Comprehensive Cervical Cancer Control
A guide to essential practice
PREFACE

Cancer is being diagnosed more and more frequently in the developing world. The recent World Health Organization report, *Preventing chronic diseases: a vital investment*, projected that over 7.5 million people would die of cancer in 2005, and that over 70% of these deaths would be in low- and middle-income countries. The importance of the challenge posed by cancer was reiterated by the World Health Assembly in 2005, in Resolution 58.22 on Cancer Prevention and Control, which emphasized the need for comprehensive and integrated action to stop this global epidemic.

Cervical cancer is the second most common type of cancer among women, and was responsible for over 250,000 deaths in 2005, approximately 80% of which occurred in developing countries. Without urgent action, deaths due to cervical cancer are projected to rise by almost 25% over the next 10 years. Prevention of these deaths by adequate screening and treatment (as recommended in this Guide) will contribute to the achievement of the Millennium Development Goals.

Most women who die from cervical cancer, particularly in developing countries, are in the prime of their life. They may be raising children, caring for their family, and contributing to the social and economic life of their town or village. Their death is both a personal tragedy, and a sad and unnecessary loss to their family and their community. Unnecessary, because there is compelling evidence — as this Guide makes clear — that cervical cancer is one of the most preventable and treatable forms of cancer, as long as it is detected early and managed effectively.

Unfortunately, the majority of women in developing countries still do not have access to cervical cancer prevention programmes. The consequence is that, often, cervical cancer is not detected until it is too late to be cured. An urgent effort is required if this situation is to be corrected. All women have a right to accessible, affordable and effective services for the prevention of cervical cancer. These services should be delivered as part of a comprehensive programme to improve sexual and reproductive health. Moreover, a concerted and coordinated effort is required to increase community awareness about screening for the prevention and detection of cervical cancer.

A great deal of experience and evidence-based knowledge is available for the prevention (and treatment) of cervical cancer and related mortality and morbidity. However, until now, this information was not available in one easy-to-use guide. This publication — produced by WHO and its partners — is designed to provide comprehensive practical advice to health care providers at all levels of the health care system on how to prevent, detect early, treat and palliate cervical cancer. In particular, the Guide seeks to ensure that health care providers at the primary and secondary levels will be empowered to use the best available knowledge in dealing with cervical cancer for the benefit of the whole community.
We call on all countries that have not already done so to introduce effective, organized control programmes for cervical cancer as recommended in this Guide. Together, we can significantly reduce the heavy burden of this disease and its consequences.

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WHO RECOMMENDATIONS

- Health education should be an integral part of comprehensive cervical cancer control.

- Cytology is recommended for large-scale cervical cancer screening programmes, if sufficient resources exist.

  Recommended target ages and frequency of cervical cancer screening:
  - New programmes should start screening women aged 30 years or more, and include younger women only when the highest-risk group has been covered. Existing organized programmes should not include women less than 25 years of age in their target populations.
  - If a woman can be screened only once in her lifetime, the best age is between 35 and 45 years.
  - For women over 50 years, a five-year screening interval is appropriate.
  - In the age group 25-49 years, a three-year interval can be considered if resources are available.
  - Annual screening is not recommended at any age.
  - Screening is not necessary for women over 65 years, provided the last two previous smears were negative.

- Visual screening methods (using acetic acid (VIA) or Lugol’s iodine (VILI)), at this time, are recommended for use only in pilot projects or other closely monitored settings. These methods should not be recommended for postmenopausal women.

- Human papillomavirus (HPV) DNA tests as primary screening methods, at this time, are recommended for use only in pilot projects or other closely monitored settings. They can be used in conjunction with cytology or other screening tests, where sufficient resources exist. HPV DNA-based screening should not begin before 30 years of age.

- There is no need to limit the use of hormonal contraceptives, despite the small increased risk of cervical cancer noted with use of combined oral contraceptives.

- Women should be offered the same cervical cancer screening and treatment options irrespective of their HIV status.

- Colposcopy is recommended only as a diagnostic tool and should be performed by properly trained and skilled providers.

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• Precancer should be treated on an outpatient basis whenever possible. Both cryotherapy and the loop electrosurgical excision procedure (LEEP) may be suitable for this purpose, depending on eligibility criteria and available resources.

• Histological confirmation of cervical cancer and staging must be completed before embarking on further investigations and treatment.

• Surgery and radiotherapy are the only recommended primary treatment modalities for cervical cancer.

• Brachytherapy is a mandatory component of curative radiotherapy of cervical cancer.

• Surgery for treatment of cervical cancer should be performed only by surgeons with focused training in gynaecological cancer surgery.

• The needs of women with incurable disease should be addressed by using existing palliative care services or establishing new ones. Providers at all care levels need to be trained and must have the resources necessary to manage the most common physical and psychosocial problems, with special attention to pain control.

• A comprehensive cervical cancer programme should ensure that opioid, non-opioid and adjuvant analgesics, particularly morphine for oral administration, are available.