



**World Health
Organization**

REGIONAL OFFICE FOR **Europe**

**Regional Cervical Cancer Prevention meeting
11-12 October 2011 – Istanbul, Turkey**

Meeting report

Address requests about publications of the WHO Regional Office for Europe to:

Publications

WHO Regional Office for Europe

Scherfigsvej 8

DK-2100 Copenhagen Ø, Denmark

Alternatively, complete an online request form for documentation, health information, or for permission to quote or translate, on the Regional Office web site (<http://www.euro.who.int/pubrequest>).

© **World Health Organization 2012**

All rights reserved. The Regional Office for Europe of the World Health Organization welcomes requests for permission to reproduce or translate its publications, in part or in full.

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either express or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use. The views expressed by authors, editors, or expert groups do not necessarily represent the decisions or the stated policy of the World Health Organization.

CONTENTS

	<i>Page</i>
Executive summary	1
Meeting report	2
1. Overview of cervical cancer prevention programmes	3
1.1 Global and regional overview: progress achieved since 2007	3
1.2 Screening – experience from Denmark	3
1.3 HPV Vaccination – experience from Denmark	4
2. Country experiences in cervical cancer prevention.....	5
2.1 Discussion: Country experiences in cervical cancer prevention	6
2.2 Discussion: Synergy among prevention strategies	7
3. Components for a comprehensive approach in cervical cancer prevention	8
3.1 Stewardship and policies.....	8
3.2 Affordability and financial sustainability.....	9
3.3 Monitoring and health information.....	10
3.4 Quality of services.....	11
4. Partners and networks	12
5. Action points	14
Annex 1 – Programme	15
Annex 2 – Participants	18

Executive summary

On 11-12 October 2011, 111 experts and policy-makers from 42 countries and 7 partner organizations gathered in Istanbul, Turkey to discuss the prevention of cervical cancer in the WHO European Region.

The objectives of the meeting were to:

1. Review progress in the European Region in primary and secondary cervical cancer prevention and define priorities for future
2. Review national policies and programmes for introducing HPV vaccines and organized screening within the broader context of cancer control and reproductive health
3. Share experiences, best practices and lessons learnt among countries in the Region
4. Create synergy between programmes of the WHO Regional Office for Europe
5. Strengthen partnership with other international organizations working in the area of cervical cancer prevention

The meeting had five key deliverables:

- Summarize and distribute the experiences and lessons learnt on HPV vaccination from early adopting countries
- Summarize progress in cervical cancer screening in the WHO European Region
- Define future regional priorities for cervical cancer prevention
- Achieve a common understanding and commitment for implementation of comprehensive approach in cervical cancer prevention
- Facilitate implementation and adoption of best practices among the countries in the Region

The meeting was jointly organized by the programme for Vaccine Preventable Diseases and Immunization and the Sexual and Reproductive Health programme of the WHO Regional Office for Europe. It was held at the request of Member States as follow up of a meeting in 2007 in Copenhagen when the HPV vaccine was introduced. Countries are at very different stages of development regarding implementation of screening and vaccine programmes. In line with the richness of experience, and the varying contexts, countries were urged to make their own decision on which way to go. There is political commitment – the New York United Nations High Level Meeting on Noncommunicable Diseases (NCDs) and the WHO European NCD Action Plan vouch for this. Participants were asked to set goals defining where they would like to be in 3-5 years time in the area of cervical cancer prevention and how they will measure progress. Measurable improvement and accomplishments can then be reviewed.

Meeting report

The meeting was opened by Cristina Profili, WR WHO Country Office for Turkey. She stressed the need to learn more from countries on actual implementation of screening and the HPV vaccine through an intersectoral, partnership oriented approach. Turkey has achieved great results in tobacco control and in engaging other ministries (for example the Ministry of Finance) – and similar good results can be transferred to cancer.

Gauden Galea, Director of the Division of Noncommunicable Disease (NCD) and Health Promotion at WHO/ Europe presented the objectives of meeting and stressed the importance of collaboration within WHO and among the multiple partners in addressing the main barriers – the resistance to vaccination and the real cost of organizing targeted vaccine programmes. He proposed setting goals over the next five years to identify measurable improvement and to review these accomplishments in five years time. There is support for implementation through the WHO European NCD Action Plan – almost every country has included NCD as a priority for next two years – cervical cancer prevention and management is one of the priorities.

The Deputy Head of Cancer Control Department at the Turkish health ministry, Nejat Öygül gave an overview of Turkey's position on the international scene regarding cancer incidence and mortality and its future plans. Cervical cancer is the third largest cause of cancer in Turkey. There are plans to launch organized screening by the end of 2011 and in 2012 an HPV vaccination programme will be introduced.

1. Overview of cervical cancer prevention programmes

1.1 Global and regional overview: progress achieved since 2007

Gauden Galea gave an overview of the burden and trends in Europe over the past 30 years including observations on vaccine and screening, the development of NCDs, and the political support gained for dealing with NCDs over the past years. The recent New York High Level Meeting adopted a global action plan for NCDs and the First Global Status Report released in Moscow in April 2011 lists a package of best buys where activities related to cervical cancer are included as one of most cost effective interventions. The NCD Action Plan agrees on 10 interventions where early detection is a top priority globally and in the European Region.

Although Europe is not the worst affected region, the technology is available to avoid most of these deaths which turns this into an issue of ethics and human rights. Although the European Region is doing better than other parts of the world, there are severe inequalities – in some countries the reported average is double that of the European average.

In his presentation, Dr Galea gave an outline of the provisions that should be in place for a country to include routine HPV vaccination in national immunization programmes:

- prevention of cervical cancer must constitute a public health priority
- vaccine introduction is programmatically feasible
- sustainable financing can be secured
- cost effectiveness of vaccination strategies in the country or region is considered

Further considerations are that:

- Target population are females who are naive to vaccine-related HPV types (from 9 to 13 years old)
- Secondary target populations of older females is recommended only if this is feasible, affordable, cost effective, should not divert resources primary target population
- HPV vaccines should be introduced as part of a coordinated strategy to prevent cervical cancer and other HPV-related diseases. If a screening programme is in place funds should not be taken away from it for vaccination. The two are both valid strategies, and ideally both should be in place.

Components of success from countries achieving high vaccination coverage include transparency in decision-making, a well-prepared delivery system, effective advocacy and communication prior to introduction and timely response to adverse events following immunization and negative publicity. This includes monitoring adverse events following immunization.

1.2 Screening – experience from Denmark

Sigrid Poulsen from the Danish National Health Board presented the Danish experience in cervical cancer prevention. Denmark has 5,7 million inhabitants and a decentralized health care system. Organized population based cervical cancer screening has taken place in some areas since 1962, nationwide implementation was reached in 2006 (3-year coverage 80%). Screening and vaccination is done by general practitioners, and screening, follow up and treatment is free of charge for a client.

Key lessons learned from the Danish experience were that there was a lower incidence and mortality of cervical cancer when screening was organized, personal invitation was very important for participation of women most at risk and for high coverage, and that organized screening was more cost-effective.

The experience resulted in revised national guidelines in 2007 as follows:

- Screening, follow-up and treatment will continue to be free of charge for the client
- Clear national guidelines, mandatory organization, flow charts are essential to ensure consistent organization of the programme at subnational level
- National call/recall system includes two recalls
- Women 23-49 years are invited every 3 years
- Women 50-64 years are invited every 5 years
- Cytology is used as the primary screening test (23-59 years)
- HPV-test is used in triage test (partly implemented)
- All cervical cytology are diagnosed in the Departments of Pathology that evaluate minimum 15.000 specimens per year (partly implemented)
- All cervical cytology results and follow up histology diagnoses are registered in national Pathology Data bank
- A national steering committee and five regional committees ensure the quality of the screening programme
- Danish quality database for cervical cancer screening is using nine quality indicators, The process includes private laboratories for diagnosis.

Revised guidelines will be issued January 2012 and include a new recommendation of HPV-test for primary screening in 60-64 olds

The experiences made in introducing the cervical cancer screening programme in Denmark may serve as a good learning experience for other countries.

1.3 HPV Vaccination – experience from Denmark

An HPV-vaccination programme has been in place since October 2008 (83% coverage with three doses of HPV vaccine). In October 2008 a catch up programme for 13-15 yr olds girls was introduced. In January 2009 the country continued with vaccination of the target group – adolescent girls at the age of 12 years. As there is no traditional school vaccine in Denmark, the HPV vaccine was integrated in the childhood immunization programme done by general practitioners (GP). By end of the catch-up programme it had achieved minimum 83% coverage. The strategy focused on information for health care workers. A full communications strategy and an information package were sent to all GPs and school health services. As the vaccine was not in the school health setting, there was a need to communicate by a direct letter to girls and parents.

A web site was key in communicating clear consistent facts and messages. The site was used by mass media. The key message was “vaccination for cancer prevention”. Careful preparation focused on communication and transparency so no claims could be made that there was collaboration with the industry. High coverage was ensured by trust in doctors, well informed health workers and the support of politicians.

Discussion centered around:

- How openness and transparency helped in dealing with resistance by anti-vaccine lobbyists – stating up front that vaccine is new and results will be monitored.
- How high vaccination coverage results in higher timely coincidence of vaccination and some diseases (diabetes, hepatitis B etc.) that can cause concerns about safety of vaccine. Importance of having baseline data on rates of conditions prior to introduction of vaccine in order to effectively monitor and communicate possible adverse events following immunization.
- Sustainable financing – how Denmark introduced the vaccine with the cost implications it entails: in Denmark the vaccine is financed by the state. The government took funds for it from the budget of patients with chronic disease.

2. Country experiences in cervical cancer prevention

The mistakes made in introducing the cervical cancer screening programme in Denmark may serve as a learning experience for other countries. Belgium, Latvia, Slovenia, Switzerland, United Kingdom, Belarus, Georgia, Lithuania and Finland presented country experiences in cervical cancer prevention. Each of the countries is at a different stage regarding screening and vaccination and contributed with challenges and experiences in relation to choosing target groups, opportunistic screening and vaccination, registration, and gaining political leverage. Some of the key points presented were:

- **Inequities:** There is great variability of cervical cancer incidence and mortality across the region, in some countries the reported average is double that of the European average. Socioeconomic inequities are killing people on a grand scale. There is a clear correlation between social indicators and coverage of cervical cancer screening.
- **Communication:** Experiences from countries who have introduced HPV vaccine show that communication is central to introducing effective vaccination programmes. Clear, transparent communication of the strong evidence for safety can counter resistance. To achieve high coverage it is essential that there is communication through trusted channels including doctors and other health workers.
- **Understand your audience** and use the right route – apart from choosing a key message relevant to the target group, it is important to use the channels of communication relevant to them. These will differ for health workers, young girls, media and parents, and from country to country.
- **Choosing the key message:** HPV vaccination prevents cancer and some countries are not linking it with sexuality education.
- **Integrating other health messages:** Common to most experiences presented is that they integrated HPV vaccine in to existing vaccine programmes and many have the school as delivery channel. There was discussion of weighing the benefits of integrating other health messages (safe sex) but on the other hand risking acceptance of HPV vaccine by involving other messages.
- **Plan for risk:** it is crucial to be prepared for what can go wrong, the anti-vaccine lobby may use opportunities to further their cause. It is necessary to ensure that the media has clear scientific facts and figures ready to counter this and that spokespersons are well-briefed and equipped to address the media.
- **Addressing concerns of the anti vaccine lobby:** Incidents coupled with media coverage can fuel the movement against vaccination. Countries with experience in this shared that they had gained the support of, for example, cancer charities and journalists by briefing them fully and making sure they have facts and figures. In addition, public attention was raised through well- informed GPs frequently appearing on morning TV, the aim was to “influence the influencers” as governments can rarely influence directly.
- **Difficulties of implementing specifically HPV vaccine** which differs from other vaccines as vaccination is provided at an age when most girls are not yet sexually active and when many parents are likely to hope that their children are not yet considering becoming sexually active. The need for communication with the vaccine recipients themselves also distinguishes HPV vaccination from the traditional routine vaccinations; information concerning the latter is necessarily aimed primarily at parents. In addition, HPV vaccination may meet moral objections from some parents. Conclusion was that good public information is vital for successful implementation, preferably with material targeted at girls and their parents.

- **Difficulties of establishing and maintaining well-organized invitation system:** reaching never examined women, improving screening coverage and response rates, establishing and maintaining quality control and ensuring management and monitoring. Increasing awareness and participation is a key challenge.
- **International partnerships proved vital** in many countries allowing them to draw from experiences at different levels of planning and implementation.
- **How a screening programme can fail:** Well designed communication to the target group and health workers is needed to carry the message. Good information among the population and medical personnel is one key to achieve acceptance to optimal screening policy.

Failings that countries have experienced in the screening process are:

- ✓ Some women remain unscreened or screened with longer intervals than recommended – even though a large proportion of the population may be screened frequently. Good information among the population and medical personnel is one key to achieve acceptance to optimal screening policy
- ✓ Sampling or diagnostic error in screening test – these are more common than usually thought and require monitoring of quality of screening services from sample taking to its examination
- ✓ Sampling or diagnostic error in triage or confirmation
- ✓ Management error; e.g. drop-out prior to management or in the management follow-up, or inappropriate management procedure
- ✓ Optimal treatment of cancer – not yet available throughout Europe

Finland presented a clear example of observed and predicted mortality by age with and without screening.

2.1 Discussion: Country experiences in cervical cancer prevention

The discussion following the country presentations covered the following points:

- **Data linkage:** both immunization and screening are underpinned by good data systems such as immunization and cancer registries. While these are important in isolation, linking the immunization and screening registries offers the future potential of: tailoring screening programmes based on immunization statistics and better identifying higher risk individuals who are not immunized and not screened.
- Using HPV vaccination visits as an opportunity to **promote other health messages** such as sexual health, tobacco control etc. and vice versa (this is more relevant to established HPV vaccination programmes). There is a need for evaluated studies of the impact of combining messages in such visits.
- **Advocacy** – there is significant potential to improve cervical cancer prevention – both through immunization and screening as a part of a wider women's health programme including breast cancer screening etc. Opportunities for government and health systems to work with key advocates in society.
- Good examples of **working in partnerships** to promote cervical cancer prevention – key members of society and organizations such as charities can be excellent partners in promoting positive messages.
- **The use of novel technologies** such as home screening kits, to help better deliver services to groups that programmes don't reach. New technologies provide a potential for different uses (Health workers visiting at home and introducing other issues, posted to home etc.) The results of a study on home collection tests with very promising results (The Netherlands) increasing coverage through well organized self-sampling will be published soon. Be aware that the term "the people who do not

attend” tends to blame risk groups when the problem is often with how the service is designed. Next European guidelines will likely have self sampling and how to keep up with the fast moving technological developments. Good evaluation systems are needed for monitoring and evaluation of programmes.

- **The woman never screened** – countries discussed how to reach those never screened – an area where few resources could accomplish a lot. Have there been any studies on social determinants on how to reach those ever screened? Any common characteristics? This would be helpful to those just starting. It is a continuous process to modify programmes. Suggestion that the next meeting could focus on the woman left unscreened and girl left unvaccinated. One should be aware that this terminology implies that we are talking about a person blamed for their non-compliance, when often the structure of society, health system and insufficient communication is to blame.
- HPV vaccination could bring significant benefits and be cost effective in countries that have no cervical cancer prevention programmes or cervical cancer screening programmes. There is already significant expertise and experience in countries to help support those countries who wish to introduce the programmes. However, high cost of HPV vaccine makes it unaffordable for many countries. The low income countries will be able to introduce HPV vaccine with the GAVI support if GAVI will include vaccine into its package. The middle-income countries can benefit from pooled procurement including procurement through UNICEF that provides affordable prices.
- Impact of **health insurance systems** – Impact of the type of financing for implementing programmes of this type. In Finland national health insurance reimburses some cost,. One needs a long term perspective to roll out a cervical cancer prevention programme (at least 10 years). This does not fit with the immediate need for shown effect for those working in the insurance business and politicians.
- A need for **transparency in vaccine prices**, to keep the prices down. There is work done by WHO to make vaccines affordable – prices should be made public as some (poorer) countries pay more for vaccines.
- It takes time for a vaccinated population grows older and results on the impact of vaccine on cervical cancer incidence became available – this is important to remember in evaluating what is affordable and what resources are available regarding combining screening and vaccination. There was a plea for **WHO to come up with guidelines for countries on how to prioritize different approaches in cervical cancer prevention** (screening and HPV vaccination) and screening methods to be used (Pap-smear vs. HPV testing).

2.2 Discussion: Synergy among prevention strategies

Rebecca Martin introduced the discussion on synergy among prevention strategies with three key questions:

- What are best practices that can be shared both what to do and what not to do?
- Some countries may be starting vaccination and screening programmes, some one programme – how should they be weighted?
- Which groups are we not reaching and why?
- There are countries where sexuality education is well established and others where there is none. Nevertheless, **possible synergies can be explored** in many areas – child and adolescent health, primary health care, immunization etc. cervical cancer can be used to strengthen collaboration across the health sector – school health, adolescent health, HIV/AIDS, etc. are all potential entry points.
- The importance of **using existing systems**, some may wish to use the school health system as delivery point. Advantage of using an established programme to deliver (such as schools) opens for

consideration of adding other health messages (anaemia, other kinds of immunization, Hepatitis B vaccine). It is a pity if the only point of contact with a physician does not give contact and information to other available services. It was recommended to include this issue in the agenda of the next meeting.

- **Monitoring if the cervical screening programme is working** requires sentinel hospitals to see incidence from fewer advanced tumours. This should give results within 3 years.
- A **dynamic, adaptable model would be the most effective** as there is a need to adapt to the varying country contexts and future developments. For example it is sometimes not cost-effective to add vaccine to a very effective screening scenario, but if screening has not been established, then a vaccine programme could be considered a priority. Development in the cost of vaccines is another dynamic factor – priorities may change as vaccines become affordable to the poorest countries in the Region.

3. Components for a comprehensive approach in cervical cancer prevention

Participants worked in four groups – stewardship and policies, affordability and financial sustainability, monitoring and health information and quality of services. Each group reported back with key points from their discussions:

3.1 Stewardship and policies

The working group discussed country experiences in developing national cervical cancer prevention policies and best practices or barriers in their implementation. The group concluded that involvement of stakeholders is key in development and implementation of a national strategy for cervical cancer prevention. Such a strategy should include a comprehensive action plan with a communications plan, available human and financial resources, monitoring and evaluation and should be based on multisectoral collaboration.

Key messages:

- Stewardship is an essential element of successful programmes
- National multisectoral collaboration supports transparent planning, implementation and sustainability
- Additional sustainable resources are needed (infrastructure, coordination, M&E) for developing cost effective, affordable programmes
- International collaboration (donors, professional organizations) plays an important role in development and implementation of national plans

Policy development and stewardship involves three steps – the **policy phase** with commitment of the government, involvement of stakeholders, and national policies and guidelines. The **planning phase** involves establishing a steering committee, capacity building, and development of action plans. The third step, **implementation** requires feasibility, piloting, quality control, monitoring and evaluation.

There was consensus that **vaccination and screening should go hand in hand and be population based and organized**. This consensus gives countries without population based programmes an argument to policy-makers for more resources to do this right.

For both policy development and programme planning, responsible government authorities should develop a systematic plan for involving stakeholders (eg NGOs, professional associations, community representatives, media, elected and appointed government officeholders, other ministries) in efforts to reduce burden of cervical cancer and developing the national strategy.

Stewardship and policy development

- Government is to adopt a national comprehensive strategy for cervical cancer control including the entire continuum of care from vaccination and screening to diagnosis, treatment and palliative care.
- Special body for advising government on programme policy and implementation (network of experts, programme managers, responsible governmental authorities) is to be established.
- Special tools for stewardship (eg charter to define aims and goals of programme and to agree roles of each stakeholder, extra funds for infrastructure, for coordination, monitoring and evaluation) are available for use.

Stewardship and programme planning

A comprehensive action plan for cervical cancer control should be developed and adopted by the government including:

- Immunization
- Monitoring, reporting and evaluation
- Reorganization of services (plan who does what)
- Quality assurance (guidelines, protocols, standards)
- Human and technical resources, (in most countries there is problem of human resources, information systems for screening, laboratory cytologists – fundamental to good screening plan.)
- Communication including a communication plan for alerts and emergencies

Discussions in the working group showed that there is a need for a national strategy and action plan.

3.2 Affordability and financial sustainability

The working group on affordability and financial sustainability discussed country experiences and provided an overview of available tools, methods, and innovative options in economics of cervical cancer prevention programmes. In summary, the group stressed the importance of economic data for making decisions on developing policies and in planning the cost of programmes. WHO has a role in supporting self-evaluation and decision-making, how to interpret the data and to calculate the cost of the programme.

A range of economic tools for decision-making about cervical cancer prevention are available to address issues about affordability, sustainability, cost-effectiveness and equity. These include costing studies, cost-effectiveness/cost-utility analyses, budget impact analyses and threshold price calculations.

Health economic models can be used to inform decision-making. These models range from very simple (proportionate outcomes) to very complex (dynamic microsimulation). The strengths and limitations of different kinds of models need to be understood before their results are used for decision-making. Model choice should be governed by the kind of decision that needs to be assessed.

Several modelling groups are open to collaboration with country-level decision-makers, including the EU-funded PREHDICT group and co-authors of a recent paper on HPV models for low and middle income countries (Jit et al. BMC Medicine 2011).

Many countries in the Region lack capacity to utilize cost-effectiveness models and to interpret the results.

There is interest from decision-maker in the WHO European Region regarding a broad range of economic analyses related to cervical cancer control. These range from purchase price comparisons to costing

studies, simple back-of-the-envelope decision models and more complex individual-based models combining vaccination and screening options. Participants are keen to collaborate with external experts in order to build capacity for economic modeling and to make decisions informed by economic analyses. WHO plans to give technical assistance and guidance as needed.

A lively discussion on prices followed where it was clear that transparency in pricing would greatly help countries. PAHOs revolving vaccine fund is an example where all countries pay the same price. An attempt to try this pooled procurement requires changes in national policies and legislation. WHO is presently looking at doing this on a smaller scale (at subregional level) and working with tiered pricing. This is taking place with support from global partners. Finally, the European Region will provide technical support to countries in strengthening skills to negotiate with vaccine suppliers.

Key concepts in costing tools:

The second part of the group on affordability and financial sustainability introduced concepts regarding different aspects of cost, depending on where a country is and what is in place:

- incremental cost
- total vs. average cost
- financial vs. economic cost

The WHO C4P costing tool which is in the final stage of development is an excel based model that allows costing of different prevention strategies including vaccination and screening options. It provides useful information for decision-makers to compare, prioritize, and consider affordability of different scenarios. The tool will soon be available on the WHO web site and countries may request technical assistance from WHO for using the tool if necessary.

ProVac Initiative in PAHO has developed a tool to conduct evaluation of cost effectiveness of new vaccines. This tool can be used by countries for self evaluation given that training and external consultancy support is provided..

3.3 Monitoring and health information

This working group discussed challenges and opportunities for monitoring of performance and impact of primary and secondary prevention programmes for cervical cancer. The group presented a set of recommendations

1. Standardized reporting of vaccine coverage monitoring data (by age and by dose) is critical:
 - use of WHO Guideline and EU Guidelines on monitoring of HPV vaccine coverage to ensure use of standardized data collection and reporting formats
 - ensure the EU guidelines being developed concur with WHO guidelines
 - ensure availability of translated guidelines especially in Russian.
2. Population-based cancer registries should be established or enhanced to evaluate impact of both immunization and screening programmes
3. Move to population-based organized screening programs
 - High participation
 - High quality testing
 - High level of follow-up diagnosis and treatment
 - Screening registers to ensure women are tracked through each screening event and the outcome is recorded

4. Health authorities should provide a legal framework for collection and reporting of information

The issue was raised whether there should be country-specific prevalence studies of HPV strains to be sure that the HPV 16/18 vaccines will cover most cancer-causing HPV strains before HPV vaccine introduction. In response, the WHO position paper says there is no absolute requirement to do this before introducing vaccination but some countries can consider establishment of sentinel surveillance after introduction of the vaccine to monitor the impact of vaccination on prevalence of HPV strains.

3.4 Quality of services

This working group considered challenges and opportunities in improving quality of HPV vaccination and cervical cancer screening based on exchange of experiences of both programmes.

Delivery of HPV vaccination programmes

- Consider using existing teenage immunization systems to deliver HPV vaccination programme
- Schools – based vaccination programmes tend to achieve high coverage
- Some countries reported that private/insurance-based systems tend to be expensive, have lower uptake, and coverage data of poorer quality
- All systems need careful, planning and organization, and coordination to be successful.

There is a distinction between the work needed in introducing a programme and after the programme is established. After the programme has become established nationally, it should be reviewed and refined for example, consider the opportunity of contact with teenagers for the HPV vaccination programmes to strengthen linkage with other adolescent and school health programmes, such as sexual health, smoking etc. Messages may differ between countries due to cultural sensitivities of the topic.

For existing screening programmes with good coverage (70% and higher) the challenge is to identify and screen those women who have never been screened, or not screened for many years. For instance testing at hospital visits (as in Spain). A strong screening programme will achieve high coverage without the need for opportunistic screening.

‘Weaker’ screening programmes with coverage at around 30% or less, have the challenge of identifying women never screened or not screened for many years. They must review the delivery of services particularly outside of urban centres, explore the potential of new screening tests to help boost coverage, such as the rapid HPV test and make use of innovative approaches, such as self sampling.

General recommendations regarding quality of services:

- to focus on clear factual information on screening and immunization interval and availability of services and adapting screening strategies as new HPV vaccines become available.
- Providing specific guidelines on adoption of screenings when vaccine is available.
- Careful planning, organization and coordination strategies are needed for achieving high coverage and implementation and to reach the unreached with innovative approaches and delivery strategies.

4. Partners and networks

Each of the partners presented their plans, and how they can help support countries in the region.

Union for International Cancer Control (UICC), Lucrecia Peinado:

<http://www.uicc.org/>

UICC is an international NGO member-based organization focused on supporting the cause of cancer control. Main areas of support are:

- Global **advocacy** to move agenda of cancer ahead
- Supporting **training** and HR development in cancer
- Supporting **country work** for example through memberships

The organization supports moving ahead on key issues of cervical cancer in next years and enhancing availability of human resources through a long history of fellowships (lately fellowships were earmarked for cervical cancer). UICC gives priority to Latin America and eastern Europe.

International Agency for Research on Cancer (IARC), Ahti Antilla:

<http://www.iarc.fr/>

IARC is providing descriptive data on cancer and prevention aspects. Randomized control trials are done; and they are evaluated systematically, along with other evidence, e.g. in the production of the European quality assurance guidelines for cancer screening where IARC has also been involved. There is ongoing work to update current guidelines for cervical cancer screening with supplements on HPV testing and vaccination. The institute also networks for cancer screening with national screening coordination and evaluation centres. There is a specific project ongoing with collaboration between IARC, European Union Partnership Against Cancer programme, and the Finnish Cancer Society – a project to organize a two week comprehensive training course on population based screening – the first course will be held in a years time. This is just one exercise, wider training will be considered for future with a focus on improving population based screening.

International Planned Parenthood Federation (IPPF) European Network, Galina Maistruk

<http://www.ippfen.org/en/http://www.eyv2011.eu/about-the-alliance/90-ippf>

IPPF has good experience working both at community, local government and European Parliament level. Currently in Ukraine a small pilot project working at rural community level with parents, schools and teachers – vaccination statistics show good results. At country level there are opportunities to develop cancer prevention programmes and integrate them as part of Health programmes including Sexual education for youth which span wider information about HPV and vaccination into tobacco use, diet etc for cancer prevention.

United Nations Population Fund (UNFPA), Rita Columbia

<http://eeca.unfpa.org/public/>

UNFPA covers 20 countries in the region. In 2008, UNFPA began a shift from primary provider to broker of technical assistance, under which UNFPA manages and facilitates access to technical assistance, which is provided by a network of institutions, individuals and internal UNFPA resources. The immediate purpose of technical assistance is to fill national partners' capacity gaps, primarily in the three areas of UNFPA's mandate: population and development; sexual and reproductive health and rights; and gender, human rights and culture. In the long term, UNFPA aims to contribute to developing sustainable national capacity. At regional level UNFPA thrives to strengthen partnerships, support knowledge and experience sharing – bringing cultures together that share the same priorities. UNFPA recently produced cervical cancer control programmatic guidance including steps to consider before starting such a programme.

Black Sea Coalition, Tamar Khomasuridze

<http://www.bsc-coalition.com/?d1=content&id=40>

The eight members of the coalition are nominated by the Ministries of Health. The coalition was created to address the need of harmonized approaches in the countries of the Black Sea – to share information, knowledge and lessons learned in breast and cervical cancer. Countries give annual reports regarding implementation of the Action Plan and guidelines are given for further development.

Centers for Disease Control and Prevention, Kashmiri Anand Date

<http://www.cdc.gov/vaccines/programs/global/default.htm>

The Global Immunization Division (GID) at the CDC works closely with the Division of STD Prevention and Control (DSTDP) and the Division of Cancer Prevention and Control (DCPC) on HPV vaccination issues. GID is primarily involved in surveillance and programmatic issues related to new vaccine introduction and evaluation. Most of this work is done in close collaboration with partners including WHO. GID is committed to assist with surveillance and HPV vaccine introduction, including assessments and evaluation prior to and after vaccine introduction (for example, post-introduction evaluations) as well as assessments of vaccine impact. The SMEs with the STD prevention and cancer prevention groups are also closely involved with other policy decisions and strategies for HPV vaccination and cervical cancer screening. Furthermore, GID conducts assessments to evaluate the impact of new vaccine introduction on immunization systems and has communication teams to assist with messaging and communications regarding vaccination.

Catalan Institute of Oncology (ICO), Xavier Bosch

<http://www.en.globaltalentnews.com/>

ICO is a research institute. They have developed a web site to access and download global information. Monographs are freely available on web of Elsevier. Information from the monographs has been distilled a 10 hour internet-based course. The Online Oncology Community course on cervical cancer is available at: <http://www.e-oncologia.org/en/cursos>

5. Action points

For WHO Regional office for Europe:

Following is a summary of the deliverables that WHO was asked to take action upon:

- Develop **guidelines on communication** for introduction of HPV vaccine
- Provide technical and consultancy **assistance to countries on use of WHO tool on costing of cervical cancer prevention programmes**. The tool allows calculation of costs of various cervical cancer prevention options, and provides useful information for decision-makers to prioritize and consider affordability of different prevention strategies.
Promote **transparency and access to comparatively low and affordable vaccine prices** with sustainable domestic financing
- Advice on **how to implement measures on never screened women** – addressing the social determinants that may cause women not covered by vaccine or screening.
- Request for a questionnaire with just one question: **“What is price of vaccine in your country?”**
- **Regular meetings and stewardship** are required – projects need long term sustainability.

For Member States:

Countries are encouraged to:

- Develop a national strategy on comprehensive cervical cancer prevention which defines long-term national strategies on different prevention options including organized screening and vaccination
- Facilitate national multisectorial collaboration to support transparent planning and promote sustainability
- Utilize available economical tools to prioritize and consider affordability of different preventive strategies
- Work in partnerships with key members of society and organizations to advocate for cervical cancer prevention
- Establish/enhance population-based cancer registries to monitor both immunization and screening programs

For countries that have introduced or consider introducing HPV vaccine:

- Consider joining pooled procurement mechanisms including use of UNICEF Supply Division’s procurement services and references to make vaccines affordable
- Utilize the experience from countries that have successfully introduced HPV vaccine in developing effective communication strategies and crises communication plans
- Consider using existing teenage immunisation systems to deliver HPV vaccination programme
- Establish a standardized system to monitor vaccine coverage by age and by dose which enables monitoring programme performance and evaluating vaccine impact at later stage
- After vaccination programme is established, consider opportunities to integrate other adolescent health messages

Each country was urged to make its own decision on which way to go. There is political commitment – the United Nations High Level Meeting on NCDs held in New York and the European NCD Action Plan vouch for this.

Annex 1 – Programme

Regional Cervical Cancer Prevention Meeting 11-12 October 2011 – Istanbul, Turkey

Monday, 10 October

16.00–18.00	Registration	
<u>Tuesday, 11 October</u>		
8.00–9.00	Registration	
9.00–9.30	Welcome by WHO Office for Turkey	Cristina Profili WHO CO for Turkey
	Welcome by WHO European Regional Office Objectives of the Meeting	Gauden Galea WHO Europe
	Welcome by the Ministry of Health of Turkey	Nejat Özgül Ministry of Health, Turkey
Session 1: Overview of cervical cancer prevention programmes		
Chair: Rebecca Martin Co-chair: Gunta Lazdane		
9.30–9.50	Global and regional overview: progress achieved since 2007	Gauden Galea WHO Europe
9.50–10.05	Denmark experience in cervical cancer prevention	Sigrid Poulsen Denmark
10.05-10.20	Discussion	
10.20-10.50	<i>Coffee Break</i>	
Session 2: Country experiences in cervical cancer prevention		
Chair: Dorian Kennedy Co-chair: Lawrence von Karsa		
Panel discussion 1: Primary cervical cancer prevention		
10.50-11.30	Country experience in implementation of HPV vaccination	Marc Arbyn Belgium
		Baiba Rozentale Latvia
		Maja Primic Zakelj Slovenia
		Anne Spaar Zographos
		Switzerland

		Dorian Kennedy United Kingdom of Great Britain and Northern Ireland
11.30-12.00	Discussion	
12.00-13.30	<i>Lunch</i>	
Panel discussion 2: Secondary cervical cancer prevention		
13.30-14.10	Countries experience in organized cervical cancer screening	Sergey Mavrichev Belarus Lela Sturua Georgia Ahti Anttila Finland Ausrute Armonaviciene Lithuania
14.10-15.00	Discussion	
15.00-15.30	<i>Coffee Break</i>	
15.30- 16.30	Discussion: synergy among prevention strategies	
16.30-16.50	Teasers of Wednesday working groups	Working group facilitators
16.50.- 17.00	General Announcements and Daily Adjournment	
19:00-21:00	Dinner	

Wednesday, 12 October

Session 3: Components for comprehensive approach in cervical cancer prevention		
Chair: Liudmila Mosina		
Working groups		
09.00.- 09.15	Working groups announcements	

09.15–10.45	Working group 1: Stewardship and policies Facilitators: Andreas Ullrich	
	Working group 2: Affordability and financial sustainability Facilitators: Ann Levin, Mark Jit	
	Working group 3: Monitoring and health information Facilitators: Susan Wang, Robert Burton	
	Working group 4: Quality of services Facilitators: Nathalie Broutet, Sigrid Poulsen	
10:45-11.15	<i>Coffee Break</i>	
11.15-12.00	Working groups (continued)	
12.00-13.00	<i>Lunch</i>	
13.00- 13.40	Feedback from working groups	Working group 1 Working group 2 Working group 3 Working group 4
13.40-14.30	Discussion	
14.30-15.30	<i>Coffee Break (Poster presentations)</i> <i>Coordinator: Marina Storgaard</i>	
Session 4: Partners and networks Chair: Gunta Lazdane Co-chair: Rebecca Martin		
Panel discussion: Collaboration and synergy		
15.30–16.20	Partners round table	CDC, GAVI, IARC, ICO, IPPF EN, UICC, UNFPA, WHO headquarters
16.20-16.50	<i>Discussion</i>	
16.50-17.20	Meeting Summary and Closing Remarks (Rebecca Martin, Gunta Lazdane)	

Annex 2 – Participants

Albania

Erida Nelaj
Immunization Programme Manager, Institute of Public Health

Donika Beba
Obstetrician, Gynaecologist

Armenia

Gayane Avagyan
Chief Specialist, Maternal and Child Health, Protection Unit, Ministry of Health

Gayane Sahakyan
National Immunization Programme Manager, Ministry of Health

Austria

Jean-Paul Klein
Director, Department III/7, Vaccination, HIV/AIDS and Tuberculosis

Azerbaijan

Faiza Kamil Aliyeva
Director, Institute of Obstetrics and Gynaecology

Afag Aliyeva
Chief of immunoprophylaxis
Republican Center for Hygiene and Epidemiology

Belarus

Sergey Mavrichev
Head of Department of Gynaecological Oncology

Vladimir Pashkovich
Head of Epidemiology Department, Republican Center for Hygiene, Epidemiology and Public Health

Belgium

Marc Arbyn
Institute of Public Health

Eline Remue
Institute of Public Health, Cancer Center

Bosnia and Herzegovina

Sabija Izetbegovic

Director of the Discipline for Gynaecology and Obstetrics, Clinical Centre of University of Sarajevo

Svjetlana Dunjic

Specialist in gynaecology and obstetrics, Gynaecology and Obstetrics Clinic, Clinical Centre Banja Luka

Bulgaria

Angel Kunchev

Chief State Health Inspector, Ministry of Health

Nikola Vassilev

Head of General and Oncologic Gynaecology Clinic, Military Medical Academy

Croatia

Bernard Kaic

National EPI Manager, Croatian Institute of Public Health, Department of infectious Disease Epidemiology

Ariana Znaor

Assistant professor

Croatian National Cancer Registry, Croatian National Institute of Public Health

Czech Republic

Pavel Kosina

University Hospital Hradec Králové

Ondřej Májek

Institute Of Biostatistics and Analysis, Masaryk University

Denmark

Sigrid Poulsen

Senior Medical Officer, Communicable Diseases & Vaccines, National Board of Health

Estonia

Tiiu Aro

Director General of the Health Board

Piret Veerus

Researcher of the Epidemiology and Biostatistics Department, National Institute for Health Development

Finland

Ahti Anttila
Mass Screening Registry/Finnish Cancer Registry

Terhi Kilpi
Director of Department of Vaccination & Immune Protection, National Institute for Health and Welfare

Georgia

Tinatin Beruchashvili
Manager, National Screening Center of Georgia

Lela Sturua
National Cancer Screening Programme Coordinator, Head of Noncommunicable Diseases Department, National Center for Disease Control and Public Health

Germany

Yvonne Deleré
Immunization Unit, Robert Koch Institute

Greece

Theodoros Agorastos
Professor of Obstetrics and Gynaecology, Aristotle University of Thessaloniki

Theodora Stavrou
Head, Health Promotion Department, Hellenic Ministry of Health and Social Solidarity

Hungary

Attila Kovacs
Deputy Chief Medical Officer, Office of the Chief Medical Officer

Italy

Antonio Federici
Ministry of Health

Kazakhstan

Alma Zhylkaidarova
National Center for Problems of Healthy, Lifestyle Development

Kyrgyzstan

Baktygul Ismailova
Epidemiologist, Department of State Sanitary, Epidemiology Surveillance, Ministry of Health

Latvia

Baiba Rozentale
Director of the State Agency “Infectology Centre of Latvia”

Marite Ergle
Senior Economist of the Outpatient Services Section of the Health Care Services Department
Health Payment Centre

Lithuania

Ausrute Armonaviciene
Head of Family Health Division, Ministry of Health of the Republic of

Montenegro

Dragan Lausevic
Director of the Center for Disease Control and Prevention, Institute of Public Health

Aleksandra Vuksanovic Bozanic
Gynaecologist, Institute of Public health

Netherlands

Marina Conyn
National Institute of Public Health and Environment

Nynke van der Veen
Programme Coordination Screening, National Institute for Public Health and Environment

Poland

Marta Czernik
Deputy Manager of Central Coordination Centre

Magdalena Klimek
Senior Specialist, Department of Health Policy, Ministry of Health

Portugal

Graça Freitas
Medical Doctor, Directorate-General of Health

Republic of Moldova

Olga Cernetchi
Head, Chair of Obstetrics and Gynaecology, State Medical and Pharmaceutical University
“Nicolae Testimitanu”

Anatolie Melnic
Head, Center for Immunoprophylaxis, National Center for Public Health, Ministry of Health

Romania

Nikula Florian, Bucharest

Russian Federation

Oleg Semenovitch Filippov
Deputy Head of Department, Development of Health Care for Children and Mothers, Ministry of Health and Social Development

Serbia

Goranka Loncarevic
Head of Department of Immunization, Institute of Public Health of Serbia

Snezana Zivkovic Perisic
Cancer Registration & Epidemiology Specialist, Institute of Public Health of Serbia

Slovak Republic

Jan Mikas
M.D., Public Health Authority of the Slovak Republic

Andrea Romančíková
M.D. Department of Health, Ministry of Health of the Slovak Republic

Slovenia

Maja Primic Zakelj
Ass. Professor Professor M.D. Specialist in Epidemiology & Public Health Institute of Oncology

Spain

Aurora Limia Sanchez
Head of Service of the Vaccines Area; General Directorate of Public Health, Ministry of Health, Social Policy and Equality

Vicenta Lizarbe
M.D. Head of the Prevention Area, Ministry of Health, Social Policy and Equality

Sweden

Bengt Andrae
MD, Department of Obstetrics and Gynaecology, Gävle Hospital

Ellen Jones
Legal Advisor; National Board of Health and Welfare

Switzerland

Anne Spaar Zographos MD,
Federal Office of Public Health; Ministry of Health

Tajikistan

Gulbahor Ashurova
Head of sector of safe motherhood of, Department providing services to mothers, children and family planning of the Ministry of health

Sohibnazar Turkov
Deputy Director of the Republican Immunization Center of the Ministry of Health

The former Yugoslav Republic of Macedonia

Jovanka Kostovska
Head, Department for Preventive Health Care, Ministry of Health

Suzana Manevska
Head, Department for Communicable Diseases
Sector for Preventive Health Care, Ministry of Health

Turkey

Nejat Ozgul
Deputy Head of Cancer Control Dept, Ministry of Health

Turkmenistan

Gyzylgul Bedirova
Head of Oncology-Gynaecology department of the Scientific Clinical Centre of Oncology

Sachly Nuriyeva
Deputy Chief, Epidemiological and Parasitological, Control Department of the State Sanitary-Epidemiologic Service Ministry of Health and Medical Industry

Ukraine

Iryna Chybisova
Senior Specialist of the Obstetric and Gynaecology Care Division of the Department of Maternity and Childhood Ministry of Health

Sergii Platov
Senior Specialist of the Division of Sanitary and Epidemiological Welfare of Population of the Department of Medical Services Quality Control, Regulatory Policy and Sanitary and Epidemiological Welfare of Population
Ministry of Health

United Kingdom United Kingdom of Great Britain and Northern Ireland

Dorian Kennedy
Head of Immunization Branch, Department of Health

Uzbekistan

Diyora Arifdjanova
Head of Maternity Division, Maternal and Child Health Department, Ministry of Health

Nodira Islamova
Leading Specialist Maternity Division, Maternal and Child Health Department, Ministry of Health

Dilorom Tursunova
Leading specialist, General Directorate of SES of Ministry of Health, National EPI coordinator

Dilmurod Yusupov
Obstetrician-Gynecologist of Maternity complex of clinic, Nr.2 of TMA, National Coordinator on Cervical Cancer Screening issues, Tashkent Medical Academy

TEMPORARY ADVISERS

Robert Charles Burton
Professor, School of public health and preventive medicine, Monah University, Australia

Mark Jit
Consultant, World Health Organization, Switzerland

Ann Levin
Consultant, World Health Organization, USA

PARTNERS

Black Sea Coalition

Tamar Khomasuridze
UNFPA AR Georgia, Member of the BS Coalition United Nations Population Fund, Georgia
CO, Georgia

Catalan Institute of Oncology (ICO)

Xavier Bosch
Unit of Infections and Cancer, Cancer Epidemiology Research Programme, Catalan Institute of Oncology, Spain

Centers for Disease Control & Prevention

Kashmira Anand Date
Medical Epidemiologist, US Centres for Disease Control and Prevention, Global Immunization Division, Centers for Disease Control and Prevention, USA

International Planned Parenthood Federation (IPPF) European Network

Galina Maistruk
President, IPPF EN's Ukrainian Member Association's, Ukraine

International Agency for Research on Cancer

Lawrence von Karsa
Head, Quality Assurance Group Early Detection and Prevention Section, International Agency
for Research on Cancer & Coordinator, European Cancer Network (ECN for Screening and
Prevention, France

United Nations Population Fund (UNFPA)

Rita Columbia
Programme Advisor on SRHR,, eastern Europe and central Asia Regional Office, United Nations
Population Fund

Union for International Cancer Control (UICC)

Lucrecia Peinado
Programme Director, Union for International Cancer Control (UICC), Switzerland

WORLD HEALTH ORGANIZATION

Headquarters

Nathalie Jeanne Nicole Broutet
Medical Officer
STI Control, Sexually Transmitted and reproductive tract Infections
World Health Organization
Switzerland

Andreas W.H. Ullrich
Medical Officer,
Chronic Diseases Prevention and Management
World Health Organization
Switzerland

Susan Wang
IVB
World Health Organization
Switzerland

Regional Office for Europe

Chinara Aidyralieva

Medical Officer
WHO Country Office, Russian Federation
Russian Federation

Vusala Allahverdiyeva
National Professional Officer
WHO Country Office, Azerbaijan
Azerbaijan

Valentina Baltag
Medical Officer, Adolescent Health
WHO Regional Office for Europe
Denmark

Toker Ergüder
National Professional Officer
WHO Country Office Turkey
Turkey

Gauden Galea
Director
Division of Noncommunicable Diseases and Health Promotion
WHO Regional Office for Europe
Denmark

Shahin Huseynov
Technical Officer
Operations in Countries
WHO Country Office Uzbekistan,
Uzbekistan

Tina Kiaer
Communications Officer
Division of Noncommunicable Diseases
WHO Regional Office for Europe
Denmark

Gunta Lazdane
Programme Manager, Reproductive Health and Rights
Division of Noncommunicable Diseases
WHO Regional Office for Europe
Denmark

Rebecca Martin
Medical Officer
Division of Health Programmes
WHO Regional Office for Europe
Denmark

Liudmila Mosina

Technical Officer
NUVI technical specialist
Vaccine-preventable Diseases and Immunization
WHO Regional Office for Europe
Denmark

Maria Christina Profili
WHO Representative Turkey
WHO Country Office Turkey
Turkey

Marina Storgaard
Secretary
Division of Health Programmes
WHO Regional Office for Europe
Denmark

Ida Strömgren
Programme Assistant
Division of Noncommunicable Diseases
WHO Regional Office for Europe
Denmark

Irina Eriksen
Programme Assistant
Country Policies, Systems and Services
Division of Country Health Systems
WHO Regional Office for Europe
Denmark

OBSERVERS

Myassa Dartell
MD, PhD student in International health
Denmark

Nina Buttman
MD, MPH, Research assistant in reproductive health
Denmark

INTERPRETERS

Olga Aleksinskaya
Freelance interpreter/translator
Russian Federation

Anna Nikolskaya
Freelance interpreter/translator
Russian Federation