African Progress in Cervical Cancer Prevention and the Road Forward

Cervical Cancer Action “Champions” Webinar — March 20, 2012

- Dr. Vivien Tsu, PATH (Moderator)
- Dr. Mike Chirenje, University of Zimbabwe
- Dr. Khadidiatou Mbaye, WHO/AFRO
- Ms. Diane Summers, GAVI Alliance
- Hon. Sarah Nyombi, Uganda Women’s Health Advocate and former MP
Please note that everyone but our speakers are on global mute until the discussion portion of the webinar—thanks for helping us keep the line clear.

During the call, please send questions to Sarah@CervicalCancerAction.org or through the chat on your ReadyTalk screen.
Overview of Cervical Cancer in Africa

Z Mike Chirenje MD FRCOG
University of Zimbabwe – University of California San Francisco Research Program
15 Phillips Avenue, Belgravia
Harare, Zimbabwe
chirenje@uz-ucsf.co.zw
Cervical Cancer is the third most common cancer in women worldwide (after breast and colon) with an estimate of 530,000 new cases a year and just over half them dying per year.

> 85% global cervical cancer burden occurs in less resourced countries with wide geographical variations in new cases per year.

Highest burden is in Eastern and Western Africa (ASR > 30 per 100,000), Southern Africa (ASR 27 per 100,000), South-Central Asia (ASR 25 per 100,000), S America and middle Africa (ASR 25 per 100,000), and lowest rates in N America, W Europe, W Asia (ASR 6 per 100,000).
Estimated Cervical Cancer Incidence Worldwide in 2008

Europe:

Asia:

S. America:

Africa
### Cervical Cancer Burden by Country Income

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- Majority of cervical cancer cases are in low income countries
- Possible target populations: Developing countries: 52.5 million girls High-income countries: 6.5 million girls

Source: 2002 Globocan data and PATH staff estimates
Cervical Cancer Burden in Africa

Cervical cancer is the second most common cancer in African women (second to breast) with approx 80,000 new cases per year.

About 53,000 (53% case burden) of the new cases die every year due to late stage presentation (stage >3b) and inadequate pathological, surgical, radiotherapy and chemotherapy services.

Peak age is late 40’s to early 50’s resulting in a major preventable family tragedy, from a slow growing cancer (10-20yrs in HIV negative).

Causes progressive wasting, offensive discharge unresponsive to antibiotics and socially embarrassing to patient and her care givers.
Estimated Age-standardised Incidence And Mortality Rates: African Women

Bar chart showing the estimated age-standardised rates of incidence and mortality for various cancers in African women.
Estimated Age-standardised Incidence And Mortality Rates: African Women

Incidence

- Breast: 92,613 (23.7%)
- Cervix uteri: 80,419 (20.6%)
- Liver: 16,947 (4.3%)
- Colorectum: 15,348 (3.9%)
- Non-Hodgkin lymphoma: 15,822 (4.1%)
- Ovary: 12,305 (3.2%)
- Oesophagus: 13,976 (3.6%)
- Kaposi sarcoma: 10,360 (2.7%)
- Other and unspecified: 10,102 (2.6%)
Efforts towards Cervical Cancer Control

Some African countries from the early 1960’s attempted offering laboratory based cytological cervical cancer screening mainly in urban settings and generally unsuccessful efforts to scale up to national coverage was observed.

These efforts were hampered by complex structures required to establish reflex recall for abnormal cytology, colposcopy services to treat CIN 2/3 with LEEP out of operating room (OPD service).

Research in the 1990’s on VIA/VILI/cryotherapy/LEEP in a few African countries has provided an acceptable alternative comparable to cytological based screening, resulting in phased introductory screening programs at several SAA sites.
Current and Future Efforts to Control Cervical Cancer in Africa

A rare opportunity for African countries to educate public that cervical cancer is a complication of persistent high risk HPV infection that can be prevented by vaccination, secondary screening (with VIA/VILI, HPV DNA test), treatment of CIN (cryotherapy or LEEP) and early cancer (surgery or chemo-radiation, radiotherapy alone) has occurred.

Through Gardasil Access Program, Lesotho (163,000), Cameroon (11,000), Uganda (1,000) and Tanzania (13,000), have gained experience on HPV vaccination mainly school based programs on girls 9-13 yrs. with plans for national scale up coverage.

Burundi and Tanzania efforts through Merck-Quigen efforts on HPV vaccination and HPV care primary screening is underway.

Uganda-PATH HPV school based vaccine introductory program
Future Efforts to Control Cervical Cancer in Africa

- There is need for each African country to have a comprehensive cancer control program for prevention, early detection, curative treatment, pain control and palliative care
- Adequate tools for monitoring and evaluating impact is essential
- THANK YOU FOR LISTENING
African progress on cervical cancer and the road forward

Dr Khadidiatou Mbaye
WHO Regional Office for Africa (AFRO)
March 20, 2012
Webinar Presentation
Background

- A regional strategy for cancer prevention and control for the WHO African Region was adopted by the 58th session of the Regional Committee in September 2008.

- A regional consultation on cervical cancer prevention and control was held in September 2008 with the objectives of:
  - Raising awareness on cervical cancer prevention and control
  - Supporting countries to develop and implement comprehensive strategies for cervical cancer prevention and control
  - Supporting countries in establishing national coordination committee for cervical cancer prevention
Background

• The situation of cervical cancer in the African Region was further discussed during the 60th session of the Regional Committee in September 2010. Among key actions proposed, we can note:
  – The improvement of knowledge and skills of health personnel
  – The implementation of visual inspection techniques followed by immediate cryotherapy
  – The establishment of adequate surveillance systems
Screening methods used in the WHO African Region

- **VIA and cryotherapy:**
  - Affordable and reduce the number of visits
  - No need for sophisticated equipment and can be performed at low-resource health facility
  - VIA available in 18 countries on limited scale
  - VIA and cryotherapy performed together in 16 countries

- **Cytology:**
  - Requires trained and skilled professionals
  - Currently not effective in most countries
  - Regionally available in only 3 countries and confined to teaching hospitals and private laboratories in 14 countries

- **HPV DNA tests:**
  - In 6 countries on limited scale
Screening and early treatment of cervical cancer

• Feedback from 20 WHO African Region countries:
  – National policies developed in 7 countries
  – Screening for precancerous lesions in expansion phase in 18 countries
  – Cervical cancer services integrated in SRH programmes in 5 countries
Challenges and way forward in scaling up cervical cancer prevention and treatment

**Challenges:**

- Limited national capacity
- Cervical cancer screening methods not available at peripheral level
- Limited knowledge and skills among health providers
- Lack of national data
- Referral mechanisms not clearly defined
- Weak coordination

**Way forward:**

- MoH to lead development and implementation of national cervical cancer prevention and control programmes
- Awareness creation and advocacy
- Development of comprehensive and integrated plans
- Allocation of adequate resources
Specific needs of HIV+ women for cervical screening

• VIA integrated in HIV care and treatment in 7 countries on pilot/research projects

• HIV testing systematically proposed when cervical cancer suspected/diagnosed in 1 country
WHO contribution to cervical cancer prevention

• Support countries to develop integrated and comprehensive cervical cancer prevention and control plans

• Building national capacity to increase cervical cancer screening and treatment coverage

• Support countries to establish cancer registries

• Support introduction of HPV vaccine as primary prevention of cervical cancer
Investing in our future: 
Update on HPV vaccine introduction

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Dr. Vivien Tsu, PATH
WHO Position Paper on HPV Vaccine

WHO recommends that HPV vaccination should be introduced into national immunization programmes where:

- prevention of cervical cancer and other HPV-related diseases is a public health priority
- vaccine introduction is programmatically feasible and financially sustainable
- cost-effectiveness aspects have been duly considered.

Recommendation is to prioritize high coverage in primary target population of girls who are 9-13 years old

Priority should be given to strategies that include populations who are likely to have less access to cervical cancer screening later in life.
WHO Position Paper on HPV Vaccine

- HPV vaccine introduction should not divert resources from effective cervical cancer screening programmes
- HPV vaccination should be introduced as part of a coordinated strategy to prevent cervical cancer and other HPV-related disease
- Opportunities to link vaccine delivery to other health programmes targeting young people should be sought
3.1 INTRODUCTION OF HPV VACCINE

STATUS: JULY 2011

The information represented here has been collected through interviews with individuals and organizations involved with the countries represented and has not been verified with individual Ministries of Health. Any oversights or inaccuracies are unintentional.
HPV Vaccine in Africa

- National introduction in Rwanda (2011)
- Rigorously evaluated demonstration project in Uganda (completed 2010)
- National introduction in Lesotho (January 2012)
- Past or ongoing pilots in Cameroon, Gambia, Ghana, Kenya, Lesotho, Mali, Nigeria, Tanzania; planned in Zambia
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<td>Child Days Plus-based (selection by age)</td>
<td>2008</td>
<td>52.6% (47.3–57.9)</td>
<td>105.5%*</td>
<td>2,388</td>
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* Over-vaccination beyond the target, due to age determination problems
Communication, Sensitization, and Mobilization

- Factbook for teachers
- Handbook for health workers
- Posters
- Radio talks and spots in community
- Mobile film van
- Leaflets for parents and girls
Acceptability Results

- Key factors influencing community acceptance:
  - Vaccine promoted as protection against cancer.
  - Interpersonal communication from health workers, teachers, and community leaders was important channel.
  - Messages were reinforced through multiple channels, including in “small” and mass media.
  - Parents were reassured to know that HPV vaccination was endorsed by government, teachers, community leaders.

- Key areas of concern or confusion among parents and girls:
  - Their main questions focused on vaccine safety, effectiveness, and side effects; they felt reassured when that information was provided.
Feasibility Results

- Adding HPV vaccination had minimal impact on other services.
- Service providers reported benefits (e.g., opportunity to be involved in health activities, increased knowledge base, and being able to offer valuable health information to others).
- Potential to integrate HPV vaccination with other school health programs.
- Coordination of efforts between health and education sectors is crucial for school-based immunization.
Challenges and Barriers to Access

• Limited focus on adolescent programs in developing countries.
  – Decisions on the optimal delivery strategy.
  – Integration with other programs like Child Days Plus is feasible but has a few challenges (e.g., limited human resources).

• Vaccination, follow-up and coverage estimates.
  – Challenges with denominator determination (census vs. head count).
  – Challenges about determining eligibility of girls based on age.
Thank you!

vtsu@path.org
GAVI Alliance Update

Diane Summers
Senior Specialist
Advocacy and Communication

Cervical Cancer Action webinar
African Progress in Cervical Cancer Prevention and the Road Forward
20 March 2012
Opening the HPV window: global disease burden

Courtesy of Progress in Cervical Cancer Prevention:
The CCA Report Card, August 2011
Why GAVI opened a funding window: Status of vaccine introduction worldwide

Status: July 2011

Source: Courtesy of Progress in Cervical Cancer Prevention: The CCA Report Card, August 2011
Comparison of cervical cancer incidence and mortality by country-income

The GAVI Alliance Board decision - November 2011

Opened a funding window for HPV country proposals provided that:

- Secretariat secures acceptable price commitments from industry for HPV vaccines
- HPV proposals demonstrate the ability of the country to deliver HPV vaccines to the new target population, including through successful demonstration projects

Requested Secretariat to work with technical partners to develop HPV demonstration projects
GAVI eligible countries and experience with HPV vaccine

Source: Courtesy of PATH – preliminary assessment of country readiness
Pathways for country HPV applications

Pathway 1 – National introduction based on demonstrated ability

**Key eligibility criteria:**
- Qualified experience in delivering complete multi-dose series to adolescent population
- At least 50% coverage post final-dose

**Implementation scenarios:**
1) “Full-blown” national introduction
2) Phased implementation

**IRC reviews:**
- HPV review schedule is synch with those of other vaccines per GAVI regular process

Pathway 2 – Demonstration program

**Key eligibility criteria:**
- Insufficient experience in immunizing adolescent population (single-dose campaigns, low coverage, etc.)

**Scale-up/transition scenarios:**
Apply to national introduction after completion of demo and “Go/No Go” decision

**IRC/or other committee reviews:**
Relatively straightforward review
Decision flow for Pathway 1 & 2

Country applications

Not approved

Natnl Intro (Pathway 1)

Approved

National Intro

Demonstrated ability needed

Country applications

Not approved

Demo Program (Pathway 2)

Approved

Scale-up “Go/No-Go”?

“Go”

“No Go”

Not Ready

Applications from another pathway
Demonstration projects

- Primary Objectives – *learn by doing*: assess potential delivery strategies & develop tools to be used for future national introduction

- Secondary Objectives – *integrated approach*: test an integrated approach to vaccine delivery, in particular a comprehensive adolescent health package and a comprehensive approach to cervical cancer.
Engaging beyond immunisation partners

- Broaden partnerships for vaccine delivery in an integrated package of interventions for girls and women
  - Adolescent: family planning, reproductive health; school health
  - Cancer prevention
- Advocacy with a wider stakeholder network - cancer, women’s health, reproductive health, maternal health, academic and research organisations - to increase political will and leadership.
Opportunities: what can be achieved by 2030

- Avert over 2 million future deaths from cervical cancer
- Immunise almost 159 million girls
- Introduce HPV vaccines into the routine immunisation of 47 low-income countries
- Strengthen comprehensive cancer prevention and control
- Synergies with family planning, HIV and adolescent health
SHAPING THE ROAD AHEAD

HON. SARAH NYOMBI
FORMER MEMBER OF PARLIAMENT
UGANDA

African Progress in Cervical Cancer Prevention and the Road Forward

Tuesday, March 20, 2012
OUTLINE OF PRESENTATION

- Cervical cancer recap
- Policy leadership (Rwanda Example)
- Forum of African First Ladies
- Pink ribbon Red ribbon alliance
- Uganda women parliamentarians
- Advocacy opportunities 2012
Cervical Cancer- Recap

- Annual global incidence – over 500,000 cases
- Annual global deaths, over 300,000 deaths
- Over 80% of the deaths occur in developing countries
- Prevention requires comprehensive approach
  - Vaccinations
  - Screening
  - Treatment
POLICY LEADERSHIP – RWANDA

- A very good example of policy leadership
- Government has put in place comprehensive approach policy and taken leadership
  - HPV vaccinations for girls (already happening)
  - Cervical cancer screening and treatment for women, including HPV DNA testing (being planned)
- It’s a national program
- It’s funded by Government of Rwanda, with HPV vaccine and care HPV tests donated by industry
- Likely to have high health impact
- Let’s encourage our governments to copy the Rwanda policy leadership!
FORUM OF AFRICAN FIRST LADIES ON BREAST AND CERVICAL CANCER

- African First Ladies have come together to advocate for breast and cervical cancer prevention
- Recent activities:
  - Direct communication with GAVI, urging HPV vaccine for Africa
  - Presentations at the UN and other global forums
  - Publication of the “Accra Declaration” in 2010 encouraging Africans to demand that their respective governments take action on breast and cervical cancer
  - Liaison with civil society partners for resource mobilization
  - Support to important regional meeting for governments and partners to discuss prevention programs
- Membership is growing
- It’s exciting to see First Ladies taking leadership on women’s health programs.
- Let’s encourage all African First Ladies to join the network!
PINK RIBBON-RED RIBBON ALLIANCE

- Collaboration between the George W. Bush Institute, the U.S. Department of State (PEPFAR), Susan G. Komen for the Cure, UNAIDS, industry, others
- Purpose: combat cervical and breast cancer in sub-Saharan Africa
- New Executive Director: Dr. Doyin Oluwole
- Now developing detailed plans for Alliance work
WORK OF UGANDA WOMEN PARLIAMENTARIANS

- Ensures equitable budget allocation for women’s health
- Pledged not to pass 2012 budget if it doesn’t have a line specifically for cervical health!
- MPs are integral members of social services committee
- Over 100 MPs signed a letter to GAVI calling upon them to subsidise HPV vaccines
Now is the time for countries to plan for improved cervical cancer prevention!
Advocate for national Non-Communicable Disease plans, including cervical cancer, to be completed in the next year
Urge governments to submit applications for HPV vaccine to GAVI
They also should seek support for screening and treatment
Influence the WHO target setting process: it should include targets for both screening and vaccination (now only include for screening)

- Meeting will be held for AFRO region sometime soon—be there and be heard!
ADVOCACY OPPORTUNITIES 2012
Slide 3

• Speak out at:
  • National health assembly in each country
  • Princess Nikky Breast Cancer Foundation Meeting for Forum of African First Ladies
  • African Organization for Research and Training in Cancer (AORTIC) Annual conference
  • FIGO annual meeting
We can do all we can to prevent women from dying!

Honorable Sarah Nyombi
Mob Tel: +256 772 401 198
Email: nyombi.sara@live.com

THANK YOU!
DISCUSSION

To ask a question you can:
1) Send your question via chat if you’re logged into the webinar interface
2) Email your question to Sarah@CervicalCancerAction.org

The moderator will pose as many of your questions as possible to the panelist during the discussion period.
Online resources

www.cervicalcanceraction.org

www.rho.org
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- Ovary
- Non-Hodgkin lymphoma
- Oesophagus
- Stomach
- Kaposi sarcoma
- Corpus uteri
- Leukaemia
- Thyroid
- Lung
- Lip, oral cavity
- Bladder

ASR (W) rate per 100,000
Estimated Age-standardised Incidence And Mortality Rates: African Women

Incidence

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3.1 INTRODUCTION OF HPV VACCINE
STATUS: JULY 2011

- **NATIONAL PROGRAMS**: HPV vaccine in national norms and available on a limited or universal basis through the public sector.
- **PILOT PROGRAMS**: HPV vaccine available through pilot or demonstration projects organized by the Ministry of Health or NGO partners.
- **NO HPV VACCINE PROGRAM**

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<td>Child Days Plus-based (selection by age)</td>
<td>2008</td>
<td>52.6% (47.3–57.9)</td>
<td>105.5%*</td>
</tr>
<tr>
<td>School-based (selection by grade)</td>
<td>2009</td>
<td>88.9% (84.7–92.4)</td>
<td>86.3%</td>
</tr>
<tr>
<td>Child Days Plus-based (selection by age)</td>
<td>2009</td>
<td>60.7% (56.0–65.3)</td>
<td>85.1%</td>
</tr>
</tbody>
</table>

* Over-vaccination beyond the target, due to age determination problems
Communication, Sensitization, and Mobilization

- Factbook for teachers
- Handbook for health workers
- Posters
- Radio talks and spots in community
- Leaflets for parents and girls
- Mobile film van
Acceptability Results

• Key factors influencing community acceptance:
  – Vaccine promoted as protection against cancer.
  – Interpersonal communication from health workers, teachers, and community leaders was important channel.
  – Messages were reinforced through multiple channels, including in “small” and mass media.
  – Parents were reassured to know that HPV vaccination was endorsed by government, teachers, community leaders.

• Key areas of concern or confusion among parents and girls:
  – Their main questions focused on vaccine safety, effectiveness, and side effects; they felt reassured when that information was provided.
Feasibility Results

- Adding HPV vaccination had minimal impact on other services.
- Service providers reported benefits (e.g., opportunity to be involved in health activities, increased knowledge base, and being able to offer valuable health information to others).
- Potential to integrate HPV vaccination with other school health programs.
- Coordination of efforts between health and education sectors is crucial for school-based immunization.
Challenges and Barriers to Access

- Limited focus on adolescent programs in developing countries.
  - Decisions on the optimal delivery strategy.
  - Integration with other programs like Child Days Plus is feasible but has a few challenges (e.g., limited human resources).

- Vaccination, follow-up and coverage estimates.
  - Challenges with denominator determination (census vs. head count).
  - Challenges about determining eligibility of girls based on age.
Thank you!

vtsu@path.org
GAVI Alliance Update

Diane Summers
Senior Specialist
Advocacy and Communication

Cervical Cancer Action webinar
African Progress in Cervical Cancer Prevention and the Road Forward
20 March 2012
Opening the HPV window: global disease burden

Cervical cancer deaths, cervix uteri (per 100,000):

- ≥ 17.6
- 5.8 to 17.6
- ≤ 5.8
- GAVI-eligible countries

Courtesy of Progress in Cervical Cancer Prevention:
The CCA Report Card, August 2011
Why GAVI opened a funding window: Status of vaccine introduction worldwide

Status: July 2011

Source: Courtesy of Progress in Cervical Cancer Prevention: The CCA Report Card, August 2011
Comparison of cervical cancer incidence and mortality by country-income

The GAVI Alliance Board decision - November 2011

**Opened** a funding window for HPV country proposals provided that:

- Secretariat secures acceptable price commitments from industry for HPV vaccines
- HPV proposals demonstrate the ability of the country to deliver HPV vaccines to the new target population, including through successful demonstration projects

**Requested** Secretariat to work with technical partners to develop HPV demonstration projects
GAVI eligible countries and experience with HPV vaccine

![Map of GAVI eligible countries and experience with HPV vaccine](source)

- **Existing/planned or past experience with HPV vaccine**
- **GAVI eligible countries**

Source: Courtesy of PATH – preliminary assessment of country readiness
Pathways for country HPV applications

Pathway 1 – National introduction based on demonstrated ability

Key eligibility criteria:
- Qualified experience in delivering complete multi-dose series to adolescent population
- At least 50% coverage post final-dose

Implementation scenarios:
1) “Full-blown” national introduction
2) Phased implementation

IRC reviews:
- HPV review schedule is synch with those of other vaccines per GAVI regular process

Pathway 2 – Demonstration program

Key eligibility criteria:
- Insufficient experience in immunizing adolescent population (single-dose campaigns, low coverage, etc.)

Scale-up/transition scenarios:
Apply to national introduction after completion of demo and “Go/No Go” decision

IRC/or other committee reviews:
Relatively straightforward review
Decision flow for Pathway 1 & 2

Country applications

Not approved

Natnl Intro
(Pathway 1)

Demonstrated ability needed

Approved

National Intro

Not approved

Demo Program
(Pathway 2)

Approved

Scale-up “Go/No-Go”?

“Go”

“No Go”

Not Ready

Applications from another pathway
Demonstration projects

- Primary Objectives – *learn by doing*: assess potential delivery strategies & develop tools to be used for future national introduction

- Secondary Objectives – *integrated approach*: test an integrated approach to vaccine delivery, in particular a comprehensive adolescent health package and a comprehensive approach to cervical cancer.
Engaging beyond immunisation partners

- Broaden partnerships for vaccine delivery in an integrated package of interventions for girls and women
  - Adolescent: family planning, reproductive health; school health
  - Cancer prevention
- Advocacy with a wider stakeholder network - cancer, women’s health, reproductive health, maternal health, academic and research organisations - to increase political will and leadership.
Opportunities: what can be achieved by 2030

- Avert over 2 million future deaths from cervical cancer
- Immunise almost 159 million girls
- Introduce HPV vaccines into the routine immunisation of 47 low-income countries
- Strengthen comprehensive cancer prevention and control
- Synergies with family planning, HIV and adolescent health
SHAPING THE ROAD AHEAD

HON. SARAH NYOMBI
FORMER MEMBER OF PARLIAMENT
UGANDA

African Progress in Cervical Cancer Prevention
and the Road Forward

Tuesday, March 20, 2012
OUTLINE OF PRESENTATION

- Cervical cancer recap
- Policy leadership (Rwanda Example)
- Forum of African First Ladies
- Pink ribbon Red ribbon alliance
- Uganda women parliamentarians
- Advocacy opportunities 2012
Cervical Cancer- Recap

- Annual global incidence – over 500,000 cases
- Annual global deaths, over 300,000 deaths
- Over 80% of the deaths occur in developing countries
- Prevention requires comprehensive approach
  - Vaccinations
  - Screening
  - Treatment
POLICY LEADERSHIP – RWANDA

- A very good example of policy leadership
- Government has put in place comprehensive approach policy and taken leadership
  - HPV vaccinations for girls (already happening)
  - Cervical cancer screening and treatment for women, including HPV DNA testing (being planned)
- It’s a national program
- It’s funded by Government of Rwanda, with HPV vaccine and careHPV tests donated by industry
- Likely to have high health impact
- Let’s encourage our governments to copy the Rwanda policy leadership!
FORUM OF AFRICAN FIRST LADIES ON BREAST AND CERVICAL CANCER

• African First Ladies have come together to advocate for breast and cervical cancer prevention
• Recent activities:
  – Direct communication with GAVI, urging HPV vaccine for Africa
  – Presentations at the UN and other global forums
  – Publication of the “Accra Declaration” in 2010 encouraging Africans to demand that their respective governments take action on breast and cervical cancer
  – Liaison with civil society partners for resource mobilization
  – Support to important regional meeting for governments and partners to discuss prevention programs
• Membership is growing
• It’s exciting to see First Ladies taking leadership on women’s health programs.
• Let’s encourage all African First Ladies to join the network!
PINK RIBBON-RED RIBBON ALLIANCE

- Collaboration between the George W. Bush Institute, the U.S. Department of State (PEPFAR), Susan G. Komen for the Cure, UNAIDS, industry, others
- Purpose: combat cervical and breast cancer in sub-Saharan Africa
- New Executive Director: Dr. Doyin Oluwole
- Now developing detailed plans for Alliance work
WORK OF UGANDA WOMEN PARLIAMENTARIANS

- Ensures equitable budget allocation for women’s health
- Pledged not to pass 2012 budget if it doesn’t have a line specifically for cervical health!
- MPs are integral members of social services committee
- Over 100 MPs signed a letter to GAVI calling upon them to subsidise HPV vaccines
Now is the time for countries to plan for improved cervical cancer prevention!

Advocate for national Non-Communicable Disease plans, including cervical cancer, to be completed in the next year

Urge governments to submit applications for HPV vaccine to GAVI

They also should seek support for screening and treatment
Influence the WHO target setting process: it should include targets for both screening and vaccination (now only include for screening)

- Meeting will be held for AFRO region sometime soon—be there and be heard!
ADVOCACY OPPORTUNITIES 2012

Slide 3

• Speak out at:
  • National health assembly in each country
  • Princess Nikky Breast Cancer Foundation Meeting for Forum of African First Ladies
  • African Organization for Research and Training in Cancer (AORTIC) Annual conference
  • FIGO annual meeting
We can do all we can to prevent women from dying!

Honorable Sarah Nyombi
Mob Tel: +256 772 401 198
Email: nyombi.sara@live.com

THANK YOU!
DISCUSSION

To ask a question you can:
1) Send your question via chat if you’re logged into the webinar interface
2) Email your question to Sarah@CervicalCancerAction.org

The moderator will pose as many of your questions as possible to the panelist during the discussion period.