

LEGISLATIVE AGENDAS: FEDERAL



2020 Federal Priorities



Health Equity: ACS CAN is committed to supporting initiatives in research, prevention, detection and provision of patient services to reduce disparities in cancer that will lead to healthier outcomes for cancer patients and survivors.

Major Campaigns

Appropriations for Cancer Research & Prevention

Support increased funding levels for cancer research and prevention that ensures continued progress in the fight against cancer at the NIH, NCI, and CDC's cancer programs including cancer registries.

Tobacco Control

Advance Congressional and administrative prevention and regulatory policies to reduce the disease and death caused by tobacco products by preventing youth initiation and increasing cessation of use of tobacco products.

Clinical Trials

Support passage of the Henrietta Lacks Enhancing Cancer Research Act of 2019, and other proposals that promote better patient access to clinical trials.

Targeted Campaigns

Access to Care (Private Insurance, ACA, Medicare, Medicaid, Prescription Drug Costs, Surprise Billing) – Advance policies that preserve protections for cancer patients and survivors and promote access to adequate and affordable insurance coverage, cancer prevention & screening, and treatment. Support legislative changes to lower the cost of prescription drugs and reduce patient out of pocket costs, while maintaining cancer patients' access to lifesaving drugs & therapies.

Patient and Survivor Quality of Life – Support Senate passage of the Palliative Care and Hospice Education and Training Act (PCHETA), to facilitate access to palliative care & coordinated care management for cancer patients and survivors.

Colorectal Cancer Screening – Support passage of the Removing Barriers to Colorectal Cancer Screening Act, to remove patient cost-sharing in Medicare for colonoscopy with polyp removal.

Ending Death from Cervical Cancer Worldwide – Support the integration of HPV vaccination and cervical cancer screening & treatment into existing global health programs.

Other Federal Legislative Priorities

Childhood Cancer – Support continued implementation of the Childhood Cancer STAR Act, which advances pediatric cancer research & increases transparency/expertise for pediatric cancer research at the NIH.

Federally Qualified Health Centers (FQHCs) – Support yearly funding for FQHC's in the annual federal appropriations process, and advocate for continued mandatory FQHC funding.

Diagnostic Reform – Support the modernization and harmonization of diagnostics oversight.

Healthy Eating and Active Living – Support implementation of quality nutrition standards for food served in schools and menu labeling standards to combat obesity.

Lung Cancer – Support initiatives that increase education, awareness and research of lung cancer including the Women and Lung Cancer Research and Preventative Services Act.

Oral Chemo Parity – Support legislation to provide coverage for oral chemotherapy drugs with the same out of pocket cost sharing as chemotherapy drugs administered intravenously by a physician.

Patient Navigation – Support policies that increase the accessibility of patient navigators for people with cancer.



Funding for Cancer Research- NIH & NCI

Background:

Cancer continues to take a tremendous toll on our nation. Almost 1.76 million Americans will be diagnosed with cancer in 2019 and more than 606,000 will die from this devastating disease. That means that as a country we lose more than 1,660 Americans every day to cancer. Recent estimates also show that cancer costs the U.S. economy more than \$216 billion annually in direct treatment costs and lost productivity.

However, because of previous investments in cancer research and prevention there is hope. Today, we have more than 16.9 million American cancer survivors and we are in the midst of a quarter century of sustained declines in cancer mortality. From 2006 through 2015, the rate of new cancer cases fell by more than one percent each year. Even more, there has been a 27 percent decrease in the cancer death rate from 1991 to 2016, meaning that two out of three patients survive at least five years after diagnosis compared to one out of two patients 40 years ago. Research advances over the past two decades have significantly improved how many cancers are prevented, diagnosed, and treated. Still, here in the U.S., the lifetime risk of developing cancer is two out of five.

Research: The NIH & NCI

The National Cancer Institute (NCI) is one of 27 institutes and centers within the National Institutes of Health (NIH). The mission of the NCI is to lead, conduct, and support cancer research activities across the nation. For the last 50 years, every major medical breakthrough in cancer can be traced back to the NCI and NIH.

With increases in federal investment in medical research over the last four fiscal years and the passage of the 21st Century Cures Act that included funding for the National Cancer Moonshot Initiative, Congress has illustrated its bipartisan support for cancer research. These increases for medical research were meant to address years of flat or cut funding, put cancer research back on track and spur additional progress – all toward the end of putting the country on the path toward finally defeating this disease. Funding from the National Cancer Moonshot Initiative has allowed the NCI to fund 159 new Cancer Moonshot awards to date. These awards are helping “leverage advances in immunotherapy, understand drug resistance and develop new technologies to characterize tumors and test therapies,” according to the NCI.

Additionally, the support provided to the NIH by Congress has led to job growth and increased economic activity in every state. More than 80 percent of federal funding for the NIH and NCI is spent on biomedical research projects at local research facilities across the country, including 50,000 extramural grants to 300,000 researchers at over 2,500 universities, medical schools, and other research institutions. According to United for Medical Research, in 2018 the NIH provided over \$28 billion in funding to scientists in all 50 states. This funding supported more than 433,000 jobs nationwide and produced over \$73.9 billion in new economic activity.

The Bottom Line:

Will you support an increase of \$3 billion (\$44.7 billion total) for the NIH and an increase of almost \$500 million (\$6.9 billion total) for the NCI in fiscal year 2021?



ADVOCACY IMPACT

Federal Funding for Research & Prevention in 2020

The American Cancer Society Cancer Action Network (ACS CAN) staff and grassroots volunteers across the nation were instrumental in the passage of a bipartisan funding bill for Fiscal Year 2020 that included significant resources to support our mission to end suffering and death from cancer.

\$296
MILLION

NCI

A \$296M increase raised the National Cancer Institute (NCI) total budget to \$6.44B.

ACS CAN's **One Degree Campaign** marked the beginning of annual NCI budget increases.



Source: NCI Budget Fact Books Archive

\$212.5
MILLION

designated to increase funding for basic science that drives innovation in diagnostics and treatment.



\$25
MILLION

&

\$50
MILLION

set aside for two childhood cancer initiatives that will put better data in the hands of care teams and explore the long-term effects of childhood cancer and its treatments.



\$693
MILLION

CDC

A \$693M increase for the Centers for Disease Control & Prevention (CDC) will fund several cancer priorities.

\$10
MILLION

increase for skin, prostate, and ovarian cancer control programs.

\$20
MILLION

increase for the Office of Smoking and Health, whose *Tips from Former Smokers* campaign helped an estimated



1 million people quit smoking and **16.4 million attempt to quit** from 2012-2018.

Source: CDC, *Tips Impact and Results*

\$50
MILLION

for data modernization, which will prioritize updating cancer reporting systems to get data into the right hands faster.



Visit fightcancer.org to join us as we continue to make fighting cancer a top priority.

More information on the funding bill is available [here](#).

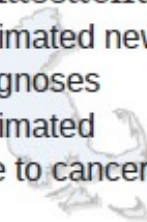


Massachusetts

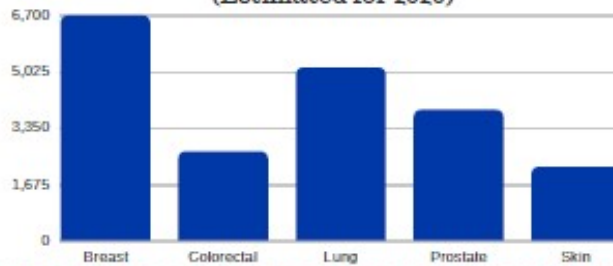
2020 Cancer Research Facts and Funding

This year in Massachusetts

- 36,990 estimated new cancer diagnoses
- 12,430 estimated deaths due to cancer

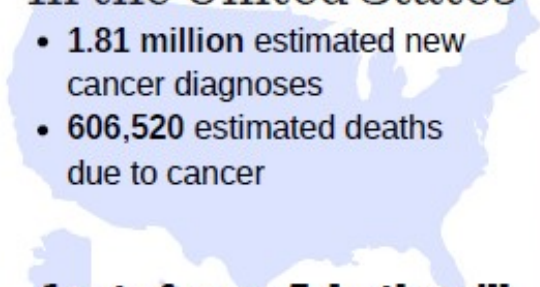


Snapshot of New Cancer Cases by Type
(Estimated for 2020)



In the United States

- 1.81 million estimated new cancer diagnoses
- 606,520 estimated deaths due to cancer



1 out of every 5 deaths will be caused by cancer

FY2019 Funding Research in Massachusetts

- Total NIH State Funding: **\$3,024,098,902**
- Total NCI State Funding: **\$396,087,873**
- NCI Designated Cancer Centers in Massachusetts: **2**

FY2019 NIH and State Economic Impact

- **36,652 jobs** in Massachusetts supported by NIH funding
- **\$7.103 billion** created in new economic activity based on NIH funding



Massachusetts Research Accomplishments

Glioblastomas are the fastest-growing type of brain cancer and are typically treated with surgery, radiation, and chemotherapy.

Unfortunately, these therapies usually do not completely cure glioblastomas and recurrence is highly likely.

Recently, scientists have been investigating the role that the PRMT5 protein plays in tumor growth. While scientists knew that higher levels of PRMT5 were linked to cancer, the exact mechanism by which PRMT5 was stimulating cancer growth was unclear. With the support of NCI funding, researchers at the Massachusetts Institute of Technology (MIT) discovered that PRMT5 regulated tumor cell growth via a process known as gene splicing. When the researchers blocked PRMT5, they discovered that the tumor cells stopped growing. The discovery could lead to the development of new therapies for this highly deadly cancer.



Massachusetts

CDC Funding for Cancer Prevention and Control

CDC cancer control program
funding allocated to
Massachusetts in 2019
\$2,985,219



National Breast and Cervical
Cancer Early Detection
Program (NBCCEDP)
\$1,050,662

709 Massachusetts women
served between 2013-2017



National Program of Cancer
Registries (NPCR)
\$857,00



Colorectal Cancer Control
Program (CRCCP)
\$570,699



National Comprehensive Cancer
Control Program (NCCCP)
\$506,858

In Massachusetts in 2020
an estimated:

- **36,990** people will be diagnosed with cancer
- **12,430** people will die from cancer

Did You Know?

Nearly half of all cancer deaths can be prevented. CDC's cancer programs target these cancers and work to prevent cancer before it starts.

Massachusetts Works to Increase HPV Vaccination in Adolescents

The Massachusetts Comprehensive Cancer Prevention and Control Network's (MCCPCN) mission is to reduce cancer incidence, morbidity, and mortality through an action plan focusing heavily on the prevention and early detection of cancers. In 2014, the MCCPCN set a goal to increase vaccination rates for the Human Papillomavirus (HPV) to 60% for adolescent girls and 37% for adolescent boys by 2021 to prevent HPV-related cancers. With funding from the CDC's Division of Cancer Prevention & Control, the MCCPCN planned to integrate education about HPV into health curriculum in school systems; collaborate with parent organizations to increase HPV vaccine uptake; and encourage providers to increase uptake of the HPV vaccine. By 2017, the MCCPCN surpassed their vaccination goal with 67% of adolescent girls and 64% of adolescent boys having completed the HPV vaccination series.

Removing Barriers to Colorectal Screenings Act



Sponsors:

Senator Sherrod Brown [D-OH], Senator Roger Wicker [R-MS], Senator Benjamin Cardin [D-MD] & Senator Susan Collins [R-ME]
Representative Donald Payne, Jr. [D-NJ-10], Representative Rodney Davis [R-IL-13], Representative Donald McEachin [D-VA-4], and Representative David McKinley [R-WV-1]

Background:

Colorectal cancer is the second leading cause of cancer death in men and women combined in the U.S. This year approximately 145,600 Americans will be diagnosed with colorectal cancer and over 51,000 of them will die from the disease. The majority of those diagnosed will be Medicare beneficiaries. Colorectal cancer is one of the few cancers that can be completely prevented through screening. Polyps, or abnormal precancerous growths, can be detected during the screening process and entirely removed, thereby stopping any cancer formation. Regular screening is the most effective way of detecting precancerous growths and early colorectal cancer. Cancers that are found at an early stage can be treated more easily, and lead to greater survival.

Approximately 90 percent of all individuals diagnosed with colorectal cancer at an early stage are still alive five years later, which means that a colonoscopy can literally save a person's life when a polyp is found and removed. Most private insurers are required to provide screening colonoscopies for individuals between the ages of 50 and 75 without cost-sharing. However, regulations currently require seniors on Medicare to pay a 20 percent coinsurance for screening colonoscopies if a polyp is removed. This loophole places an unfair financial burden on seniors with Medicare for this life-saving screening.

Research shows that out-of-pocket costs to patients creates financial barriers that discourage the use of recommended preventive services, particularly for those with lower incomes. Seniors on Medicare can be particularly vulnerable to cost sharing, as approximately 34 percent of those on Medicare are under 200 percent of the federal poverty level (FPL) and are on limited incomes. Barriers to preventive care lead to poorer health outcomes and increased health care costs. Fixing the Medicare loophole for polyp removal during a screening colonoscopy is critical for many reasons:

- An estimated **\$14 billion is spent annually** on colorectal cancer treatments in the U.S, with projections increasing to **\$20 billion by 2020**, with Medicare bearing as much as half of the cost.
- Treatment costs for an individual with stage IIB colorectal cancer could **exceed \$240,000 a year**.
- Preventing colorectal cancer through polyp removal or catching cancer at an earlier stage saves lives and can reduce costs for the Medicare program.
- A recent study estimated that **58 percent of all colorectal cancer deaths in 2020 will be due to "non-screening"** – this means that thousands of colorectal cancer deaths could be avoided if people are screened according to ACS and USPSTF recommendations.
- Cost sharing for polyp removal during a screening colonoscopy may discourage patients from getting their screening altogether.

About the Bill:

The Removing Barriers to Colorectal Cancer Screening Act would close the loophole that leads to seniors on Medicare receiving a surprise bill for a life-saving cancer screening. Eliminating this surprise bill could increase the number of seniors on Medicare who are screened for this devastating disease. By passing this bill, Congress would help increase screening rates among seniors and reduce death and suffering from colorectal cancer.

The Bottom Line: Please support S. 668/H.R. 1570, the Removing Barriers to Colorectal Cancer Screening Act, by asking Senate or House Leadership to fix the loophole this year.

Removing Barriers to Colorectal Screenings Act



Colorectal Cancer Screening Saves Lives

Support S. 668 and H.R. 1570, the Removing Barriers to Colorectal Cancer Screening Act

Colorectal Cancer in the U.S.¹

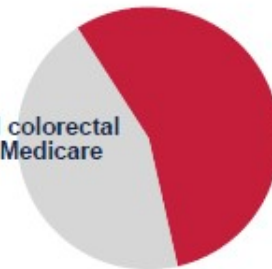
Estimated in 2019:

145,000 Americans will be diagnosed with colorectal cancer.



51,000 Americans will die from colorectal cancer.

More than half of all colorectal cancer patients are Medicare beneficiaries.²



colorectal cancer is the **second-leading cause of cancer death** when men and women are combined.

Did you know?

Five-year relative survival rate for colorectal cancer is only 14 percent when caught at a later stage. If caught at an early stage with screening, the survival rate improves to 90 percent.

The Value of Screening and How It Saves Lives

Why is screening so critical?



- 1 Colorectal cancer is preventable. It begins as a non-cancerous formation, known as a polyp.
- 2 If a polyp is detected during the screening process the entire polyp is removed.
- 3 The removal of the polyp **stops** the polyp from becoming cancerous.

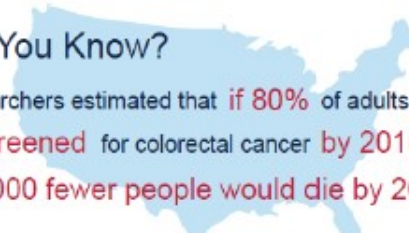


More screening means more polyps can be removed before developing into cancer.³

2000	vs.	2015
38%		63%
Screening Rate		Screening Rate
21		14
Deaths per 100,000		Deaths per 100,000

Did You Know?

Researchers estimated that **if 80%** of adults were **screened** for colorectal cancer **by 2018**, **203,000 fewer people would die by 2030**.⁴



Removing Barriers to Colorectal Screenings Act

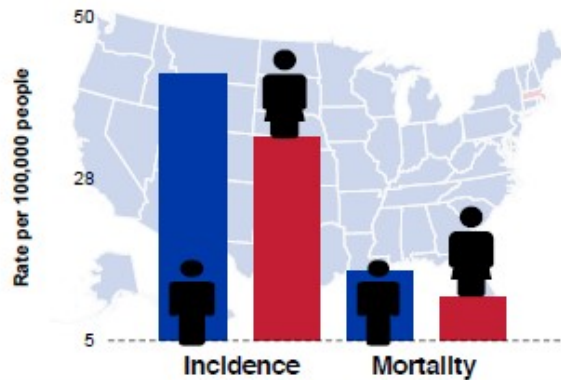
Colorectal Cancer In Massachusetts

In 2019, Massachusetts will have an estimated...

2,840 new colorectal cancer diagnoses

870 deaths due to colorectal cancer

Massachusetts Colorectal Cancer Incidence & Death Rates 2011-2016



ACS CAN URGES CONGRESS TO SUPPORT S.668 AND H.R.1570, THE REMOVING BARRIERS TO COLORECTAL CANCER SCREENING ACT

Background:

1,313,191 of Massachusetts residents are Medicare beneficiaries.⁷

By 2030, Massachusetts' elderly population is estimated to reach 1.5 million (20.9%).⁸

Problem:

No cost-sharing for screening colonoscopy, but Medicare beneficiaries are required to pay a 20% coinsurance if a polyp is removed during screening.

This coinsurance can exceed 300 dollars which is a major disincentive to screening

Solution:

S. 668 and H.R. 1570, the Removing Barriers to Colorectal Cancer Screening Act



Eliminates Unexpected Cost

Outcome:



Screening Rates



Death Rates

1. American Cancer Society. Cancer Facts & Figures: 2019. Atlanta: American Cancer Society, 2019.
 2. American Cancer Society. Cancer Facts & Figures: 2019. Atlanta: American Cancer Society, 2019.
 3. American Cancer Society. Cancer Prevention & Early Detection Facts & Figures 2017-2018. Tables and Figures 2018. Atlanta: American Cancer Society, 2018.
 4. Meester, ROS, Doubeni, CA, Zauber AG, Goerde SL, Levin, TR, Corley, DA, et al. (2015). Public health impact of achieving 80% colorectal cancer screening rates in the United States by 2018. Cancer, 121: 2281-2285. doi: 10.1002/onco.29398.
 5. American Cancer Society. Cancer Facts & Figures: 2019. Atlanta: American Cancer Society, 2019.
 6. American Cancer Society. Cancer Facts & Figures: 2019. Atlanta: American Cancer Society, 2019.
 7. Centers for Medicare and Medicaid. Medicare Enrollment Dashboard. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Dashboard/Medicare-Enrollment/Enrollment%20Dashboard.html>. Used December 2018 Total Medicare Enrollment Data. Accessed March 2019.
 8. U.S. Census Bureau, Population Division, Interim State Population Projections, 2005. Accessed January 11, 2017. <https://www.census.gov/population/projections/detailedstatepyramid.html>. Census Bureau took website down, but numbers should be similar to last year.

Background

Individuals with pre-existing conditions such as cancer need access to comprehensive and affordable health care services. Prior to 2014, insurers could deny coverage to an individual with cancer or charge more for coverage. Now, because of the health care law, people with cancer and survivors are protected against insurance denials due to a pre-existing condition.

However, ACS CAN is concerned that over the past year, policymakers and the administration have taken several legislative and regulatory actions that could make it harder for individuals with pre-existing conditions to obtain health insurance coverage that is adequate, affordable, and available, thereby jeopardizing access to life-sustaining care.

Repealing the Individual Mandate Penalty

In December 2017, Congress enacted the Tax Cut and Jobs Act, which among other things, repealed the individual mandate penalty as of January 1, 2019. The Congressional Budget Office (CBO) estimated that repealing the mandate penalty would result in 13 million Americans losing coverage by 2027 and would increase premiums in the individual market. ACS CAN opposed repealing the individual mandate penalty because it would eliminate a key incentive for individuals to enroll in comprehensive health insurance coverage. Without the requirement to purchase insurance, healthy people tend to avoid buying coverage until they need it, leaving insurance plans to cover a sicker population and driving up costs for everyone in the health care system.

Expanding Short-term, Limited Duration Insurance

In August 2018, the administration issued a final rule that would expand access to short-term, limited duration (STLD) health insurance. ACS CAN is concerned that these policies are exempt from important consumer protections, such as prohibitions on lifetime and annual dollar limits, limits on the use of preexisting condition exclusions, and the prohibition on charging people based on their health history.

Without these protections, individuals could find themselves enrolled in policies that fail to provide coverage of medically necessary services. The Urban Institute estimates that enactment of the STLD final rule would increase the number of people without comprehensive coverage by 2.6 million in 2019 and could drive up premiums for people in the individual market.

Cutting Navigator Funding

In July 2018, the administration announced that it intended to significantly reduce funding to Navigators who provide outreach, education, and enrollment assistance to consumers to enroll in Marketplace or Medicaid coverage. The administration intends to reduce funding by 84 percent compared to 2016 funding levels. Navigators would also be required to inform individuals about Association Health Plan (AHP) and STLD coverage options – options that likely provide less comprehensive coverage. The concern is that cutting Navigator funding could significantly reduce the number of individuals who enroll in Marketplace coverage.



Preserving Access to Affordable, Quality Health Coverage

(Continued)

Encouraging Association Health Plans

In June 2017, the administration finalized a regulation that would expand access to AHPs. ACS CAN has long been concerned about AHPs because these plans are not subject to many of the consumer protections provided in the individual and small group markets – like the requirement that plans provide access to Essential Health Benefits (EHBs). These plans tend to attract younger and healthier individuals, leaving older and sicker individuals in the ACA-compliant individual and small group markets. The final rule estimated that 4 million individuals would choose to enroll in AHPs, of which 3.6 million would be dis-enrolling from other (possibly more comprehensive) coverage. This could drive up premiums in the individual market and could leave millions of Americans without comprehensive health insurance coverage.

Cumulative Impact

The cumulative impact of these proposals jeopardizes a cancer patient's access to the kind of care they need and undermines the stability of the individual insurance market. For example, the Urban Institute estimated the combined effort of eliminating the individual-mandate penalty and finalizing the STLD rule as proposed would increase ACA-compliant plan premiums by an average of 18.3 percent in the 45 states that do not already prohibit or limit these plans.

ACS CAN Policy

Adequate, affordable, and available health insurance coverage is critical for individuals with cancer and survivors. ACS CAN calls on policymakers to support public policies that:

1. Provide cancer patients and survivors access to affordable, comprehensive health care;
2. Stabilize the individual and small group markets; and
3. Protect patients from discrimination against pre-existing conditions.

To that end, ACS CAN supports establishing reinsurance programs, limiting the availability of expanded short term, limited-duration insurance policies, and increasing funding for navigators.

Palliative Care and Hospice Education and Training Act



Sponsors:

Senator Tammy Baldwin [D-WI] and Senator Shelley Moore Capito [R-WV]

Representative Elliot Engel [D-NY-16] and Representative Tom Reed [R-NY-23]

Background:

Palliative care improves quality, controls costs, and enhances patient and family satisfaction for the rapidly expanding populations of individuals with serious or life-threatening illness. In 2000, less than one-quarter of U.S. hospitals had a palliative care program, compared with nearly three-quarters in 2013. This growth comes in response to the increasing numbers and needs of Americans living with serious, complex, and chronic illnesses and the realities of the care responsibilities faced by their families.

Palliative care is a relatively new medical specialty, and more must be done to ensure patients and providers understand the benefits of palliative care and that an adequate palliative care workforce is available to provide the comprehensive symptom management, intensive communication, and level of coordination of care that addresses the episodic and long-term nature of serious chronic illness.

About the Bill:

- **Palliative Care and Hospice Education Centers:** Establishes Palliative Care and Hospice Education Centers to improve the training of interdisciplinary health professionals in palliative care and provides students with clinical training in appropriate sites of care; and provide traineeships for advanced practice nursing.
- **Workforce Development:** Establishes fellowship programs within the new Palliative Care and Hospice Education Centers to provide short-term intensive courses focused on palliative care. Supporting the team approach to palliative care, the fellowships will provide supplemental training for faculty members in medical schools and other health profession schools, including pharmacy, nursing, social work, chaplaincy, and other allied health disciplines in an accredited health professions school or program so providers who do not have formal training in palliative care can upgrade their knowledge and skills for the care of patients.
- **Nurse Training:** Creates special preferences in existing nurse education law for hospices and palliative nursing, in education, practice and quality grants, workforce development, and nurse retention projects.
- **Palliative Care Education and Awareness:** Provides for the establishment of a national campaign to inform patients, families, and health professionals about the benefits of palliative care and the services that are available to support patients with serious or life-threatening illnesses. It also directs the dissemination of information, resources, and materials about palliative care services to health professionals and the public in a variety of formats, in consultation with professional and patient stakeholders.
- **Enhanced Research:** Using existing authorities and funds, this bill directs the NIH to expand national research to improve the delivery of palliative care to patients with serious illnesses.

The Bottom Line:

Please support S. 2080/H.R. 647, the Palliative Care and Hospice Education and Training Act (PCHETA), by cosponsoring it in the House or Senate and asking Leadership to pass the bill this year.



Palliative Care and Hospice Education and Training Act

Organizations Supporting PCHETA:

Alzheimer's Association
Alzheimer's Impact Movement
American Academy of Hospice and Palliative Medicine
American Academy of PA's
American Cancer Society Cancer Action Network
American College of Surgeons Commission on Cancer
American Geriatrics Society
American Heart Association ☒ American Stroke Association
American Psychological Association
American Psychosocial Oncology Society
American Society of Clinical Oncology
Association of Oncology Social Work
Association of Pediatric Hematology/Oncology Nurses
Association of Professional Chaplains
The California State University Institute for Palliative Care
Cambia Health Solutions
Cancer Support Community
Catholic Health Association of the United States
Center to Advance Palliative Care
Children's National Health System
Coalition for Compassionate Care of California
Colorectal Cancer Alliance
Compassus
Courageous Parents Network
ElevateHOME ☒ Visiting Nurse Associations of America
The Gary and Mary West Health Institute
The George Washington Institute for Spirituality and Health
GO2Foundation for Lung Cancer
HealthCare Chaplaincy Network
Hospice and Palliative Nurses Association
Leukemia & Lymphoma Society
Motion Picture & Television Fund
National Alliance for Caregiving
National Association for Home Care & Hospice
National Association of Social Workers
National Brain Tumor Society
National Coalition for Cancer Survivorship
National Coalition for Hospice and Palliative Care
National Comprehensive Cancer Network
National Hospice and Palliative Care Organization
National Palliative Care Research Center
National Patient Advocate Foundation
National POLST Paradigm
Oncology Nursing Society
Pediatric Palliative Care Coalition
Physician Assistants in Hospice and Palliative Medicine
Prevent Cancer Foundation
ResolutionCare Network
Social Work Hospice & Palliative Care Network
Society of Palliative Care Pharmacists
St. Baldrick's Foundation
Supportive Care Coalition
Supportive Care Matters
Susan G. Komen
Trinity Health

Eliminating Death from Cervical Cancer



ACS CAN's Vision -- With modest, focused resources, death from cervical cancer can be eliminated worldwide, through human papillomaviruses (HPV) vaccination combined with simple, inexpensive, evidence-based screening and treatment. Cervical cancer is largely preventable and treatable. We know what to do. We know how to do it. And the world can afford it. With nearly 90 percent of deaths from cervical cancer occurring in low-and middle-income countries (LMICs), cervical cancer deaths can be dramatically reduced by providing HPV vaccination and cervical cancer screening and treatment services to girls and young women.

Prevention by Vaccination

- Virtually all cervical cancers are caused by HPV. By protecting individuals and building population-immunity, HPV vaccination can prevent most cervical cancers before women and girls become infected with the HPV virus.
- The HPV vaccine is safe. Available since 2006, more than 200 million doses have been administered worldwide with no serious vaccine-attributable adverse impacts.
- The HPV vaccine is effective and life-saving. Extensive studies demonstrate that the two most common vaccines are 90 percent effective against 70 percent of cervical cancer-causing HPV types.¹
- HPV vaccines are affordable and cost-effective. At \$4.50 per dose in many LMICs, HPV vaccination is one of the most cost-effective cancer prevention methods according to the World Health Organization (WHO), the leading global authority on health, and other global health experts who characterize it as a “best buy” in virtually all LMICs, including those with high incidence of cervical cancer.²

Preventive Screening and Treatment

While the primary objective of HPV vaccination is to prevent cervical cancer in the first place, we must have effective and affordable screening and treatment options for women who are already infected with the HPV virus.

Even invasive cervical cancer can often be successfully treated if detected at an early stage. With access to screening and treatment options, the estimated five-year net survival from cervical cancer is now between 60 and 70 percent in many high-income countries. Therefore, women, regardless of vaccination status, should receive screening and treatment of precancerous lesions.

The lab-based Pap test, central to reducing incidence and mortality in higher-income countries, is not easily implemented in LMICs that lack the necessary laboratory capacity and supporting logistics. Therefore, the WHO recommends alternative but very effective screening and treatment methods specifically for LMICs. These include:



Eliminating Death from Cervical Cancer

Visual Inspection with Acetic Acid (VIA) – WHO recommends this screening strategy in LMICs where resources are limited. It can be successfully performed by non-physician providers. The VIA test is based on application of diluted acetic acid (vinegar) to the cervix during examination. Abnormal cervical tissue appears white after application. The advantage of this method is that it is inexpensive and abnormal tissue can be found and treated in a single visit to the clinic.

Pre-cancer treatment – Abnormal precancerous cervical changes discovered during screening can be treated by means of one of several low-cost methods including³:

- Cryotherapy, which destroys cells with extreme cold. According to WHO guidelines, cryotherapy is the treatment of choice in LMICs, because of its ease of use and lower price. However, a reliable supply of gas (generally nitrous oxide) can be difficult, especially in rural areas.
- Thermo-coagulation, by contrast, destroys cells with heat and uses electricity to generate temperatures of 100–120 °C. It is also safe, low-cost, has high client acceptance levels and can be used in low-resource clinical settings.
- Loop electrosurgical excision procedure (LEEP), which removes abnormal tissue with a wire loop heated by electric current.

Promising alternative tests also exist for future use in LMICs. For example, the HPV DNA test requires a machine to analyze samples from the cervix and test for the presence of HPV infection. By enabling women to collect their own cervical samples, the test can facilitate screening in women who would not have otherwise been screened because of culturally conservative customs. The cost of the test and follow-up care following a positive test remain issues to be addressed with the use of this test.

Broadening Success

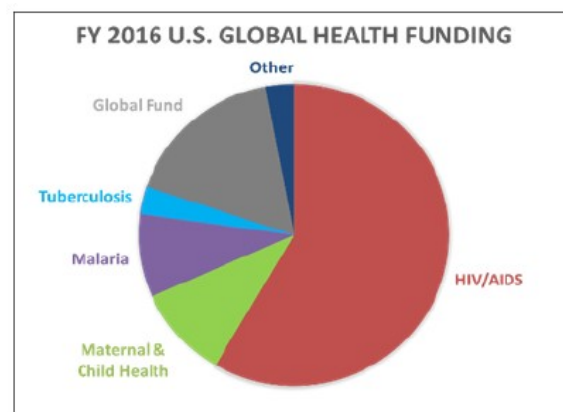
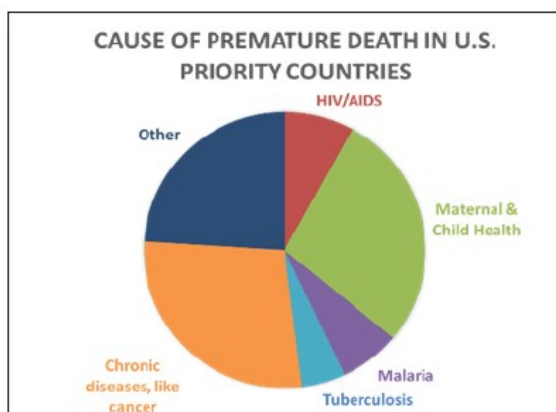
HPV vaccination as well as screening and treatment programs in Africa, Asia, and Latin America have shown that these procedures work in low-resource settings and have the potential to significantly reduce mortality. For instance, an assessment of VIA screening by primary health workers in India showed a 31 percent reduction in cervical cancer mortality.⁴ Forty-four LMICs (including many high-prevalence countries in Africa and Asia) have introduced the HPV vaccine on a national or pilot basis, and 53 have introduced new screening and preventive treatment programs on a pilot or early nationwide basis. However, few LMICs have achieved high rates of coverage. A study of HPV immunization programs in 64 countries found that coverage of females averaged only 2.7 per-cent in less developed regions.⁵ HPV vaccination and cervical cancer screening and treatment programs can be effectively integrated into existing in-country health and education programs.

Eliminating Death from Cervical Cancer



The Challenge

U.S. Government (USG) supports health programs in many LMICs, in part, to save lives, promote economic development and advance U.S. interests. Unfortunately, the current funding is not well aligned with the actual causes of death in those countries that the USG supports. As evidenced in the charts, while more than a quarter of deaths in those priority LMICs is from chronic diseases, such as cancer, virtually no funding is provided to prevent those deaths. As stated earlier, HPV vaccination and cervical cancer screening are proven effective strategies to eliminate deaths from cervical cancer. USG assistance to help end cervical cancer deaths would begin to address this disparity between the causes of death and the focus on global health funding.



The Strategy Going Forward

ACS CAN calls on Congress to direct U.S. global health appropriations to support a campaign to eliminate death from cervical cancer. Funds should be used to:

- Scale-up vaccination, screening and treatment services for girls and women, beginning in high-prevalence, lower-income countries.
- Continue innovation and sharing of lessons learned to strengthen and expand current programs, especially in high-prevalence, lower-income countries.
- Track progress and encourage accountability with agreed-upon progress indicators, monitoring and evaluation.

1 http://www.who.int/vaccine_safety/committee/GACVS_HPVS_statement_17Dec2015.pdf

2 <https://openknowledge.worldbank.org/bitstream/handle/10986/22552/9781464803499.pdf?sequence=3&isAllowed=y>

3 http://apps.who.int/iris/bitstream/10665/94830/1/9789241548694_eng.pdf?ua=1

4 <https://www.ncbi.nlm.nih.gov/pubmed/24563518>

5 [http://thelancet.com/journals/langlo/article/PIIS2214-109X\(16\)30099-7/fulltext](http://thelancet.com/journals/langlo/article/PIIS2214-109X(16)30099-7/fulltext)

We can end death from cervical cancer.

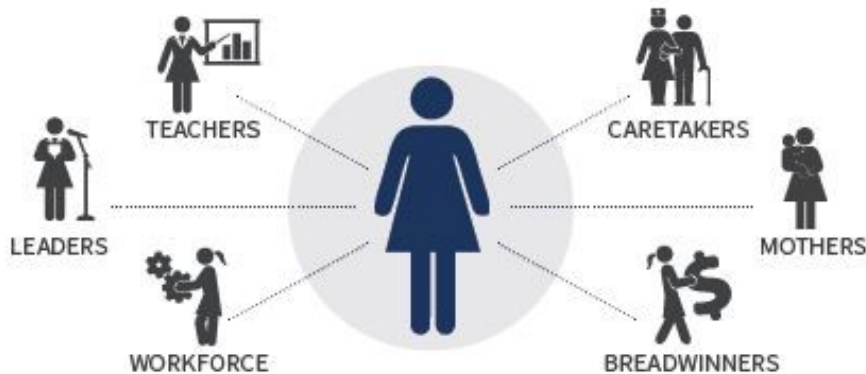
Ninety percent of all cervical cancer deaths occur in low- and middle-income countries. Cervical cancer is the leading cause of cancer deaths among women in 38 of these countries, mainly in sub-Saharan Africa.



At the current rate, deaths from cervical cancer will rise nearly 66 percent by 2030.



Women are essential to the development and well-being of our communities. No woman has to die from cervical cancer.



We can end death from cervical cancer.

Despite the 527,600 new cases of cervical cancer every year, U.S. global health funding ignores the problem.



LESS THAN 1/2 OF 1% OF FUNDING GOES TOWARD CERVICAL CANCER ANNUALLY.⁴

Death from cervical cancer is preventable through vaccination, screening and treatment.

The World Health Organization reports that the tools to prevent cervical cancer deaths are cost-effective forms of cancer prevention.⁵



We can prevent a young woman from dying from cervical cancer for less than the cost of a pair of jeans!

\$13

TO FULLY IMMUNIZE A GIRL⁶

+

\$20

TO SCREEN AND TREAT A WOMAN⁷

What can we do?

Advocate for scaled-up vaccination, screening and treatment services.



Support the integration of HPV vaccination and cervical cancer screening and treatment into existing U.S. global health programs.



Visit acscan.org/globalcervical to join us.



SOURCES:

- <https://www.acscan.org/policy-resources/global-impact-cervical-cancer>
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- <http://www.ppi.org/library/news/press-releases/2013/hpv-price-announcement/>
- <http://pinkribbonsandribbons.org/wp-content/uploads/2016/08/costs-infographic-2.pdf>

