IAS

International AIDS Society iasociety.org

Person-centred care approaches for preventing HPV-related cancers among people living with HIV

Webinar will commence shortly

19 February 2024

Instructions for participants

- Please ask questions to presenters and panelists in the Q&A box
- The chat is for any technical issues or for introductions
- Session recording and slides will be sent to all participants

IAS

Co-organizers of this webinar

Pre-meeting, 22 July 2023

Putting people first in the prevention, treatment and care of HPV-related cancers among people living with HIV

IAS 2023

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- Show all (5)
- IAS 2023 (5)

Living with HIV and HPV: Call to action

View

Living with HIV and HPV: Current and future research gaps

View

Living with HIV and HPV: Good-practice models for HPV-related cancer elimination

View

Living with HIV and HPV: State of the art guidance for HPV vaccination, screen and treat

View

Living with HIV and HPV: The scale of the challenges

View

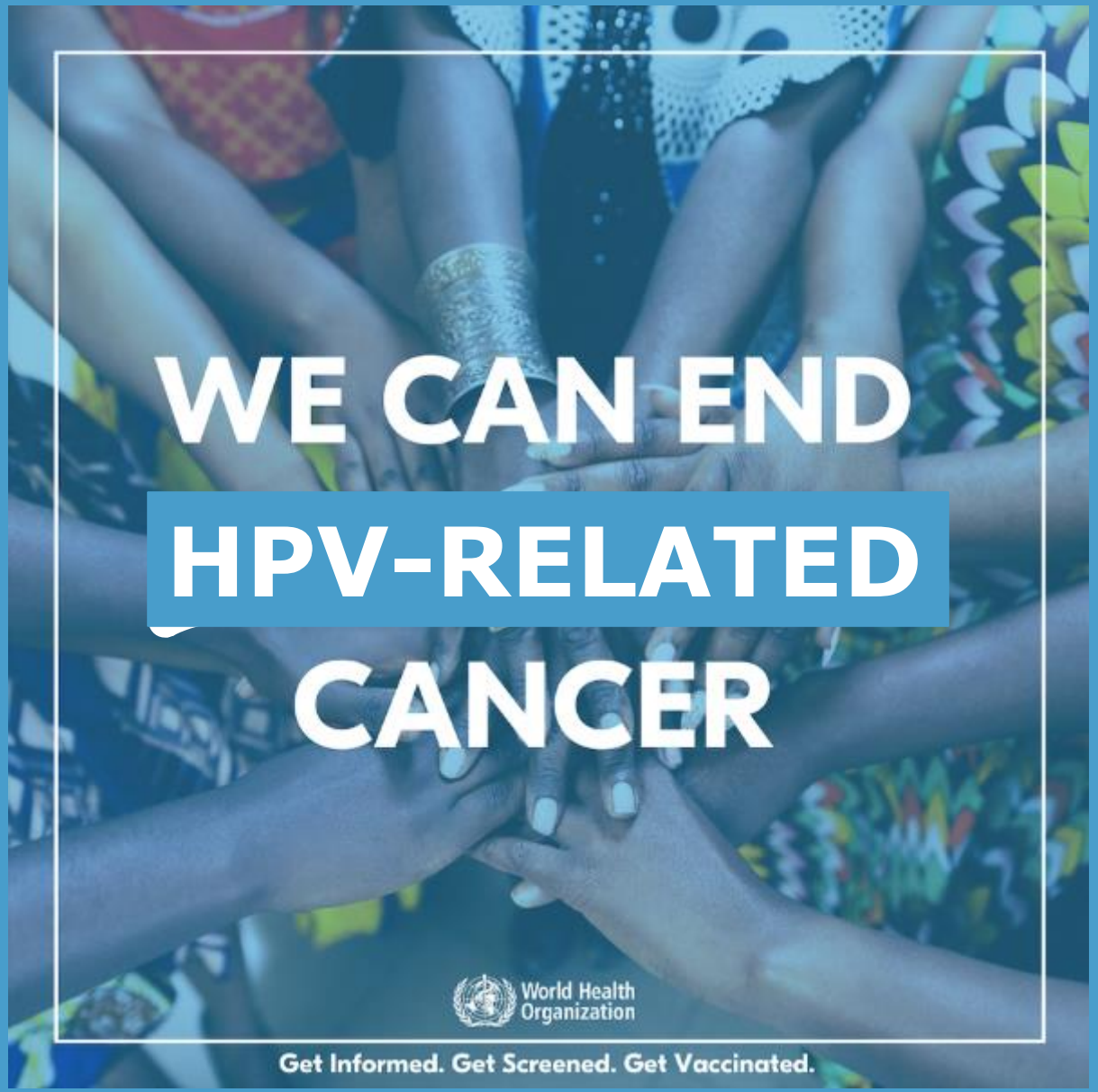
1 to 5 of 5

IAS 2023

Our call to action from the IAS 2023 pre-meeting

- Let communities lead!
- Improve general awareness that HPV causes cancer: to encourage vaccination and regular screening
- Routine anal cancer screening, normalize routine digital anal rectal examinations (DAREs)
- Improve HPV vaccination coverage among people living with HIV
- Simplify screening, triage and treatment options
- More point-of-care HPV testing and reduced price of HPV DNA tests
- Convince governments to invest in HPV, HBV and HCV – related cancer prevention, beyond cervical cancer elimination

IAS 2023


WE CAN END
HPV-RELATED
CANCER
World Health Organization
Get Informed. Get Screened. Get Vaccinated.

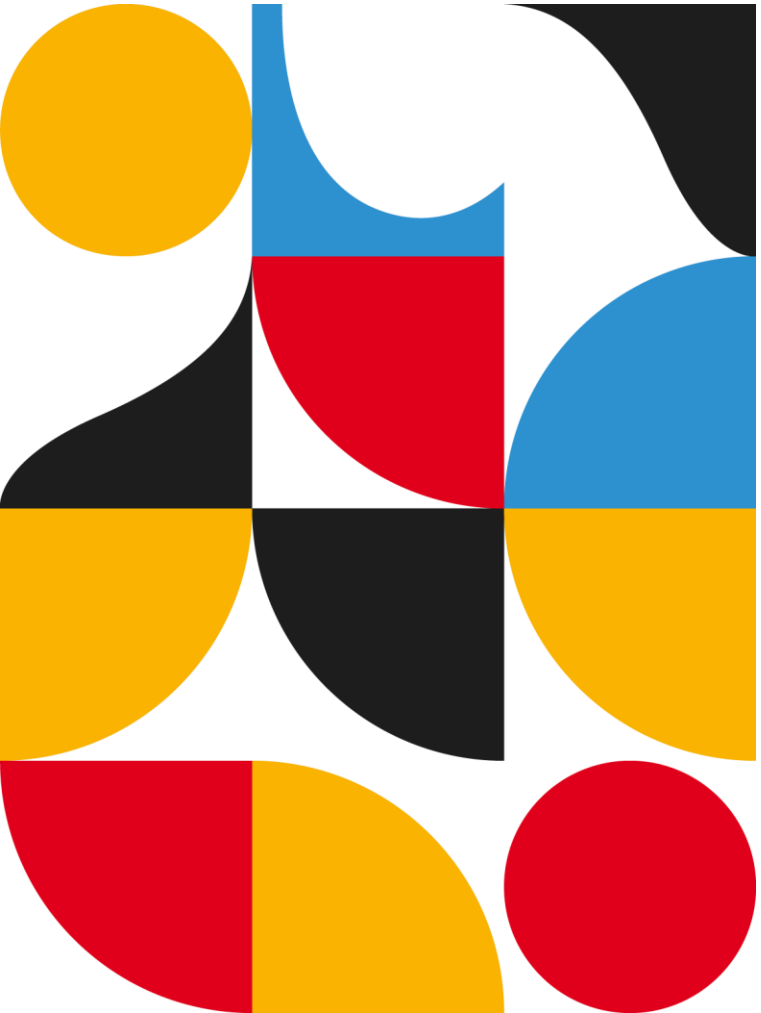
IAS

Our programme today

Topic	Presenter
Updates in HPV-related WHO guidance, especially for people living with HIV	**Meg Doherty**, World Health Organization, Switzerland
The role of civil society in cervical cancer elimination in Africa	**Benda N. Kithaka**, African Cervical Health Alliance, Kilele Health Association, Kenya
Building the investment case for cervical cancer elimination, including for people living with HIV	**Karen Canfell**, The Daffodil Centre, Cancer Council NSW and the University of NSW, Australia
The integration of HIV service delivery and cervical cancer screening and treatment programmes: key lessons learnt	**Helen Kelly**, World Health Organization, Switzerland
Malawi's approach to cervical cancer secondary prevention: the model of HIV/CxCa services integration	**Doreen Ali**, Malawi Ministry of Health, Malawi
Improving access to HPV testing	**Maribel Almonte**, World Health Organization, Switzerland
Updates to anal cancer screening evidence	**Andrew Grulich**, The Kirby Institute, University of NSW, Australia
Discussion with presenters and lived experience advocate **Sally Agallo Kwenda**, NCD Alliance, Kenya	Moderated by **Mary Nyangasi**, World Health Organization, Switzerland

AIDS 2024

More to come at AIDS 2024



- Theme: Put People First!
- Diverse pre-conference programme on 20 – 21 July
- Dedicated talks on HPV-related cancer within the main conference programme 22 – 26 July
- Global village of activists and community representatives

Updates in HPV-related WHO guidance, especially for people living with HIV

Meg Doherty,
WHO, Switzerland

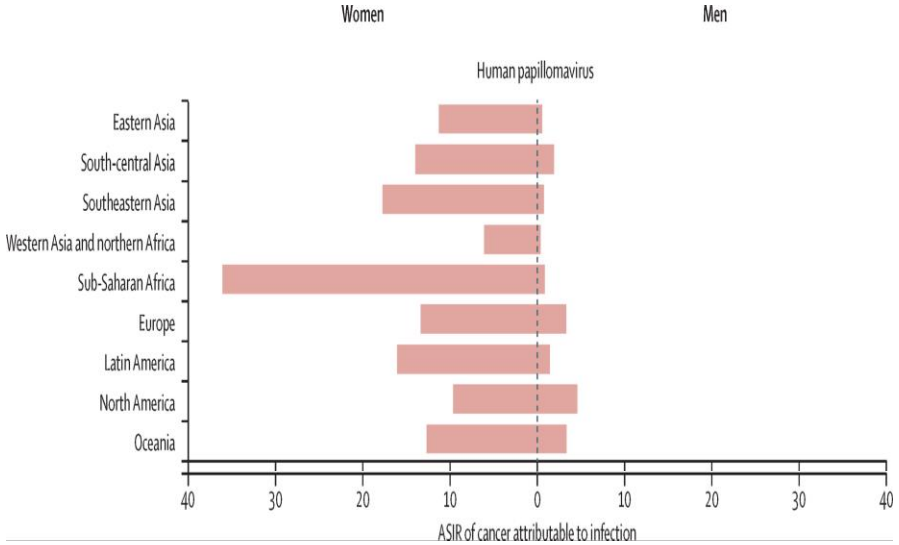
World Health Organization

Updates in HPV-related WHO guidance and investments for people living with HIV

Meg Doherty
Director
Department of Global HIV, Hepatitis and STI Programmes

HPV-associated cancers among people living with HIV

- People living with HIV **have 2-fold ↑ risk of high risk (HR)-HPV acquisition and 2-fold ↓ decreased risk of HR-HPV clearance** vs. individuals in general population[1]
- **Cervical cancer** represents approx. 80% of HPV-attributable cancer burden[2;]
  - Women living with HIV (WLHIV) have **6-fold ↑ risk of cervical cancer** vs. women in general population[3]
- **Anal cancer** incidence higher in PLHIV*[4,5]
  - **85 per 100,000** (men who have sex with men [MSM] with HIV),
  - **32 per 100,000** (heterosexual men living with HIV),
  - **22 per 100, 000** (WLHIV),
  - **19 per 100,000** (MSM without HIV);
  - 2 per 100,000 (Men without HIV)[6]
  - => increasing risk with age
- **Anogenital warts** also more common in PLHIV[7]



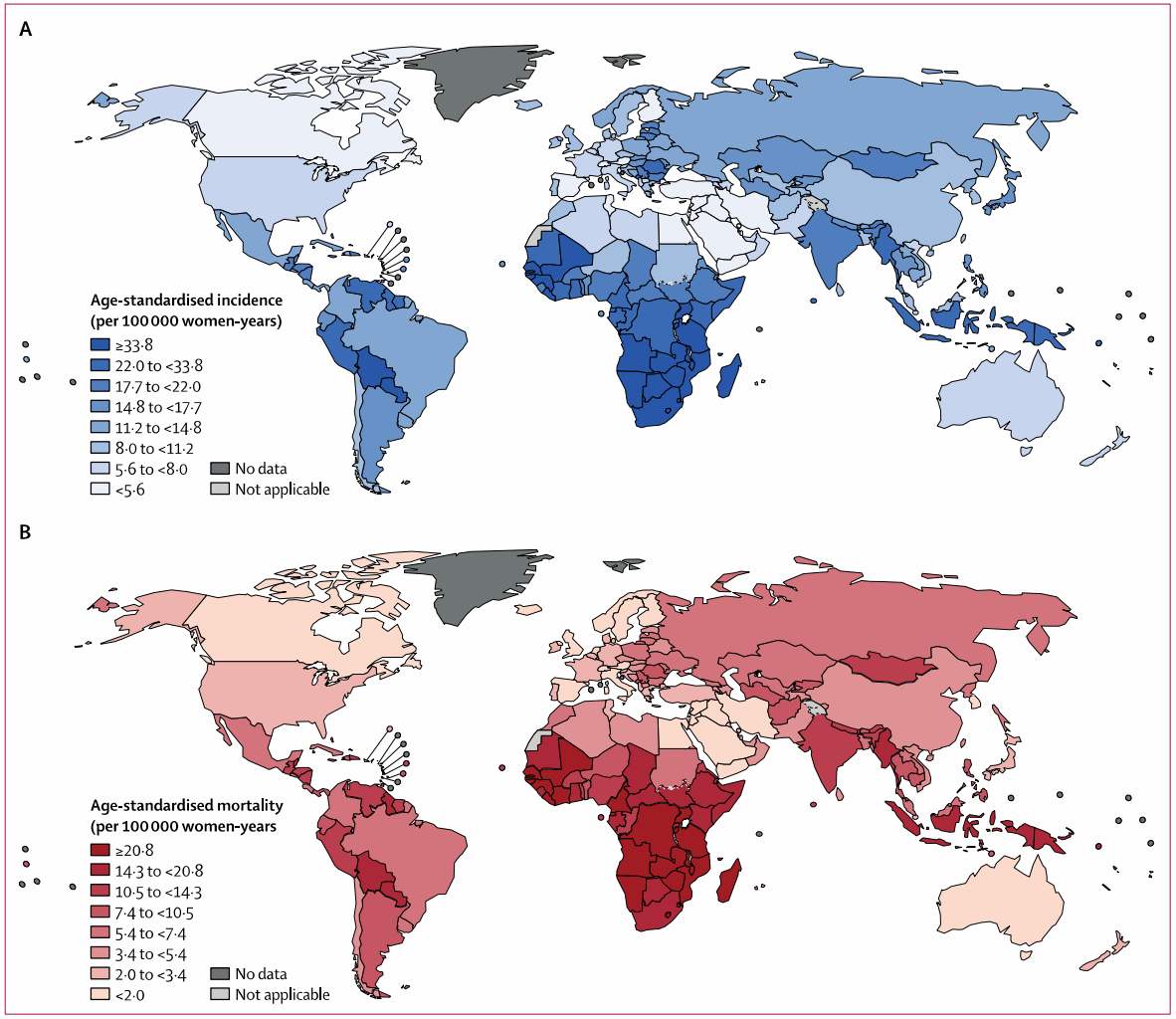
ASIR per 100 000 person-years of HPV , by sex in 2018

*Incidence rates (IRs), as cases per 100 000 person-years

1Looker et al. J Int AIDS Soc. 2018 Jun;21(6):e25110; 2*de Martel et al Lancet Glob Health. 2020 Feb;8(2):e180-e190; 3*Stelzle et al Lancet Glob Health. 2021 Feb;9(2):e161-e169; 4*Clifford et al. Int J Cancer. 2021 Jan 1;148(1):38-47;* 5Stier et al. Am J Obstet Gynecol. 2015 Sep;213(3):278-309; 6Silverberg et al, Clin Infect Dis. 2012 Apr;54(7):1026-34. ; [7]Low, *BMC Infect Dis* 2011

World Health Organization

Cervical cancer incidence and mortality in 2022



661,044 cervical cancer cases, 341,831 deaths

Incidence range: 2 to 85 cases per 100,000 women-yrs

Morality range: 1 to 56 per 100,000 women-yrs

Geographical and socioeconomic inequalities in cervical cancer globally:

- **Access to HPV vaccination**
- **Access to cervical cancer screening and treatment**
- **Impact of HIV**

Source: Singh et al. Lancet Glob Health. 2023 Feb;11(2):e197-e206.

World Health Organization

Global Cervical Cancer Elimination Threshold & Targets

Threshold for Elimination as a Public Health Problem:
Age-adjusted incidence rate < 4 / 100,000 women

2030 Targets

90%

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

70%

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

90%

of women identified with cervical disease (precancer or cancer) receive treatment and care

SDG 2030 Target 3.4:
30% reduction in mortality from NCDs

human reproduction programme hrp research for impact
UNDP-UNFPA-UNICEF-WHO-WORLD BANK

World Health Organization

New WHO recommendations on HPV vaccine schedules can optimize vaccine coverage

Primary target : girls 9 to 14 years of age

2-dose schedule for all ages starting from 9 years old

Option: 1-dose schedule for 9 to 20-year-olds

Prioritize the vaccination of Immunocompromised/HIV+ populations – also at ages beyond primary target - with at least 2 doses, ideally 3

"Current evidence suggests that a single dose has comparable efficacy and duration of protection as a 2-dose schedule and may offer programme advantages, be more efficient and affordable, and contribute to improved coverage. From a public health perspective, the use of a single dose schedule can offer substantial benefits that outweigh the potential risk"

2022, 97, 645–672 No 50

World Health Organization
Organisation mondiale de la Santé

Weekly epidemiological record
Relevé épidémiologique hebdomadaire

16 DECEMBER 2022, 97th YEAR / 16 DÉCEMBRE 2022, 97e ANNÉE
No 50, 2022, 97, 645–672
http://www.who.int/wer

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Human papillomavirus vaccines: WHO position paper (2022 update)

Introduction

In accordance with its mandate to provide normative guidance to Member States on health policy matters, WHO issues a series of regularly updated position papers[1] on vaccines and combinations of vaccines against diseases that have an international public health impact. These papers are concerned primarily with the use of vaccines in large-scale vaccination programmes.

The vaccine position papers are drafted by the WHO SAGE Secretariat; they summarize essential background information on diseases and vaccines and conclude with the current WHO position on the use of the vaccines worldwide. Before finalization, the position papers are reviewed by a large group of external subject-matter experts and end-users. The Grading of Recommendations Assessment, Development and Evaluation (GRADE) and the evidence-to-recommendation tables are published alongside the position paper. The methods followed by SAGE[2] and the processes[3] for preparation of vaccine position papers are described on the WHO website. The position papers are intended for use by national public health officials and managers of immunization programmes. They may also be of interest to vaccine advisory groups, international funding agencies, health professionals,

Vaccins contre les papillomavirus humains: note de synthèse de l'OMS (mise à jour de 2022)

Introduction

Conformément à son mandat, qui prévoit qu'elle fournisse aux États Membres des orientations à caractère normatif en matière de politique sanitaire, l'OMS publie une série de notes de synthèse[1] régulièrement mises à jour sur les vaccins et les associations vaccinales contre les maladies ayant une incidence sur la santé publique internationale. Ces notes portent principalement sur l'utilisation des vaccins dans le cadre de programmes de vaccination à grande échelle.

Les notes de synthèse sur les vaccins sont rédigées par le secrétariat du SAGE de l'OMS; elles résument les informations essentielles sur les maladies et les vaccins associés et présentent en conclusion la position actuelle de l'OMS concernant l'utilisation de ces vaccins à l'échelle mondiale. Avant leur mise en forme définitive, elles sont examinées par un large groupe d'experts externes et d'utilisateurs finals. Les résultats de l'évaluation GRADE (Grading of Recommendations Assessment, Development and Evaluation) et les tableaux des données à l'appui des recommandations sont publiés en même temps que la note de synthèse. Les méthodes employées par le SAGE[2] et la procédure suivie[3] pour élaborer les notes de synthèse sur les vaccins sont décrites sur le site Web de l'OMS. Les notes de synthèse sont destinées aux responsables nationaux de la santé publique et aux administrateurs des programmes de vaccination, mais elles peuvent également présenter un intérêt pour les

[1] WHO vaccine position papers. Geneva: World Health Organization (www.who.int/teams/immunization-vaccines-and-biologicals/policies/position-papers, accessed August 2022).

[2] Guidance for the development of evidence-based vaccine-related recommendations. Geneva: World Health Organization; 2017 (www.who.int/publications/m/item/guidance-for-the-development-of-evidence-based-vaccine-related-recommendations, accessed August 2022).

[3] WHO position paper process. Geneva: World Health Organization; 2020 (www.who.int/publications/m/item/who-position-paper-process, accessed August 2022).

[1] WHO vaccine position papers. Genève: Organisation mondiale de la santé (www.who.int/teams/immunization-vaccines-and-biologicals/policies/position-papers, consulté en août 2022).

[2] Guidance for the development of evidence-based vaccine-related recommendations. Genève: Organisation mondiale de la santé; 2017 (www.who.int/publications/m/item/guidance-for-the-development-of-evidence-based-vaccine-related-recommendations, consulté en août 2022).

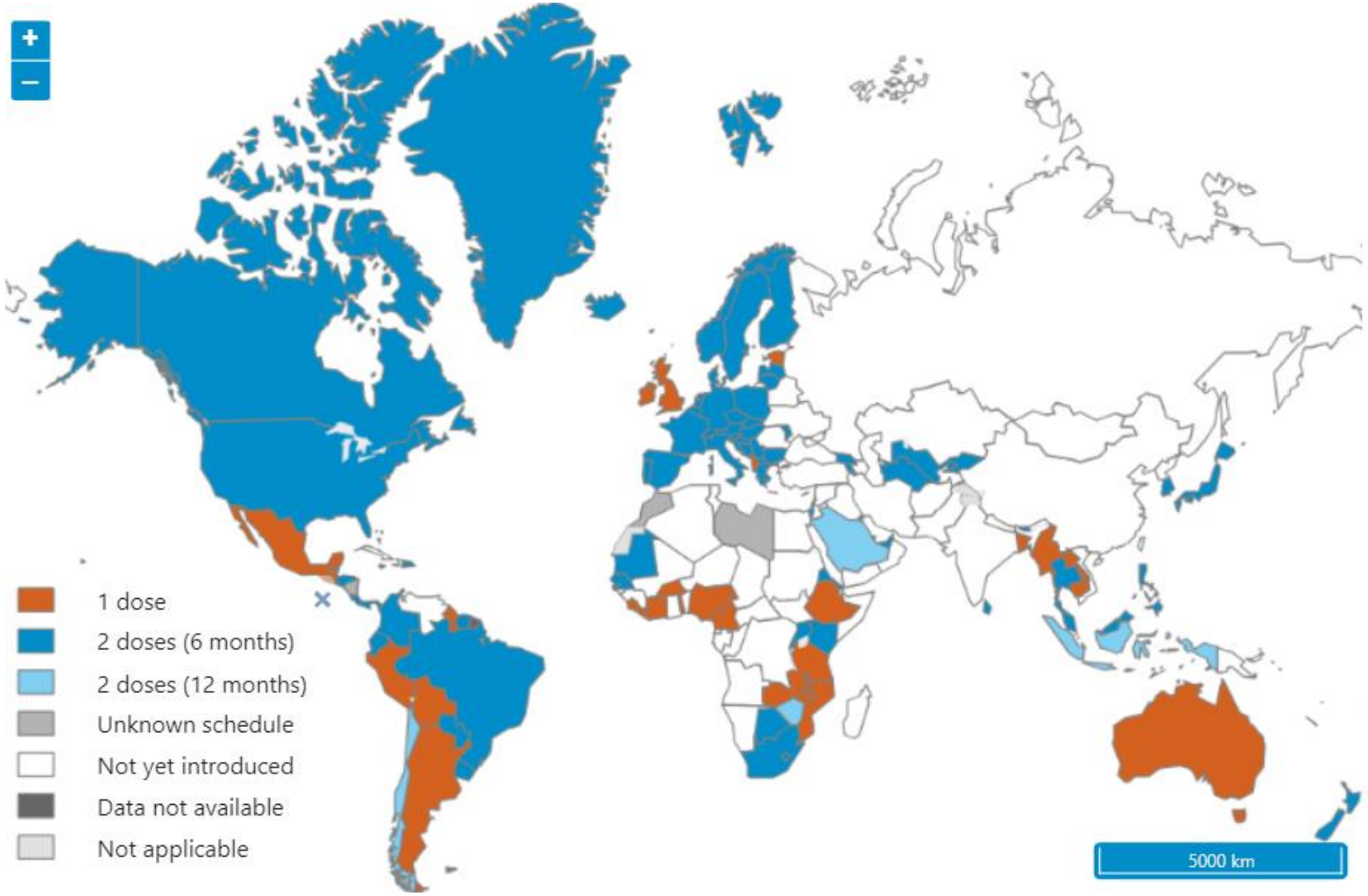
[3] WHO position paper process. Genève: Organisation mondiale de la santé; 2020 (www.who.int/publications/m/item/who-position-paper-process, consulté en août 2022).

645

Source: https://www.who.int/publications/i/item/who-wer9750-645-672

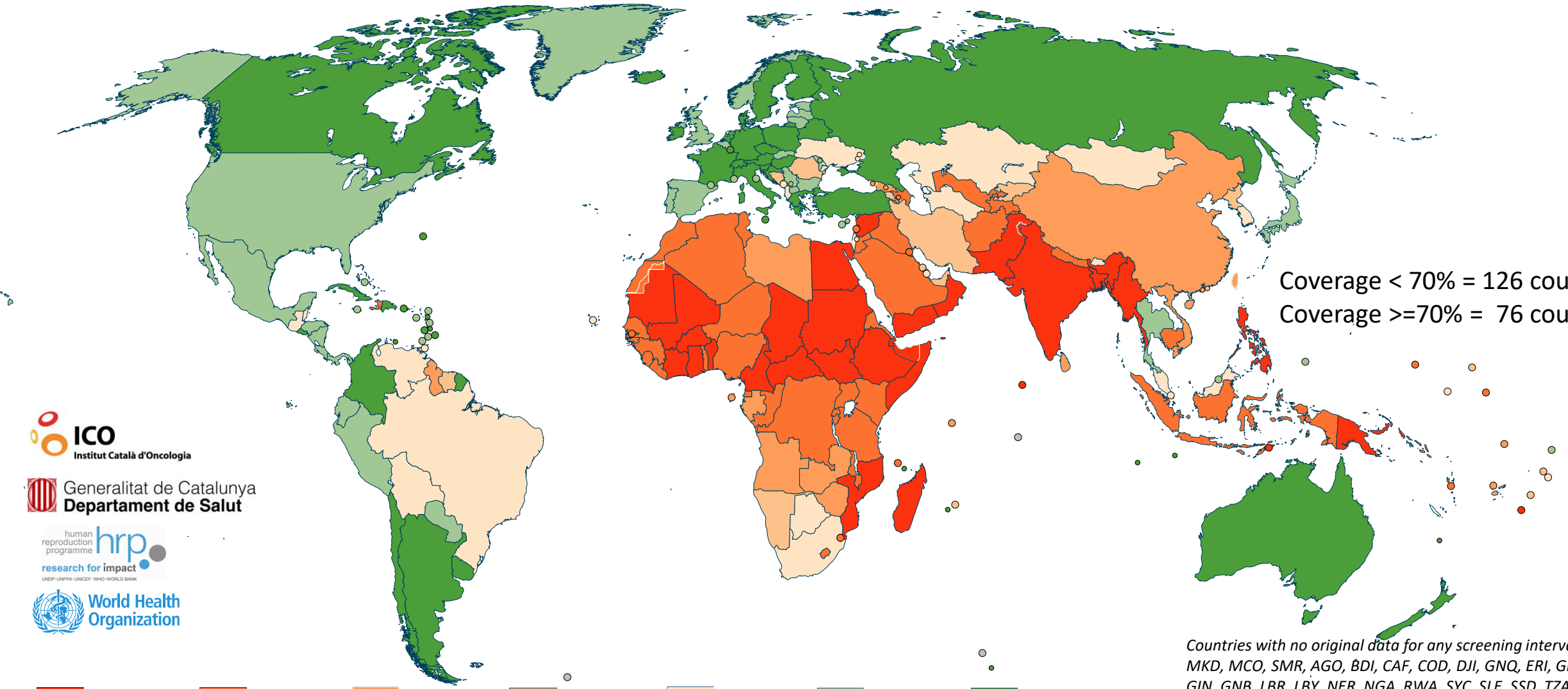
Single-dose schedule adaptation has potential to improve coverage & speed up introductions

- 37 Countries adopted 1 dose (*in HIC,MIC&LIC*)
- All new GAVI countries applications for 1- dose



World Health Organization

Ever in lifetime screening coverage (2019), women aged 30-49y by country



Coverage < 70% = 126 countries
Coverage >=70% = 76 countries

ICO Institut Català d'Oncologia

Generalitat de Catalunya
Departament de Salut

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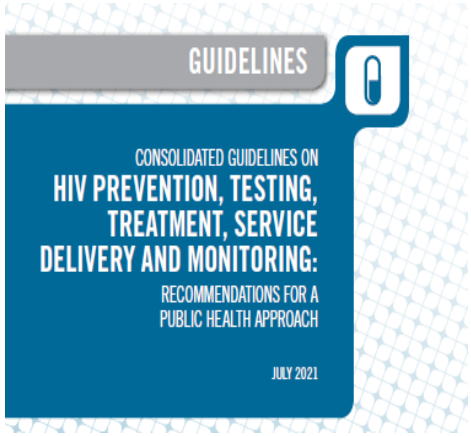
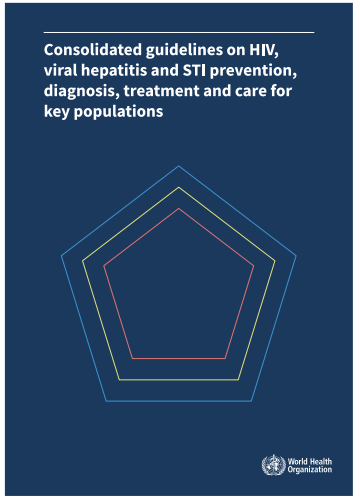
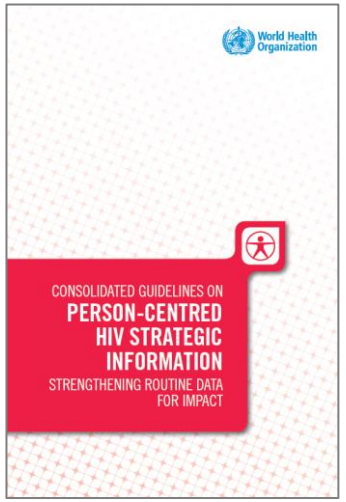
0-9% | 10-19% | 20-34% | 35-49% | 50-69% | 70-89% | 90-100%

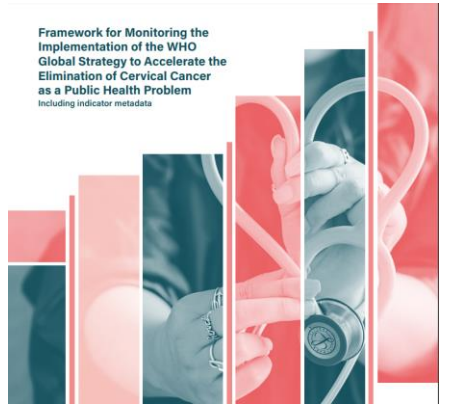
Countries with no original data for any screening intervals: MKD, MCO, SMR, AGO, BDI, CAF, COD, DJI, GNQ, ERI, GMB, GIN, GNB, LBR, LBY, NER, NGA, RWA, SYC, SLE, SSD, TZA, TGO, ATG, PAN, SUR, VEN, ASM, COK, NIU, WSM, VUT, AFG, BHR, KHM, PRK, PSE, YEM

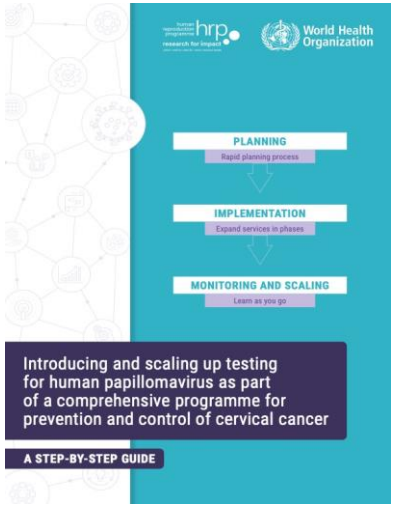
Several WHO Guidelines and products related to HPV/cervical cancer

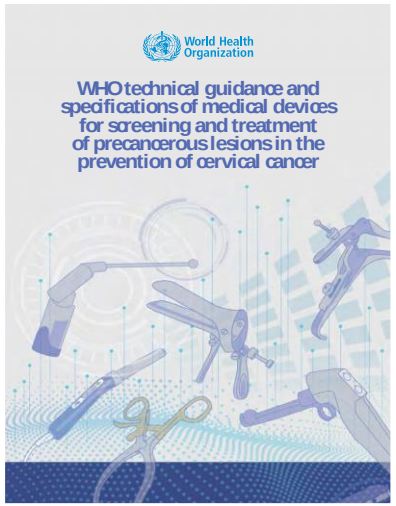


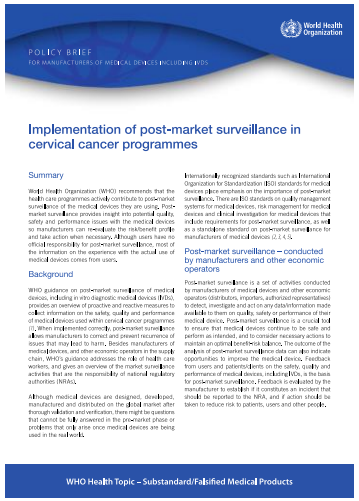


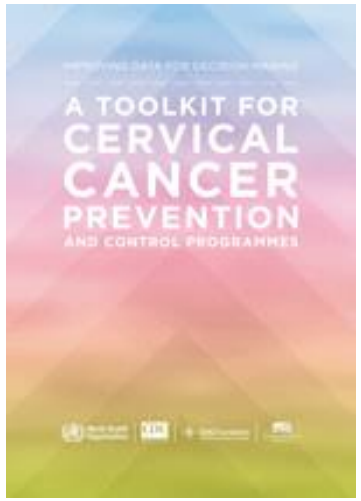












World Health Organization

Summary Recommendations: WHO suggests using the following strategy for cervical cancer prevention

For the general population of women

Screen and Treat OR Screen, Triage and Treat

- HPV DNA as primary screening test
- Starting at age 30
- Every 5 to 10 years screening interval

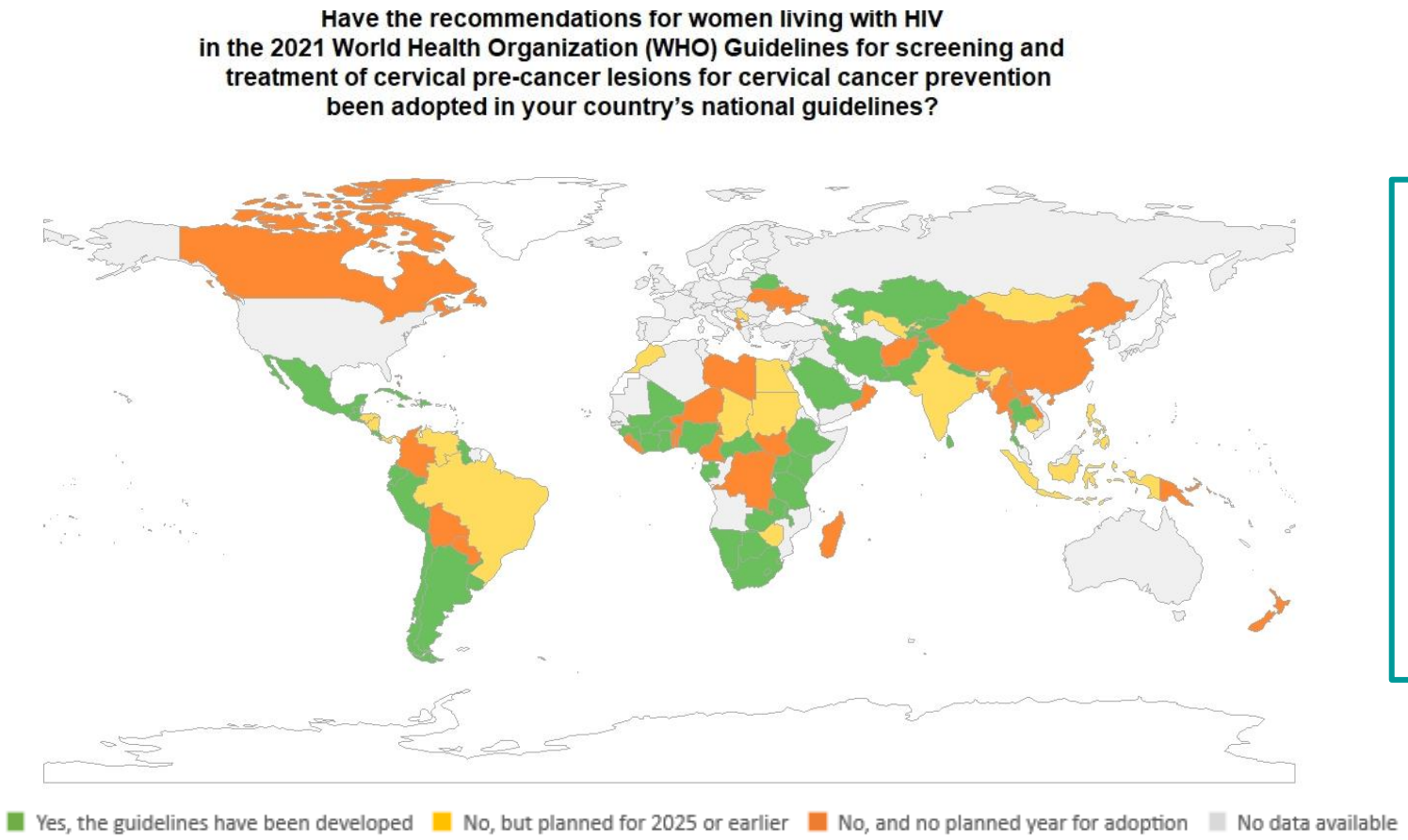
For women living with HIV

Screen, Triage and Treat

- HPV DNA as primary screening test
- Starting at age 25
- Every 3 to 5 years screening interval

When providing HPV DNA testing, WHO suggests using either provider or self-collected samples

2023 National Commitments and Policy Instrument on adoption of 2021 WHO recommendations into national guidelines



Of the 98 reporting countries:

- **50** have already adopted the recommendations from the *2021 WHO guidelines* for women living with HIV in their national guidelines
- **19** plan to do so by 2025

World Health Organization

Focus: Policy & program implementation

- **Support ministries of health in adopting guidelines**
  - Increase country-level impact to reduce cervical cancer incidence and mortality across the 3 pillars (prevention, screening, treatment)
- **Bi-directional integration of HIV and cervical cancer services**
  - Improve service provision in settings with high HIV prevalence
  - Facilitate referrals between programs
- **Strengthen facility-based monitoring of cervical cancer screening & treatment**
- **Further strengthen links with the community**
  - Advocate for better counselling, patient education, availability of treatment and screening tests
  - Involve community of women and community of PLHIV in all aspects of programme development
- **Address knowledge gaps with living guidelines and implementation science**

Acknowledgements

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Linda Eckert
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Margaret Happy
Ruth Awori

Marie-Claude Boily
Ruanne Barnabas
Cari Van Schalkwyk
Karen Canfell
Kate Simms
Michaela Hall
Adam Keane
Michael Chung
Nelly Mugo

Guideline Development Group Members

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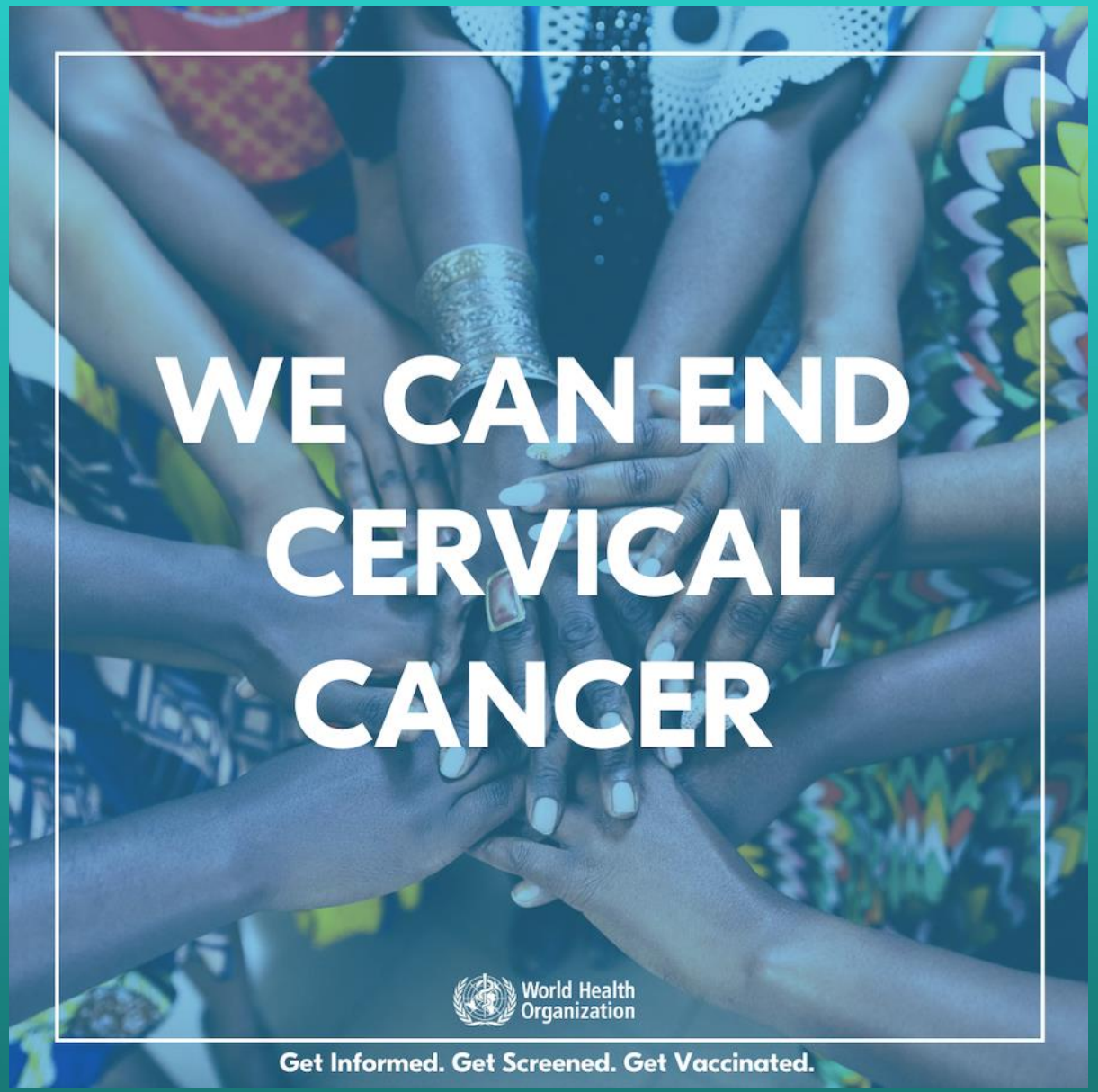
Unitaid
Innovation in Global Health

World Health Organization



World Health Organization

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Benda N. Kithaka,
African Cervical Health Alliance, Kilele Health Association, Kenya

The role of civil society in cervical cancer elimination in Africa

cervical cancer elimination in Africa

the role of civil society

Ms. Benda Kithaka
Executive Director, KILELE Health Association
Secretariat Lead – African Cervical Health Alliance (ACHA)
Technical Advisor – HPV Cancers Prevention & Women's Health
Independent Consultant – Health Advocacy & Communications
www.kilelehealth.org

ACHA

African Cervical Health Alliance

FIND
Diagnosis for all

KILELE
HEALTH ASSOCIATION

A CERVICAL CANCER FREE AFRICA

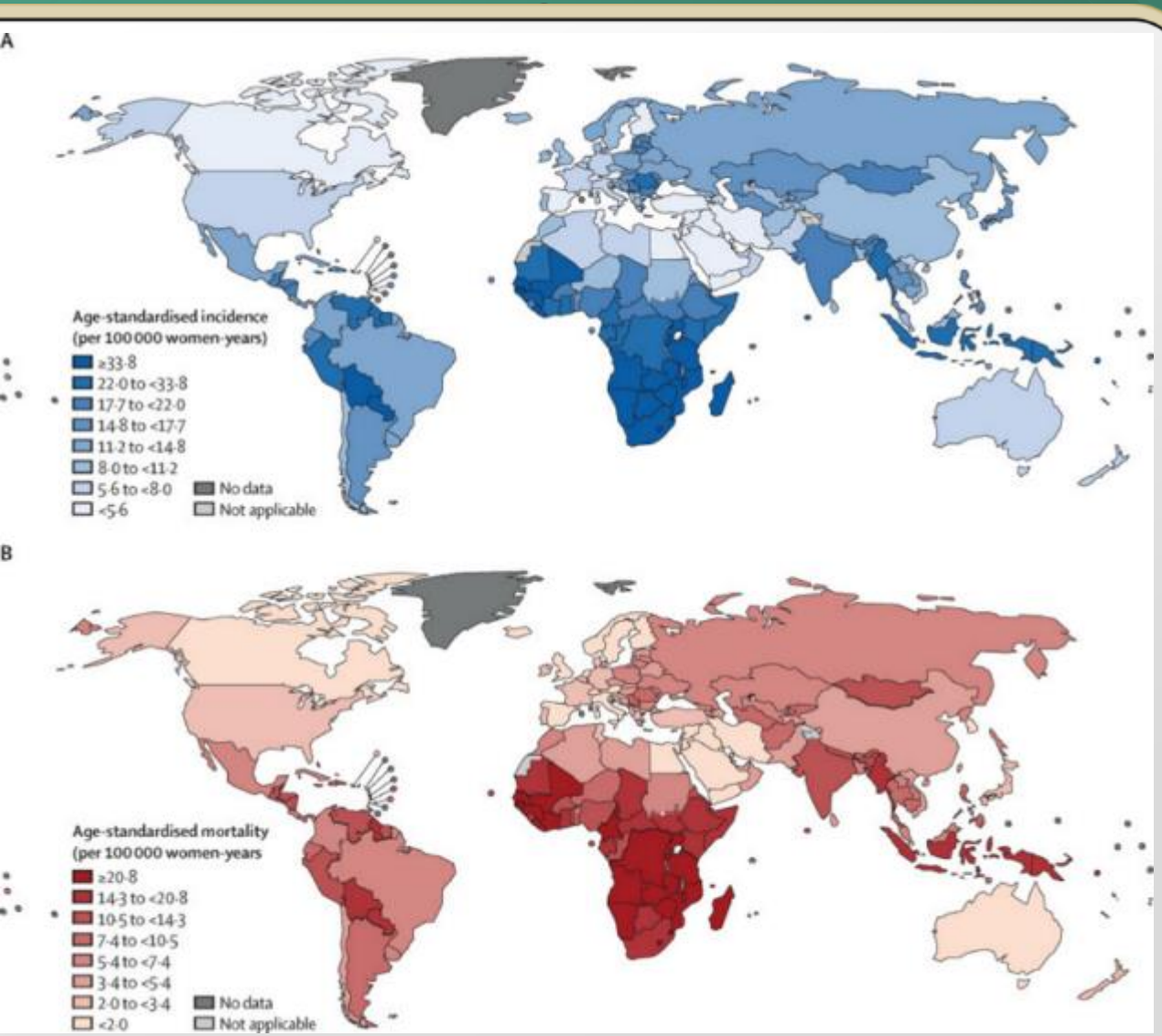
director@kilelehealth.org

ACHA
African Cervical Health Alliance

NAME:	• **African Cervical Health Alliance (ACHA)**
VISION:	• **An Africa Free of Cervical Cancer**
MISSION:	• Empower communities to increase access to prevention and control of cervical cancer in Africa by 2030, as we work to achieve the WHO 90-70-90 Targets.

Values: **Accountability, Cooperation, Trust, Unity, Respect, Integrity**

A Network of grassroots Civil Society Organizations (CSOs) in Africa, working together across diverse geographies, to put community action centerstage in the elimination of cervical cancer in Africa.



Africa leads the World in Age standardized Incidence and Mortality.

Global estimates of incidence and mortality of cervical cancer in 2020: a baseline analysis of the WHO Global Cervical Cancer Elimination Initiative

The Lancet Global Health, Elsevier. February 2023, © 2022 World Health Organization. Elsevier Ltd. https://doi.org/10.1016/S2214-109X(22)00501-0

FIND Diagnosis for all

KILELE HEALTH ASSOCIATION

ACHA African Cervical Health Alliance

World Health Organization

ACHA African Cervical Health Alliance

CSOs supporting the WHO 90-70-90 Cervical Cancer Elimination Targets

90%

of girls

fully vaccinated with HPV vaccine by the age of 15

70%

of women

screened by the age of 35, and again by the age of 45

90%

of women

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

Clear Metrics – Primary, Secondary, Tertiary Prevention

FIND Diagnosis for all

KILELE HEALTH ASSOCIATION

Cervical cancer in Africa Situational Analysis?

Poor Awareness

Few African Countries have invested in public health approaches to cervical cancer elimination

Fear & Stigma

Communities face cancer deaths daily, instilling fear of screening

Late Diagnosis

Many families cannot afford diagnostic tests, leading to delays in treatment

Limited Access

Access to care is limited, by distant treatment centers and fewer personnel

Escalating Numbers

Cancer Care costs are very high, often out of pocket by families
No. of Women on the increase
Risk to families is heightened

Global HIV Aids Movement lessons for cancer CSOs in Africa

ACHA
African Cervical Health Alliance

- **Respectful stakeholder engagement**
  - ✓ Global Solidarity
  - ✓ Leveraging resources, expertise, shared lessons
  - ✓ Building best practices
- **Framing and messaging**
  - ✓ Human rights-based approaches
  - ✓ Focus on equity and access
  - ✓ Addressing social determinants of health
  - ✓ Stigma reduction
- **Community-led advocacy**
  - ✓ Empowerment and inclusivity in decision making
  - ✓ Consultations in program design
  - ✓ Raising awareness, education and support
  - ✓ Advocating for policy changes

ACHA
African Cervical Health Alliance

Putting People First

- **Policy Advocacy for Change**
  - Prioritize elimination for every woman and girl
  - Focus on equity and access
  - *Increased funding, improved infrastructure and integrated services*
- **Research & *People-Centered* Care Interventions**
  - Safeguarding cervical health
  - Involvement of clients / caregivers in decision-making, respectfully
  - Addressing barriers to care – culture, stigma, language
  - *Individuals prioritized, a responsive system (preferences, values, needs)*

Addressing the Cervical Cancer Burden in Africa

16

Countries

Population ~ 693.7 M

22

Organizations

Cancer Alliance

(26 Member Orgs)

LVCT

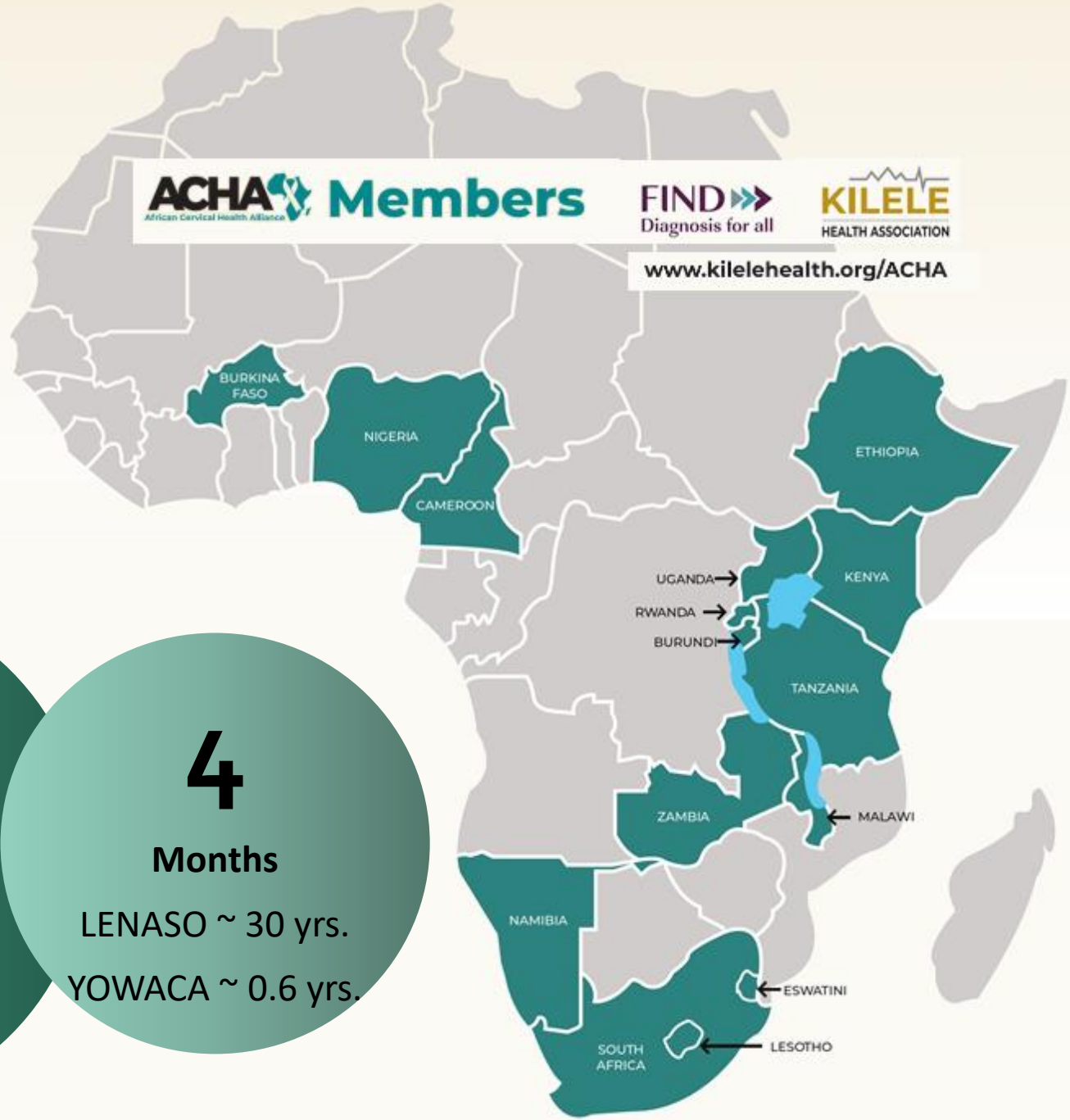
(607,081 Pax +)*

4

Months

LENASO ~ 30 yrs.

YOWACA ~ 0.6 yrs.



FIND - ACHA – KILELE Health - Workshop on Qualitative Research Methods February 2024, Nairobi, Kenya.

ACHA Members Learning Qualitative Research Methods February 2024

5 Workstreams for ACHA Engagement

1. Targeted
   Advocacy and Research
2. Focused
   Capacity Building and Training
3. Sustainable
   Fundraising and Resource Mobilization
4. Strategic
   Community Engagement and Outreach
5. Standardized
   Communications and IEC Materials

ACHA
African Cervical Health Alliance

To partner, join or support ACHA, email the Secretariat. director@kilelehealth.org

Let Communities Lead

World AIDS Day 2023

ACHA
African Cervical Health Alliance

Benda Kithaka
Secretariat Lead, Founder – KILELE Health
NAS Apartments, Milimani Rd. Nairobi, Kenya
https://www.kilelehealth.org/acha/

Building the investment case for cervical cancer elimination, including for people living with HIV

Karen Canfell,
The Daffodil Centre, Cancer Council NSW and the University of Sydney, Australia

Building the investment case for cervical cancer elimination, including for people living with HIV

IAS Webinar
February 19 2024

Karen Canfell

Director, The Daffodil Centre
Professor & NHMRC Leadership Fellow
Cancer Council NSW &
Faculty of Medicine and Health, University of Sydney

NHMRC Centre of Research Excellence in Cervical Cancer Control

This is a multi-institutional agreement in partnership with:

The Daffodil Centre

Australian Centre for the Prevention of Cervical Cancer

UNSW Kirby Institute

Disclosures

I am co-PI of an investigator-initiated trial of cervical screening, *Compass*, run by the Australian Centre for Prevention of Cervical Cancer (ACPCC), which is a government-funded not-for-profit charity. The ACPCC has received equipment and a funding contribution from Roche Molecular Diagnostics.

I am also co-PI on a major implementation program *Elimination of Cervical Cancer in the Western Pacific* which has received support from the Minderoo Foundation and equipment donations from Cepheid Inc.

The WHO global strategy

The three pillars of cervical cancer control

WHO 2030 targets

Vaccination	Screening	Treatment
90% of girls fully vaccinated by age 15	70% of women HPV screened at 35 and 45	90% of women identified with precancer or cervical cancer treated

Cervical cancer threshold for elimination as a public health problem: 4 cervical cancer cases per 100,000 women per annum

RoI

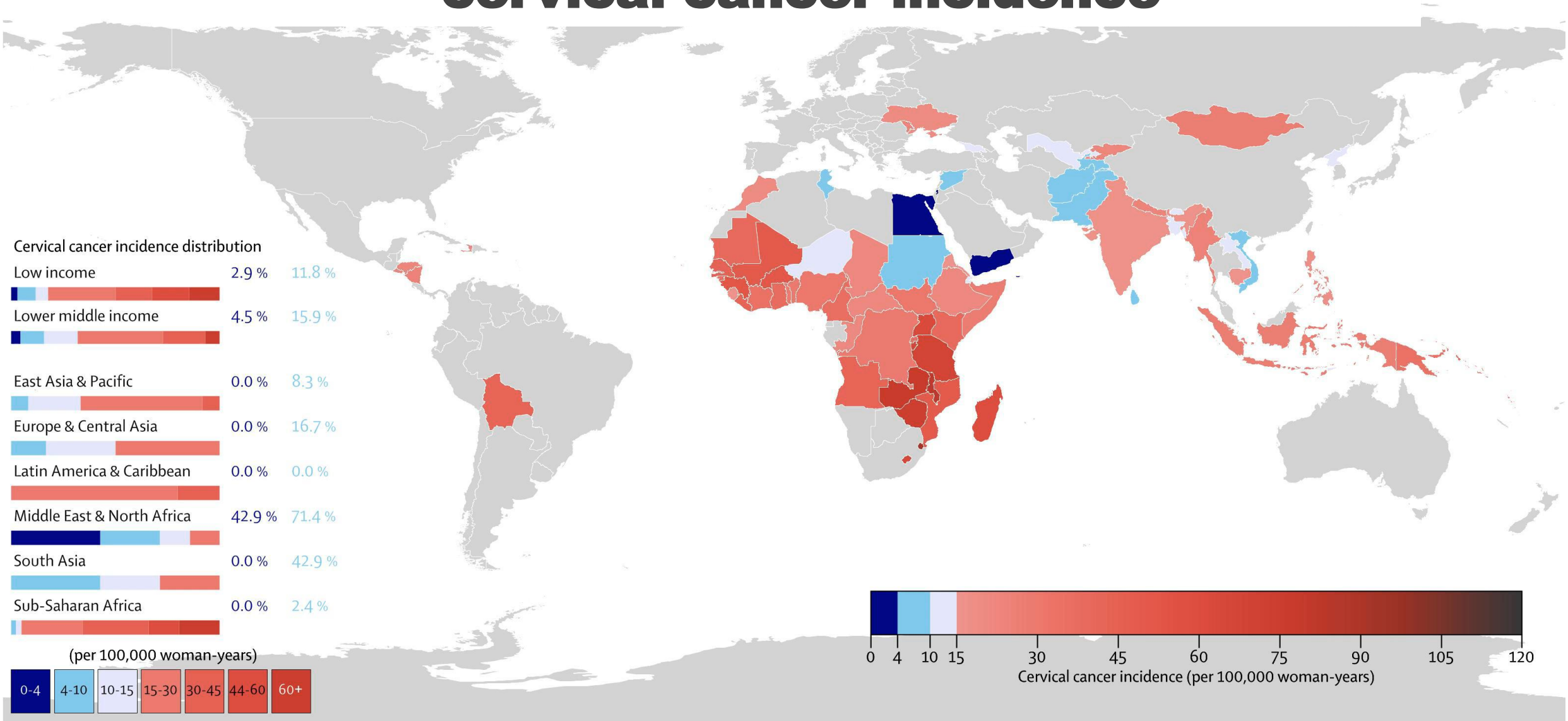
US $3.20 returned to the economy for every dollar invested through 2050 and beyond.

The figure rises to US $26.00 when the benefits of women's improved health on families, communities, and societies are considered.

World Health Organisation. Global strategy towards eliminating cervical cancer as a public health problem, November 2020.

2020

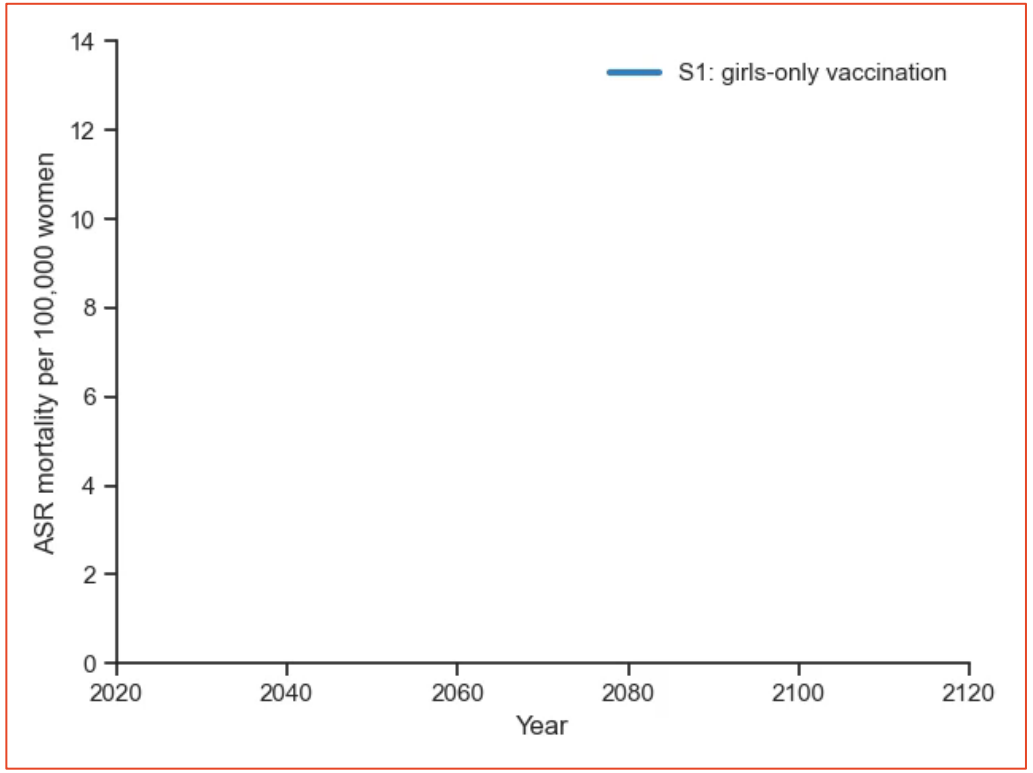
Impact of successful implementation on cervical cancer incidence



Brisson M/ Kim JJ,/Canfell K, et al. Impact of HPV vaccination and cervical screening on cervical cancer elimination: a comparative modelling analysis in 78 low-income and lower-middle-income countries. *Lancet* Jan 30 2020.

Impact of successful implementation on cervical cancer mortality

Across 78 LMIC



Combined impact of three pillars results in both short- and longer-term population-wide benefits:

300,000-400,000 deaths averted by 2030

14.6M deaths averted by 2070

62.6M deaths averted over the course of the century

The Daffodil Centre

Canfell K/Kim JJ/Brisson M et al., Mortality impact of achieving WHO cervical cancer elimination targets: a comparative modelling analysis in 78 low-income and lower-middle-income countries *Lancet* Jan 30 2020

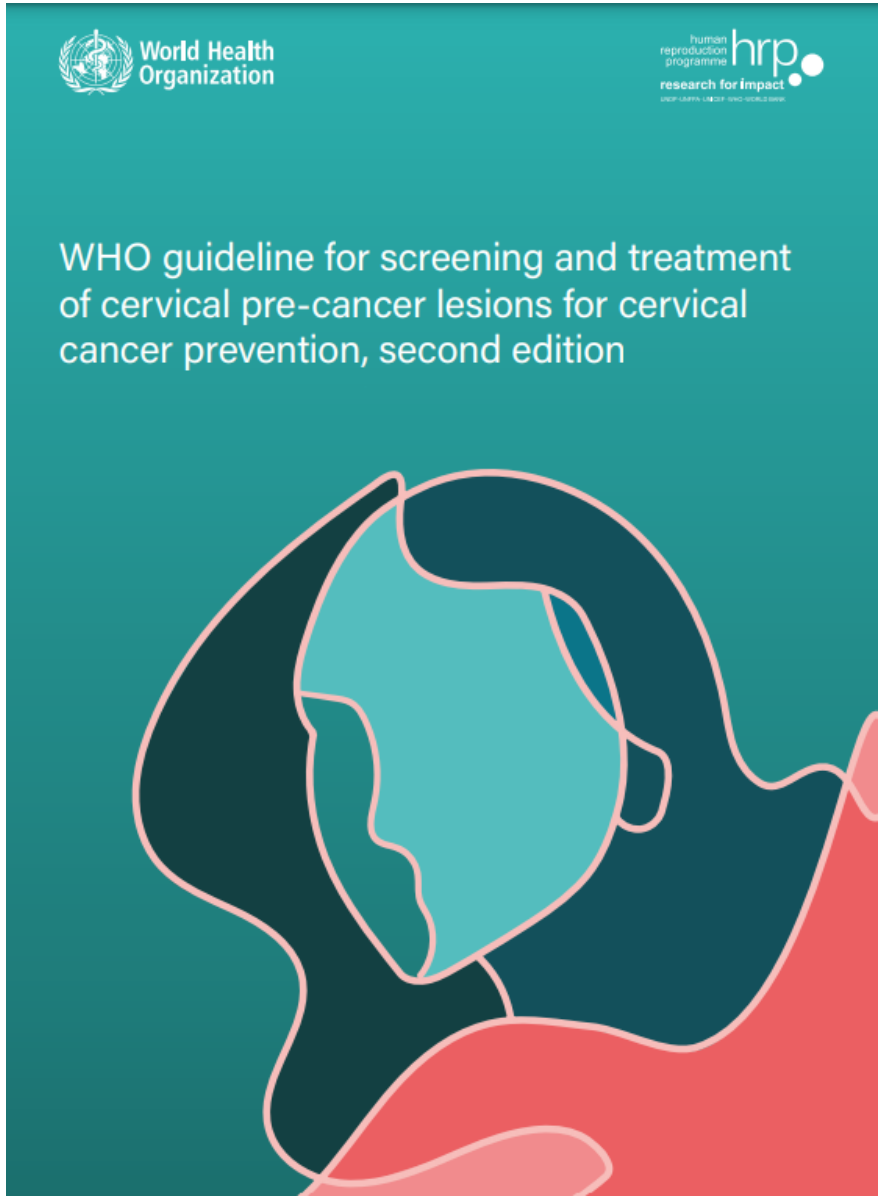
Cancer Council | The University of Sydney

The Daffodil Centre

Cancer Council | The University of Sydney

HPV screening

Impact & investment case



In LMIC, the 2021 WHO screen-and-treat Guidelines provide models for implementation of primary HPV screening

*"WHO recommends using **HPV detection as the primary screening test** rather than VIA or cytology in screening and treatment approaches among **both the general population of women and women living with HIV**"*

WHO guideline for screening and treatment of cervical pre-cancer lesions for cervical cancer prevention, 2nd edition: https://www.who.int/publications/i/item/9789240030824

HPV screening provides the greatest benefits for the least harms, including in women living with HIV, and is the most cost-effective approach

nature medicine

Article

https://doi.org/10.1038/s41591-023-02600-4

Benefits, harms and cost-effectiveness of cervical screening, triage and treatment strategies for women in the general population

Received: 19 December 2022

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Check for updates

Kate T. Simms[1,20], Adam Keane[1,20], Diep Thi Ngoc Nguyen[1], Michael Caruana[1], Michaela T. Hall[1], Gigi Lui[1], Cindy Gauvreau[2,3], Owen Demke[4], Marc Arbyn[5,6], Partha Basu[7], Nicolas Wentzensen[8], Beatrice Lauby-Secretan[9], Andre Ilbawi[10], Raymond Hutubessy[11], Maribel Almonte[7,12], Silvia De Sanjosé[8,13], Helen Kelly[14], Shona Dalal[15], Linda O. Eckert[16,17], Nancy Santesso[18], Nathalie Broutet[19] & Karen Canfell[1]

nature medicine

Article

https://doi.org/10.1038/s41591-023-02601-3

Benefits and harms of cervical screening, triage and treatment strategies in women living with HIV

Received: 22 December 2022

Accepted: 20 September 2023

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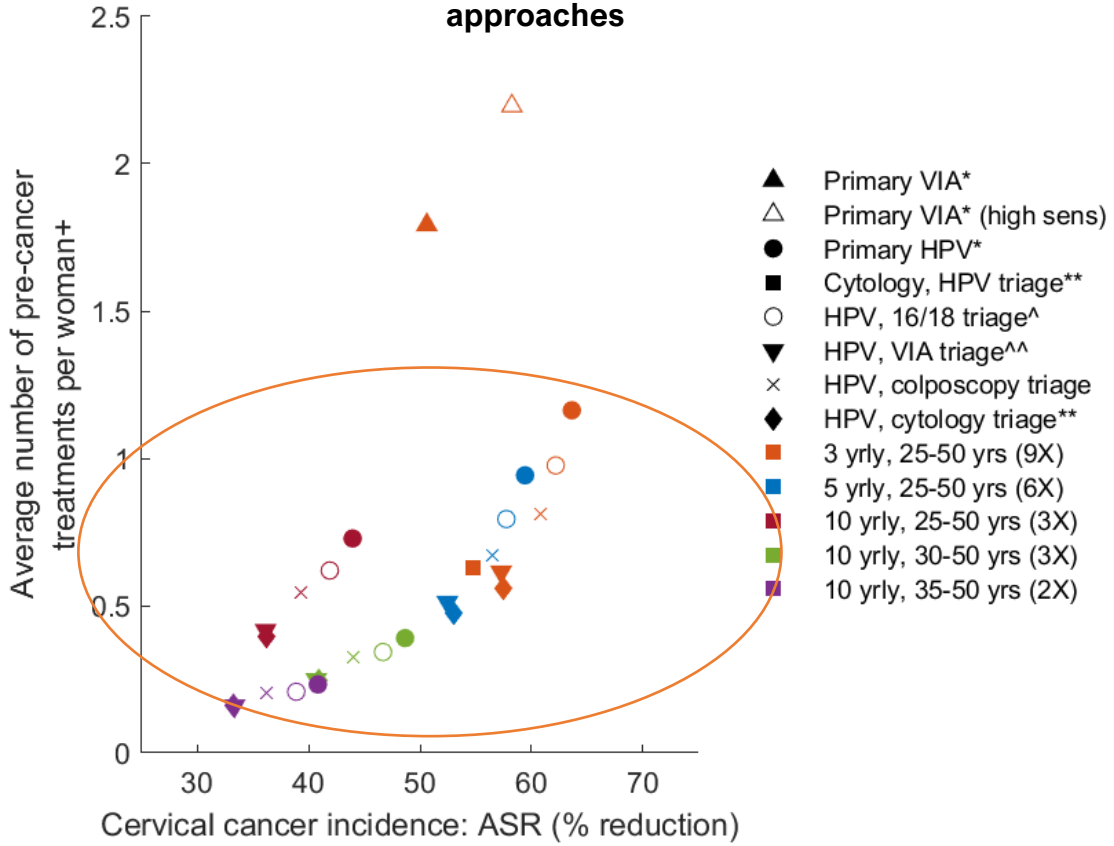
Check for updates

Michaela T. Hall[1], Kate T. Simms[1], John M. Murray[2], Adam Keane[1], Diep T. N. Nguyen[1], Michael Caruana[1], Gigi Lui[1], Helen Kelly[3], Linda O. Eckert[4], Nancy Santesso[5], Silvia de Sanjose[6,7], Edwin E. Swai[8], Ajay Rangaraj[9], Morkor Newman Owiredu[9], Cindy Gauvreau[10,11], Owen Demke[12], Partha Basu[13], Marc Arbyn[14,15], Shona Dalal[9], Nathalie Broutet[16] & Karen Canfell[1]

Average lifetime precancer treatment events in women living with HIV, for different screening approaches



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Making HPV testing accessible and affordable to all women must be a priority

54% increase in GeneXpert instrument numbers across (non-US) Pacific Island Countries and Territories between Jan 2020 and Dec 2022

Badman S., Cepheid Diagnostics, personal communication, April 2023.

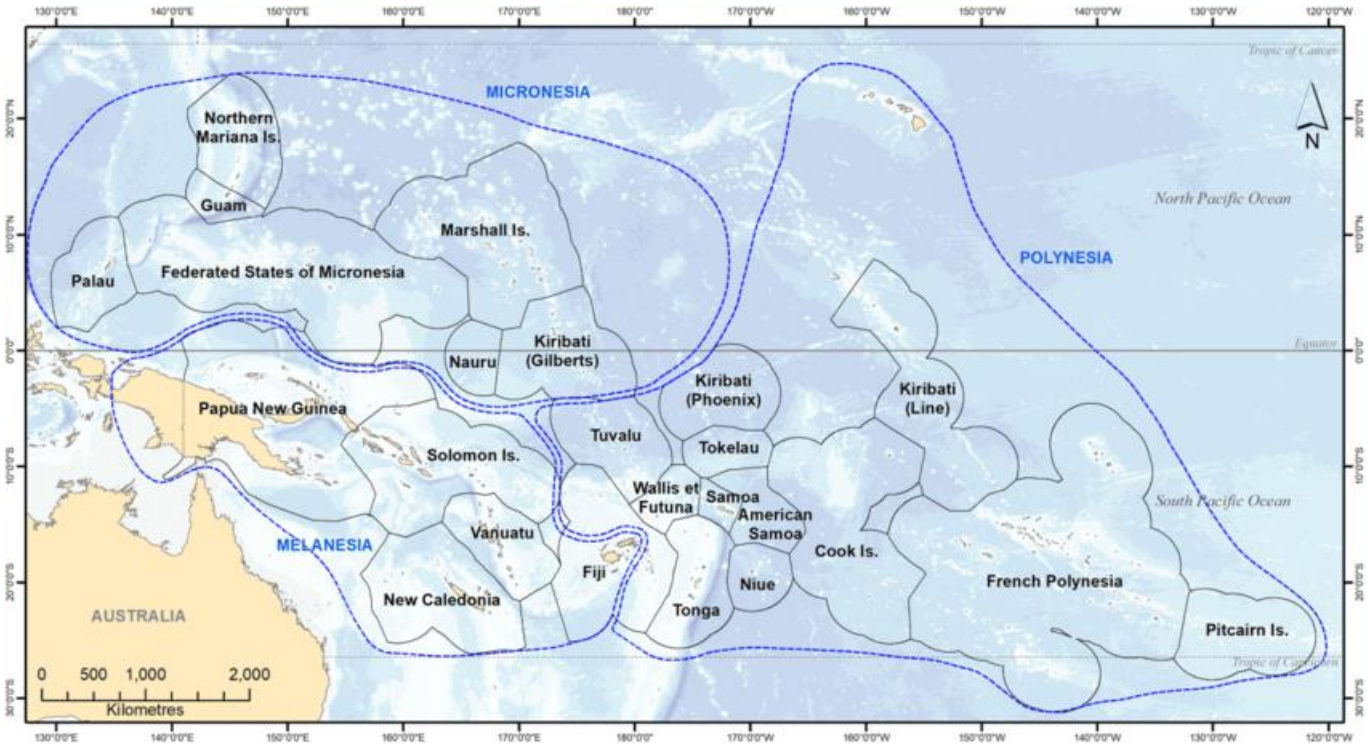

Image credit: McKenzie, et al. Marine Pollution Bulletin 167.

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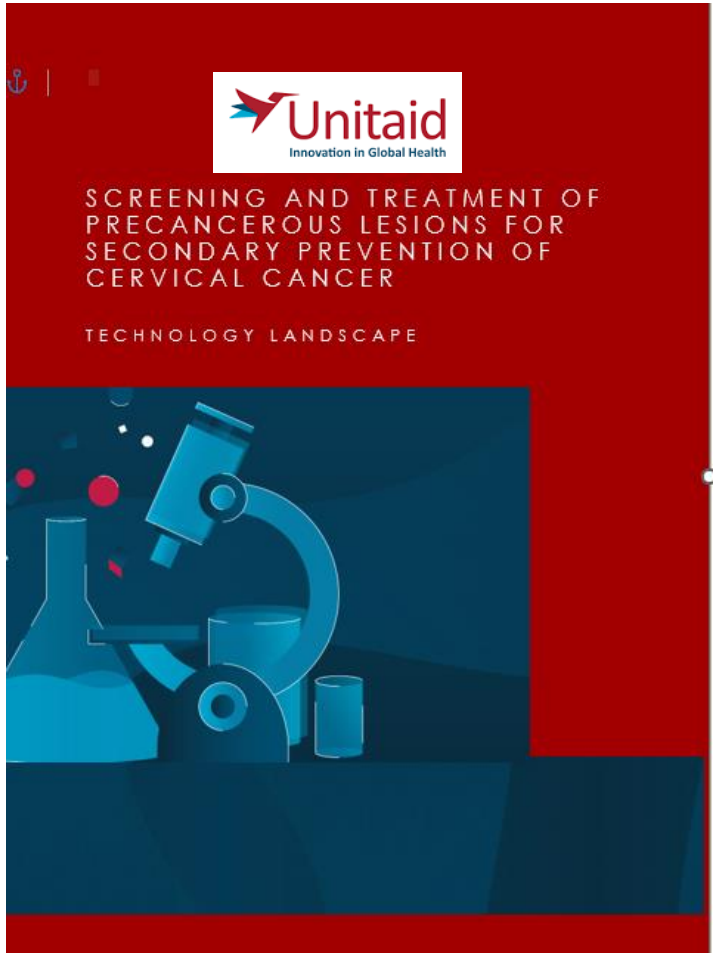
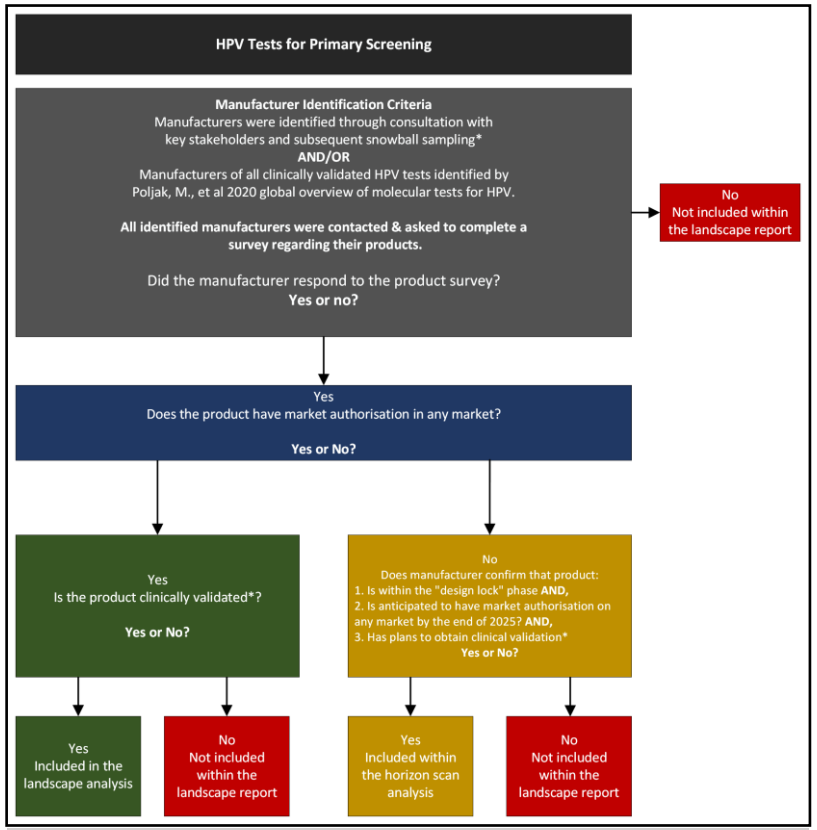
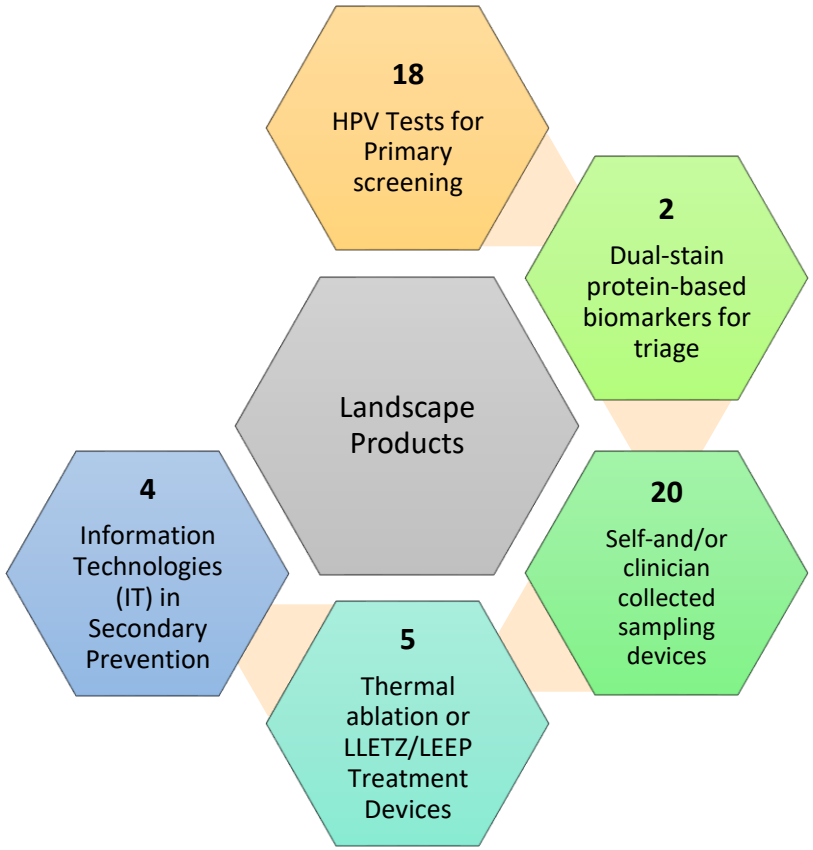
Making HPV testing accessible and affordable to all women must be a priority





Inclusion criteria for primary HPV tests



Preliminary, pending final review. Not for further distribution.

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Screening and treatment of precancerous lesions for secondary prevention of cervical cancer: Technology Landscape 2023, Unitaid (in prep)

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Global implementation

Cervical cancer elimination

Elimination of Cervical Cancer in the Western Pacific (ECCWP)

MINISTRY OF HEALTH
GOVERNMENT OF VANUATU

NHMRC Centre of Research Excellence in Cervical Cancer Control

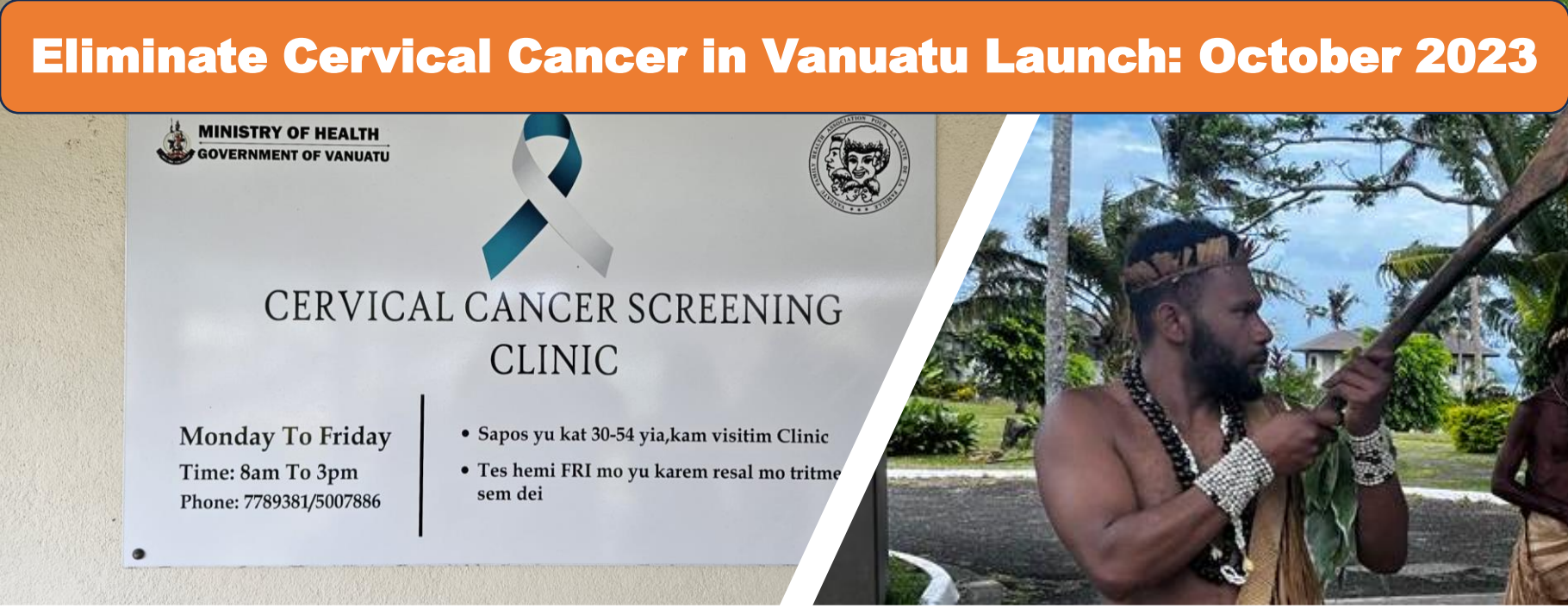
Daffodil Centre
A partnership between Cancer Council NSW and The University of Sydney

UNSW Kirby Institute

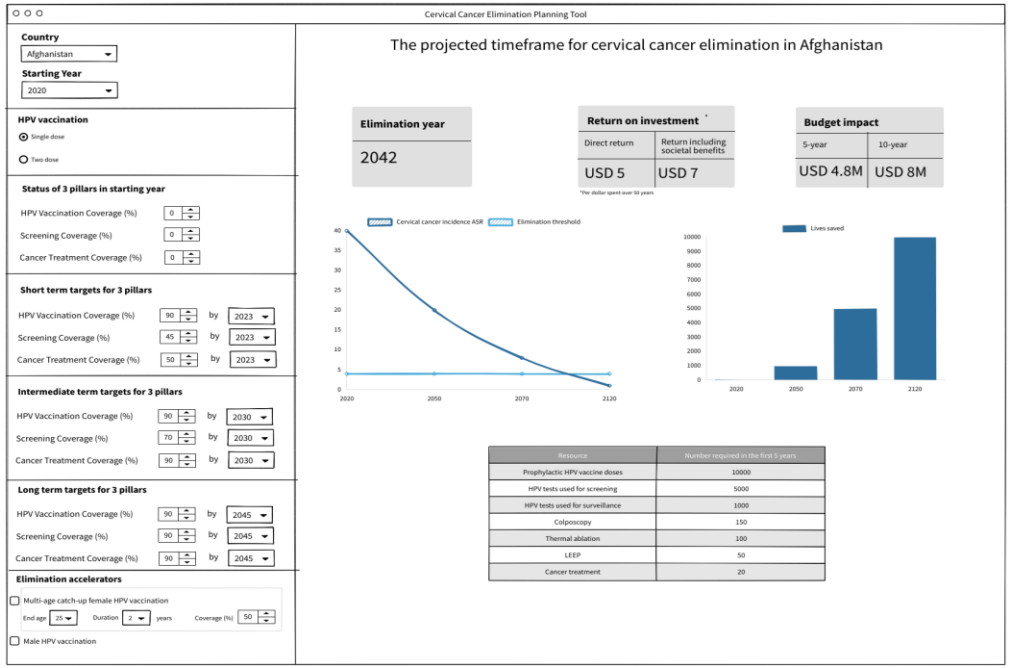
Australian Centre for the Prevention of Cervical Cancer

family planning australia
Reproductive & Sexual Health

Eliminate Cervical Cancer in Vanuatu Launch: October 2023



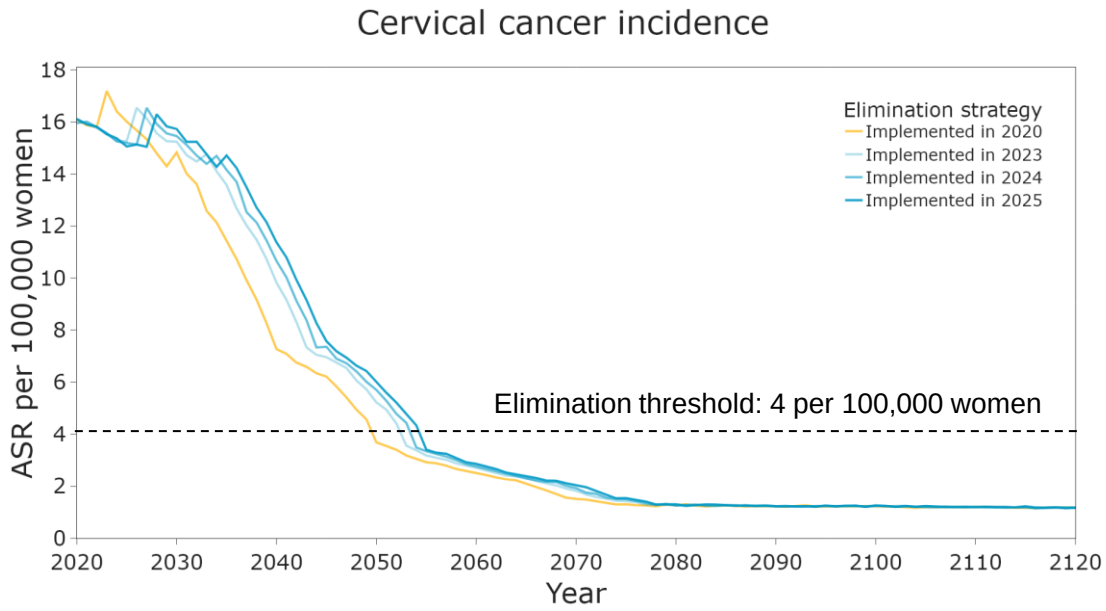
Prospects for elimination in LMIC:
The example of Vanuatu



Piloting of use of a new Elimination Planning Tool (EPT)

I-PaRCS International Partnership for Resilience in Cancer Systems

CANCER RESEARCH UK



Vanuatu could eliminate cervical cancer in 2050-54

The Daffodil Centre

Rivas D, Daffodil Centre and IARC teams, Prospects for cervical cancer elimination in LMIC: Design and outputs of a new Elimination Planning Tool (EPT), In prep.

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The Elimination Partnership in the Indo-Pacific for Cervical Cancer (EPICC)

- Supported by the Australian Government Department of Foreign Affairs and Trade (DFAT), Partnerships for a Health Region (PHR) 5-year initiative.
- The $12.5 million regional aid grant will build on prior philanthropic funding and will leverage longstanding local, regional and international partnerships to accelerate the elimination of cervical cancer in the Indo-Pacific region.
- EPICC will extend an implementation footprint in a country-led, co-designed fashion.

EPICC's six priority areas of work

1. Strengthening primary prevention through HPV vaccination
2. Improving secondary prevention through cervical cancer screening & early treatment for precancerous lesions - implementation work
3. Improving secondary prevention through cervical cancer screening & early treatment - labratory strengthening
4. Improving secondary prevention through cervical cancer screening & early treatment - digital health registries
5. Supporting the realisation of WHO 2030 target for treatment and Palliative care
6. Policy, modelling support and sustainable financing mechanisms for countries considering initiating cervical cancer elimination initiatives.

EPICC Consortium

EPICC – Elimination Partnership in the Indo-Pacific for Cervical Cancer; The Daffodil Centre – A partnership between Cancer Council and The University of Sydney; Australian Centre for the Prevention of Cervical Cancer; Kirby Institute; family planning australia; Unitaid; NCIRS

EPICC Global Implementation Partners

UICC – global cancer control; IGCS; NIH National Cancer Institute

EPICC is supported by the Australian Government through the Partnerships for a Healthy Region initiative

Recommendations for greater equity in cancer control

"Implement programmes for the routine screening of common cancers … and vaccination against HPV and hepatitis B, and ensure that access to these early detection programmes is available and affordable."

UICC, World Cancer Day, 2024 Equity Report
(Available to download at uicc.org)

UICC
World Cancer Day is an initiative of the Union for International Cancer Control.

The Daffodil Centre

Cancer Council | THE UNIVERSITY OF SYDNEY

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The Cervical and HPV Stream at The Daffodil Centre: Dr Kate Simms, A/Prof Megan Smith, Prof Deborah Bateson, Ms. Chloe Jennet, Ms. Caitlin McLachlan, Mr. Timothy Balshaw, Ms. Laura Sergeant, Dr Adam Keane, Dr James Killen, Dr Diep Nyugen, Dr Michaela Hall, Dr Xin An, Ms. Susan Yuill, Ms. Dominique Louw, Dr Daniela Rivas, Dr, Louiza Velentzis, Dr, Michael Caruana, Dr Telma Costa, Dr, Matthew Palmer, Dr Monjura Nisha, Dr Rubana Islam, Dr Elizabeth Kennedy, Dr Lauren Winkler, Ms. Kay Rimalos, Ms. Helen Liang, Ms. Gigi Lui, and special thanks to Anna Kelly.

Members of the NHMRC Centre for Research Excellence in Cervical Cancer Control (C4)

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The I-PaRCS consortium members and Steering Group: Dr Isabelle Soerjomataram, Dr Freddie Bray, Mr Rami Rahal, Dr Julie Torode, A/Prof Iris Lansdorp-Vogelaar, Dr. Ophira Ginsberg & Prof Richard Sullivan. Particular acknowledgement also to A/Prof Julia Steinberg, Dr. Karen Chiam, Suzanne Hughes Dr Michael Caruana and Prof Michael David at the Daffodil Centre.

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Other collaborators whose work I have highlighted here: Dr Florence Guida & Prof Valerie McCormack,

The women and people, families and communities impacted by cervical cancer

The integration of HIV service delivery and cervical cancer screening and treatment programmes: key lessons learnt

Helen Kelly,
WHO, Switzerland

Integration of HIV and cervical cancer screening and treatment programs

Helen Kelly

Department of Global HIV, Hepatitis and STI Programmes

World Health Organization

Background

- Women living with HIV have **2x ↑** HR-HPV persistence and **6x ↑** cervical cancer compared to women without HIV [1,2] but effective ART with sustained HIV viral suppression reduces risk [3]
- High quality screening and treatment programmes are effective in reducing cervical cancer [4]
- Enhanced prevention strategies including HPV vaccination and **3-yearly screening** effective approach to reduce cervical cancer incidence among women living with HIV [5]
- Women living with HIV attending specialist services
  - 82% of women and girls 15 years+ receiving ART through clinic or community-based services
  - 76% with suppressed HIV viral load [6]
- Existing HIV care infrastructure provides opportunity to offer cervical cancer screening and treatment with regular follow-up [7]
- Screening and treatment coverage estimates yet unknown
- Women living with HIV in sub-Saharan Africa **2x ↑** ever had a cervical cancer screening event in their lifetime, compared to women in the general population in that same setting [8]

1Looker et al. 2018, J Int AIDS Soc, 21:e25110; 2Stelzle at al, PLoS Med. 2021 Jan 11;18(1); 3Kelly et al Lancet HIV. 2018 Jan;5(1); 4Vaccerella 2013; European J Cancer. 49, 3262–3273; 5Boily et al, EClinicalMedicine. 2022 Nov 17;54; 6UNAIDS AIDSInfo 2022; 7Sigfrid et al, PLoS One. 2017 Jul 21;12(7); 8Yang et al, PLoS Med. 2023 Jan 12;20(1)

World Health Organization

How do we improve integration of cervical cancer screening and treatment and HIV services?

WHO Think tank meeting, May 2023

Objectives:

- Document different models of service delivery for cervical cancer screening and treatment for women living with HIV
- Successes, challenges and lessons learned

	N countries	N delegates
AFRO	19	79
EMRO	5	11
EURO	7	32
PAHO	7	23
SEARO	4	15
WIPRO	7	17
Total	49	177

Main themes:

1. Introduction and/or scale-up of HPV-DNA testing
2. Role of self-collection in increasing access to screening
3. Retaining women in the screening-triage-treatment cascade
4. Monitoring and evaluation

- HIV and cervical cancer programme managers,
- cervical cancer or HIV advocates, members of civil society and cancer survivors

Models of delivery

- Different models of care => HIV prevalence, geographic setting, donor activity
  - Integrated in HIV clinics
  - maternal and child health (MCH), reproductive health or family planning clinics, and available for all women, irrespective of HIV status.

- VIA most widely used screening modality
  - HPV based screening with VIA triage of HPV-positive women was being introduced in majority of settings
  - Some with self-sampling
  - Where HPV-DNA used, centralised through existing lab systems or decentralized (hub-spoke) models

- Thermal ablation most common treatment modality (also cryotherapy, LLETZ)

- In all settings, incremental increases in screening coverage were reported
  - further scale-up requires overcoming some challenges

1. Introduction of/scaling up HPV-DNA testing

- Cost of HPV-DNA tests + infrastructure needs

- Opportunities for increasing system efficiencies and cost savings
  => existing laboratory systems
  => establishment of guidelines on multi-disease testing [1]

- integration lab testing multi-disease platforms (HPV, CD4+, HIV VL monitoring, TB)
- Existing human resources
- Established referral networks
- Lab management information system (LMIS)

BUT reported challenges with capacity/availability

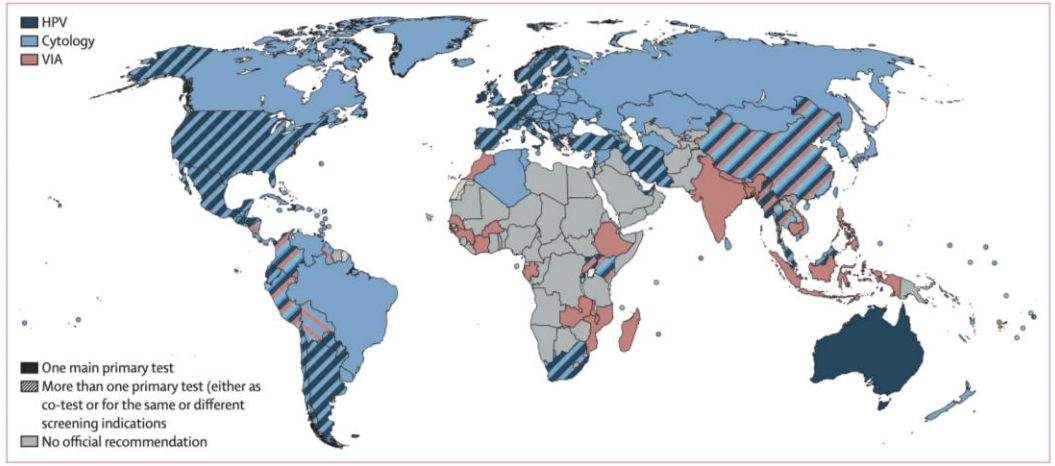


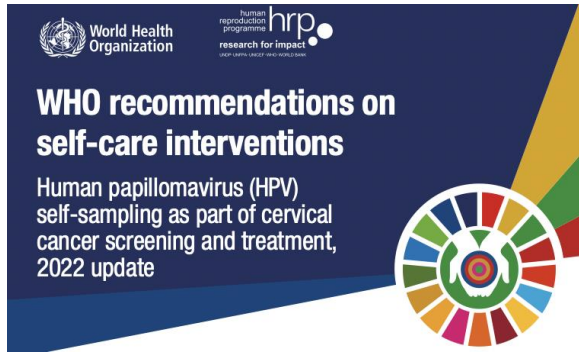
Figure 1: **Official recommended tests for primary cervical cancer screening**

1 WHO Considerations for adoption and use of multidisease testing devices in integrated laboratory networks; Bruni et al, 2022 Prev Med 2021 Mar; 144;

World Health Organization

2. Self collection for HPV-DNA testing

- More acceptable to women vs. VIA speculum exam, easy to collect
- Acceptable to healthcare providers; feasible to introduce within HIV clinics, saves time of healthcare provider
- Established infrastructure to collect and transport samples and communicate results
- Temperature-stable flocked swabs (~2 weeks)
  - community- based screening, improving access to hard-to-reach settings
  - batching of samples and facilitates outreach campaigns
- Innovations in ART delivery, **differentiated service delivery**, community-based models of care => **HPV self-collection** to women in their homes/community.
- Plan quantity of tests, turn-around-times for results + strategies to communicate the results to women, referral systems for screen-positive women (triage and treatment if required)
- Engagement and participation of communities in generating demand, rolling-out self-collection and ensuring linkage to follow-up care



3. Retaining women in the screening-triage-treatment pathway

- Existing HIV care infrastructure => opportunity to offer screening, triage, treatment as part of regular follow-up

- But challenges in same-day triage and/or treatment where HPV-DNA test result may not be returned during a visit

- Alignment of cervical cancer screening, triage or treatment visits with the ART-visit schedule = systems based solution
  - well-established appointment system
  - comprehensive data collection and reporting = important retention tool
  - integrated health work force in HIV care can ensure patient navigation, support and adherence

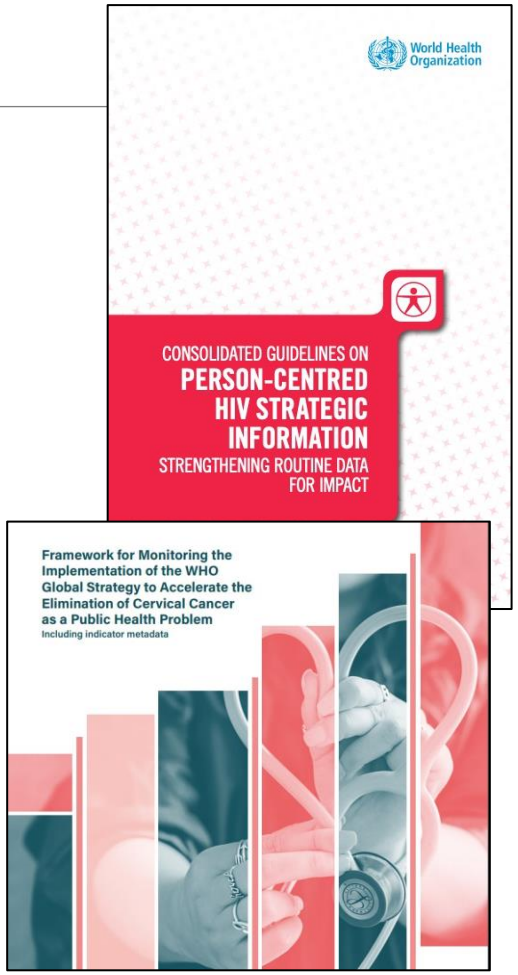
- Established civil society organisations for community awareness and education
  - peer navigation, community based organisations used in HIV prevention, care and treatment
  - women with lived experience and survivors of cervical cancer to help women understand the screening-triage and treatment pathway => positive impact on retaining women in the care pathway

4. Data needs for monitoring

- Monitoring and evaluation as **fourth pillar** toward achieving cervical cancer elimination
  - person centred care
  - strengthen services

- Screening and treatment for cervical cancer is recommended and should be recorded in routine HIV reporting systems that monitor services received by women living with HIV[1]

- Established monitoring systems in HIV management for patient management and programmatic evaluation
  - Well-established appointment system supported by comprehensive data collection and reporting => important retention tool
  - interoperable data systems and use of unique identifiers to link data for different diseases;
  - conduct of national data workshops;
  - harmonization of monitoring indicators



1Consolidated guidelines on person-centred HIV strategic information: strengthening routine data for impact
https://www.who.int/publications/i/item/9789240055315

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Summary

- Integration of cervical cancer screening, triage and treatment in HIV services provide opportunities to increase access and uptake of cervical cancer screening among women living with HIV

- Monitoring coverage important towards achievement of cervical cancer elimination
  - introduction of and scale up of programmes for screening, triage and treatment
  - frequency of screening
  - evaluating impact on clinical outcomes

- Long-term sustainable approaches to ensure the continuity of programmes.

- Engagement and participation of civil society, in particular the community of women living with HIV and women with lived experience of cervical cancer

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Michaela Hall
Adam Keane
Michael Chung
Nelly Mugo

Guideline Development Group Members

human reproduction programme hrp
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Innovation in Global Health

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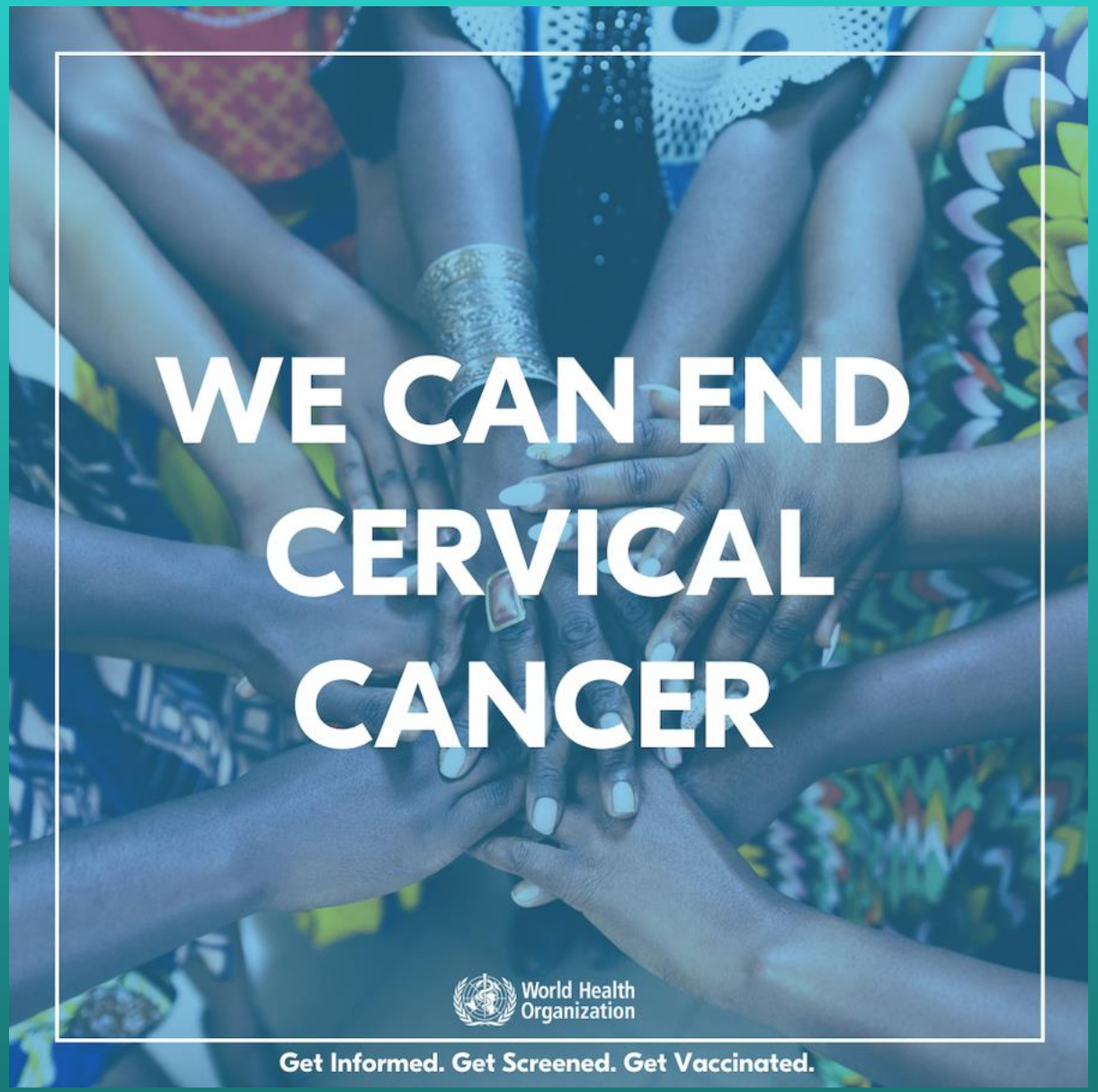

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Doreen Ali,
Ministry of Health, Malawi

Malawi's approach to cervical cancer secondary prevention: the model of HIV/CxCa services integration

Malawi's approach to cervical cancer secondary prevention: the model of HIV/CxCa integration

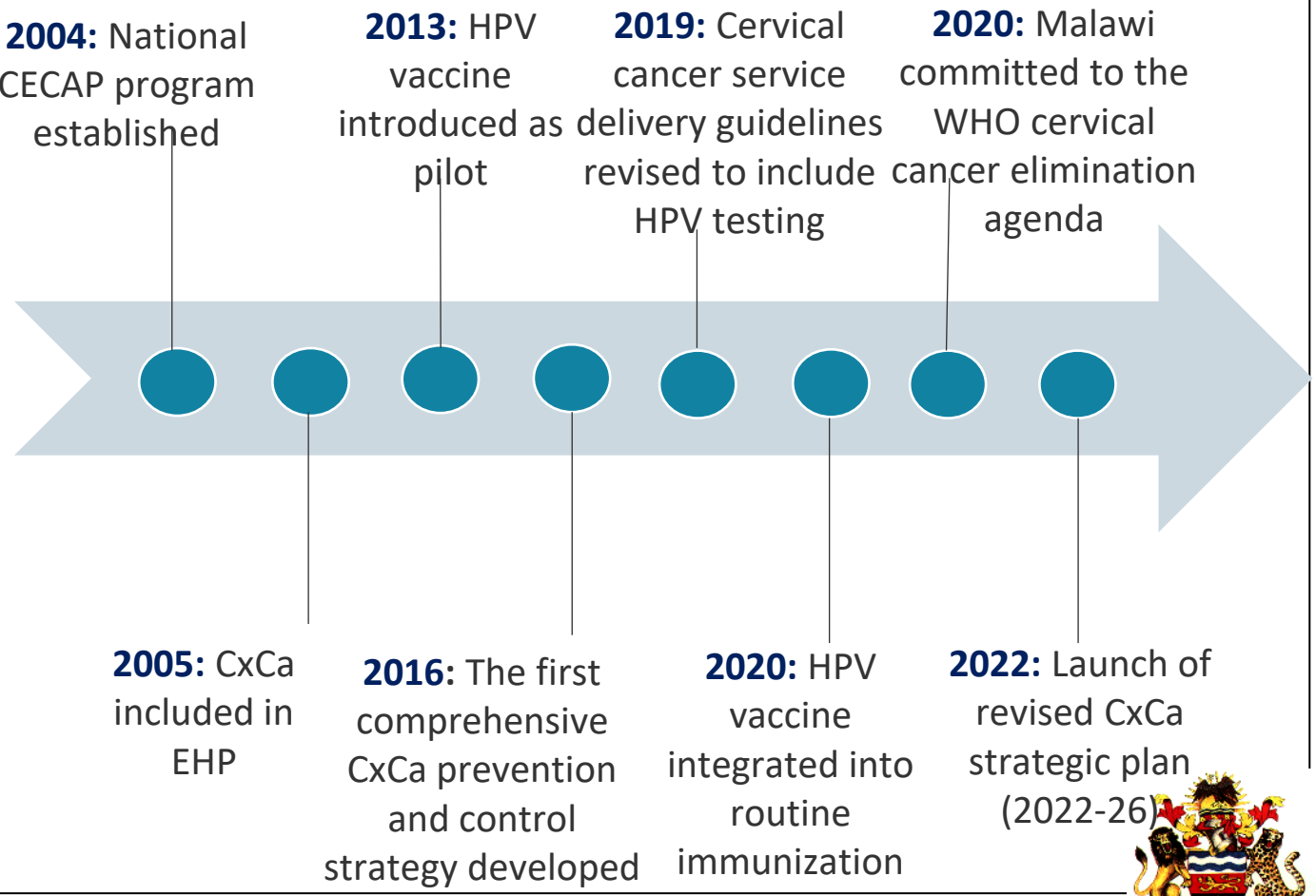
Doreen Namagetsi Ali
Director, Reproductive Health Services
Ministry of Health, Malawi

Background

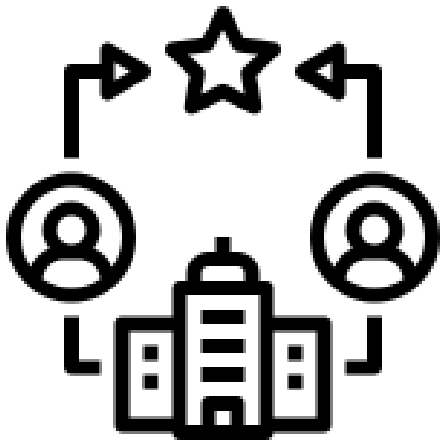
Country profile

- ~950k people live with HIV
- HIV prevalence is twice as high among women compared to men
- Cervical Cancer estimates (Globocan 2020)
  - Total new cervical cancer cases - **4,145 new cases**
  - Total deaths due to cervical cancer - **2,905 deaths**
  - Age standardized incidence rate for CxCa - 67.9/100,000
  - Age-standardized mortality rates - 51.5 per 100,000
- ~43% women living with HIV screened for CxCa by 2021

Timeline of key CECAP milestones



HIV/CxCa integration approaches



- In **2018**, cervical cancer screening and treatment was **integrated** into the routine ART services.
  - → Cervical cancer screening and treatment services are provided to women living with HIV, in the same room (mostly) or through referral to the CxCa clinic.
  - → CxCa messages are integrated into routine client counselling provided by provider.
  - → Almost all ART providers have received training on CxCa screening and precancer treatment.
  - → Most ART clinics have thermal ablation devices to ensure same day treatment for eligible VIA + lesions.
  - → ART clinic volunteers and expert clients conduct demand creation & sensitization at the facility and in the community.

HIV/CxCa integration approaches …

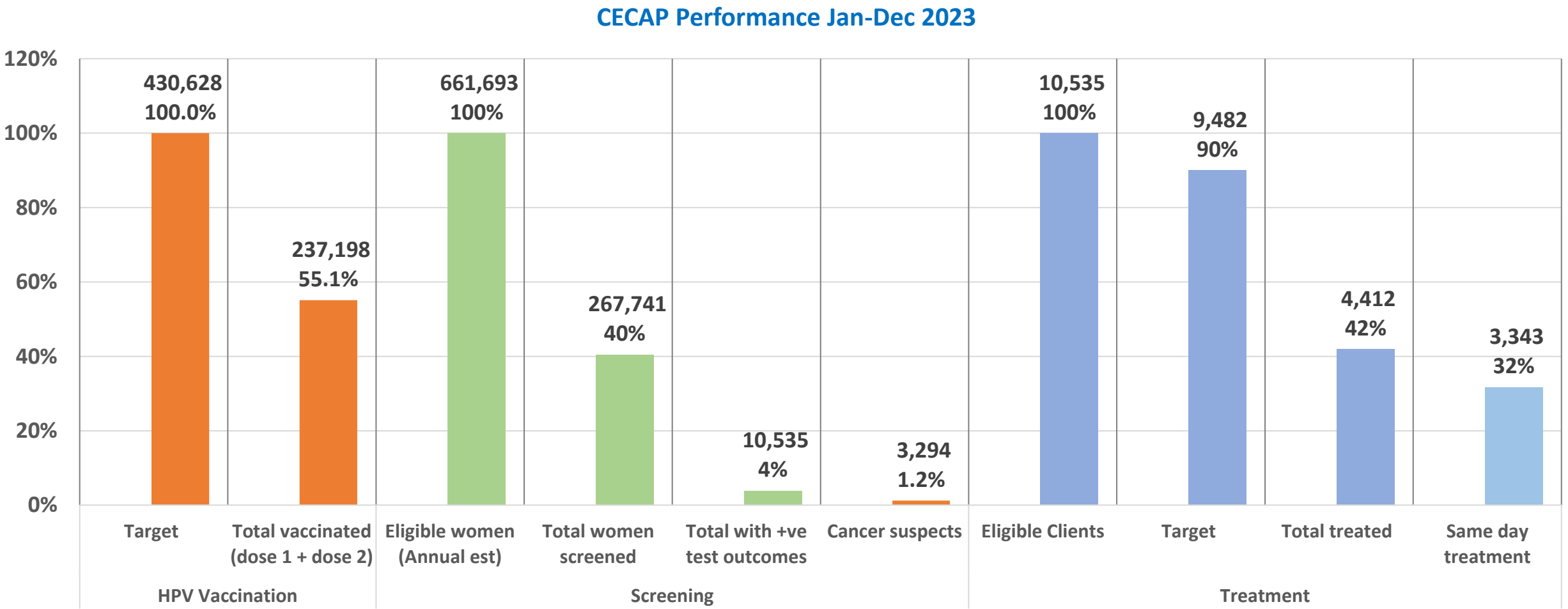
Client flow

- → Every client coming to ART clinic (either new or follow up) is offered CxCa screening information and service.
- → After health talks (client education), clients are offered cervical screening before proceeding to access ART services.
- → In facilities doing HPV testing, HPV sample is taken soon after client education, and sent to laboratory so ensure result is ready before the woman leaves the facility.
- → A unique identifier (color code) is put on client master card. This is used to identify their subsequent visit - for provider to know whether client is due for screening or not.

Key achievements

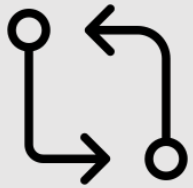
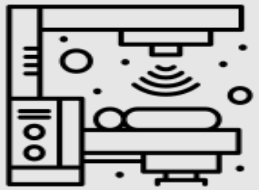
- Integration opened opportunities for financing - leveraged funding from PEPFAR and Global Fund investments for HIV
    - PEFPAR – supports 129 facilities through its IPs – training, mentorship, supplies, …
    - Global Fund – Supported procurement of TA and LEEP devices through NFM2 and NFM3 and 35k HPV tests included in NFM4
    - Unitaid – supported introduction of HPV testing including self-sampling, procurement of TA and LEEP devices and capacity building of providers
    - HSJF - ~200k pledge training of providers, mentorship and review meeting for 2024
- Expanded screening services from 81 to 475 facilities between 2019 to 2023.
- Increase in access to cervical cancer screening for women living with HIV:
    - ✓30% of all women screened in 2019 were women living with HIV
    - ✓This has increased to 64% in 2023
- Treatment coverage for precancerous lesions increased from 36% in 2019 to 49% in 2023.

Path to elimination (90-70-90 targets)



Challenges

 **Lack of Funding**	• CxCa secondary prevention services are only available in 60% of target facilities and only 18 facilities provide HPV testing
	• Lack of training and mentorship for providers
	• Inadequate human capacity/lack of resources to build health care worker's capacity to provide specialized services
	  ○ LLETZ treatments
	  ○ Gynecology surgery
	• Poor data system

 **Lack of awareness and cultural and societal factors**	• Poor health seeking behavior leading to delayed presentation • Poor precancer treatment rate due to societal factors (e.g. women needing to consult their husbands before thermocoagulation)
 **Lost to follow up**	• Same day result delivery is challenging in HPV testing leading to high lost to follow up • Lack of strong systems for patient tracking
 **Poor tertiary care**	• Lack of radiotherapy services • Limited pathology service with long waiting time • Few chemotherapy drugs available

Maribel Almonte,
WHO, Switzerland

Improving access to HPV testing

Improving access to HPV testing

Maribel Almonte, MPH, MSc, PhD
Cervical Cancer Elimination Initiative
Department of Non-Communicable Diseases, Rehabilitation and Disability

World Health Organization

70% women screened with a high-performance test & 90% of women with identified cervical disease treated

Strategic Actions

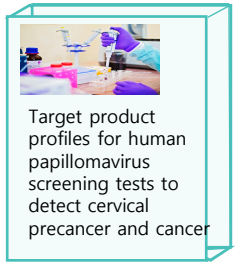
- Promote simple screening algorithms to increase retention to the screening continuum and improve programmes' efficiency
- Understand barriers, improve communication/ information to create enabling environment for screening
- Ensure affordable supply of quality assured, high performance screening tests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

70% women screened with a high-performance test & 90% of women with identified cervical disease treated

Ensure affordable supply of quality assured, *high-performance screening tests* & treatment devices

1. Living systematic reviews and recommendations to update 2021 guideline on screening and treatment of precancer lesions to prevent cervical cancer

2. Target Product Profiles for HPV screening tests

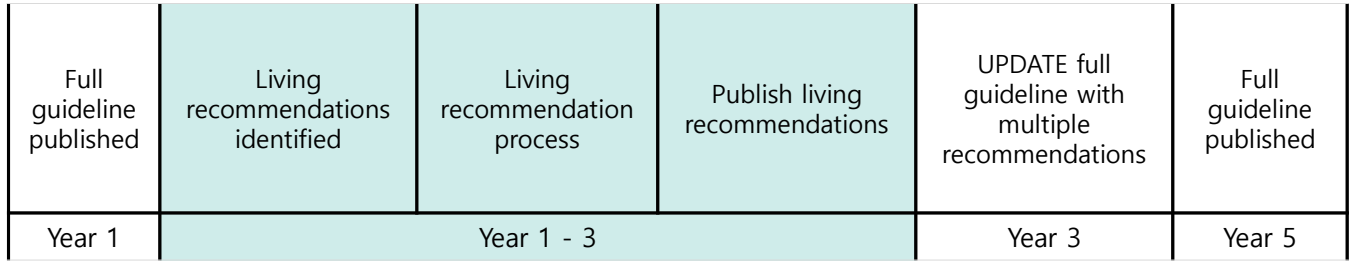


3. HPV tests Private Sector Dialogues

World Health Organization

Living Systematic Reviews and Recommendations for update of guideline on cervical screening and treatment of precancer lesions to prevent cervical cancer

- Many new or rapidly evolving evidence-based strategies for cervical cancer screening and treatment
- Stakeholders should not have to wait 3 to 5 years for an update of a guideline to know what should be implemented or removed from practice
- Some recommendations become 'living' within the 3 to 5 year updating process

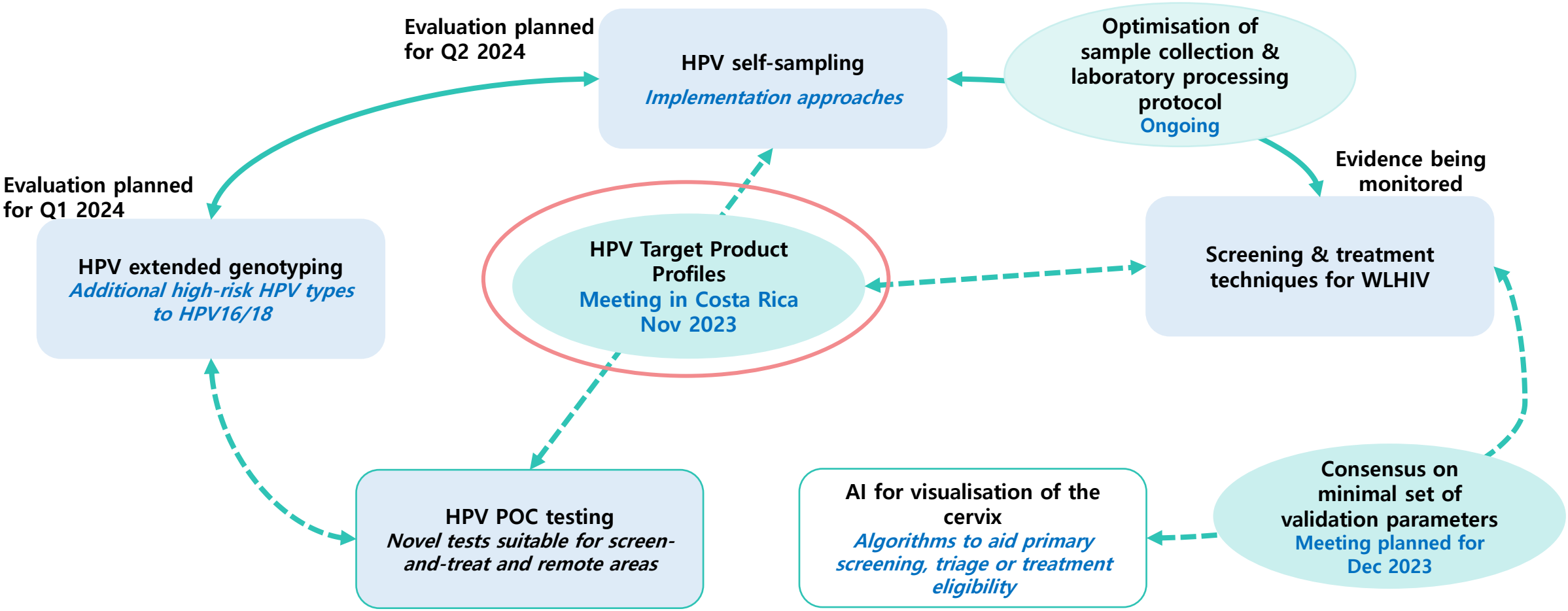


- More efficient ongoing process of reviewing evidence and making recommendations (all sources)

Living Systematic Reviews and Recommendations for Cervical Screening and Treatment 2022 – 25

- ✓ **More efficient use of resources for countries with established programme**
- ✓ **More suitable options for countries**

Living Systematic Reviews and Recommendations
Five priorities for evidence assessment



World Health Organization

What is a Target Product Profile: TPP ?

WHO TPP development is a **WHO-led** process

- Indicates the product characteristics to meet a global health needs
- **WHO TPPs** guide and coordinate development of new health products with clear product characteristics considering populations, access and equity from the outset.
  - PPC – Preferred Product Characteristics: Early indication of priorities
  - TPP – Target Product Profile: Minimal and optimal characteristics
- TPPs aim to incentivize R&D for priority health products of public need

Developing WHO TPPs and PPCs

Identify need

- Literature review
- Consult experts
- Landscape analysis

Scope

- Prepare scope & purpose
- Clearance within WHO
- Determine there is an external audience

Develop

- Prepare draft v0
- Convene panel & consult v0.1
- Post draft for 28 days

Finalize

- Prepare v1.0
- Refine with panel
- Clearance within WHO
- Disseminate
- Retire after 5 years

Developing WHO Target Product Profiles for HPV screening tests to detect cervical precancer and cancer

Identify need

- Literature review
- Consult experts
- Landscape analysis

Scope

- Prepare scope & purpose
- Clearance within WHO
- Determine there is an external audience

Develop

- Prepare draft v0
- Convene panel & consult v0.1
- Post draft for 28 days

- WHO WG of 39 members: experts, stakeholders and women's groups
- Scope questionnaire, Delphi surveys
- TPPs for HPV laboratory and point-of-care testing
- 6 TPPs Domains: Technical Specification, Performance, Design Operation, Conditions, Data & Connectivity, Cost
- 36 sets of minimal & preferred characteristics agreed
- **Self-collection minimal characteristic for future tests**
- Genotyping spectrum, result output, **COST**, largely discussed, particularly for POC testing

HPV TPPs v0.1

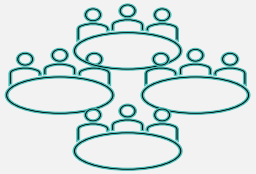
Laboratory Testing

Point-of-care Testing

Public Consultation 28 days

Increasing access to HPV tests

Private Sector Dialogues



To strengthen commitment and contribution of the private sector to <u>increase access to HPV tests</u>

Target Product Profiles for HPV laboratory & point-of-care tests

Other coordinated activities:
- Clinical validation of HPV tests
- PQ of HPV tests

Evaluation of use of novel technologies from living guidelines

In summary

- To support countries efforts to implement and scale-up of HPV testing to reach 70% screening coverage elimination target:

1. Living guidelines: evaluation of novel screening and treatment techniques to prevent cervical cancer as evidence becomes available. Four priorities on HPV testing techniques.

2. HPV TPPs: minimal and preferred characteristics for tests in pipeline or current one undergoing improvement.

3. Private Sector Dialogues: strengthen commitment of private sector for increasing access to HPV tests.

WHO team for the living guidelines and HPV TPPs

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Special thanks to the Guideline Development Group for the living systematic reviews and recommendations, the HPV TPPs Working Group members and to all observers, and to BMGF, FIND and Unitaid for their kind support for this technical work

Andrew Grulich,
The Kirby Institute,
UNSW, Australia

Updates to anal cancer screening evidence

Update to HPV-associated anal cancer screening: new evidence and guidelines

Andrew Grulich

February 2024

UNSW Kirby Institute

UNSW SYDNEY

Treatment of anal cancer precursors prevents cancer (2022)

The NEW ENGLAND JOURNAL of MEDICINE

- ANCHOR trial in > 4400 people with HIV with high-grade anal cancer precursors (HSIL)
- Randomized 1:1 to either ablation (mostly electrocautery) or active monitoring without treatment
- High-resolution anoscopy every 6 months
- Median follow-up 26 months
- **57% (95% CI 6-80%) reduction in anal cancer incidence** in those randomized to ablative treatment

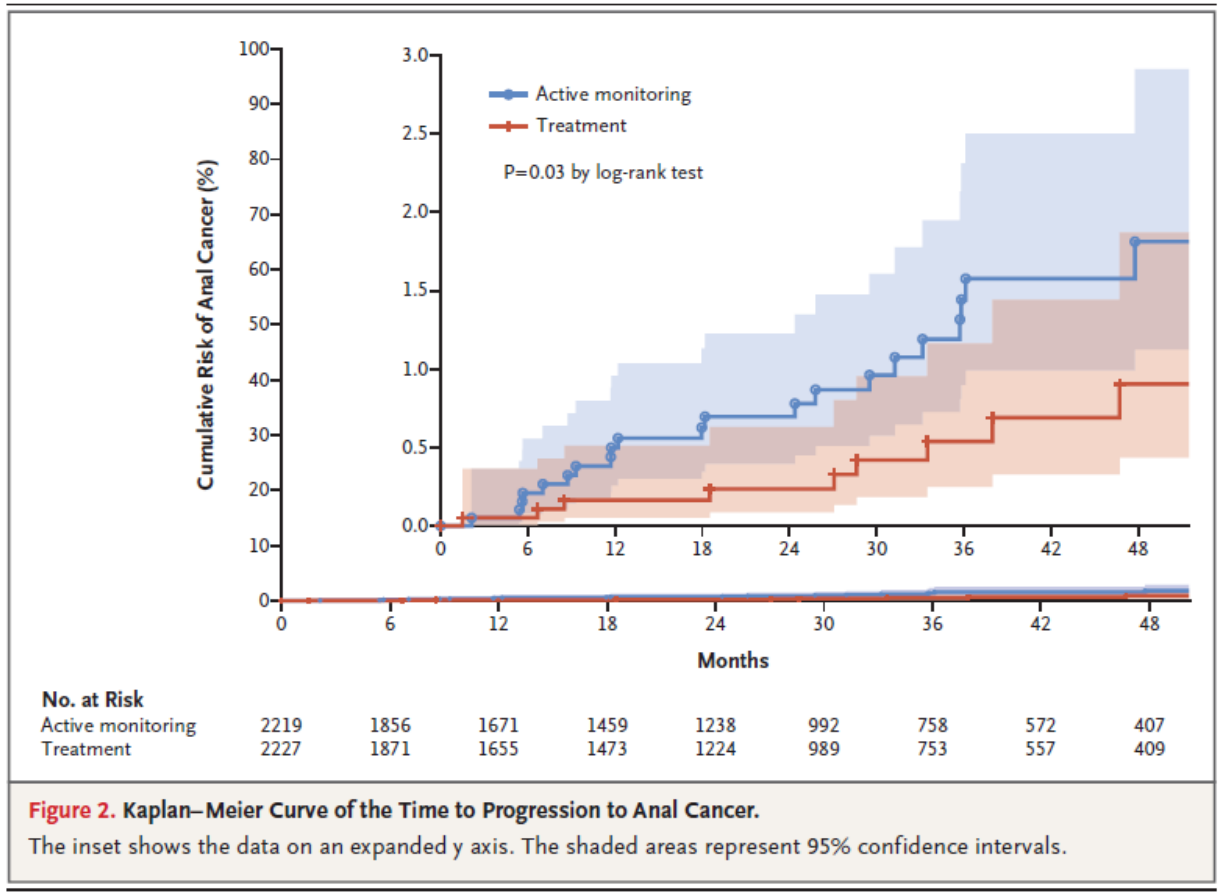

Figure 2. Kaplan–Meier Curve of the Time to Progression to Anal Cancer.
The inset shows the data on an expanded y axis. The shaded areas represent 95% confidence intervals.

UNSW Kirby Institute

UNSW SYDNEY

J Palefsky et al, NEJM 2022;386:2273-2282.

Anal cancer screening guidelines (in press)

DOI: 10.1002/ijc.34850

IJC INTERNATIONAL JOURNAL of CANCER uicc

SPECIAL REPORT

International Anal Neoplasia Society's consensus guidelines for anal cancer screening

Elizabeth A. Stier[1] | Megan A. Clarke[2] | Ashish A. Deshmukh[3,4] | Nicolas Wentzensen[2] | Yuxin Liu[5] | I. Mary Poynten[6] | Eugenio Nelson Cavallari[7] | Valeria Fink[8] | Luis F. Barroso[9] | Gary M. Clifford[10] | Tamzin Cuming[11] | Stephen E. Goldstone[12] | Richard J. Hillman[6,13] | Isabela Rosa-Cunha[14] | Luciana La Rosa[15,16] | Joel M. Palefsky[17] | Rosalyn Plotzker[18] | Jennifer M. Roberts[19] | Naomi Jay[17]

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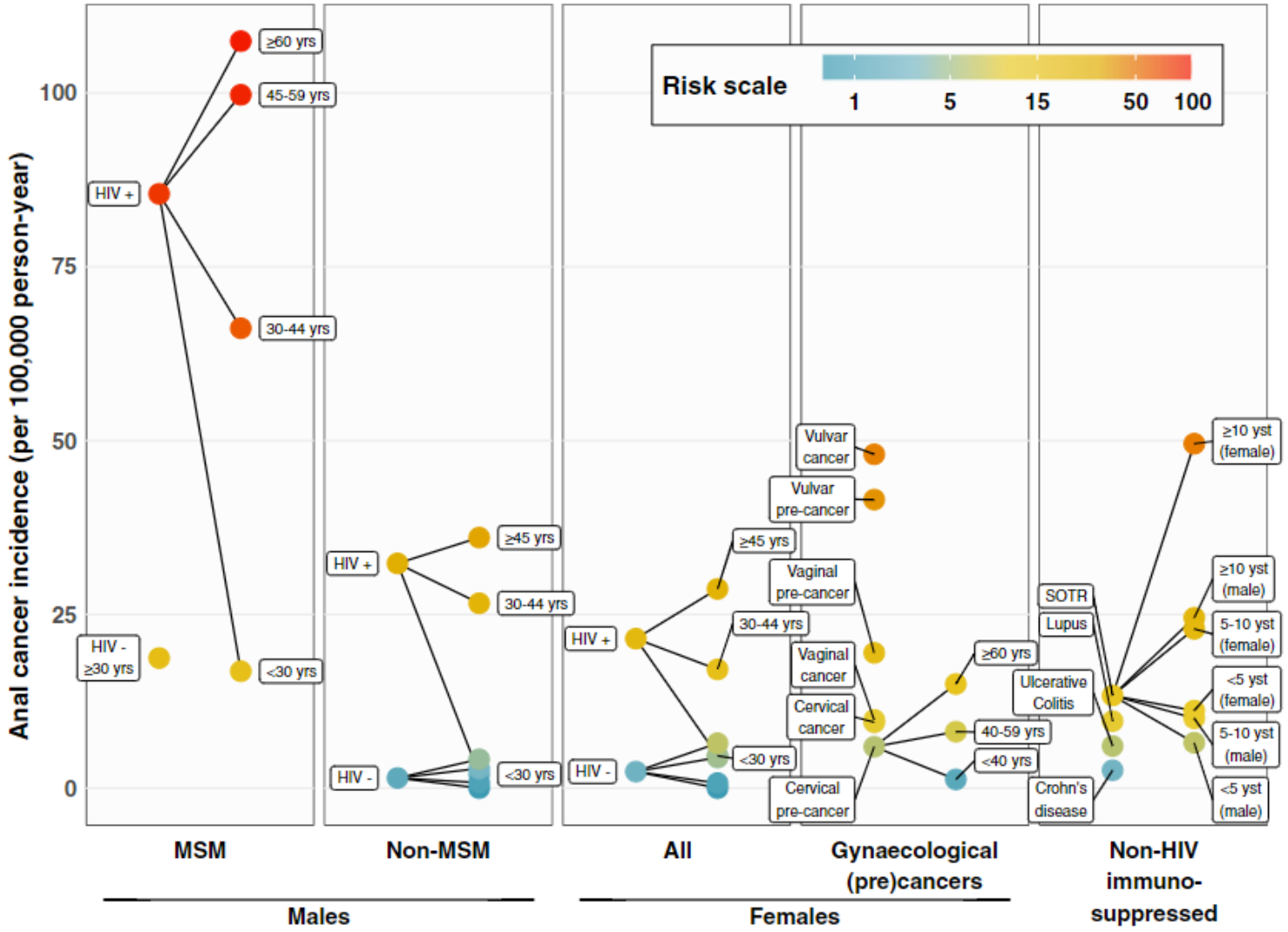
Who to screen?



G Clifford et al, Int J Cancer 2021;148:38-47

Who to screen?

- People at >10x risk of anal cancer (incidence >17/100,000pa)

TABLE 1 Populations for screening.

Population—Risk category	When	Anal cancer incidence[2,5] per 100,000 person-years
Risk Category A (incidence ≥ 10-fold compared to the general population)		
MSM and TW with HIV	Age 35	>70/100,000 age 30–44 >100/100,000 age 45+
Women with HIV	Age 45	>25/100,00 age 45+
MSW with HIV	Age 45	>40/100,000 age 45+
MSM and TW not with HIV	Age 45	>18/100,000 age 45–59 >34/100,000 age 60+
History of vulvar HSIL or cancer	Within 1 year of diagnosis	>40/100,000
Solid organ transplant recipient	10 years post-transplant	>25/100,000

EA Steir et al, Int J Cancer, doi: 10.1002/ijc.34850

Which screening test

- No universal agreement
  - Anal cytology alone (referral threshold of any abnormality)
    - Anal cytology with HRHPV testing as triage
  - HRHPV testing
    - Most sensitive, but low specificity in high-prevalence populations
    - HRHPV testing with cytology triage

- All have relatively limited specificity, leading to high referral rates
  - Need for a triage test to increase specificity in identifying HSIL
    - Several candidates: methylation markers are most promising
    - Others: p16/Ki67 staining, repeated-test screening to identify people with chronic HRHPV (as opposed to acute self-limiting infection)

Next steps

Expert guidelines recommend anal cancer screening and treatment of HSIL in people living with HIV

- The major challenge is lack of HRA infrastructure
- Capacity building is critical
  - health system funding for training, clinic infrastructure
  - screening should initially be targeted towards those at highest risk
- Research to improve screening and treatment methods
- New guidelines are a foundation for advocacy and expansion of HRA and screening infrastructure
- Watch this space: CDC guidelines expected soon

Our panellists

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Meg Doherty,
WHO, Switzerland

Benda N. Kithaka,
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The Daffodil Centre, Cancer Council NSW and the University of Sydney, Australia

Doreen Ali,
Ministry of Health, Malawi

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Helen Kelly,
WHO, Switzerland

We look forward to seeing you in Munich in July 2024

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