IPPF

CERVICAL CANCER STRATEGY 2020–2024

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FOREWORD

Human papillomavirus (HPV) is the primary cause of cervical cancer. HPV transmission can happen to sexually active people, regardless of their gender or sexuality. Cervical cancer is the fourth most common cancer among women in the world. All countries are affected, especially low- and middle-income countries (LMICs). Some people face higher individual risk, such as people who are immunocompromised, and sex workers, while some are marginalized by the current health systems, such as poor people and those living in rural areas, people living with disabilities, LGBT and displaced populations.

IPPF's Strategic Framework 2016–2022 commits the organization to lead a locally owned, globally connected movement that provides and enable services and champions SRHR. Addressing cervical cancer and transmission of sexually transmitted infections (STIs) is a core part of the Integrated Package of Essential Services (IPES). IPPF – with its deep and extensive reach to women, girls, and other affected populations, particularly in LMICs – is in a unique position to potentially make a big difference through this Strategy. Led by the World Health Organisation (WHO), this global momentum to eliminate cervical cancer provides IPPF with a great opportunity to work collectively with WHO and other partners to contribute to several Sustainable Development Goals (SDGs) and targets.

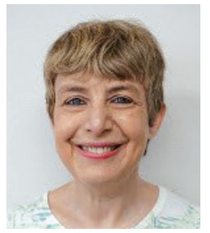
A comprehensive cervical cancer prevention (CCCP) should include primary, secondary, and tertiary prevention, which is in line with the client-centred and life-course approach. IPPF provides CCCP to save lives, strengthen health equity, address stigma and harmful social/gender norms that create barriers to access of timely and high-quality services, and fulfil the sexual and reproductive health and rights (SRHR) of all people. The IPPF Cervical Cancer Strategy 2020–2024 is underpinned by the principles of inclusiveness, human rights, gender equality, and health equity and aligned with IPPF Strategic Framework 2016–2022, Gender Equality Strategy and Implementation Plan, Secretariat Business Plan, and the global trend for cervical cancer prevention (90-70-90 target).

This IPPF Cervical Cancer Strategy reflects IPPF's commitments and front-line experience in implementing cervical cancer programmes. We believe this Strategy will help IPPF to:

- Adopt a multi-sectoral approach to integrate CCCP into women's health programmes, non-communicable disease (NCD) control programmes, and essential health services of Universal Health Coverage (UHC).
- Develop and distribute context-specific and age-appropriate information to achieve long-term social and behavioural change.
- Introduce and scale up CCCP through identifying missed opportunities, adopting an optimization approach and single-visit approach for cervical cancer screening and treatment, and enabling CCCP via different service delivery channels.
- Generate additional resources to expand and strengthen Member Association-led CCCP across the Federation.

As IPPF is moving to a MA-centred Federation, I see this strategy as a critical resource to support their work and hope it will be rolled out through peer-to-peer learning and capacity sharing. In addition, it is important to see CCCP as going beyond service delivery and being fully integrated in our advocacy and partnerships so that it continues to receive the attention and resources needed.

Working together, we can eliminate cervical cancer!



Manuelle Hurwitz
Director, Programmes
IPPF

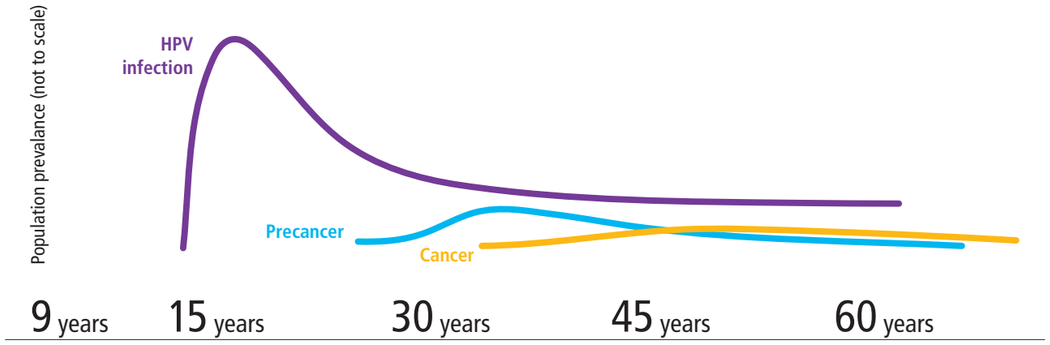
OVERVIEW

Cervical cancer is the fourth most common cancer among women in the world. It is estimated that there were 570,000 new cases in 2018. All countries are affected, especially low- and middle- income countries (LMICs). In 2018, 85 per cent of the 311,000 deaths from cervical cancer occurred in less developed regions.[1] The higher rates of cervical cancer incidence and mortality in LMICs reflect the limited equitable access to high-quality information, vaccination, screening and treatment, and cancer management in these countries. It is estimated that, without adequate and timely interventions, the annual number of new cases will reach 700,000 and the annual number of deaths will increase to 400,000 over the next 10 years. In low-income countries, mortality rates for cervical cancer are projected to rise by 27 per cent, compared with only 1 per cent in high-income countries between 2015 and 2030.[2]

Human papillomavirus (HPV) is the primary cause of cervical cancer. In addition to cervical cancer, HPV is also associated with cancers of the anus, vulva, vagina, penis, and oropharynx. There are more than 100 types of HPV; at least 14 types are classified as cancer causing (or high risk). HPV 16 and HPV 18 belong to the cancer-causing type and cause nearly 70 per cent of cervical cancers worldwide.[3] HPV is mainly transmitted through unprotected sexual contact, including skin-to-skin genital contact. Usually, sexually active individuals will be exposed to HPV transmission some time in their lives. Most HPV infections are self-limiting and can be cleared up by the immune system. However, if the infection persists, it may lead to precancerous cervical lesions or even cervical cancer. For people with weakened immune systems, such as those with poorly controlled human immunodeficiency virus (HIV) infection, the risks are far greater.

Cervical cancer is the most common cancer among women living with HIV (WLHIV) and it is up to five times more likely to affect WLHIV compared to their HIV-negative counterparts. It is evident that women and girls living with HIV have a higher risk of persistent HPV infection and of developing cervical lesions at a younger age.[4] **A comprehensive cervical cancer prevention (CCCP) initiative should include primary, secondary, and tertiary prevention, which is in line with the client-centred and life-course approach.**[5] The CCCP initiative should follow the natural progression of the disease and identify opportunities to deliver effective interventions to relevant age groups and target populations. Because of this, it is essential to reaffirm that **prevention interventions at all three levels should coexist**.[6] For example, the introduction of HPV vaccination can reduce HPV transmission and prevent other HPV-related diseases, which adds value to CCCP without substituting cervical cancer screening and treatment. All CCCP interventions over the life-course are summarized in Figure 1.

Figure 1 All interventions of comprehensive cervical cancer prevention over the life-course. (Information in this figure is adapted and modified from World Health Organization publications[1,3,5,6], UNFPA/IPPF publication[7], and IPPF's *A How-to-Guide to Cervical Cancer Screening and Treatment Programmes*.[8])



PRIMARY PREVENTION	SECONDARY PREVENTION	TERTIARY PREVENTION
Girls 9–14 years • HPV vaccination* **Girls and boys, as appropriate** • Health information and warnings about tobacco use • Sexuality education tailored to age and culture • Condom promotion and provision for those engaged in or considering sexual activity • Male circumcision	**Individuals with a cervix, 30 years or older** • Screening options, such as ◦ Visual inspection with acetic acid and Lugol's iodine (VIA/VILI) ◦ HPV test ◦ Cytology ◦ Others, including artificial intelligence–based tool • Treatment options for precancerous lesion, such as ◦ Cryotherapy ◦ Thermal ablation ◦ Loop electrosurgical excision procedure (LEEP)	**All affected populations as needed** • Treatment for cancerous lesion at any age ◦ Surgery ◦ Radiotherapy ◦ Chemotherapy ◦ Combination of the treatment options above • Palliative care

* To reduce HPV transmission, IPPF recommends that vaccination be made available for all girls and boys if resources allow.

To improve cervical cancer control and eliminate cervical cancer as a public health problem, the World Health Organization (WHO) made a call to action[9] in 2018. The WHO and sexual and reproductive health (SRH) and non-communicable disease (NCD) community have worked together to develop the cervical cancer global elimination strategy. The strategy has set a **90-70-90 target** for 2030,[5] which consists of:

- 90 per cent of girls fully vaccinated with HPV vaccine by age 15.
- 70 per cent of women screened using a high-performance test, by 35, and again by 45 years of age.
- 90 per cent of women identified with cervical disease receive treatment.
  - 90 per cent of women with pre-cancer treated.
  - 90 per cent of women with invasive cancer managed.

IPPF'S WORK TOWARDS CERVICAL CANCER ELIMINATION

To reduce HPV transmission and contribute to the elimination of cervical cancer, IPPF provides CCCP to save lives, strengthen health equity, address stigma and harmful social/gender norms that create barriers to access of timely and high-quality services, and fulfil the sexual and reproductive health and rights (SRHR) of all people.

Addressing cervical cancer and sexually transmitted infections (STIs) transmission is a core part of IPPF's mandate and is included within the **Integrated Package of Essential Services (IPES)**.[10] The IPES promotes service provision for the most pressing SRH needs of the population; the eight major components are counselling, contraception, abortion, STIs, HIV, gynaecology, maternal health, and sexual- and gender-based violence. This broad range of SRH services is intended to meet the most pressing needs of the populations served by IPPF Member Associations (MAs). It is clear that HPV transmission can occur in sexually active people, regardless of their gender or sexuality. IPPF acknowledges that cervical cancer can affect any individual with a cervix – including women, girls, transgender men, non-binary and intersex people – referred to as **affected populations** in this Strategy.[3,11–13] Some people face higher individual risk, such as people who are immunocompromised, tobacco users, and sex workers, while some are marginalized by the current health system, such as people living in LMICs, people living in rural areas, people living with disabilities, displaced populations, and sexual and gender minorities. All these populations are referred to as **priority populations** in this Strategy.[8]

IPPF's experience in delivering restricted projects with a specific focus on CCCP has proved the effectiveness of cervical cancer programmes. The Cervical Cancer Screening and Preventive Therapy (CCSPT) (2012–2017) and Cervical Cancer Scale-up Fund (2015–2018) are two projects that set up a strong foundation for IPPF's cervical cancer prevention work. Investments to selected MAs have resulted in an increase in capacity and provision of cervical cancer services. IPPF MAs have demonstrated their capacity to address stigma and social/gender norms, introduced new technology to their communities, and provided quality and user-friendly services to affected populations. At the same time, one of the keys to success for the MAs that have implemented these restricted-fund projects is a good partnership with public sector players. In order to establish an enabling environment, it is therefore vitally important to raise awareness among stakeholders – such as ministry of health officials, parliamentarians, and the general public – by advocacy work to prioritize cervical cancer within national health policy.

In 2011, prior to introduction of the two projects above, IPPF MAs provided 2.6 million cervical cancer–relevant services globally. After the projects, the number of cervical cancer-relevant services provided by IPPF MAs worldwide increased to 14 million in 2019. In 2019, a total of 252.3 million clinical services were provided by IPPF MAs. The biggest contributors were contraceptive, gynaecological, STIs, and obstetric services. The impact of this intensive and focused investment has been seen across the Federation, with the most significant progress having been made by the MAs involved in the cervical cancer projects. For example, Reproductive Health Uganda (RHU) – IPPF's Ugandan MA – was involved in both CCSPT and Cervical Cancer Scale-up Fund projects. RHU provided 9,000 cervical cancer–relevant services in 2011 and this number increased more than fourfold to nearly 380,000 in 2019 after their involvement in the two projects.

IPPF's key achievements from previous cervical programming – such as integrated SRH services, single-visit approach, and community engagement, with inclusion of men and boys – were presented on many platforms. Enhancing and replicating these programmes at additional MAs will lead to greater impact under the Federation. IPPF needs to build on these experiences by scaling up intensive and focused investment in cervical cancer programmes by adopting the following approaches into the strategy.

INTEGRATED SRH SERVICES

From CCSPT's experience, when women seek cervical cancer prevention, more than 75 per cent of them will access an HIV/STI test, and one-third of them will go home with a contraceptive method. It is observed that 80 per cent of women receiving integrated cervical cancer and contraceptive services choose long-acting reversible contraception (LARC).[14] This reflects the high acceptance rate of integrated contraception and CCCP. Some IPPF MAs are comprehensive HIV service providers in the country, which facilitates the integration of HIV and CCCP. Other IPPF MAs collaborate with HIV partners and clinics to enable one-stop shop services to reduce clinic visits and ensure women living with HIV can receive quality cervical cancer information and service at the same clinic. Integrated SRH services with cervical cancer programmes is recommended by IPPF where staff have been provided sufficient training and support. Different populations have different needs. To meet clients' needs, in addition to contraceptive and HIV services, other relevant SRH services listed in the IPES, such as breast cancer examinations, are used as entry points and are integrated into the service package.[8] This approach has facilitated the sustainability of cervical cancer services as part of the integrated package of SRH services offered by MAs, increased SRH service provisions beyond cervical cancer–related ones, and reduced missed opportunities.

SINGLE-VISIT APPROACH

Where feasible to implement in LMIC settings, IPPF recommends a single-visit approach for secondary prevention of cervical cancer, which combines screening and treatment services in one visit to avoid client loss to follow-up. From IPPF's CCSPT experience, women in LMICs have welcomed this approach and the coverage rate of treatment for precancerous lesion reached 80 to 100 per cent in project sites.[13] A single-visit approach is especially welcomed by people living in rural areas and by displaced populations because it reduces clinic visit frequency. In addition to high acceptability, IPPF MAs indicate that a single-visit approach has a positive economic impact on both IPPF MAs and clients, including cost savings from sterilization products on IPPF MA supply side and reducing out-of-pocket payments and opportunity cost for clients. IPPF provides CCCP through different service delivery channels. It has been observed that offering the single-visit approach through mobile clinics is effective but not always efficient due to factors such as staff time, logistics, costs, etc. This reflects that there is an urgent need for an innovative financial mechanism and strong commitment from the government, partners, and community to lighten the financial burden and address health inequity.

IPPF CERVICAL CANCER WORKING GROUP (WG)

The IPPF cervical cancer working group (WG) was set up in 2012. The WG members include representatives from the IPPF Secretariat and MAs, who continue to provide technical guidance and support to cervical cancer–relevant discussions across the Federation. The WG also carries out programmatic support and field visits to the project sites and coordinates MA-to-MA visits and the learning process. To widely share the IPPF experience internally and externally, the WG developed four case studies to highlight the Federation's experience introducing cervical cancer prevention in the African context. The publication, *A How-to-Guide to Cervical Cancer Screening and Treatment Programmes*, summarizes IPPF's recommendations on CCCP, including HPV vaccination, options for cervical cancer screening and treatment, and referral pathway strengthening.[8] IPPF's visibility at the World Cancer Congress 2018 was increased through the efforts of the WG. All academic publications have been assembled in the 2019 IPPF publication, *From the Field, to the World – IPPF's Cervical Cancer Prevention Journey*.[15] The WG encourages IPPF colleagues to actively participate in cervical cancer forums at the national, regional, and global level, including in the WHO cervical cancer multi-stakeholder meetings.

CERVICAL CANCER STRATEGY 2020-2024

VISION

TO ELIMINATE CERVICAL CANCER AS A PUBLIC HEALTH PROBLEM AND REDUCE HPV-RELATED DISEASES IN A WORLD WITHOUT DISCRIMINATION.

MISSION

IPPF PROVIDES AND ENABLES WOMEN, GIRLS, AND OTHER AFFECTED POPULATIONS TO HAVE EQUITABLE ACCESS TO COMPREHENSIVE CERVICAL CANCER PREVENTION (CCCP) IN A WORLD WITHOUT DISCRIMINATION.

OUTCOME 1

100
Governments respect, protect and fulfil sexual and reproductive health rights and gender equality
Advocacy

PRIORITY 1
Galvanize commitment and secure legislative policy and practice improvement on cervical cancer elimination.

PRIORITY 2
Engage key stakeholders as advocates for financial commitment for cervical cancer elimination.

STRATEGY
- Enable universal health coverage (UHC) to improve access to CCCP
- Adopt a multi-sectoral approach

OUTCOME 2

1 billion
people to act freely on their sexual and reproductive health and rights
Demand generation

PRIORITY 3
Empower women, girls, and other affected populations in all their diversity by providing information and access to CCCP.

STRATEGY
- Develop and distribute context-specific information, education, and communication (IEC)

OUTCOME 3

2 billion
quality integrated sexual and reproductive health services delivered
Service delivery

PRIORITY 4
Deliver integrated CCCP to women, girls, and other affected populations.

PRIORITY 5
Introduce appropriate cervical cancer screening and treatment to affected populations in different settings.

PRIORITY 6
Enable CCCP through public and private health sectors, self-care, and digital health interventions.

STRATEGY
- Identify missed opportunities
- Adopt an optimization approach and a single-visit approach
- Enable CCCP via different service delivery channels, including self-care

OUTCOME 4

A high performing, accountable and united Federation
Sustainability

PRIORITY 7
Support partners in identifying, piloting and documenting sustainable funding models for delivering CCCP.

PRIORITY 8
Strengthen MA-led CCCP.

STRATEGY
- Generate additional resources to expand CCCP at MAs
- Set up regional learning centre

STRATEGIC FRAMEWORK

IPPF's Strategic Framework 2016–2022[16] commits the organization to lead a locally owned, globally connected movement that provides and enable services and champions SRHR. IPPF – with its deep and extensive reach to women, girls, and other affected populations, particularly in LMICs – is in a unique position to potentially make a big difference through this Strategy. Led by WHO, this global momentum to eliminate cervical cancer provides IPPF with a great opportunity to work collectively with WHO and other partners to contribute to several Sustainable Development Goals (SDGs) and targets.

The IPPF Cervical Cancer Strategy 2020–2024 has been developed to strengthen and expand IPPF CCCP work. It is underpinned by the **principles** of inclusiveness, human rights, gender equality, and health equity. This Strategy is aligned with the *IPPF Strategic Framework 2016–2022, Gender Equality Strategy and Implementation Plan*,[17] *Secretariat Business Plan, IPPF Advocacy Common Agenda*,[17] and the global trend for cervical cancer prevention (90-70-90 target).[5] This Strategy is prepared with a purpose to clarify IPPF's pathway to strengthen CCCP in the Federation's work and ensure women, girls and other affected populations can have access to age-appropriate CCCP information and services. All recommended interventions are based on evidence and IPPF experience working in the field. The outcome statements used here are from the *IPPF Strategic Framework 2016–2022*, which highlights the Federation's efforts in advocacy, demand generation, service delivery, and sustainability, with the priority objectives being specific to cervical cancer work. The overarching framework for this Cervical Cancer Strategy is as follows:

STRATEGY VISION AND MISSION

Vision To eliminate cervical cancer as a public health problem and reduce HPV-related diseases in a world without discrimination.

Mission IPPF provides and enables women, girls, and other affected populations to have equitable access to comprehensive cervical cancer prevention (CCCP) in a world without discrimination.

STRATEGIC OUTCOME AREAS

Outcome 1: 100 governments protect and fulfil sexual and reproductive health rights and gender equality (Advocacy)

- Priority objective 1: galvanize commitment and secure legislative policy and practice improvement on cervical cancer elimination.
- Priority objective 2: engage key stakeholders as advocates for financial commitment for cervical cancer elimination.

Strategies to achieve priority objectives:

- Although Cervical Cancer is not a specific thematic priority of the IPPF Advocacy Common Agenda,[18] it is included in the first thematic priority on Universal Access to Sexual and Reproductive health, particularly in the integration of SRHR in Universal Health Coverage packages. Cervical Cancer also interrelates with several of the advocacy common agenda pathways and therefore, IPPF commits to undertake the following strategies in selected regions and countries.

- **Enable universal health coverage (UHC) to improve access to CCCP:** Differential access to CCCP is not just a problem between developed and developing countries but also within and between countries and regions. Tertiary prevention of cervical cancer – such as invasive cancer treatment or palliative care – is expensive, which pushes clients and their families into financial difficulty or to near-bankruptcy. UHC aims to address health inequity and ensure access to quality health services and information for all people without the risk of financial hardship. WHO's UHC framework[19] includes cervical cancer control as one of the 16 essential health services in four categories as indicators of the level and equity of coverage in countries. To advance progress towards UHC, having robust financing structures that protect individuals from financial hardship is key. IPPF's UHC working group will support MAs to work with priority countries and their governments to ensure CCCP is integrated into the essential health services of UHC and recognized in the benefit packages.

  Government should make essential UHC services available and accessible to all. However, many governments, particularly in the LMICs, may not obtain sufficient revenues from their national budgets and insurance schemes, and may not have capacity to ensure funding. This highlights the importance of bringing other financial resources into UHC, including external aid and other innovative funding mechanisms, such as a community funding pool. This approach will be piloted in MAs in the Africa Region.

- **Adopt a multi-sectoral approach:** IPPF will apply a multi-sectoral approach and engage stakeholders at different levels, including policy-makers, decision-makers, social movements including feminist movements, civil society organizations, and affected populations. In selected regions and countries, the Federation will activate the network and forge partnerships with global and regional influencers such as the Union for International Cancer Control (UICC) and national cancer societies, to ensure cervical cancer elimination remains a global, regional, and national priority. To address health inequity, IPPF will join global advocacy efforts to expand access to HPV vaccination, address cost concerns for vaccines and HPV testing, and enable technology to reach LMICs more quickly. IPPF MAs will take the technical lead at the country level and contribute to national cancer strategies, associated policy frameworks, task forces, guideline revision, and programme implementation. This approach aims to integrate CCCP into women's health programmes, put cervical cancer at the forefront of national NCD control programmes, and secure resources accordingly.

Outcome 2: 1 billion people to act freely on their sexual and reproductive health and rights (Demand generation)

- Priority objective 3: empower women, girls, and other affected populations in all their diversity by providing information and access to CCCP.

Strategies to achieve priority objective:

- **Develop and distribute context-specific information, education, and communication (IEC):** The IPPF Secretariat will ensure MAs are aware of the global trend of CCCP and provide technical assistance if needed. IPPF MAs will assess the needs and challenges of CCCP implementation within their particular contexts. If CCCP is new to the context, the MAs will conduct a knowledge, attitudes, and practices survey to better understand people's knowledge level, perceptions of CCCP, and main barriers they face in accessing relevant services. Based on the feedback received, key messages will be tailored and incorporated into comprehensive sexuality education (CSE) programming and health promotion campaigns through a range of initiatives.

  To ensure CSE programmes provide **age-appropriate information** about HPV vaccination and HIV/STI screening, prevention, and treatment, teacher training aids will be developed. Additional IEC materials will be made available to parents and community members to encourage them to talk about CCCP, including primary prevention in out-of-school settings. These educational materials will provide community members with evidence-based information and ideas for delivering messages in engaging ways that increase knowledge and encourage behavioural change. IPPF MAs will expand health promotion messaging about CCCP to women, girls, and other affected populations so that they are informed of and aware that CCCP is a life-course approach and can be an integral aspect of fulfilling their SRHR. Health promotion campaigns will be delivered to different audiences via different platforms and opportunities, including through radio, social media, influencers and peer-to-peer support groups. These distribution channels are the gateway through which medical information enters communities, and constitute another critical way to reach audiences for awareness-raising activities. At the country level, IPPF MAs will engage satisfied clients, champions, and community representatives, including men and boys, to address social/gender norms and health inequity. This will also help in building a supportive environment and achieving long-term social and behavioural change.

Outcome 3: 2 billion quality integrated sexual and reproductive health services delivered (Service delivery)

- Priority objective 4: identify missed opportunities and deliver integrated CCCP to women, girls, and other affected populations.
- Priority objective 5: introduce innovative, quality, and effective cervical cancer screening and treatment to the affected populations in different health settings.
- Priority objective 6: enable CCCP through public and private health sectors, self-care, and digital health interventions.

Strategies to achieve priority objectives:

- **Identify missed opportunities:** IPPF MAs have built a high degree of trust with their communities through providing client-centred integrated SRH information and services. The IPPF Secretariat recommends that MAs integrate CCCP into the SRH services they provide, leveraging this rights-based opportunity to reach affected populations throughout their life-course, and to create linkage to other SRH services, particularly contraceptive and HIV-related services. Based on the WHO recommendations and national guidelines, IPPF MAs will provide information and services tailored to meet the needs of different groups. They will upgrade and strengthen multiple service delivery channels, including static clinics, mobile clinics, and community health workers, and ensure that their service providers and staff are equipped with the latest cervical cancer knowledge and skills to provide client-centred information and services.

  In countries with national HPV vaccination programmes, IPPF MAs will support and complement government actions to distribute and provide primary prevention, including CSE, condom promotion, and HPV vaccination, to young people. IPPF acknowledges HPV transmission can happen in all sexually active individuals, including boys, men who have sex with men, and sex workers. Hence, immunization programmes could reduce HPV transmission. IPPF recommends that vaccination be made available for all girls and boys if resources allow.[7,8]

  Women, girls, and other affected populations living with HIV should be aware that they are more

vulnerable to HPV acquisition than their HIV-negative counterparts. They should also know the benefits of HPV vaccination and cancer screening and treatment. If clients are not aware of their HIV status, health providers will encourage them to be tested for HIV at the same visit.[8]

For survivors of female genital mutilation (FGM), health providers will explain the benefits of receiving cervical cancer screening and the less uncomfortable screening option, such as HPV sampling or use of a smaller speculum.[20]

These services will be provided at the primary healthcare level. If clients need further services, such as palliative care or treatment for invasive cancer, they will be referred to the specific health facilities.

- **Adopt an optimization approach and a single-visit approach:** In recent years, high-quality and effective cervical cancer screening and treatment options have become available (all updated information is summarized in Figure 1). IPPF MAs will introduce and scale up high-quality and appropriate screening and treatment options. In late 2020, the IPPF Secretariat will introduce HPV testing in selected MAs in the Western Hemisphere Region and thermal ablations in selected MAs in the Africa Region, which will be expanded to the regions via restricted projects. Different cervical cancer screening and treatment options have their strengths and weakness. The perfect and affordable combination of screening and treatment does not exist; therefore, the IPPF Secretariat recommends what it refers to as an **"optimization approach"**.[21] Optimization is commonly used in mathematical and socioeconomic discussions – the idea is to change some actors relative to the set and propose which might be the best for any new given situation.

  IPPF acknowledges that the context in which MAs operate is not fixed. To continue service provision, IPPF MAs should be familiar with more than one option for cervical cancer screening and treatment so that they can switch and provide the most appropriate option to affected populations based on their individual medical needs (e.g., FGM survivors), local context, geographic environment, and differences between service delivery channels. This approach is to ensure people's equitable access to services, optimize the availability of cervical cancer screening and treatment if needed, and increase the coverage rate. For example, in countries where many cervical cancer screening options are available, IPPF MAs should consider which screening option(s) can be easily delivered via home-based cervical cancer screening during the extended lockdown due to the COVID-19 pandemic, to ensure that the affected population's SRH needs are not neglected. When it comes to humanitarian settings, cervical cancer–relevant information and services are not the priority during the acute crisis; however, they should be considered once the situation has recovered.

  Screening without providing needed treatment is not ethical. The IPPF Secretariat recommends MAs ensure service delivery channels are capable of providing screening and treatment for precancerous lesion if needed. To reduce health facility visits and prevent loss to follow-up, a **single-visit approach** is recommended to ensure affected populations can receive quality and timely cervical cancer screening and treatment at the same visit. If a single-visit approach is not feasible, IPPF MAs will develop and maximize communication channels, including digital health interventions (DHIs), such as via WhatsApp or hotlines, to deliver screening results, plan treatment if needed, and organize any necessary referrals for cancer treatment. The IPPF Secretariat will set up a standard quality assurance process.

- **Enable CCCP via different service delivery channels:** To broaden the coverage of CCCP, IPPF MAs will equip and train public and private health providers across multiple service delivery channels, including associated health facilities and social franchises. IPPF MAs will also establish and strengthen referral networks to provide a pathway for invasive cancer treatment if needed. In addition, healthcare providers will be provided with technical support to ensure provision of quality CCCP, through regular quality-of-care assessments, supportive supervision, and mentorship and access to appropriate policies, guidelines, and job aids. Community-based healthcare via mobile health brigades and units, or networks of volunteers, promotors, distributors, as well as through home visits, is another important and growing category of service channel as global healthcare starts to move outside of the clinic.

  Self-care represents another channel, already increasing in relevance for health systems globally, with HPV self-sampling being an alternative option for cervical cancer screening.[22] HPV self-sampling gives individuals the control and privacy to collect their own specimens for screening for cervical cancer, while the health system will review the results and assist them in interpreting and acting on these results, including accessing treatment when applicable. If this is available in the country, IPPF MAs should support clients to have adequate information, make informed choices, and receive the services and follow-up if needed. DHIs encompass another increasingly necessary category of service delivery channels, and will require partners to introduce and strengthen various telecommunications and other virtual methods of providing and promoting services.

Outcome 4: A high performing accountable and united Federation (Sustainability)

- Priority objective 7: support partners in identifying, piloting and documenting sustainable funding models for delivering CCCP.
- Priority objective 8: strengthen MA-led CCCP across the Federation.

Strategies to achieve priority objectives:

- **Generate additional resources to expand CCCP at MAs:** The IPPF Secretariat will seek restricted funding opportunities to provide capacity building, technical support, and integration of CCCP at service delivery points. IPPF will also work with MAs to propose financial mechanisms to ensure the sustainability of CCCP in their contexts. In addition to community-based health insurance, which has been proposed under UHC, social enterprise is another mechanism for income generation. The IPPF social enterprise uses entrepreneurial and business methods, including specialized services or products, to generate revenue/surplus. This strengthens financial sustainability, builds business confidence, and enables IPPF MAs to fulfil its parallel social mission and ensure that no one is left behind.[23]

- **Set up regional learning centre:** IPPF has documented best practices, case studies, and lessons learned based on its experience in the field. To continue its success, the IPPF Secretariat will work with MAs to widely share the project experience and improve operational effectiveness, including through networks, capacity building, commodity management, and financial accountability. The Secretariat will work with MAs to set up learning centres in their sub-region/region. These MAs will serve as a resource and training hub and be qualified to provide MA-to-MA technical support to other MAs that share similar social determinants, such as culture, geography, and policy. This will facilitate project implementation and scale-up in the regions. These MAs will be responsible for strengthening the multi-sector coalitions in their regions and will work closely with the Secretariat to continue the well-established strategic partnership with different expertise, such as HIV and advocacy organizations, at local, regional, and global levels.

CONCLUSION

Working together, we can eliminate cervical cancer!

To reduce HPV transmission and eliminate cervical cancer, IPPF provides CCCP to save lives, strengthen health equity, address stigma and harmful social/gender norms that create barriers to access of timely and high-quality services, and fulfil all people's SRHR. In addition to supporting other IPPF strategies, the *IPPF Cervical Cancer Strategy 2020–2024* will ensure IPPF's CCCP work is aligned with the global trends. **This Strategy will lead the IPPF Secretariat and MAs to**:

- Adopt a multi-sectoral approach to integrate CCCP into women's health programmes, NCD control programmes, and essential health services of UHC.
- Develop and distribute context-specific and age-appropriate information to achieve long-term social and behavioural change.
- Introduce and scale up CCCP through identifying missed opportunities, adopting an optimization approach and single-visit approach for cervical cancer screening and treatment, and enabling CCCP via different service delivery channels.
- Generate additional resources to expand and strengthen MA-led CCCP across the Federation.

This Strategy will be reviewed and updated if needed every three years according to global trends, as well as the development of project experience, new evidence and technologies, and other potential opportunities.

KEY MESSAGES

1. Cervical cancer is the fourth most common cancer among women in the world. All countries are affected, especially low- and middle-income countries (LMICs), which reflects the limited equitable access to high-quality information, vaccination, screening, and treatment for precancerous lesions and invasive cancer.

For more information, please see **Overview**

2. Human papillomavirus (HPV) is the primary cause of cervical cancer. In addition to cervical cancer, HPV is relevant to cancers of the anus, vulva, vagina, penis, and oropharynx. There are more than 100 types of HPV. At least 14 types are classified as cancer-causing (or high-risk) types.

For more information, please see **Overview**

3. HPV transmission can happen to sexually active people, regardless of their gender or sexuality. IPPF acknowledges that cervical cancer can affect any individual with a cervix, including women, girls, transgender men, non-binary and intersex people, who are referred to as affected populations in this Strategy. Some people face higher individual risk, such as people who are immunocompromised, tobacco users, and sex workers, while some are marginalized by the current health system, such as people living in the LMICs, people living in rural areas, people living with disabilities, displaced populations, and sexual and gender minorities. They are referred to as priority populations in this Strategy.

For more information, please see **IPPF's work towards cervical cancer elimination**

4. Cervical cancer is the most common cancer among women living with HIV (WLHIV). Women and girls living with HIV have a higher risk of persistent HPV infection and of developing cervical lesions at a younger age.

For more information, please see **Overview**

5. A comprehensive cervical cancer prevention (CCCP) should include primary, secondary, and tertiary prevention, which is in line with the client-centred and life-course approach. The CCCP initiative follows the natural progression of the disease and identifies opportunities to deliver effective interventions to relevant age groups and target populations. All three levels of prevention should coexist. This means the introduction of HPV vaccination should not be a substitute for cervical cancer screening and treatment.

For more information, please see **Overview**

6. IPPF provides CCCP to save lives, strengthen health equity, address stigma and harmful social/gender norms that create barriers to access of timely and high-quality services, and fulfil the sexual and reproductive health and rights (SRHR) of all people. Addressing cervical cancer and transmission of sexually transmitted infections (STIs) is a core part of the Integrated Package of Essential Services (IPES). IPPF's key achievements from previous cervical programming are integrated SRH services, single-visit approach, and community engagement, inclusive of men and boys. IPPF is keen to build on these experiences by scaling up intensive and focused investment in cervical cancer programmes by adopting these approaches in the Strategy.

For more information, please see **IPPF's work towards cervical cancer elimination**

7. IPPF, with its deep and extensive reach to women, girls, and other affected populations, particularly in LMICs, is in a unique position to potentially make a big difference in this initiative. *The IPPF Cervical Cancer Strategy 2020–2024* is underpinned by the principles of inclusiveness, human rights, gender equality, and health equity. This Strategy is aligned with *IPPF Strategic Framework 2016–2022, Gender Equality Strategy and Implementation Plan, Secretariat Business Plan*, and the global trend for cervical cancer prevention (90-70-90 target).

For more information, please see **Strategic Framework**

8. *IPPF Cervical Cancer Strategy 2020–2024* aims to:

   - Adopt a multi-sectoral approach to integrate CCCP into women's health programmes, NCD control programmes, and essential health services of UHC.
   - Develop and distribute context-specific and age-appropriate information to achieve long-term social and behavioural change.
   - Introduce and scale up CCCP through identifying missed opportunities, adopting an optimization approach and single-visit approach for cervical cancer screening and treatment, and enabling CCCP via different service delivery channels.
   - Generate additional resources to expand and strengthen MA-led CCCP across the Federation.

For more information, please see **Conclusion**

REFERENCES

1. World Health Organization (2014) *Comprehensive Cervical Cancer Control – A Guide to Essential Practice, 2nd edition*. Geneva: WHO. Available at: <www.who.int/reproductivehealth/publications/cancers/cervical-cancer-guide/en/>. Accessed 25 June 2020.

2. Knaul F, Rodriguez N, Arreola-Ornelas H, Olson J (2019) Cervical cancer: lessons learned from neglected tropical diseases. *The Lancet Global Health*. 7(3), E299–E300. Available at: <www.thelancet.com/journals/langlo/article/PIIS2214-109X(18)30533-3/fulltext>. Accessed 25 June 2020.

3. World Health Organization (2019) *Human papillomavirus (HPV) and cervical cancer*. Available at: <www.who.int/en/news-room/fact-sheets/detail/human-papillomavirus-(hpv)-and-cervical-cancer>. Accessed 25 June 2020.

4. UNAIDS (2016) *HPV, HIV and cervical cancer: leveraging synergies to save women's lives*. Available at: <www.unaids.org/en/resources/documents/2016/HPV-HIV-cervical-cancer>. Accessed 25 June 2020.

5. World Health Organization (2020) *Draft: Global Strategy Towards Eliminating Cervical Cancer as a Public Health Problem*. Geneva: WHO. Available at: <www.who.int/docs/default-source/cervical-cancer/cervical-cancer-elimination-strategy-updated-11-may-2020.pdf>. Accessed 25 June 2020.

6. World Health Organization (2020) *WHO Technical Guidance and Specifications of Medical Devices for Screening and Treatment of Precancerous Lesions in the Prevention of Cervical Cancer*. Geneva: WHO. Available at: <www.who.int/medical_devices/publications/tech_specs_precancerous_Lesions_cervical_cancer_devices/en/>. Accessed 25 June 2020.

7. UNFPA/IPPF (2017) *Global Sexual and Reproductive Health Package for Men and Adolescent Boys.* Available at <https://www.unfpa.org/publications/global-sexual-and-reproductive-health-package-men-and-adolescent-boys>. Accessed 24 July 2020.

8. IPPF (2019) *A How-to-Guide to Cervical Cancer Screening and Treatment Programmes*. London: IPPF. Available at: <www.ippf.org/sites/default/files/2019-05/How-to-Guide%20to%20CCP%20English%20version.pdf>. Accessed 25 June 2020.

9. World Health Organization (2018) *Cervical cancer: an NCD we can overcome*. Available at: <www.who.int/dg/speeches/detail/cervical-cancer-an-ncd-we-can-overcome>. Accessed 25 June 2020.

10. IPPF (2014) *Integrated Package of Essential Services*. London: IPPF.

11. Nadarzynski T, Smith H, Richardson D, Pollard A, Llewellyn, C. (2016) Perceptions of HPV and attitudes towards HPV vaccination amongst men who have sex with men: a qualitative analysis. *British Journal of Health Psychology*. 22(2), 345–361. Available at: <https://onlinelibrary.wiley.com/doi/abs/10.1111/bjhp.12233>. Accessed 25 June 2020.

12. Park I, Introcaso C, Dunne E (2015) Human papillomavirus and genital warts: a review of the evidence for the 2015 Centers for Disease Control and Prevention Sexually Transmitted Diseases Treatment Guidelines. *Clinical Infectious Diseases*. 61(Suppl 8), S849–S855. Available at: <https://academic.oup.com/cid/article/61/suppl_8/S849/345712>. Accessed 25 June 2020.

13. Siebler K (2012) Transgender transitions: sex/gender binaries in the digital age. *Journal of Gay & Lesbian Mental Health*. 16(1), 74–99.

14. IPPF (2018) *Project Report: Cervical Cancer Screening and Preventative Therapy via Reproductive Health Networks*. London: IPPF.

15. IPPF (2019) *From the Field, to the World: IPPF's Cervical Cancer Prevention Journey*. London: IPPF. Available at: <www.ippf.org/sites/default/files/2019-05/Abstracts_IPPF%2014.3.2019%20final.pdf>. Accessed 25 June 2020.

16. IPPF (2014) *IPPF's Strategic Framework 2016–2022*. London: IPPF. Available at: <www.ippf.org/resource/ippfs-strategic-framework-2016-2022>. Accessed 25 June 2020.

17. IPPF (2017) *Gender Equality Strategy and Implementation Plan: Placing Gender Equality at the Heart of Implementing IPPF's Strategic Framework*. London: IPPF. Available at: <www.ippf.org/sites/default/files/2018-04/IPPF%202017%20Gender%20Equality%20Strategy%20-%20English.pdf>. Accessed 25 June 2020.

18. IPPF (2019) *IPPF Advocacy Common Agenda.* Available at: <https://www.ippf.org/sites/default/files/2019-12/IPPF%20Advocacy%20Common%20Agenda%20English.pdf>. Accessed 21 July 2020.

19. WHO (2019) *Universal health coverage (UHC)*. Available at: <www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc)>. Accessed 25 June 2020.

20. IPPF (2018) *IPPF Handbook: Addressing the Needs of Women and Girls Affected by Female Genital Mutilation in Service Delivery Facilities*. Available at: <www.ippf.org/resource/addressing-needs-women-girls-affected-fgm-service-delivery-facilities-handbook>. Accessed 26 June 2020.

21. Seay J, Kobetz E (2018) Optimizing cervical cancer screening and triage in low-resource settings. *Journal of Global Oncology*. 4(4), 1–2.

22. WHO (2019) *WHO Consolidated Guideline on Self-care Interventions for Health: Sexual and Reproductive Health and Rights*. Geneva: WHO. Available at: <www.who.int/reproductivehealth/publications/self-care-interventions/en/>. Accessed 25 June 2020.

23. IPPF (2018) *Social Enterprise in IPPF: Mapping Social Enterprise Activities Among Member Associations*. London: IPPF. Available at: <www.ippf.org/static/IPPF%20SE%20Mapping%20Report.pdf>. Accessed 25 June 2020.

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