soacha Colombia

No CCS for migrants without having social security number. The only way they are being helped is through research projects that are indiscriminate.

Areas whit lots of migrants (mostly Venezuelans), opportunistic availability of health interventions supported by foreign funding (USAID), but more on HIV, HPV/cervical cancer is never included.

No info in general screening registries where the participants are born.

Women entering the hospitals with advanced cancers are disproportionally Venezuelan.

For the general population, coverage of cytology is quite high, but the same group of people is not being reached. HPV testing is available , but too expensive.

Self-sampling for hard to reach communities failed, due to logistical problems (transport of samples), only 25% of the samples received a result. Follow-up is challenging, questioning the use of the test.

Support

migrant-friendly healthcare system

Prevent misinformation by developing **health policies**

Amended guidance (screening >65 yo; no screening pre sexual activity woman with infibulation)

Migrant Health Centers (MHCs) within the framework **primary healthcare** institutions (Turkey)

Well organized programs, that are **easy to navigate**, well promoted and with **no costs** associated

Mobile clinics to overcome barriers such as transportation, checkpoints, cost and gendered expectations around mobility and domestic responsibilities.

Community-based programs using culturally sensitive approaches tailored to individual ethnic groups within broader immigrant communities. including discussions about religious values in relation to health

Offering information leaflets and sending invitation letters in **migrants' native language** and bilingual HCPs

M-Health for digitization of registering, information, counselling, results and surveillance

?

Your experience here

Opportunities: HPV POC testing

YES

Partly inspired by COVID 19, innovations could revolutionize HPV screening by enabling faster, more affordable, and thus more accessible HPV point-of-care tests.

For example:

A low-cost, paper-based hybrid capture assay to detect high-risk HPV DNA for cervical cancer screening in low-resource settings†

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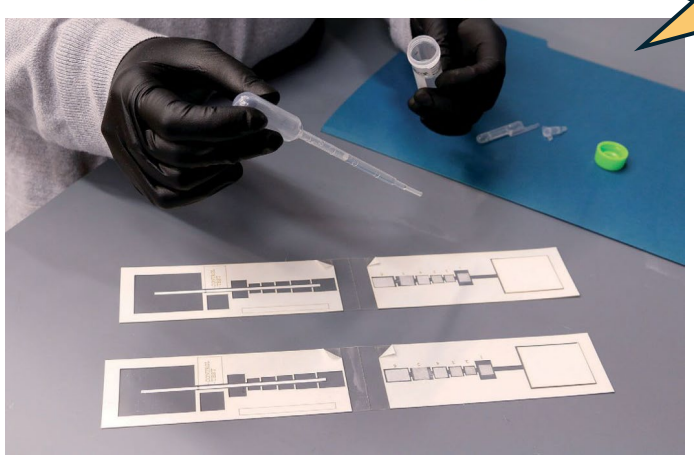

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BUT

Independent evaluation of new tests, both laboratory and clinical. Funds? Time?

Preferably with extended genotyping and very high performance, as it may be the only screening opportunity

No screening without available treatments > possibility of mobile thermal ablators and leep.

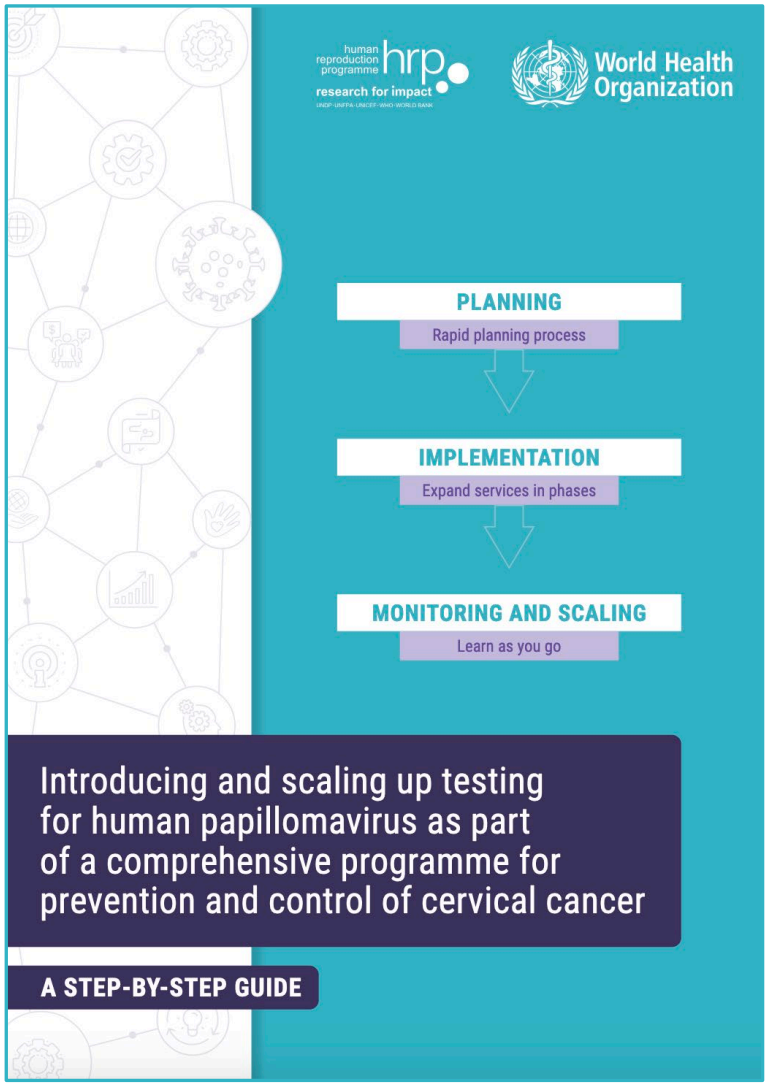
No golden bullet, should be adapted to settings.

Extrenal/internal quality assurance, lab capacity?

Continuous (re)training

Invasive cancer management

Further WHO technical products



Implementation Guidance

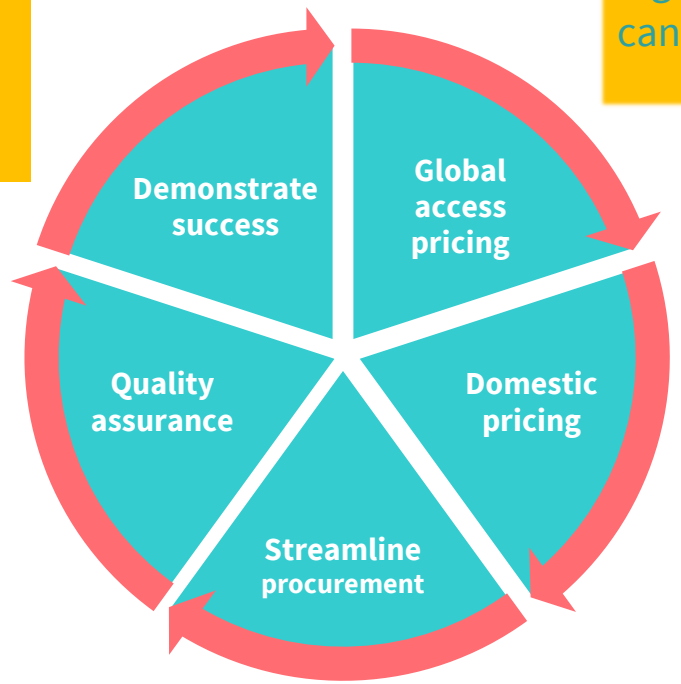
In development

Private Sector Dialogue on HPV Screening Tests

WHO preliminary ASKs to private sector

LMICs that have shown a successful pathway to scale-up HPV-based cervical cancer screening face difficulties for sustainability

Current costs of HPV NAT assays remain relatively high, and there is insufficient funding for cervical cancer screening programmes



264 NATs in the market, 79% without clinical performance &/or analytical performance validation with internationally acceptable criteria

Discrepancy in access prices offered to global donors/procurers and NGOs, compared to prices offered by local distributors for government and other local public sector providers

All required supplies should be procured from same provider, sample collection kits, collection media, self-sampling kits

Thank you

World Health Organization

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