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**FRAMEWORK FOR THE IMPLEMENTATION OF THE GLOBAL STRATEGY TO
ACCELERATE THE ELIMINATION OF CERVICAL CANCER AS A PUBLIC
HEALTH PROBLEM IN THE WHO AFRICAN REGION**

Report of the Secretariat

EXECUTIVE SUMMARY

1. Within the context of universal health coverage and reduction in premature mortality from noncommunicable diseases (NCDs), cervical cancer mortality and morbidity bring to the fore the social and economic inequities across developing and developed countries. The cause of cervical cancer is known; it is an infection with oncogenic strains of the human papillomavirus (HPV) that is exacerbated by risk factors such as early sexual activity, early childbearing and HIV coinfection, as well as smoking.
2. Health system weaknesses, poor health and cancer literacy, as well as social, cultural, economic and gender-based barriers that are prevalent in the African Region have resulted in increased vulnerability and poor access to cervical cancer prevention and control services for women and girls in Africa. Consequently, the Region has the highest burden of cervical cancer globally.
3. In response to the cervical cancer burden, WHO has developed a global strategy to accelerate the elimination of cervical cancer as a public health problem, which proposes cost-effective interventions. Modelling has shown that it is indeed possible to eliminate cervical cancer if cost-effective interventions are implemented nationwide. These interventions include vaccinating all girls with the human papillomavirus (HPV) vaccine, screening all women with a high-performance test as well as prompt treatment of all women identified with cervical disease, to achieve the set targets.
4. The objective of this regional framework is to contribute to the global goal of accelerating the elimination of cervical cancer as a public health problem by reducing the age-adjusted incidence rate of cervical cancer to less than 4 per 100 000 women by implementing interventions to reach the vaccination, screening and treatment targets set for 2030. The framework sets targets and milestones and defines guiding principles and priority interventions to guide Member States in accelerating the elimination of cervical cancer as a public health problem in the Region. It also contains provisions for its regular monitoring, evaluation and adaptation. The implementation of the priority interventions is underpinned by the strengthening of existing national, regional and international partnerships as well as the building of new ones.
5. The priority interventions include needs assessment and resource mobilization across the cervical cancer prevention and control continuum; HPV vaccination and palliative care; and adopting a health system strengthening approach to ensure universal access to population-specific prevention and care.
6. The Regional Committee is invited to examine and adopt the actions proposed.

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ABBREVIATIONS

AFRO	WHO Regional Office for Africa
HIC	high-income countries
HIV	human immunodeficiency virus
HMIS	health management information system
HPV	human papillomavirus
LMIC	low- and middle-income countries
NCDs	noncommunicable diseases
UHC	universal health coverage
VIA	visual inspection with acetic acid
PAP	Papanicolaou smear test
WHO	World Health Organization

INTRODUCTION

1. Cervical cancer is caused mainly by persistent infection by oncogenic strains of the human papillomavirus (HPV). HPV 16 and 18 account for most of the cases. The infection is usually transmitted by sexual contact and causes squamous intraepithelial lesions in the cervix. Most lesions disappear due to immunological intervention. However, it is estimated that in about 2% of all women in low-resource countries, these lesions remain and can cause cancer.¹

2. Cervical cancer is the fourth most common cancer among women globally. In the African Region, cervical cancer is the second most common cancer with 110 755 new cases, accounting for the highest number of cancer deaths — 72 705 in 2020. More than half of cervical cancer cases occur among HIV-positive women in countries with high HIV prevalence.

3. This cancer disproportionately affects the most vulnerable worldwide, and strikes women in the prime of their life. In the African Region, the proportion of women dying from cervical cancer is about 68%, whereas in many high-income countries, the proportion is as low as 30%.²

4. This regional framework has been developed to facilitate the implementation of the Global strategy to accelerate the elimination of cervical cancer by Member States of the African Region. The framework takes into consideration, the WHO Global Report, resolutions and decisions, strategies and action plans, as well as WHO regional guidance documents, following the adoption of the World Health Assembly resolution (WHA73.2) on the Global strategy to accelerate the elimination of cervical cancer as a public health problem for the period 2020–2030. It describes the priority interventions, actions, targets and milestones in line with the global strategy to address the high burden of cervical cancer in the African Region.

CURRENT SITUATION

5. The African Region is disproportionately affected by cervical cancer, with 19 Member States having the highest burden of cervical cancer globally.³ In 2020, the Region accounted for 21% of global cervical cancer mortality.² If the current trend is maintained, by 2030, cervical cancer mortality will increase to 400 000 globally, with the African Region's share increasing to 30%.

6. This situation is explained by socioeconomic and cultural factors as well as poor access to health care services. In addition, women living with HIV are six times more likely to develop cervical cancer, and to develop it at a younger age than women who are HIV-negative. HIV and cervical cancer are closely interlinked and contribute to the high burden of morbidity and mortality in the Region. Both diseases reflect geographical, gender and socioeconomic inequalities and disparities.⁴

¹ World Health Organization (2014). *Comprehensive cervical cancer control: a guide to essential practice*, 2nd ed. World Health Organization. <https://apps.who.int/iris/handle/10665/144785>

² Marc Arbyn Et al. Estimates of incidence and mortality of cervical cancer in 2018: a worldwide analysis. *Lancet Glob Health* 2020;8: e191–203. December 4, 2019. [https://doi.org/10.1016/S2214-109X\(19\)30482-6](https://doi.org/10.1016/S2214-109X(19)30482-6)

³ International Agency for Research on Cancer, "Cancer Today - Cancer Incidence and Mortality Data: Sources and Methods by Country," 2020. [Online]. Available: (https://gco.iarc.fr/today/online-analysis-multi-bars?v=2020&mode=population&mode_population=countries&population=900&populations=900&key=asr&sex=2&cancer=23&type=0&statistic=5&prevalence=0&population_group=0&ages_group%5B%5D=0&ages_group%5B%5D=17&nb_items=20&group_cancer=1&include_nmssc=1&include_nmssc_other=1&type_multiple=%257B%2522inc%2522%253Atrue%252C%2522mort%2522%253Atrue%252C%2522prev%2522%253Afalse%257D&orientation=horizontal&type_sort=0&type_nb_items=%257B%2522top%2522%253Atrue%252C%2522bottom%2522%253Afalse%257D, accessed 25 March 2021)

⁴ WHO. WHO leads the way towards the elimination of cervical cancer as a public health concern. September 2018. Geneva: WHO; 2018 (<https://www.who.int/reproductivehealth/cervical-cancer-public-healthconcern/en/>)

7. In most countries, cervical cancer prevention and control is coordinated within the ministry of health, as a standalone programme or embedded into either the NCD or cancer control or sexual and reproductive health programme. There is either low or no budgetary allocation specifically for cervical cancer prevention and control. Funding for cervical cancer programme activities stem from the sexual and reproductive health programme, the cancer control programme, the adolescent reproductive and sexual health programme or the NCD programme⁵.

8. The key intervention in primary prevention of cervical cancer is HPV vaccination of girls aged 9-14 years, before they become sexually active. Despite the availability of safe and effective vaccines that prevent infection, only 16 Member States have existing HPV vaccination programmes.⁶

9. National screening and treatment programmes targeting the general population are available in 34 Member States. However, most of these screening interventions are based on low-performance screening tests such as visual inspection with acetic acid (VIA) and Papanicolaou (Pap) smear test. More than 70% of Member States in the Region report participation rates below 50%, some as low as 10% or even less⁷ due to lack of organized programmes, ineffective population outreach, fragmented service delivery, unavailable infrastructure and limited financial resources.

10. Currently, most women with cervical cancer in the Region are diagnosed at late stages, while many countries lack adequate diagnostic, treatment or palliative care services. Access to treatment of such late-stage disease (for example, cancer surgery, radiotherapy and chemotherapy) may be very limited, resulting in a higher rate of death from cervical cancer. As a result, 37% to 77% of women diagnosed with cervical cancer in the Region die within five years of diagnosis⁸. Furthermore, a disproportionate number of cancer patients have poor access to pain relief.

ISSUES AND CHALLENGES

11. **Low access to preventive services in the African Region:** The high cost of HPV vaccines has precluded access for many Member States in the Region for their introduction and scale-up. Recently, supply constraints have started to affect the rate and scale of introductions, and this will further delay the introduction of the vaccines in many countries in the Region. Only 33% of Member States in the African Region have introduced the HPV vaccine, compared to the Region of the Americas (86%), the European Region (70%) and the Western Pacific Region (52%)⁹. In some Member States, coverage is low due to factors such as choice of delivery strategy, insufficient communication and vaccine hesitancy.

12. **Limited availability of population-based screening programmes:** Screening services are not generally available at peripheral health facilities due to lack of the required infrastructure and

⁵ Assessing Country Capacity and Preparedness for Introducing or Scaling Up a Comprehensive Cervical Cancer Prevention and Control Programme. Baseline Report, December 2014. Brazzaville: World Health Organization; 2017. Licence: CC BY-NC-SA 3.0 IGO

⁶ Botswana, Côte d'Ivoire, Ethiopia, Gambia, Kenya, Liberia, Malawi, Mauritius, Rwanda, Senegal, Seychelles, South Africa, Uganda, United Republic of Tanzania, Zambia and, Zimbabwe.

⁷ Assessing national capacity for the prevention and control of noncommunicable diseases: report of the 2019 global survey. Geneva: World Health Organization; 2020. Licence: CC BY-NC-SA 3.0 IGO.

⁸ Allemani C, et al., Global surveillance of trends in cancer survival 2000–14 (CONCORD-3): analysis of individual records for 37 513 025 patients diagnosed with one of 18 cancers from 322 population-based registries in 71 countries. *The Lancet*, 391(10125), 1023-1075; and Assessing national capacity for the prevention and control of noncommunicable diseases: report of the 2017 global survey. Geneva, World Health Organization; 2018

⁹ WHO. Immunization, Vaccines and Biologicals (IVB) World Health Organization. <https://www.who.int/immunization/documents/en/>

limited financial resources for governments and users alike. The fragmentation of service delivery and ineffective population outreach also contribute to late diagnosis. Where services are available, low-performance screening tests such as VIA and Pap smear are used. Recommended high-performance screening tests include HPV testing. In addition, low level health literacy, myths, misinformation and negative cultural practices prevent women from getting screened. This is worsened by the fact that women's groups and communities are not involved in the decision-making process for the development and implementation of cervical cancer screening and treatment programmes.

13. **High operational cost of treatment of precancerous lesions:** One of the major challenges to expanding cervical cancer screening is insufficient access to safe and effective treatment of cervical precancers once they are detected. Most Member States use cryotherapy to treat precancerous lesions. For women identified with precancerous lesion, the treatment is either delayed or not provided due to the bulky nature of gas containers for cryotherapy, its unavailability and recurrent costs.¹⁰

14. **Inadequate skilled human resources for cancer prevention and control:** There is scarcity of specialized health personnel (including oncologists and pathologists) for cancer prevention and control. The pool of skilled workers is also unevenly distributed, with high concentrations in urban areas. Even in the urban areas, access to the pool of skilled workers is limited, as many of them work in the private sector rather than in public health care. There is also a shortage of adequately skilled nurses to improve accessibility and quality of cervical precancer and cancer care, despite the fact that they are often the first point of contact with their communities in Africa.

15. **Inadequate infrastructure for tertiary management:** Quality pathology infrastructure and treatment options are often not accessible. Radiation therapy is only available in 22 Member States¹¹. Cancer treatment is associated with catastrophic health expenditure and about 80% of women do not have access to palliative care.

16. **Weak monitoring and evaluation system:** Timely and reliable data are not available to ensure that marginalized groups are appropriately reached by interventions to assess service uptake trends and incorporate feedback for better programme performance in most of the Member States in the Region. For instance, although 13 Member States indicated the availability of a population-based national cancer registry, only six cancer registries – Algeria, Kenya, Seychelles, South Africa, Uganda and Zimbabwe – were found to be of adequate quality to be included in Volume XI of *Cancer Incidence in Five Continents*. Volume XI is the most current edition of this document and contains information from 343 cancer registries in 65 countries for cancers diagnosed from 2008 to 2012.¹²

VISION, GOALS, OBJECTIVES, MILESTONES AND TARGETS

17. **Vision:** An African Region free of cervical cancer as a public health problem.

18. **Goal:** To ultimately eliminate cervical cancer as a public health problem in the African Region.

¹⁰ Paul P, Winkler JL, Bartolini RM, Penny ME, Huong TT, Nga IT, et al. Screen-and-treat approach to cervical cancer prevention using visual inspection with acetic acid and cryotherapy: experiences, perceptions, and beliefs from demonstration projects in Peru, Uganda, and Vietnam. *Oncologist*. 2013;18(12):1278-1284

¹¹ IAEA. Directory of Radiotherapy centers. Number of radiotherapy per million populations. Availability of radiation therapy. Available at <https://dirac.iaea.org/Query/Map2?mapId=0> (Accessed on 22/12/2019)

¹² International Agency for Research on Cancer (IARC). *Cancer Incidence in Five Continents (CI5) Volume XI*. <https://publications.iarc.fr/Databases/Iarc-Cancerbases/Cancer-Incidence-In-Five-Continents-Vol.-XI-2017>

19. Objectives:

The objectives are to:

- (a) introduce and scale up HPV vaccine in routine national immunization programmes.
- (b) increase coverage of, and access to screening and appropriate management of precancerous lesions.
- (c) increase coverage of, and access to diagnosis and management of cervical cancer and palliative care as needed.
- (d) strengthen capacity for monitoring and evaluation of cervical cancer prevention and control for performance tracking.

20. Targets and milestones:¹³

- (a) Targets by 2030
 - (i) 90% of girls are fully vaccinated with the HPV vaccine by the age of 15 years.
 - (ii) 70% of women are screened with a high-performance test by the ages of 35 and 45 years.
 - (iii) 90% of women identified with cervical disease (precancerous and cancer cases) receive appropriate treatment.¹⁴
- (b) Milestones by 2024
 - (i) 90% full HPV vaccination of girls by the age of 15 years achieved in at least 20 Member States.
 - (ii) 25% cervical cancer screening coverage using high-performance tests for women aged 30–49 years achieved in at least 10 Member States
 - (iii) 50% treatment rate for women identified with cervical precancer achieved in at least 10 Member States.
 - (iv) 25% treatment rate for women identified with cervical cancer achieved in at least 10 countries.
- (c) Milestones by 2028:
 - (i) 90% full HPV vaccination of girls by the age of 15 years achieved in at least 40 Member States.
 - (ii) 50% cervical cancer screening coverage using high performance test, for women aged 30–49 years achieved in at least 30 Member States
 - (iii) 60% treatment rate for women identified with cervical precancer achieved in at least 30 Member States.
 - (iv) 50% treatment rate for women identified with cervical cancer achieved in at least 30 Member States

GUIDING PRINCIPLES

21. Leadership and accountability: Elimination of cervical cancer as a public health problem in the Region relies on strong government leadership, ownership, investment and accountability both at national and subnational level.

22. Human rights, gender and equity: All cervical cancer prevention and control interventions should be based on promoting human rights, gender and equity in accessing health care and other essential social services.

¹³ Annex

¹⁴ Appropriate treatment targets include: 90% of women who screen positive are treated for precancer lesions and: 90% of women with invasive cancer are appropriately managed according to national treatment protocols.

23. **Evidence-based and forward-looking actions:** The interventions proposed in this Framework are up to date and evidence based (including research), to ensure high-quality and effective policies and services.
24. **Community engagement and participation:** Emphasis on the implementation of this framework should be placed on community-based interventions, ensuring active community participation and ownership by local governments, civil society, in particular women's associations, local leaders, religious leaders and individual citizens.
25. **Multisectoral and multidisciplinary approaches:** Broad partnerships, multisectoral and multidisciplinary coordination mechanisms and integrated approaches are critical for the successful implementation of the Framework.
26. **Funding sustainability:** Sustaining interventions requires mobilization and proper allocation of domestic resources. For long-term sustainability, the financing of cervical cancer interventions should be supported from domestic resources.
27. **Cross-border collaboration:** To achieve the elimination target, cross-border collaboration with neighbouring countries to share best practices is important.

PRIORITY INTERVENTIONS AND ACTIONS

28. **Assessing needs and mobilizing resources:** Guided by this Framework, Member States will conduct national needs assessments through a multisectoral consultative process to appraise existing capacity, identify status and opportunities for efficient interventions and define requisite resources to implement priority activities. Member States will also develop resource mobilization plans to guide implementation of national strategic plans.
29. **Developing and implementing strategies to ensure a sustainable supply of HPV vaccines:** Strategies and policies for HPV vaccine introduction and scale-up should be developed and implemented taking into consideration the peculiarities of the target populations. Additionally, market-shaping strategies are needed to achieve affordable prices for countries at various income levels and to maintain a healthy market for HPV vaccines.
30. **Improving communication and social mobilization for HPV vaccine:** Evidence-based communication and social mobilization efforts will be required for various target audiences to overcome vaccine hesitancy. Strategies should be put in place to address adverse events with rapid response plans or crisis communication plans and to counter misinformation that may ensue. Member States should consider a regional platform for strengthening vaccine confidence and addressing vaccine hesitancy as well as dealing with anti-vaccine misinformation.
31. **Defining the cervical cancer management package to be included in the UHC benefit package:** The description of this package will be done through the development of innovative and integrated service delivery models that are suitable for front-line health care workers and scalable across the continuum of care in a tiered approach. It will include integrating screening and treatment interventions for the prevention and control of cervical cancer into sexual and reproductive health services as well as HIV services and promoting the use of portable devices that are easy to decentralize and appropriate for integration of screening and treatment at the same location.
32. **Expanding service coverage in different contexts:** The types of facilities where a single-visit approach to effective screening and treatment of cervical precancerous lesions can be

implemented will be identified and matched with models of care that are the most effective, considering factors such as: existing infrastructure and human resources; culturally appropriate methods for community outreach; urban and rural settings; and the burden of HIV coinfection and HIV-cervical cancer comorbidity. Efforts should be made to ensure screening services are decentralized and integrated into the primary health care (PHC) system. In addition, patients should be linked to social support programmes, such as transport and housing during treatment.

33. Ensuring an affordable supply of high-performance screening tests and treatment devices: Introducing innovations is crucial. Countries should anticipate and plan ahead for transitions between technologies. Member States of the African Region are encouraged to develop common approaches to procuring affordable high-performance tests, sharing regulatory data, improving supply planning and evaluating new technologies. Pooled procurement and common quality assurance mechanisms and processes could help Member States to achieve these goals.

34. Improving the affordability and accessibility of HPV testing by achieving operational efficiencies: Design efficient, integrated networks of laboratory services to maximize the impact of limited human and financial resources, which should be adapted to the volumes and capacity of each testing facility. Leverage the existing installed base of multiplex analysers that may be used for other forms of molecular testing (such as TB, HIV, viral hepatitis). Integrate referral of cervical samples into existing systems and add capacity where needed. Standardize procurement, training, and quality assurance. Implement post-market surveillance for all tests to ensure that safety nets are in place as programmes scale up.

35. Establishing referral pathways and people-centric linkages throughout the continuum of care: Member States will: minimize delays in accessing diagnostic and treatment services by establishing and streamlining care pathways. Effective referral networks linking different levels of facilities will improve the continuity of care; identify and implement interventions such as patient navigation programmes, which have proven to be effective; strengthen appropriate communication plans targeting patients and providers to improve service utilization; link patients to other social support programmes, such as transport and housing during treatment; and develop intercountry referrals to support smaller populations with limited capacities.

36. Investing in anatomical pathology services: Member States will: optimize the competencies of health care workers to deliver diagnosis interventions; provide equipment and consumables and establish efficient logistics systems to ensure timely transport of samples and reporting of histopathology results; consider developing telepathology solutions and regional pathology centres for countries that lack capacity to interpret samples locally; and partner with international professional pathology societies.

37. Expanding surgical oncology capacity: Member States will: build capacity to perform gynaecological oncology surgery for improving access to surgical treatment of cervical cancer and bringing broader benefits to the health system; optimize cancer surgery capacity and ensure availability of critical resources for blood banking, anaesthesia, surgical instruments and consumables; leverage innovative solutions, such as telementoring, eLearning, mLearning and low-cost virtual reality surgical simulation; provide adequate hospital infrastructure, such as operating room space and hospital beds; and apply principles of management science to facilitate more efficient use of constrained resources.

38. Ensuring curative treatment by investing in radiotherapy: In high-burden countries: replace low-dose brachytherapy with high-dose brachytherapy and provide the necessary supportive infrastructure; build complete radiation teams comprising radiation oncologists, medical physicists and radiation therapists; introduce and maintain training, especially for

brachytherapy, to ensure that clinicians have the manual skills to provide safe and effective treatment; include radiotherapy supplies in procurement and supply planning and invest in quality management and safety; allocate a budget for maintenance costs; and select appropriate radiation equipment for the health system's capacity.

39. **Improving access to chemotherapy:** Include chemotherapy drugs in national essential medicines lists, and in procurement and supply planning; invest in quality storage, management and safety of chemotherapy programmes.

40. **Planning for early integration of palliative care:** Programmes should incorporate end-of-life care and pain relief, as well as psychological support, family support and other services to identify and manage symptoms and provide supportive care across the spectrum of care. Where possible, home-based models of palliative care should be integrated into primary health care.

41. **Reducing cancer stigma:** Patient awareness and education initiatives, especially through survivor and women's groups (including women living with HIV), should be developed to demonstrate that cervical cancer can be prevented and cured if treated in time, and that patients can enjoy a good quality of life.

42. **Monitoring and evaluation:** Member States will develop a monitoring and reporting framework on their implementation and progress towards the attainment of the regional targets and provide annual updates to the WHO Secretariat on progress. WHO shall continuously monitor long-term cervical cancer control and elimination programmes at country and regional levels. WHO will also produce and disseminate biennial reports on the cervical cancer elimination initiative; report to the Regional Committee in 2024 and 2028, and conduct an analysis of risk factors for timely remedial actions to be taken.

43. **Ensuring partnership, intersectoral and multisectoral collaboration:** In collaboration with Member States, WHO will organize and coordinate activities with a broad set of partners, at national, regional and global levels. WHO and other UN agencies will continue to spearhead their joint work on supporting Member States in addressing the situation of cervical cancer in the Region. Through the global initiative on cervical cancer elimination, WHO will bring on board external partners and provide adapted technical expertise to Member States.

44. **Promoting research and development.** All Member States should develop a research plan to generate evidence and fill knowledge and implementation gaps in cervical cancer prevention and control. The efforts of Member States to undertake research in order to build evidence and improve cervical cancer interventions will be supported and facilitated by WHO and partners.

ACTIONS PROPOSED

45. The Regional Committee is invited to examine and adopt the actions proposed.

Annex: Summary of objectives, targets and milestones of the Framework

<i>Objectives</i>	<i>Current status/baseline (2020)</i>	<i>Targets by 2030</i>	<i>Milestones</i>		
			<i>By 2024</i>	<i>By 2026</i>	<i>By 2028</i>
To introduce and scale up HPV vaccine in routine national immunization schedules	<ul style="list-style-type: none"> 33% of Member States have introduced HPV vaccine Three Member States (Ethiopia, Mauritius and Rwanda) have HPV coverage of 80% and above for girls 15-year old in 2019. 	90% of girls are fully vaccinated with the HPV vaccine by the age of 15 years in all 47 Member States	90% full HPV vaccination of girls by the age of 15 years achieved in at least 20 Member States	90% full HPV vaccination of girls by the age of 15 years achieved in at least 30 Member States	90% full HPV vaccination of girls by the age of 15 years achieved in at least 40 Member States
To increase coverage of, and access to screening and appropriate management of precancerous lesions	Data not available. Conduct regional survey	70% of women are screened with a high-performance test by the ages of 35 and 45 years in all 47 Member States	25% cervical cancer screening coverage using high-performance tests, for women aged 30-49 years achieved in at least 10 countries	40% cervical cancer screening coverage using high-performance tests, for women aged 30-49 years achieved in at least 20 Member States	50% cervical cancer screening coverage using high-performance tests, for women aged 30-49 years achieved in at least 30 Member States
To increase coverage of, and access to diagnosis and management of cervical cancer and palliative care as needed	Data not available. Conduct regional survey	90% of women identified with cervical precancerous lesions receive treatment in all 47 Member States	50% treatment rate for women identified with cervical precancer achieved in at least 10 Member States	60% treatment rate for women identified with cervical precancer achieved in at least 20 Member states	60% treatment rate for women identified with cervical pre-cancer achieved in at least 30 Member States
	Data not available. Conduct regional survey	90% of women identified with cervical cancer receive treatment in all 47 Member States	25% treatment rate for women identified with cervical cancer achieved in at least 10 countries	40% treatment rate for women identified with cervical cancer achieved in at least 20 Member states	50% treatment rate for women identified with cervical cancer achieved in at least 30 Member

<i>Objectives</i>	<i>Current status/baseline (2020)</i>	<i>Targets by 2030</i>	<i>Milestones</i>		
			By 2024	By 2026	By 2028
					States
To strengthen capacity for monitoring and evaluation and the health management information system (HMIS) for cervical cancer prevention and control for easy global, regional and national target tracking	Data not available. Conduct regional survey	Data collection and HMIS for cervical cancer prevention and control strengthened, ensuring regular monitoring and evaluation of activities under the framework	Monitoring and performance indicators identified, and quality control mechanisms defined for planned interventions in all 47 countries. Challenges and lessons learnt documented and utilized for decision-making in all Member States. Capacity to report and use cervical cancer data increased from 10% in 2019 to 50% in all countries	HMIS and data collection tools for cervical cancer prevention and control strengthened for easy global, regional and national target tracking	Strong data systems for cervical cancer available at the national and regional levels