Evidence for the path to cervical cancer elimination

Elimination of cervical cancer is at the forefront of the global health agenda with the launch of the WHO Initiative for the Elimination of Cervical Cancer in 2018.1 Human papillomavirus (HPV) vaccination is expected to be a priority agenda item on health for the 2020 G20 Summit in Riyadh following the 2019 commitment to universal access to vaccination in the G20 Osaka Leaders’ Declaration2 and the Okayama Declaration of the G20 Health Ministers.3 This political momentum should be coupled with the latest evidence to pinpoint outstanding areas for action and to implement responsive strategies.

Cervical cancer is one of the top five cancers with the greatest proportion of avoidable cancer mortality—premature deaths resulting from health system failures that could otherwise be avoided on the basis of existing medical advancements and with access to high-quality health care.4 As evidenced by the importance of quality markers in health care, including the effectiveness and timeliness of care,5 an immense opportunity exists to bridge the gap in what can be achieved and what is achieved on the prevention and treatment of cervical cancer. Fundamental to any response is reliable assessment of the global burden of cervical cancer.

In their Article in The Lancet Global Health, Marc Arbyn and colleagues6 present the latest estimates of cervical cancer incidence and mortality worldwide, using the International Agency for Research on Cancer’s GLOBOCAN data from 2018 and updating a similar analysis done in 2008.7 Arbyn and colleagues estimated that approximately 570,000 cases of cervical cancer and 311,000 deaths from the disease occurring worldwide in 2018. The annual age-standardised incidence (ASI) worldwide of cervical cancer was estimated to be 13.1 per 100,000 women-years, with an approximate range of less than 2 to 75 per 100,000. Overtime comparison of global patterns revealed that cervical cancer shifted from being the third most common malignant tumour to the fourth most common. However, despite global progress on primary and secondary prevention, Arbyn and colleagues’ updated analysis indicated that about 84% of cervical cancer cases occur in low-resource countries (defined as countries with a human development index [HDI] value lower than 0.80), a minimal change in distribution of the burden from a decade ago when this proportion was 85%. Additionally, Arbyn and colleagues found an inverse trend between both the ASI and the age-standardised mortality rate and the level of human development, as derived from the HDI. These data show the ongoing presence of the global cancer divide—disparities in morbidity and mortality within and between countries that are concentrated among the poor.8

The younger age profile of the disease compared with that of most other types of cancer, with cervical cancer being among the top three cancers in 146 (79%) of 185 countries in women younger than 45 years, provides further cause for concern.6 Especially as, according to the CONCORD 3 study, the global 5-year cervical cancer survival ranged between 50% and 70% over the time period of 2000–14.9 The situation is starker in specific areas of the world. In eastern, middle, southern and western Africa, Arbyn and colleagues reported that cervical cancer was the leading cancer among women in 2018, highlighting these geographical areas as a pressing priority for the ambitious WHO cervical cancer elimination initiative. In 2008, cervical cancer was also the leading cancer among women in central America, south-central Asia, and Melanesia;7 however, persistent efforts have yielded health gains in these parts of the world.

Arbyn and colleagues have made the GLOBOCAN data more accessible and strengthened the existing analysis of global disparities in cervical cancer. The authors have substantiated the grave impetus to ensure that cervical cancer remains a public health priority and called governments and the international community to task to accelerate progress on cervical cancer prevention and treatment alongside the broader aim to achieve universal health coverage.

As the cervical cancer elimination movement moves forward, all valued health goals should be pursued. Previous findings on the burden of serious health-related suffering, which could be ameliorated with adequate palliative care that is insufficient in much of the world today, estimated that 80% of individuals who have serious health-related suffering live in low-income and middle-income countries and that nearly a quarter of this burden is associated with cancer, including cervical cancer.10 The alleviation of suffering with access to care throughout the care continuum must be a priority in the quest for better health for all initiatives, including disease-specific ones.
Moreover, the disaggregation of data to examine health inequities (such as the burden of cervical cancer) among the most marginalised is necessary, to protect the needs of the populations most at risk, including indigenous communities, refugees and immigrants, and individuals in the lesbian, gay, bisexual, transgender, queer or questioning, and intersex community.

In this era of misinformation and anti-immunisation campaigns, as well as persistent stigma surrounding cancer in various parts of the world, various challenges stand on the path to elimination of cervical cancer. Improved cancer surveillance and continued evidence-based public awareness activities can serve to counter some of these challenges.

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