

2026 Advocacy Poster Booklet

IGCS-IGCAN Gynecologic Cancer
Survivor Caregiver Advocacy Summit



IGCS | IGCAN
International Gynecologic Cancer

2026
ADVOCACY SUMMIT



AstraZeneca

GILEAD
Creating Possibilities

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Dear Advocates,

Thank you for sharing your work as part of the 2026 IGCS-IGCAN Advocacy Summit in Montreal. We are incredibly grateful for the time, passion, and dedication represented throughout this year's poster presentations.

Advocacy is at the heart of IGCAN, and this collection reflects the extraordinary ways individuals and organizations around the world are working to improve the lives of those affected by gynecologic cancers. From raising awareness and strengthening support networks to advancing health equity, patient-centered care, prevention, research, and policy, each poster demonstrates the power of advocacy to turn lived experience into meaningful action.

This booklet brings together perspectives, ideas, and initiatives from advocates across diverse communities and healthcare settings. We hope these posters not only celebrate the important work already underway, but also encourage new conversations, connections, and collaborations that extend well beyond our time together in Montreal.

To every individual and organization who contributed: thank you. Your work strengthens our global advocacy community and helps move us toward a future where every person affected by gynecologic cancer can access informed, equitable, compassionate, and patient-centered care.

We are proud to showcase your work and grateful to have you as part of the IGCAN community.

With gratitude,
Dr. Abhishek Shankar
IGCS/IGCAN Advocacy Committee Chair

Dr. Tracey Adams
IGCS/IGCAN Advocacy Committee Vice Chair

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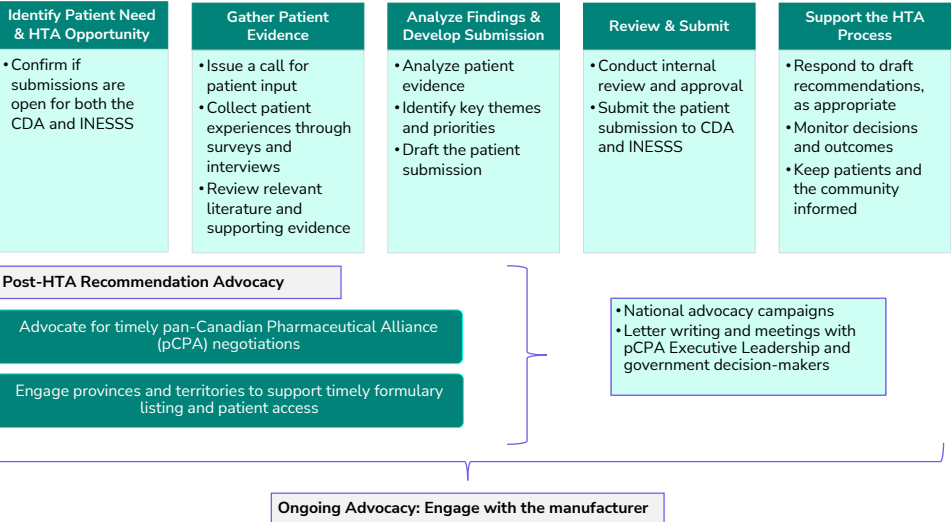
CENTERING THE PATIENT VOICE TO ADVANCE TIMELY, EQUITABLE ACCESS TO EMERGING THERAPIES

Alexandria Tadman & Stephanie Gosselin, Ovarian Cancer Canada (OCC)

Timely access to innovative therapies is critical for patients who have exhausted standard treatment options. Delays in drug review and funding at each step of the process can have life threatening consequences for those living with ovarian and other gynecological cancers. Centering the patient voice ensures that decisions reflect lived experience and unmet need. Advocacy plays a critical role in elevating patient and caregiver perspectives to advance more equitable access to treatments.

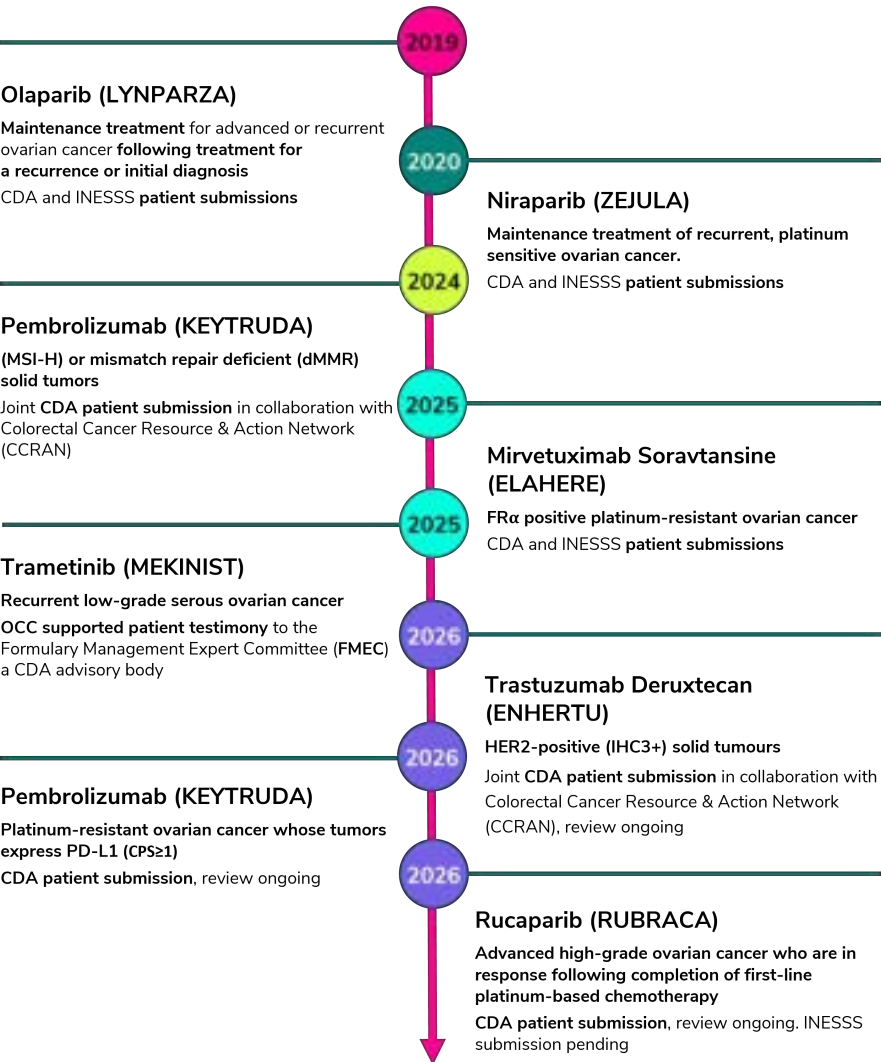
Ovarian Cancer Canada (OCC) gathers patient and caregiver perspectives through online surveys, telephone interviews, online community discussion groups and social media posts. Findings and insights inform patient submissions and expert committee testimony which support decisions on the review, approval and public funding of tests and therapies across Canada.

OCC PATIENT SUBMISSION DEVELOPMENT AND ADVOCACY PROCESS



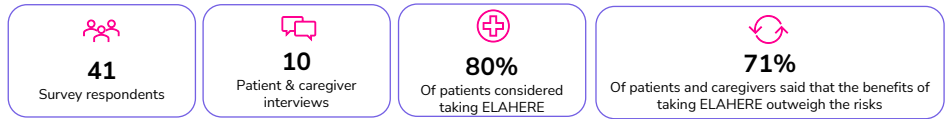
The patient and caregiver voice is highly valued by the Canadian drug approval and reimbursement system. Engaging with the ovarian cancer community early and highlighting the human impact through patient testimony is critical to the success of the submission progress. Advocacy extends beyond the submission itself and requires ongoing engagement to achieve timely and equitable access to therapies.

OCC PATIENT SUBMISSIONS COMPLETED



In March 2025, OCC submitted patient evidence to Canada's Drug Agency (CDA) and the Institut national d'excellence en santé et en services sociaux (INESSS) in support of ELAHERE (mirvetuximab soravtansine). By sharing the lived experiences and perspectives of patients and caregivers, these submissions helped inform reimbursement decisions. ELAHERE received Health Canada approval in September 2025 and in October 2025, the CDA issued a positive recommendation to reimburse ELAHERE with conditions, recognizing its value for Canadians living with platinum-resistant ovarian cancer.

OCC ELAHERE PATIENT SUBMISSION: KEY FINDINGS



"It's very devastating, it's extremely emotional, it's physical, it's social, it impacts everything. And just the idea, what's next for me if I'm resistant, what is going to be next for me? And yet there's a drug that's out there, but it's out of reach." - **Ovarian Cancer Patient**

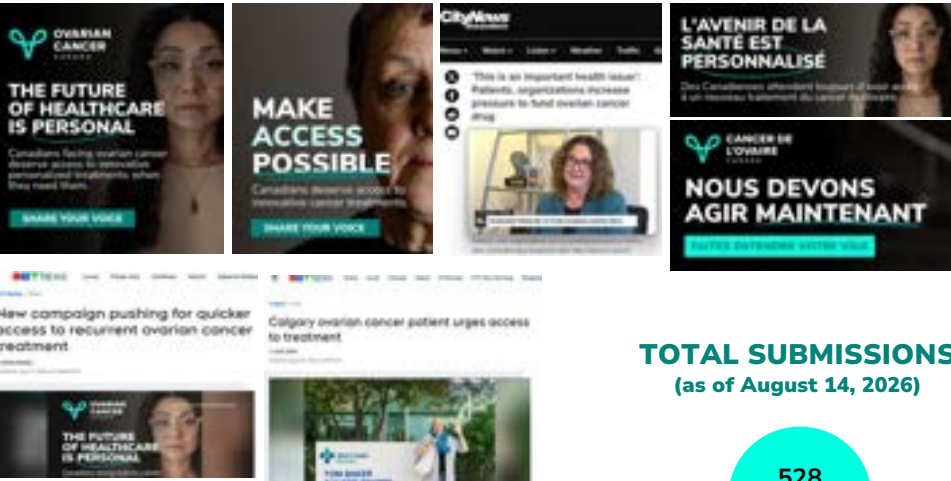
"...it drives me absolutely crazy and makes me very anxious realizing that I might die before the Health Canada approval and funding of ELAHERE. With it, I would be able to gift my children more time with their mother. It makes me feel let down by a country which I love and which progressiveness I have always admired and participated in." - **Ovarian Cancer Patient**

"I did travel to the U.S. to explore this option. I was tested for FOLR1 and the result was Positive 3+, 100%. The travel and cost did not make this option seem feasible... There are not a lot of options in treatment for those with ovarian cancer and knowing that there are options available which are not accessible is very frustrating." - **Ovarian Cancer Patient**

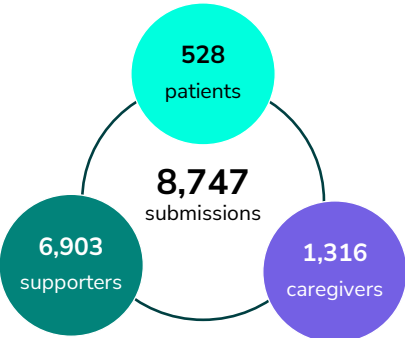
OCC NATIONAL ELAHERE ADVOCACY CAMPAIGN JULY 2026

After years of advocacy, patients with platinum-resistant ovarian cancer are still waiting for access to ELAHERE. Following Health Canada approval and the positive CDA recommendation, pricing negotiations between the pan-Canadian Pharmaceutical Alliance (pCPA) and manufacturer AbbVie concluded without an agreement in May 2026. This means that eligible Canadians still cannot access the treatment through public drug plans. In response, OCC launched a national advocacy campaign mobilizing Canadians to call on provincial and territorial decision-makers to help restart negotiations and secure public access to ELAHERE.

CAMPAIGN VISUALS & MEDIA EXPOSURE



TOTAL SUBMISSIONS (as of August 14, 2026)



PROVINCES AND TERRITORIES REACHED



STRUCTURED SURVIVORSHIP PATHWAY FOR GYNECOLOGIC CANCER IN TUNISIA: A PILOT MODEL FOR THE MENA-AFRICA REGION

Azza Chabchoub, Yasmine ben cheikh brahim, Montasser Ghaleb, Semia Zaraa, Yosr Zenzri, Lamia Naija, Tarek ben dhiab- Institut Salah Azaïez, Tunis, Tunisia

Introduction / Problem

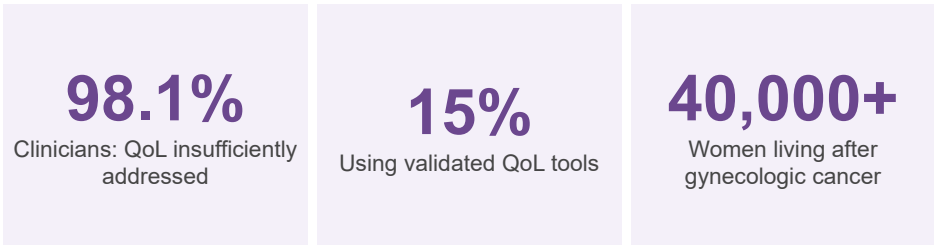
Tunisia records ~10,700 new female cancers annually: ~4,400 breast, ~707 endometrial, and ~414 cervical cancers (National Cancer Registry, ISA 2024). With 5-year survival exceeding 50%, more than 40,000 women are living after gynecologic cancer. Yet, no structured survivorship pathway exists in Tunisia or across the MENA-Africa region.

Survivors face complex long-term sequelae:

- Chronic fatigue (60–80%), lymphedema, premature menopause, and sexual dysfunction
- Cardiotoxicity, neuropathy, and cognitive impairment
- Fear of recurrence (40–70%), anxiety, depression, and difficulties with social reintegration

A national survey of 53 oncology professionals (2026) — the first of its kind in Tunisia — showed:

- 98.1% believe that post-treatment QoL is insufficiently addressed
- Only 15% use a validated QoL assessment tool (e.g., EORTC QLQ-C30)
- Nearly half report no structured QoL infrastructure in their center



Stakeholders

- A multilevel coalition was mobilized across three levels:
- Clinical: oncologists, gynecologists, nurses, psycho-oncologists, physiotherapists, dietitians, social workers - particularly at Institut Salah Azaïez (ISA), Tunisia's national cancer reference center
 - National policy: Ministry of Health (PNLCC), Tunisian Society of Medical Oncology (SOMA), Society of Gynecology, medical faculties, national health insurer (CNAM), general practitioners, patient associations
 - International: MASCC, OECI, IGCS-IGCAN, Oncopole Toulouse (France) - providing scientific legitimacy, technical expertise, and accreditation pathways
 - Regional replication targets: Sousse, Sfax, Monastir cancer centers

Engagement

A multi-pronged strategy was deployed:

1. First national QoL survey (n=53) — established an evidence base and built consensus.
2. Structured survivorship consultation launched at ISA — a 20-minute consultation using a 5-step framework: cancer history review, late-effects screening, psychological assessment, lifestyle evaluation, and GP liaison through a written Survivorship Care Plan (SCP).
3. Context-adapted SCP developed and piloted — provided to each patient and her GP at the end of treatment.
4. National multidisciplinary roundtable (May 2026) — convened oncologists, GPs, nurses, psychologists, policymakers, and patient advocates.
5. International legal benchmarking — France, the UK, the USA, Australia, and WHO resolutions were reviewed to support legislative advocacy.
6. Three-phase national roadmap (2026–2030) formally proposed.



Results (including ongoing)

The roundtable achieved unanimous clinical consensus (100%) for a structured 5-step pathway:
End-of-treatment summary + SCP → Transition consultation (oncologist + nurse) → Targeted multidisciplinary supportive care → Shared GP follow-up → Long-term surveillance

The ISA survivorship consultation is now operational — the first structured post-treatment QoL consultation in Tunisia and the MENA-Africa region.

- Three-phase roadmap adopted:
- Phase 1 (2026–27): Pilot the SCP nationally; launch the first MENA-region DIU in supportive care; integrate survivorship into oncology residency training.
- Phase 2 (2027–28): Establish a dedicated supportive care department at ISA; incorporate survivorship into the Public Health Code; designate regional centers in Sousse, Sfax, and Monastir.
- Phase 3 (2028–30): Prepare ISA for OECI accreditation candidacy; develop a MENA-region survivorship standard; hold a regional conference in Tunis (2029).
- Ongoing: Establish a national working group; develop a prospective QoL registry (EORTC QLQ-C30); submit legislative proposals to the Ministry of Health by the end of 2027.

Tunisia's cancer registry (60% population coverage) and Africa's highest radiotherapy coverage rate position it as the ideal MENA-Africa pilot for structured gynecologic cancer survivorship.



FIVE YEARS OF PATIENT ADVOCACY IN ISRAEL: AMPLIFYING THE PATIENT VOICE IN GYNECOLOGIC CANCER DRUG REIMBURSEMENT PROCESSES

Bar Levy, Founder and CEO, HaBait Shel Bar - Israel Women's Cancer Association (RA)

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HaBait Shel Bar

Israel Women's Cancer Association

Introduction

Over the past years, advanced treatments for gynecologic cancers have been evaluated by the Israeli Health Basket, a national drug reimbursement committee, lacking direct patient representation. Historically, this absence caused critical information gaps resulting in the denial of vital therapies. To address this systemic flaw, HaBait Shel Bar – Israel Women's Cancer Association (HSB) – a national patient advocacy organization which was established 5 years ago, is representing the patient voice in front of decision-makers.

Stakeholders

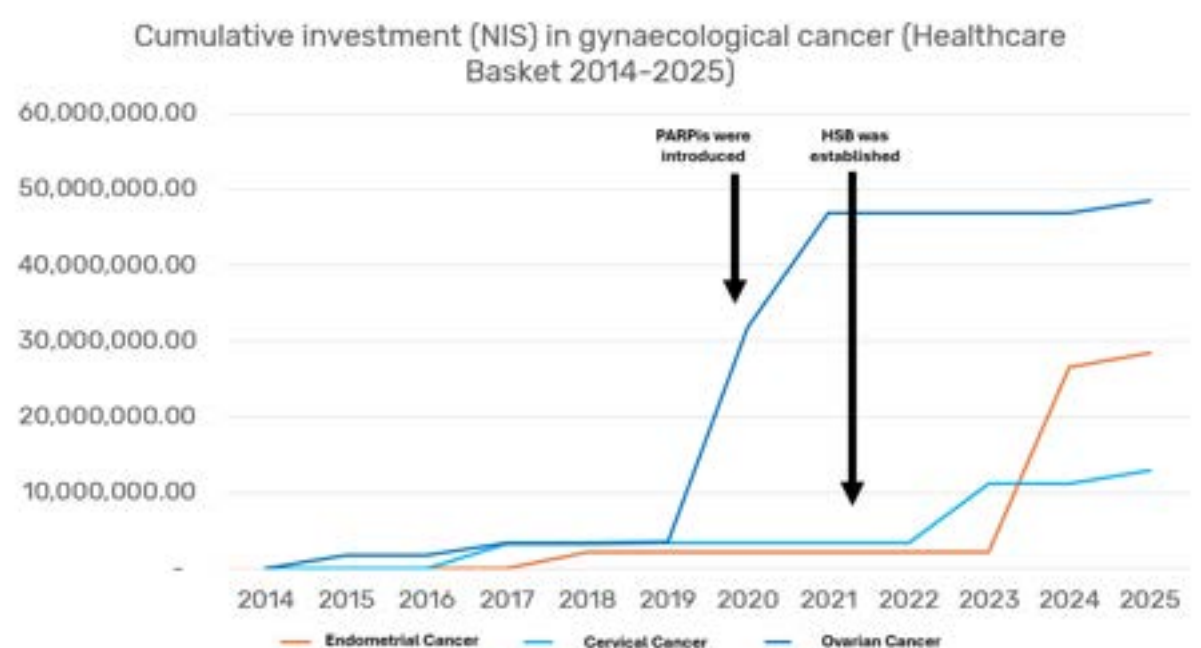
Key stakeholders include the Israeli Society of Gynecology Oncology (ISGO), the Ministry of Health, national reimbursement committee members, media representatives, and patients.



An ovarian cancer patient, Liat Ganani, Joins Bar Levy to a special hearing at the Israeli Parliament calling to reimburse drugs for gynecological cancers, 2025

Engagement

Over this five-year period, HSB partnered with ISGO to gather local epidemiological data and conduct quality of life studies with its patients communities. To address the committee's specific information gaps, the HSB and ISGO submitted joint letters and confidential patient testimonials directly to decision-makers. Concurrently, targeted media briefings were held to elevate public awareness of the unmet needs in gynecologic cancer care and secure journalistic support.



Results

This sustained advocacy model successfully influenced policy, resulting in the inclusion of essential treatments in the national health basket. Specifically, this systemic shift facilitated the public funding of 17.182 million US dollars in therapies for gynecologic cancers and preventative medicine over the past five years. Ongoing efforts aim to establish permanent patient representation on national committees. Partnering together with the clinicians, addressing decision-makers' knowledge gaps with localized data and personal testimonials, together with media coverage and public pressure can be highly effective for healthcare advocacy.



'TACTILE GEOMETRY IN CLINICAL EDUCATION: A TRCN-VALIDATED APPROACH TO HEALTH LITERACY'

An Indigenous Papercraft Framework for Visualizing Complex Health Concepts

PRESENTER: BASHIR ABUBAKAR | Founder, The Abubakar Blueprint
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BACKGROUND & PROBLEM STATEMENT



THE GLOBAL CHALLENGE: HEALTH LITERACY BARRIERS

Complex medical terminology and anatomical structures create barriers in low-literacy/multilingual communities



THE EDUCATIONAL GAP: TEXT-HEAVY MESSAGING

Traditional messaging relies on dense text or 2D diagrams, which fail to convey 3D anatomical structures effectively.



PROJECT OBJECTIVE

Deploy MatMeetCraft to translate complex concepts into hands-on, 3D papercraft models. A language and engagement.

METHODOLOGY (MatMeetCraft Framework)



Hands-on creation of anatomical models

TACTILE VISUAL LEARNING

Students/community assemble 3D geometric models representing biological structures.

3-STAGE PEDAGOGY



Mat Foundation
(Basic geometric forms)



Meet Intersection
(Mapping to anatomical structures)



Craft Application
(Assembling tangible models, e.g., organ models)



Classroom engagement and paper model assembly

VALIDATION, IMPACT & CONCLUSION

NATIONAL PEDAGOGICAL VALIDATION

Validated by Teachers Registration Council of Nigeria (TRCN) for educational rigor.

KEY FINDINGS & IMPACT

- Drastically increases engagement
- Bypasses language barriers; universal visual/tactile medium.

GLOBAL CONCLUSION

MatMeetCraft is an effective tool for global health education. Research presented demonstrates its value as a validated contribution to improve global health literacy.

Cervical Cancer Screening Through Home-Based HPV Test in Odisha

INTRODUCTION- As per GLOBOCAN 2022

6,60,000 new cases of cancer cervix are added every year; Among them 3,50,000 deaths take place. (Ca. Cervix- World wide)

INDIA contributes 25% (1/4TH) of all world cancer cervix burden.

❑ Norway India Partnership Initiative – NIPI

A Health Initiative between Governments of Norway and India initiated in 2006

Vision: To provide catalytic, strategic and innovative support to National Health Mission and State Health Societies

NIPI OBJECTIVES-

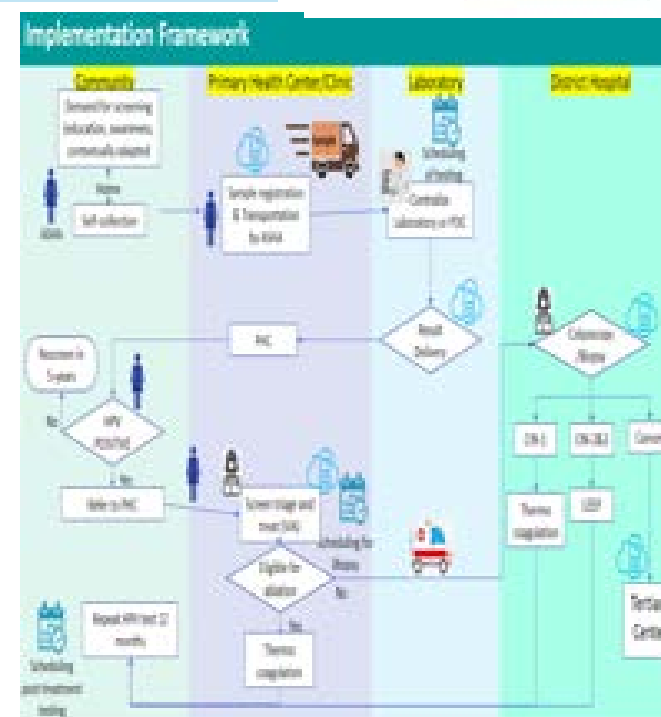


- The pilot is done under the leadership of NCD Division, Odisha and NHM Odisha
- Expert support and guidance provided by Dr. Bhagyalaxmi Nayak Madam
- Implementation and technical support provided by NIPI

- To improve coverage of cervical cancer screening
- To know the actual prevalence of HPV infection in urban slum population

Name of Municipal Corporation	Doctor	Nurse	ASHAs	HW(F)
Bhubaneswar	5	16	19	19
Cuttack	10	19	40	23
Total	15	35	60	42

Name of Municipal Corporation	Number of UPHC/UCH C	Number of Slums	Total Slum population	Targeted Beneficiaries
Bhubaneswar	09+3	19	61505	5000
Cuttack	10+2	43	62645	5000
Total	24	62	124150	10000



✓ This is a pilot study. This is a very optimistic study. This kind of studies if continued and encouraged further can help eliminating cancer cervix in near future.

DISCUSSION & CONCLUSION- ASHAs played a major role in this pilot study.

The choice to be able to self sampling encouraged women to access more screening and treatment coverage.

The screening rate was 76% . Prevalence rate of HPV was 7%. 42% of Screen positive women received treatment.



Transitioning From Campaign-Based Screening to Integrated Cervical and Breast Cancer Prevention Services in Rwanda

Caleigh Smith; Sabrina Bedell; Callixte Habihirwe; Eric Rusagura; Theodomir Sebazungu; Marc Hagenimana; Jean de Dieu Hategekimana; Euloge Nzobonankira; Emmanuel Manirakiza; Kenneth Ruzindana



BACKGROUND

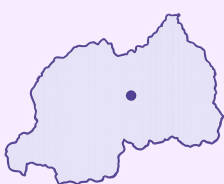
- Cervical cancer remains a leading cause of cancer-related death among women in Rwanda
- Limited access to breast cancer early-detection services contributes to approximately 80% of cases presenting with stage III-IV disease
- Screening campaigns have expanded access and detection of HPV and preinvasive cervical disease
- However, campaign-based services are time-limited and may not ensure continued screening, treatment, referral or provider competency after the campaign ends
- Sustainable prevention requires integration into routine care, longitudinal mentorship, reliable referral pathways, and local health-system leadership

OBJECTIVES

- ✓ Establish a sustainable, district-led mentorship model to maintain high-quality cervical and breast cancer screening, treatment of precancerous lesions, and referral services after completion of a district-wide campaign
- ✓ Evaluate the feasibility and early operational outcomes of transitioning from campaign-based screening to a sustainable, district-led service model

SETTING & STAKEHOLDERS

Nyarugenge District, Rwanda



Setting:

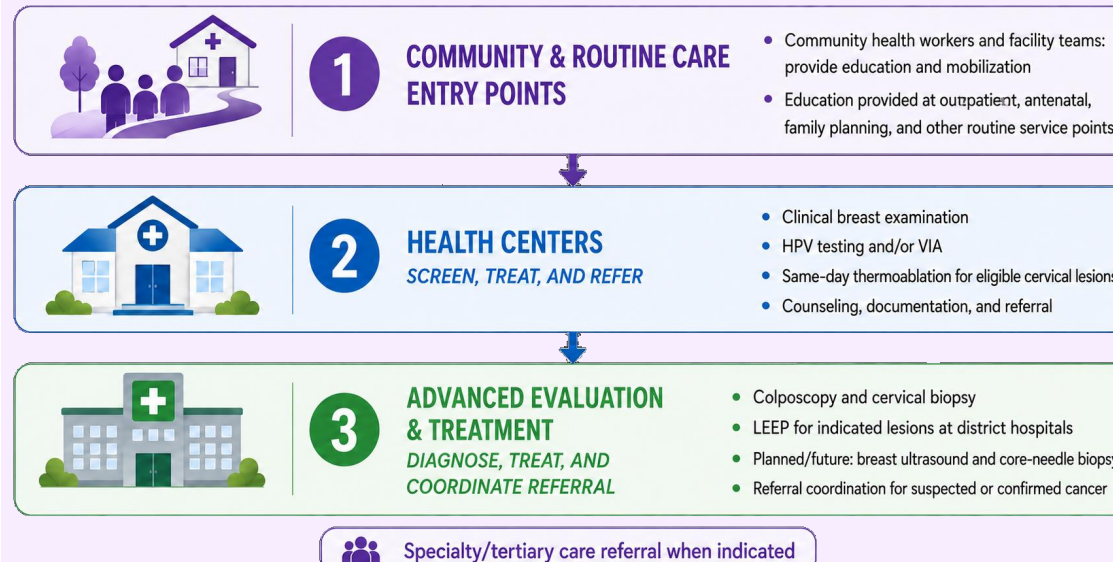
- 13 district health centers
- 2 district hospitals
- 4 referral hospitals

Stakeholders:

- Patients / District Population
- Ministry of Health
- District Health Teams
- District and referral hospitals
- Community Health workers
- Development Partners

PROGRAM MODEL

Following the November 2025 – March 2026 campaign, cervical and breast cancer prevention services transitioned to a district-led model implemented across health



CROSS-CUTTING SUPPORTS



METHODOLOGY



EARLY RESULTS (APRIL – JUNE 2026)

✓ 13/13 health centers maintained integrated services across the first 3 months

Table 1. Screening Outcomes (April–June 2026)

Indicator	April	May	June	Total
Breast cancer screening encounters	363	389	435	1,187
Cervical cancer screening encounters	177	217	231	625
VIA primary screen	140	165	195	500
VIA triage	23	27	24	74
Total VIA positive*	15	16	18	49
Referrals for suspected cervical cancer diagnosis	7	4	5	16
Documented thermoablation*	11	8	—	19
Documented LEEP*	7	7	—	14

* VIA positive was defined as a VIA result eligible for either thermoablation or LEEP.

* June data export did not include comparable treatment procedure fields; totals for documented thermoablation and documented LEEP reflect April and May only.

Screening & Treatment Outcomes



LEEP & Histopathology

Characteristic	Overall cohort, N=26
Participant characteristics	
Age, median (IQR), years	43 (36–47)
HIV-positive	9 (34.6%)
Parous	23 (88.5%)
Indication for LEEP	
HPV-positive with type 3 transformation zone	20 (76.9%)
Visible cervical lesion or abnormal VIA finding	3 (11.5%)
Other indication	3 (11.5%)
Histopathology	
Any precancerous lesion	7 (26.9%)
High-grade precancer	3 (11.5%)
Low-grade lesion	4 (15.4%)
Benign/inflammatory/normal	6 (23.1%)
Other or unclear pathology	13 (50.0%)

CHALLENGES & ADAPTATIONS



CONCLUSIONS

- All 13 facilities maintained cervical and breast cancer prevention services during the first 3 months after the campaign period.
- Early results demonstrated continued screening, treatment of cervical precancer, and referral for advanced care despite operational barriers related to supply, staffing, and transportation.
- This model demonstrates the feasibility of integrating campaign-initiated services into district-level care delivery.

NEXT STEPS

- Continue longitudinal mentorship and competency-based supervision across participating facilities.
- Strengthen HPV testing availability and sustainable supply chain to work towards integration into routine care delivery.
- Improve patient-level tracking of referral and treatment completion.
- Evaluate longer-term outcomes and refine the model for expansion to additional districts in collaboration with national and district leadership.

ACKNOWLEDGEMENTS & PARTNERS



We thank the Ministry of Health, district health teams, facility staff, and community health workers involved in these efforts.

This work is made possible with support from our partners:



Community-Partnered Trans- and Non-Binary Inclusive Cervical Cancer Screening Clinic: An Advocacy-Driven Model of Care

Charlotte Lemieux-Bourque¹, Ana Clouâtre¹, Niève Séguin¹, Lio Lepage²

¹Faculté de Médecine de l'Université de Montréal, ²Aide aux Trans du Québec

Background

Transgender and non-binary individuals experience significant barriers to cervical cancer screening, including:

- Gender dysphoria
- Prior negative healthcare experiences
- Lack of provider training
- Limited access to inclusive gynecologic services

These barriers contribute to lower screening uptake and increased inequities in preventive care.

Community-Partnered Initiative

In collaboration with community organizations, healthcare providers, trainees, and transgender and non-binary individuals, we created a resident-led dedicated cervical cancer screening clinic grounded in trauma-informed and gender-affirming care.

Key adaptations included:

- ✓ Optimization of booking processes
- ✓ Outreach strategies using gender-neutral language
- ✓ Flexible examination approaches based on patient preferences
- ✓ Community outreach
- ✓ Presence of a peer support worker from a transgender community organization during clinic visits
- ✓ Provider education in inclusive gynecologic care

Impact & Ongoing Growth

The initiative is entering its fourth iteration and has demonstrated steady growth.

- Clinic appointment utilization increased progressively across successive iterations of the program. All clinic appointment slots were filled during the current year.
- The initiative has highlighted a significant unmet need for inclusive cervical cancer screening services as many participants were undergoing their first cervical cancer screening or were underscreened according to current recommendations.
- Media attention has reinforced the importance of advocacy-driven healthcare initiatives.
- Current efforts focus on expanding access and developing sustainable models of care.

Learning Through Iteration

Creating inclusive services is not a linear process.

Despite careful planning, we encountered challenges and received feedback indicating areas that could be improved.

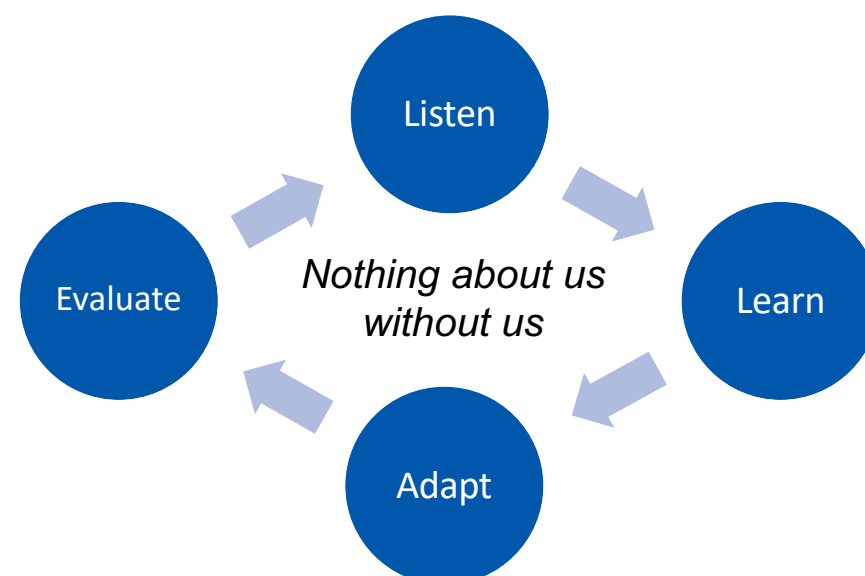
Examples included:

- Administrative processes that unintentionally created barriers
- Language and clinical routines that were not always as inclusive as intended
- Logistical aspects of appointments that affected accessibility and comfort

Each clinic cycle incorporated participant feedback and led to tangible changes such as:

- ✓ Modification of booking processes
- ✓ Refinement of communication materials
- ✓ Adjustment of clinic workflows
- ✓ Ongoing provider education
- ✓ Strengthening community partnerships

This iterative approach helped improve the safety, accessibility, and affirming nature of the clinic over time.



Take Home Messages

1. Transgender and non-binary people are the experts.
2. Inclusive services are built through continuous learning and adaptation.
3. Making mistakes is part of the process.
4. Sustainable advocacy requires collaboration, humility, and responsiveness.

Strengthening Ovarian Cancer Awareness Through Patient Led Advocacy: Improving Public Messaging, Correcting Screening Misconceptions and Influencing Policy for Earlier Diagnosis

Patient advocacy changed cervical-screening messaging in Northern Ireland

Christine Campbell, Patient Advocate, Dr Fiona Furlong , Senior Lecturer, School of Pharmacy, QUB

The Problem:

- A persistent and harmful misconception in Northern Ireland is that cervical screening detects ovarian cancer
- I identified a communication gap in Northern Ireland’s public health messaging: cervical screening information did not explicitly state that it does not detect ovarian or other gynaecological cancers
- This omission risked false reassurance and delayed diagnosis

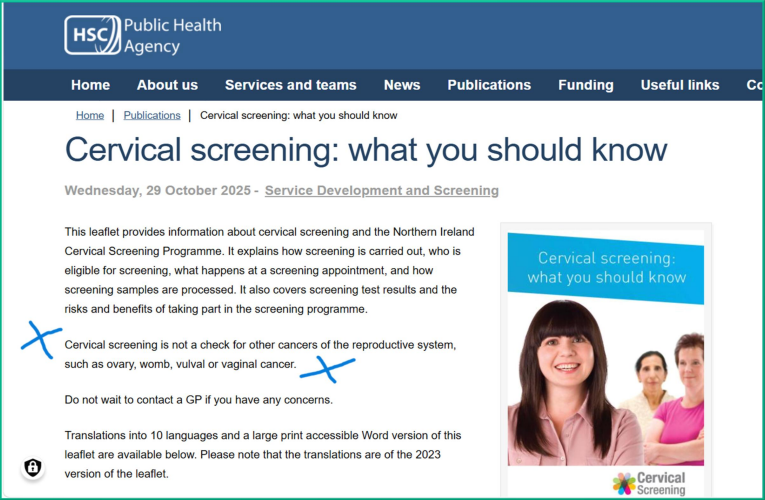
Who we engaged:

- Women and people with ovaries, affected by ovarian cancer and their families
- Department of Health and Public Health Agency
- Primary care professionals
- Cancer charities and advocacy organisations
- University partners supporting early-diagnosis education
- Patient advocates bringing lived-experience insight

What we did:

- Lobbied health bodies to clarify cervical-screening wording
- Shared lived experience to show the risks of misinformation
- Partnered with cancer charities to amplify the message
- Co-developed syllabus awareness teaching materials with pharmacy students.
- Joined community events and campaigns to improve understanding.

What changed:

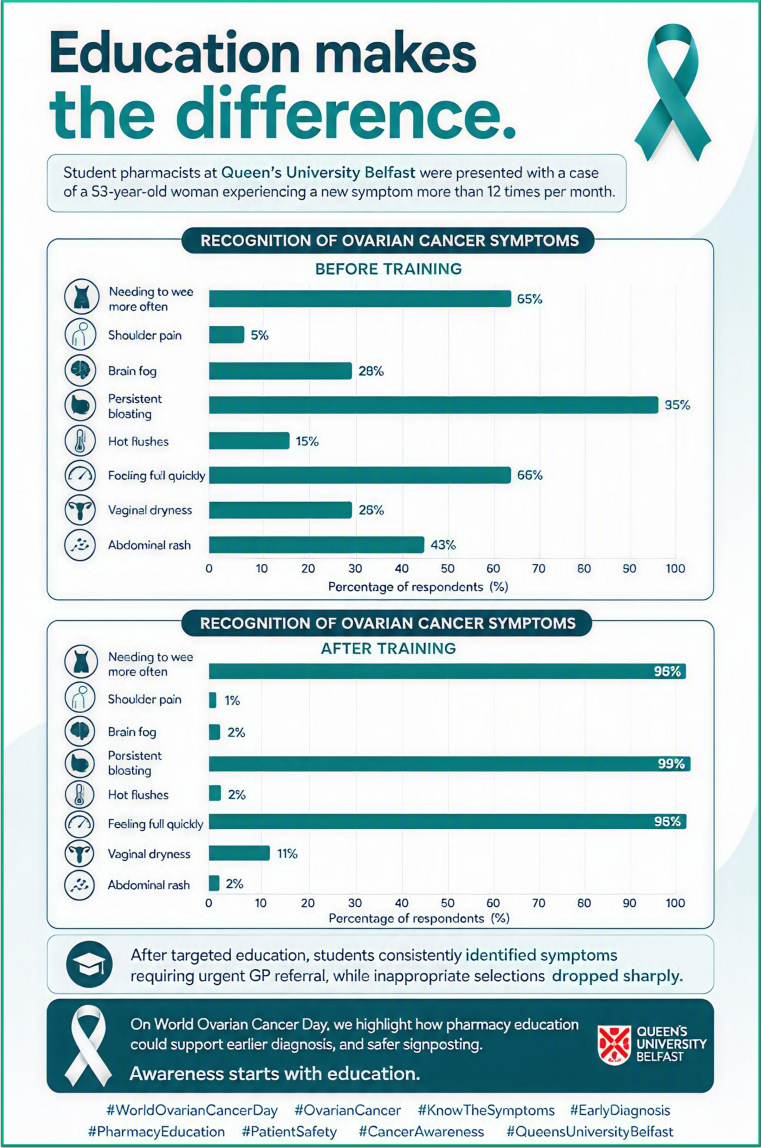


Public Health Agency NI has amended cervical screening public health messaging on all its platforms and media

Results:

- Patient experience can change public health communication
- Policy change: cervical-screening information now states that it does not detect ovarian or other gynaecological cancers
- Clearer messaging has strengthened public-health communication and awareness
- Increased awareness, empowerment, earlier diagnosis, greater survivorship
- Next steps: expand education outreach, monitor understanding and promote patient-led co-production
- Lived experience can shape accurate, accessible messaging and meaningful system change

Before and After Targeted Student Education



Celebrating the change of wording with fellow patient advocates

Patient Pain Experiences After Laparoscopic Hysterectomy for Gynecologic Cancer in an ERAS Same-day Discharge (SDD) Program: A Qualitative Interpretive Description Study

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Introduction

Implementation of Enhanced Recovery After Surgery (ERAS) pathways have reduced surgical complications, length of stay, and healthcare expenses⁽¹⁻³⁾. SDD is safe and effective in appropriately selected gynecologic oncology patients undergoing minimally invasive hysterectomy with ERAS⁽⁴⁻⁶⁾. Multimodal analgesia, a central ERAS principle, reduces post-operative opioid use and its associated risks like new opioid use disorder, which may affect cancer patients in higher rates^(7,8). Studies show a general tendency to over-prescribe opioids after surgery, which are then often improperly disposed of or diverted⁽⁹⁻¹²⁾. However, uptake of low- or no-opioid prescribing is still highly variable and there is limited patient-reported data of pain management post-SDD. Our institution's approach is to provide clear instructions for multimodal analgesia (scheduled acetaminophen and NSAID) prior to SDD, and no opioid prescription unless requested and discussed with the care team.

Objective

This study aims to characterize patients' post-operative pain experiences within our ERAS/SDD program and opioid-sparing protocol through the following questions:

1. What is the pain experience of patients undergoing laparoscopic hysterectomy with SDD?
2. What do patients expect regarding postoperative pain after SDD hysterectomy? Does their experience match expectations?
3. Are there any factors that improve the pain experience post-operatively?

Methods

This qualitative study used *Interpretive Description*, an applied qualitative methodology designed to generate clinically meaningful insights for healthcare practice. Using purposive sampling, adults were recruited from a single Canadian tertiary care centre after laparoscopic hysterectomy for gynecologic malignancy and SDD. Semi-structured telephone interviews were completed between 4-6 weeks post-operatively, transcribed verbatim using Rev.com™, then reviewed for accuracy and deidentified. Data saturation was achieved at 12 interviews. Ages ranged from 41 to 81 years. Transcripts were managed in Quirkos™ qualitative analysis software. Using an inductive, iterative interpretive process informed by Thorne's 2025 approach, data collection and analysis took place concurrently. Analysis moved from immersion in the data to provisional coding, pattern identification, and interpretive synthesis, with emphasis placed on relationships, variation, and clinical significance rather than frequency alone. Constant comparison, reflexive memoing, and examination of divergent cases were used throughout analysis. Clinical and disciplinary expertise were treated as analytic resources, and interpretations were iteratively tested against the full dataset to support rigor, coherence, and interpretive credibility. An audit trail of coding and analytic decisions was maintained throughout the study.

Discussion

- **Pain:** Most participants endorsed a positive experience with opioid-free analgesia following laparoscopic hysterectomy within an ERAS/SDD pathway. Pain satisfaction did not consistently align with reported pain severity, suggesting these experiences are not only shaped by physical pain, but also by the prominent emergent theme of the "patient paradigm", encompassing their internal beliefs, prior experiences, and understanding of illness and recovery. Limited adherence to dual-agent multimodal analgesia and an observed case of opioid diversion further support the need for continued optimization of patient education and opioid-sparing ERAS pathways.
- **Education:** Participants consistently valued written educational materials as an important resource. Verbal discussions at initial consultation remained important for trust-building and contextualizing recovery expectations, while counselling delivered immediately post-operatively was associated with poor recall. Despite awareness of the care team contact, participants dissatisfied with pain control did not seek additional support, highlighting potential perceived barriers to communication. Peer narratives are seen as an important resource, with many expressing a desire for greater access to this from reputable sources.
- **Limitations:** Collection of demographic and clinical data on was limited. Full assessment of adherence to analgesic recommendations was beyond the scope of this study. Future work in this area should include mixed-methods approaches, and aim to further characterize patient conceptualizations of pain, barriers to help-seeking, and the role of peer-informed knowledge in shaping recovery experiences.

Conclusion

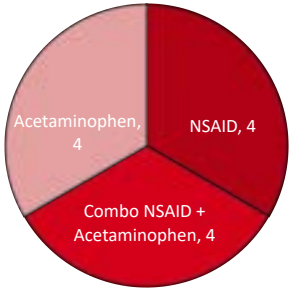
1. Most patients felt their pain was **adequately controlled with non-opioid analgesia**.
2. Perception of **adequate counselling** is strongly associated with a positive pain experience.
 - Written materials are a key resource and supplement in-person discussions.
 - Teaching provided after surgery, prior to discharge, is poorly retained.
3. Expectations around post-operative pain management and analgesic agents should be **established preoperatively**. Education should emphasize the **care team's contact info**.
 - Further study is needed to characterize perceived barriers in communication
4. Patients value experiential knowledge through **peer narratives** as an adjunct to clinical teaching.
5. Each patients' **individual paradigm** is complex and integral in how patients conceptualize pain. Understanding this can help individualize clinical counselling to optimize patient experiences.

Results

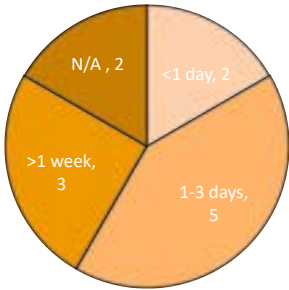
1. What is the pain experience of patients after laparoscopic hysterectomy with SDD?

- Most patients (10 of 12) felt non-opioid analgesia was adequate for pain.
 - "I really didn't have any pain. I didn't have any discomfort, nothing." Pt 6
 - "By the third day I was up and doing everything by myself." Pt 11

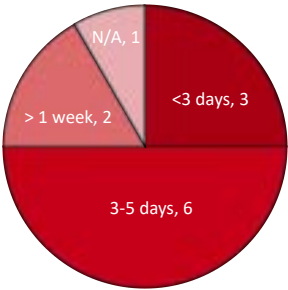
ANALGESIC USED



DURATION OF USE



DURATION OF 'WORST PAIN'



1A) Drivers of Medication Use and Selection

- **Internal psychological factors** – thoughts, feelings, beliefs that influence medication selection and use
 - Perceived medication efficacy – "Tylenol doesn't do anything for me" Pt 1
 - Self-perception as being medication-averse – "I'm not one for popping pills" Pt 10
- **Caregiver input** – "My husband made me take a Tylenol (...) But I didn't really need it" Pt 11

1B) Opioid diversion – one patient requested a prescription due to pre-operative anxiety around pain, then ended up giving her unused supply to her husband for a back injury

- "(He) needed it more than I did because I didn't even take it. I only took one Tylenol and that was it." Pt11

2. What do patients expect regarding postoperative pain after SDD hysterectomy? Does their experience match expectations?

- Most patients' experiences did not match expectations, usually reporting less pain than anticipated
 - "It's a big surgery, but I was surprised how well I was doing." Pt 8

2A) Patient Paradigm – this prominent emergent theme captures attitudes, beliefs, self-directed research, shaping patients' outlook on illness, surgery, and recovery outside of information provided by the care team

- **Prior medical care** – "You never left a dental surgery without pain medication or a prescription for it, and yet you have a major abdominal surgery and leave without, and it wasn't even discussed." Pt 5
- **Peer narratives** – lived experiences were highly sought and valued
 - "If you don't hear from people on how things went, nobody ever learns anything about pain." Pt 1
 - "If you have a focus group for people, you will help address a lot of concerns." Pt 9
- **Utilitarian mindset** – "(the cancer) was my concern. I wasn't really thinking about (the pain) really." Pt 4
- **Good pain vs bad pain** – one patient's anxiety around differentiating 'good vs bad pain' drove prolonged analgesic use. In contrast, another patient saw her postoperative pain as a measure of recovery and saw non-opioid agents as a "less intrusive type of medication" Pt 7

2B) Clinical teaching and resources

- **Format** – In-person discussions during initial consult were important for building relationships with patients, even if the level of content recall was variable. Paper handouts were seen as a key adjunct for content
 - "Having that conversation, having that support really makes a difference. Reading is not the same." Pt 9
- Preoperative discussion around prescriptions was also important in setting expectations.
 - "I was ok with that (...) I knew that I wasn't going to be getting any prescription medication." Pt 6
- **Post-anesthetic amnesia** – many patients identify the day of surgery as an inappropriate time for teaching, using descriptors like "blurry" (Pt 3), "barely coherent" (Pt 5) for their state of mind after surgery

2C) Non-pain related concerns – "I was concerned not so much about healing itself, but about other things that I had heard could be problems after hysterectomy, like constipation and prolapse" Pt 5

- **Sleep and positioning** – "That's why I was dreading sleep. (...) It's just there's no good position." Pt 9

3. Are there any factors that improve the pain experience post-operatively?

3A) Perception of 'adequate teaching' – this is crucial in shaping patients' overall pain experience and sense of trust in their care team, but not always the accuracy of their pain expectations.

- "They took (me) through everything that I was supposed to get done and yeah, it was wonderful." Pt 4
- Those dissatisfied with non-opioid pain control also felt they had inadequate preoperative teaching
 - "I think there should have been more conversation prior to my surgery. It just happened very fast and so I didn't really know what to expect to be honest." Pt 12

3B) Sources of support

- **Clinical care team** – a trustful relationship and ease in communication was protective
 - **Perceived accessibility** – despite knowing the clinic contact, some expressed apprehension in reaching out, including both patients dissatisfied with pain control, alluding to potential perceived barriers.
 - "Yes I have that phone number but (...) it's almost like you don't want to bother them, should I ask?" Pt 9
- **Family and caregivers** – important supports, though many also report early return to function after surgery
 - "I don't think I could have survived without him there because it was really hard to get out of bed" Pt 12

3C) Non-pharmacologic adjuncts – most patients identified use of an adjunct during recovery

- **Heat/cold packs** – "(the) thing that was a real help was the cold packs and the heating pad." Pt 7
- **Mobilization** – "I was pushing myself a little bit to move and just not be laying around all the time." Pt 12
- **Abdominal support** – "In terms of coughing or sneezing to make sure that I had a pillow nearby to do that (...) that was a very helpful thing, especially considering my entire household was sick." Pt 3



Interview Guide



References

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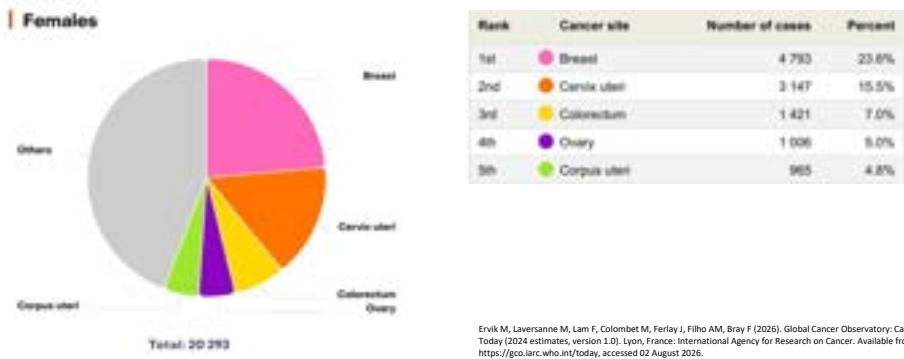
*No disclosures

Implementation of IGCS Adapted Phase-3 Hands-On Training to Continue Building National Capacity for Cervical Cancer Screening in Uzbekistan

Dilfuza Aniyozova¹, Sonia Parra², Aziza Umarova¹, Natalya Nadirkhanova³, Kate Harris²
¹Agency for Strategic Development and Reforms under the President of the Republic of Uzbekistan, Tashkent, Uzbekistan; ²University of Utah Health, Dept Obstetrics and Gynecology, Salt Lake City, UT, United States of America; ³Republican Specialized Scientific and Practical Medical Center for Mother and Child Health, Tashkent, Uzbekistan

Introduction

- Cervical cancer is the 2nd most common cancer amongst women and the 4th leading cause of cancer death in Uzbekistan.
- There currently does not exist a national cervical cancer screening program in Uzbekistan.
- The government of Uzbekistan has made screening a priority by establishing the National Program for the Control of Cervical and Breast Cancer in 2025-2030.
- To accomplish this, it is critical that all general gynecologists in Uzbekistan be able to perform colposcopies and treat preinvasive disease of the cervix.
- **In 2025, the government of Uzbekistan collaborated with the University of Utah to launch an in-person adaptation of the International Gynecologic Cancer Society (IGCS) Preinvasive Disease Program.**



Stakeholders

- Ministry of Health in Uzbekistan has collaborated with all 14 regional mother and child health centers in the country.
- **22 general gynecologists representing all 14 regions participated in the in-person preinvasive disease of the cervix training.**



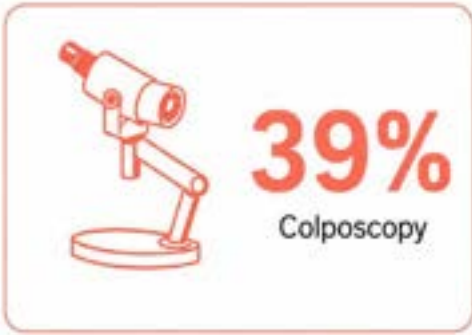
Engagement

- All 22 general gynecologists completed a 5-day in-person didactic session as part of Phase 1 and 2 of the IGCS Preinvasive Disease Program in February 2025.
- **They completed Phase 3 in March 2026, which included a one-day refresher course with hands-on simulation, followed by observed practice in colposcopy, thermal ablation, and loop electrosurgical excision procedure (LEEP).**



Results

Increase in Clinical Confidence to Perform:



Number of Cases Since January 2026



Future Work

- Initiatives are underway to have all 22 general gynecologists finish the required procedure observations in order to receive the IGCS Preinvasive Disease Program certificate of completion.
- **These 22 general gynecologists will then help provide similar trainings within each of the 14 regions of the country with the goal to train all 209 district general gynecologists how to screen, diagnose, and treat preinvasive disease of the cervix.**



This initiative has been generously funded by the Stirling Foundation.

REAL-WORLD CERVICAL CANCER BURDEN AND ADVOCACY GAPS IN WESTERN INDIA: A MULTICENTRIC RETROSPECTIVE ANALYSIS

Presenting author- Krushna Chaudhari

A Rajbhoj, D. Morzaria, U. Maheshwari, A. Joshi, V. Maniar, P. Kalaskar, K. Joshi, C.V. Pethe, R. Wategaonkar, S. Sheth, R. Dave, M. Randive, N. Bayas, P. Devde, K. Tamkhane, K. Jobanputra, T. Sethjiwala, S. Dhande, D. Pal, M. Mekha, P. Kendre, K. Chaudhari, N. Salunkhe, N. Shaikh, S. Jagiasi, T. Patil

INTRODUCTION

Cervical cancer remains a major public health concern in Western India, driven by low HPV vaccination, inadequate screening, poor awareness, and delayed healthcare access, resulting in advanced-stage presentation and poor outcomes.

METHODS

A retrospective multi centric study of 422 cervical cancer patients (2018–2024) evaluated demographics, screening molecular practices, treatment patterns and access to advanced therapies to identify key advocacy gaps relevant to prevention, awareness, and equitable access to care.

RESULTS

Descriptive details of the cohort

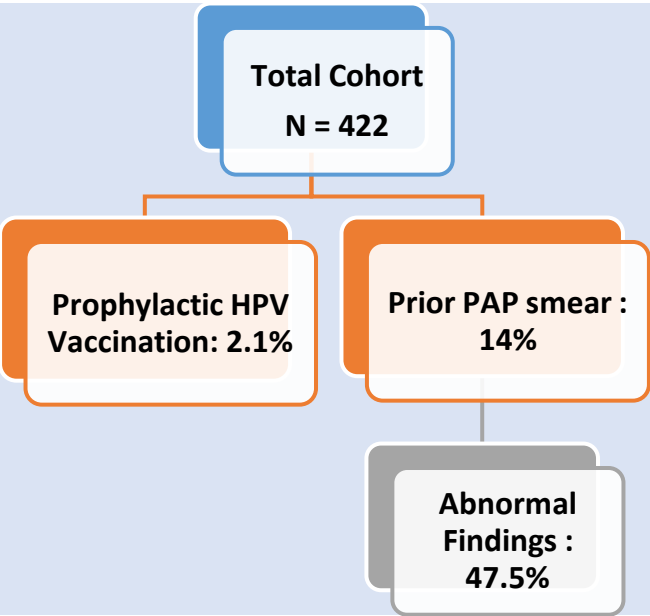
Median age : 56.5 years (IQR 49–65)

Range of the cohort
1. 40–60 years : 57.3%
2. >60 years : 37%

Mean annual percentage of cervical cancer (2018-2024) : 1.1%

Baseline Disease Stage
1. Stage III (46%)
2. Stage IV (22.7%)

Preventive Measures



HPV Testing and Positivity

Performed in 55%
(232/422)

Positivity in 24.1%
(56/232)

Testing Done

Molecular Profiling :
9%

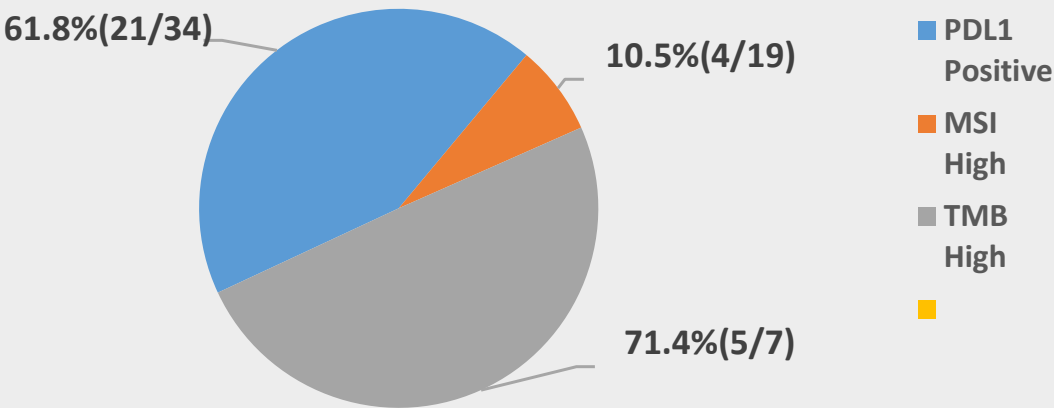
Mutations Detected :
36.8%

PIK3CA
42.9%

TP53
21.4%

KRAS
21.4%

Immunotherapy Indicators



Median Follow-up time = 28.7 months (95% CI 26.5 – 30.9)

Clinical Outcome

•Immunotherapy Utilization : 7.5%
•Overall Response Rate (ORR) : 72.2%

Survival & Follow up

•Mortality : 17.8%
•Lost to Follow-up : 27%

CONCLUSION

These findings underscore the need for strengthened advocacy and streamlined referral pathways to improve cervical cancer outcomes in Western India.

BREAKING BARRIERS IN GYNECOLOGIC CANCER AWARENESS IN LOW-RESOURCE SETTINGS OF PAKISTAN

Author: **Dr. Huma Sheikh**
(MRCOG.UK.MRCPI.IRELAND, Member.IGCS., Pakistan.)

Introduction/Problem:

Women in low-resource communities of Pakistan often present late with gynecologic cancers due to stigma, low literacy, cost barriers, modesty concerns, misinformation, and limited screening or referral access.

Stakeholders:

The model engages women, adolescent girls, families, lady health workers, midwives, primary-care doctors, gynecologists, cancer survivors, teachers, community and religious leaders, media groups, local health authorities, hospitals, and policy makers.

Engagement:

A six-step community advocacy model is proposed.

Step 1: Map barriers by identifying high-risk communities, myths, literacy gaps, cost barriers, and weak referral points.

Step 2: Engage stakeholders through women’s groups, schools, clinics, survivor voices, and trusted community leaders.

Step 3: Craft messages in simple Urdu and local languages on HPV vaccination, cervical screening, warning symptoms, and cancer myths.

Step 4: Deliver outreach through clinic counselling, school and community sessions, social media, symptom cards, and family-focused education.

Step 5: Build referral navigation by linking primary care with oncology services and fast-tracking women with postmenopausal bleeding, abnormal bleeding, persistent discharge, vulvar lesions, pelvic pain, abdominal distension, early satiety, or unexplained weight loss.

Step 6: Monitor and advocate using simple indicators for awareness, vaccine acceptance, screening uptake, referral completion, and stage at presentation.

Results (including ongoing):

The model is expected to improve awareness, reduce stigma, increase HPV vaccine and screening acceptance, support earlier presentation, and strengthen community-to-clinic referral pathways. Ongoing monitoring can guide scalable policy advocacy for equitable gynecologic cancer prevention in Pakistan.



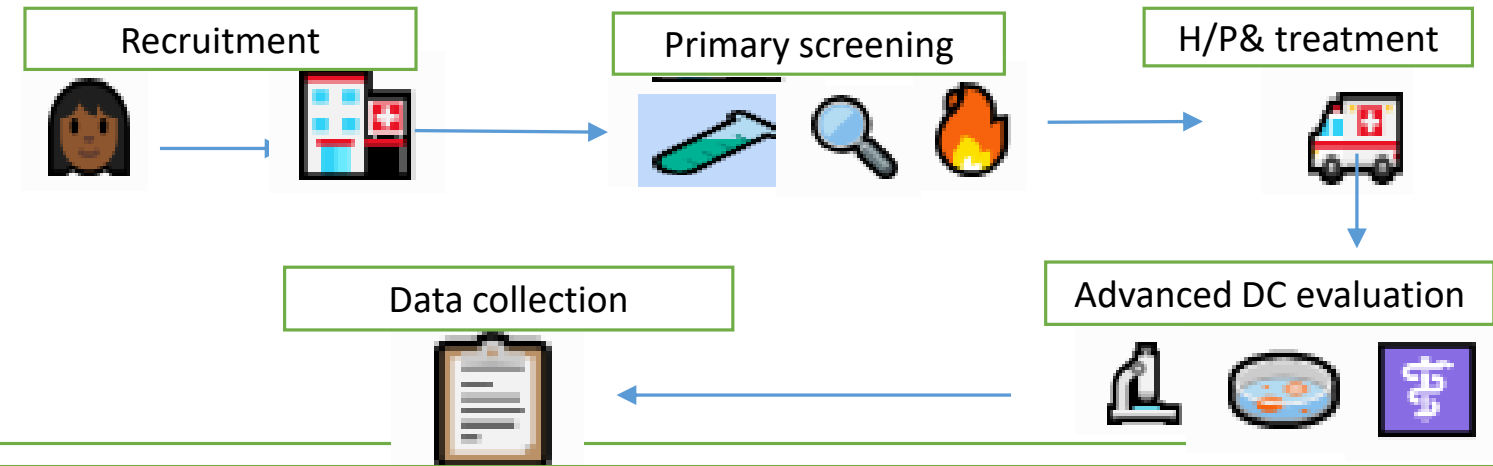
IMPLEMENTATION AND PRELIMINARY RESULTS OF A DISTRICT-WIDE CERVICAL CANCER SCREENING PROGRAM IN RWANDA

Eric RUSAGURA, MD; Theodomir SEBAZUNGU, MD; Caleigh Smith, MD; Euloge NZOBONANKIRA; Sabrina Bedell, MD; Claire Dunlap; Marc Hagenimana; Jean De Dieu Hategekimana, MD; Emmanuel Manirakiza, MD; Kenneth Ruzindana, MD

BACKGROUND

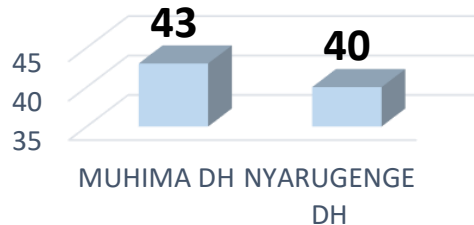
- **Cervical cancer** remains a public health challenge in sub-Saharan Africa
 - **Access** to screening, diagnostic evaluation, and treatment is a challenge
 - **The World Health Organization (WHO)** recommends use of high-risk HPV DNA as one of the screening tools for cervical cancer
- ❖ RCCPC implemented campaign-based HPV-based cervical cancer screening Nyarugenge District
- ❖ **Stakeholders:** Women living with HIV age 25-50 years, women aged 30-50 years, Rwanda Biomedical Center, Ministry of Health, public and private health facilities, district hospitals in Nyarugenge District, community health workers (CHW), and cervical cancer expert providers
- ❖ **Period:** November 2025 – March 2026

METHODS

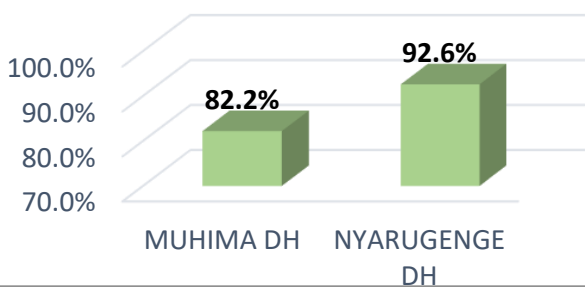


RESULTS

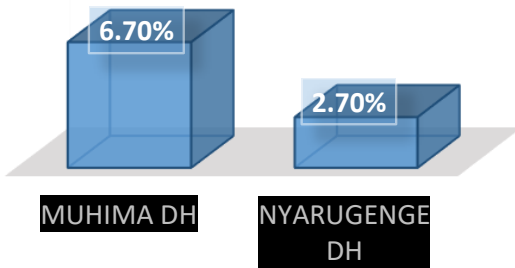
Median age in years



Rate of LEEP procedure



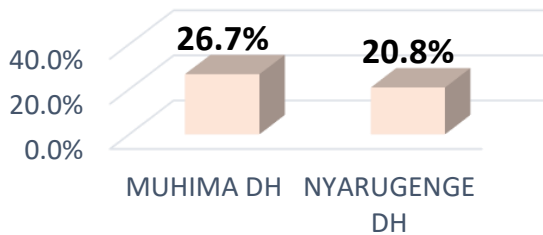
RATE OF INVASIVE CERVICAL CANCER



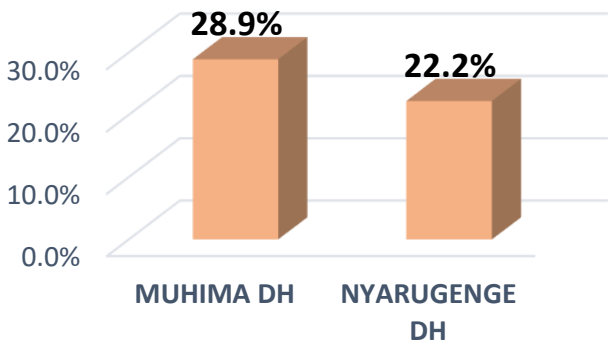
Prevalence of HIV



Rate of CIN



Rate of Cervicitis



CONCLUSION: District-wide HPV-based cervical cancer screening is feasible and achieves high screening coverage with effective detection of cervical precancerous and invasive cancer in a low-resource setting. These preliminary findings support this campaign-based model of HPV-based screening while strengthening referral, diagnostic, and treatment capacity to accelerate cervical cancer elimination in Rwanda.

Acknowledgements: Rwanda Biomedical Centre (RBC), Huntsman Cancer Institute (HCI), Imbuto Foundation, Clinton Health Access Initiative (CHAI)





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PATIENT-CENTERED ARTIFICIAL INTELLIGENCE FOR CERVICAL CANCER SCREENING AND NAVIGATION IN LOW-RESOURCE SETTINGS

Ibrahima Moubarak

Ligue Nigérienne de Lutte contre le Cancer (LNLC), Niamey, Niger



BACKGROUND



Cervical cancer is the fourth most common cancer among women worldwide and a leading cause of death in low- and middle-income countries.

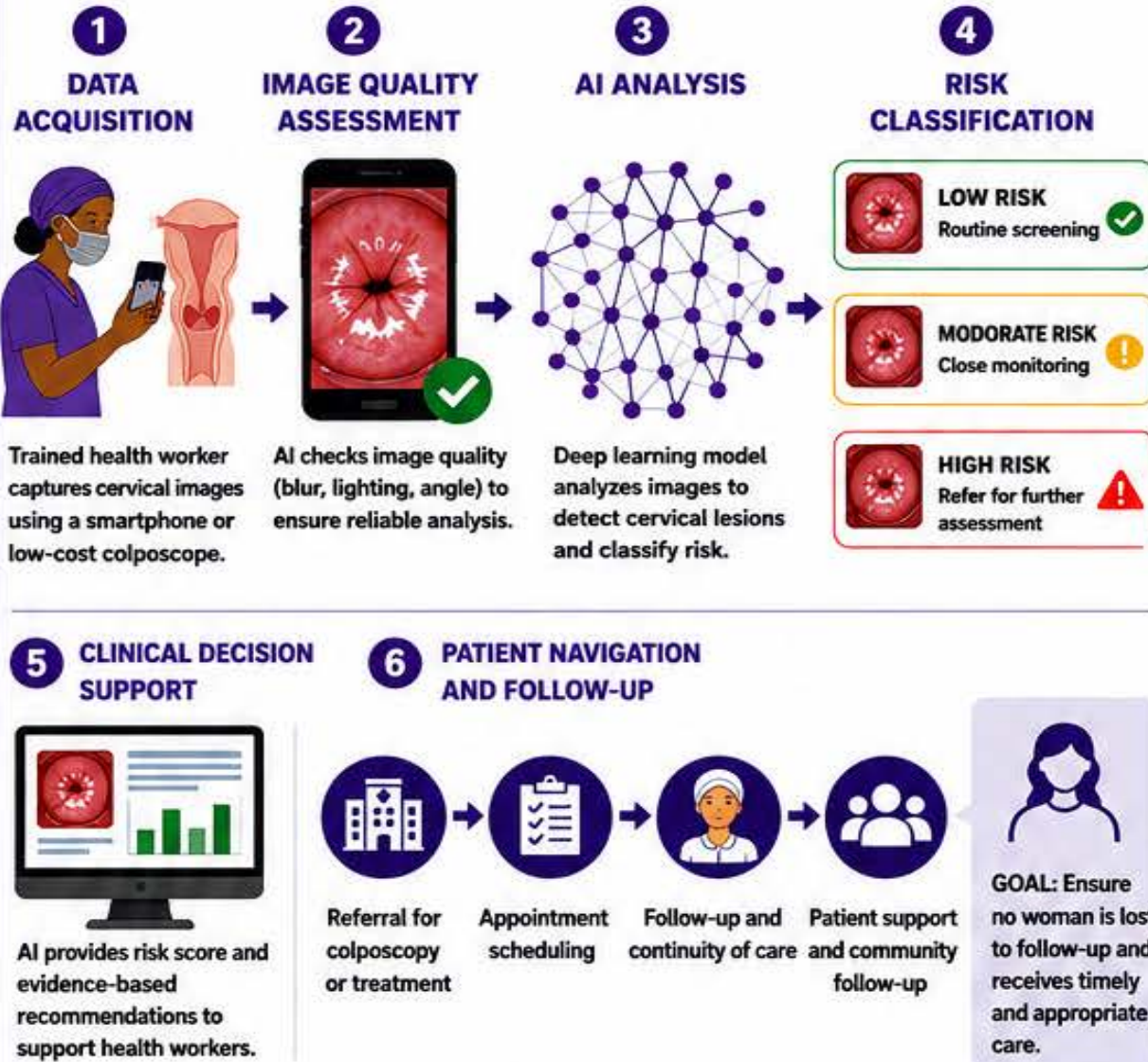


Limited access to screening, shortage of skilled professionals, and delayed diagnosis contribute to poor outcomes.



Artificial intelligence (AI) offers opportunities to improve accuracy, support clinical decision-making, and facilitate timely referral.

AI-ASSISTED CERVICAL CANCER SCREENING AND NAVIGATION WORKFLOW



EXPECTED IMPACT



Improve accuracy and quality of cervical cancer screening.



Support early detection and timely treatment.



Strengthen healthcare professionals' capacity.



Improve patient navigation and reduce loss to follow-up.



Increase access to quality screening in underserved communities.

OBJECTIVE



To propose a **patient-centered AI-driven framework** that supports cervical cancer screening, **improves diagnostic accuracy**, and **strengthens patient navigation** in low-resource settings.

CONCLUSION



This patient-centered AI framework has the potential to **transform cervical cancer screening and navigation** in low-resource settings by combining **technology, human capacity, and strong patient engagement**.

REFERENCES

- Sung H, et al. Global Cancer Statistics 2020: GLOBOCAN Estimates of Incidence and Mortality Worldwide for 36 Cancers in 185 Countries. *CA Cancer J Clin.* 2021.
- WHO. Global Strategy to Accelerate the Elimination of Cervical Cancer as a Public Health Problem. 2020.
- Esteva A, et al. Deep learning: A new frontier for artificial intelligence in medicine. *Nat Med.* 2019.



**LNLC
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Ensemble pour prévenir
le cancer du col de l'utérus
et sauver des vies.

ACKNOWLEDGMENTS



We acknowledge the support of the **Ligue Nigérienne de Lutte contre le Cancer (LNLC)** and all **health workers and communities** committed to cervical cancer prevention.



THE EMPATHY CARE: PATIENT ADVOCACY FOR ADHERENCE AND RETENTION

DIYA SUR ¹, Roma Gupta ², Debangi Sarkar ², Shatavisa Mukherjee ², Bidya Basfore ², Kheyali Mukherjee ², Daity Bhattacharjee ², Asima Mukhopadhyay ²

1 Patient Advocate and partner – Sarbojaya, Kolkata Gynecological Oncology Trials & Translational Research Group
2 ROCK, Kolkata Gynecological Oncology Trials & Translational Research Group, Kolkata India



Introduction

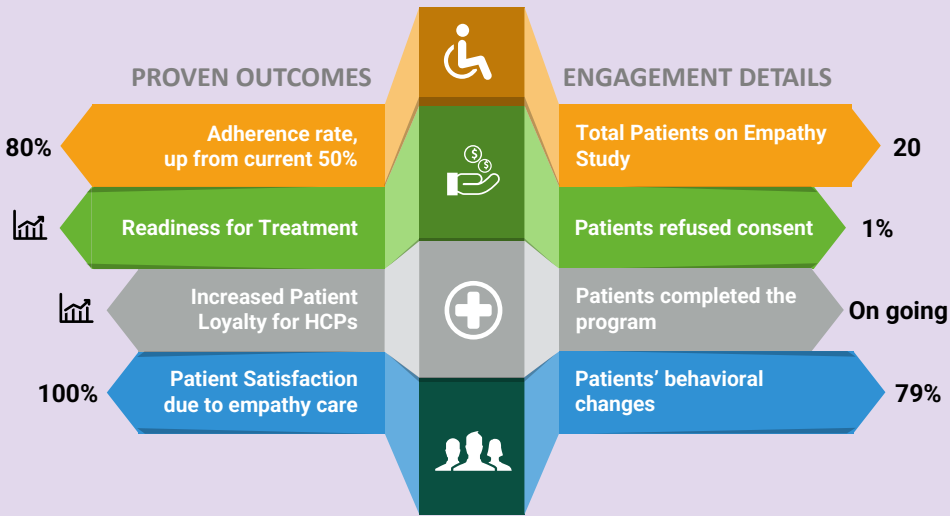
- Patient advocacy is not very centralized or structured in India and other lower-and middle-income countries. There are random programs by few oncology institutions which are not inclusive or consider the larger uneducated women population who have a lot of social stigma and communication issues. This big gap in advocacy leads to low adherence to treatment protocols and dropouts including in clinical trials.
- In KOLGOTRG, the GCIG group from India, we introduced a unique advocacy program called **Empathy Care, based on Stanford's Design Thinking patient centric principles combined with psycho-oncology care** as part of our trials, engaging with patients for their emotional and physical well-being resulting in retention, education and adherence.
- The program is based on the principles of inclusivity and diversity conforming to GCIG code of conduct, specially customised for a lower-and middle-income setting and is run by a patient partner and advocate.
- Empathy – the humane factor is the core principle of this disruptive and uniquely dynamic design of the program to enhance Patient Engagement through Patient emotional Councilors/advocates.

Methods:

- An in-depth qualitative patient study is done to gather detailed empathetic touch points helping us to design tailored solutions to make the program patient-centric.
- The Empathy Program employed as a component a three-phase psycho-oncologic intervention comprising deep empathy profiling, validated psychological screening (PHQ-9, FACT-O, MMSE), and cognitive-behavioral interventions delivered by a patient advocate.
- It introduces a validated model for patient-advocate-led counseling, which leverages 'same boat' experience to bypass cultural stigmas and improve the accuracy of mental health assessments.. Additional support is extended through a network of research nurses, trial coordinators , dynamic data monitoring and quality assurance within a trial framework.
- The principal method is patient engagement, education, awareness and psycho-oncology interventions for trauma, stress and depression. The method considers the fact that all advocacy methods cannot be same for all.

Implementation and impact

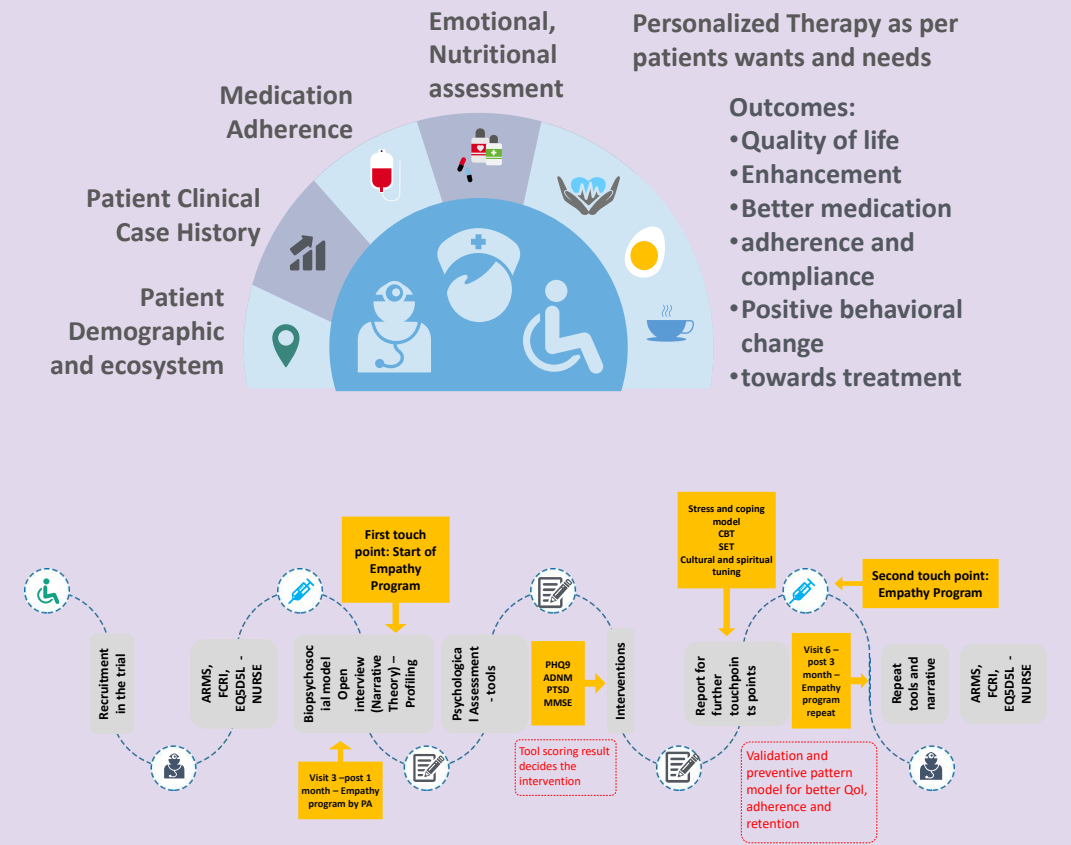
- **The Key Stakeholders:** To keep the population of affected women, inclusive and diversified, we selected a pilot cohort of women enrolled in a PARP inhibitor maintenance de-escalation clinical trial IPIROC (Intermittent PARP Inhibitor Regimen in Ovarian Cancer) funded by the Indian Council of Medical Research (IPIROC#03;CTRI/2025/09/094172).
- Both face-to-face and virtual platforms were utilized to conduct the empathy sessions within the first 3 months of recruitment to promote treatment adherence, retention in the trial and patient satisfaction. The patient demographics consisted of mostly low-to-middle class strata with significant physical, mental and financial toxicity.
- Various types of emotional and empathy interventions are associated with significant, small-to-medium effects on emotional distress and quality of life. The hypothesis of the methodology administered by a patient advocate was strongly proven since all the sample population expressed satisfaction and relaxed and felt they could express better as 'they are both on the same boat'. This helps in clear and accurate assessment and treatment.



Results and lessons learnt

The Empathy Program demonstrates that the success of oncology therapy in LMICs is as much a behavioral challenge as it is a biological one. The program tracks several indicators of impact:

1. Readiness for Treatment: Psychological intervention ensures patients are emotionally prepared for the rigors of chemotherapy and maintenance.
2. Long-Term Adherence: By reducing both the cost (through IPIROC) and the psychological resistance to therapy, the model achieves better retention in clinical trials.
3. Behavioral Changes: Psychoanalysts' observations confirm that patients become more expressive and agentic in their care, moving away from the "learned helplessness" that often accompanies a cancer diagnosis.
4. The women from LMIC's with less to zero literacy, stigmas and communication issues felt at ease to speak to the advocate and discuss their stress, fear and family and social stigmas and was receptive to the interventions and expressed confidence and relief and commitment towards the treatment.
5. There are some cases where the advocate could not provide disease education or awareness since stigma made the family not disclose about the disease to the patient. In such cases, general discussion provided confidence.
6. Future work involves quantitative and qualitative assessment of embedding empathy in trial designs and involving patient survivor and PPI groups such as Sarbojaya.

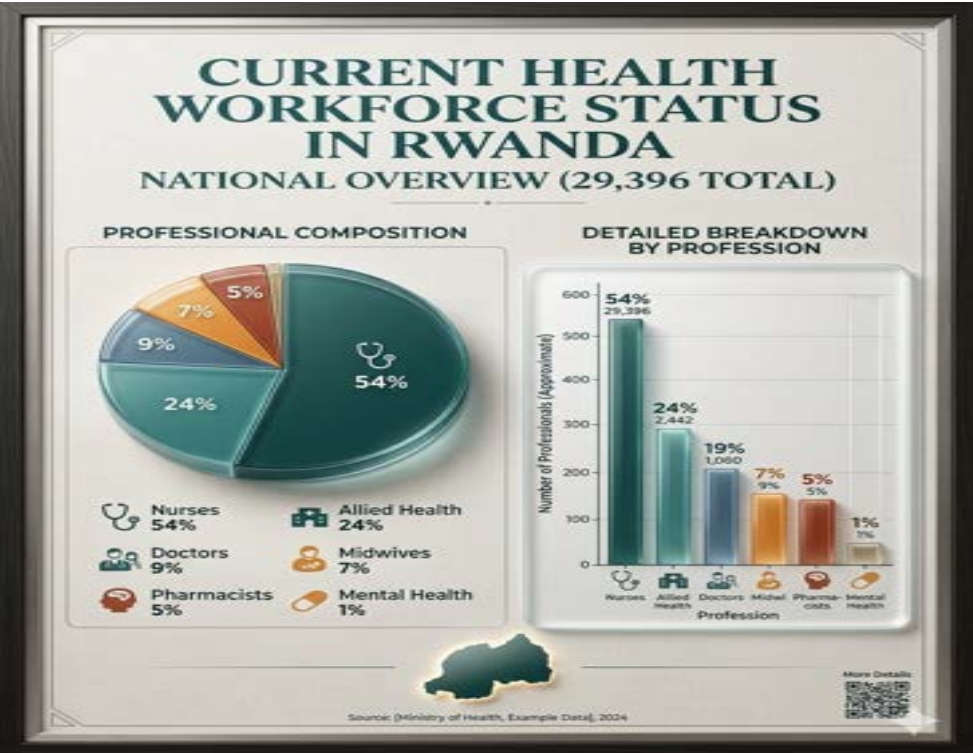


EXPANDING CERVICAL DYSPLASIA TREATMENT CAPACITY IN RWANDA THROUGH TASK SHIFTING OF LEEP AND COLPOSCOPY TO NURSES AND MIDWIVES

Euloge NZOBONANKIRA; Emmanuel Manirakiza,MD; Marc Hagenimana; Jean De Dieu Hategekimana,MD; Sabrina Bedell,MD
Rwanda Biomedical Center; Rwanda; Huntsman Cancer Institute, Utah,USA

BACKGROUND

- Cervical cancer** causes over 342,000 deaths annually worldwide.
- Rwanda** has achieved major progress in HPV vaccination (94%) and screening; but limited capacity for treatment of precancerous lesions.
- In 2021, only 1 gynecologist performed all LEEP cases in Rwanda.
- Nurses and midwives** constitute 61% of Rwanda’s health workforce, task shifting is a strategic method to expand access to treatment.



RESULTS

Capacity Built: Three nurses and midwives achieved advanced-level mastery and are currently mentoring new trainees, while 20 additional personnel remain under supervised clinical training.

Measurable Impact: In 2025, approximately **450 out of 916 LEEPs** performed nationwide were done completely independently by validated nurses and midwives.

Systemic Benefit: Significantly expanded patient access to life-saving treatment and dramatically reduced dependence on rare oncology specialists.

Table: Impact of Task Shifting on National LEEP Capacity

Performance Metric	Before Strategy (2021)	After Strategy (2026)	Strategic Health Impact
Active LEEP Operators	1 (Gynecologist)	4 Fully Validated (+20 Trainees under supervision)	Expanded provider base by 400%
Eligible Workforce Pool	Restricted to Specialists	61% of Health Workforce (Nurses: 54% Midwives: 7%)	Democratized care across the national nursing grid
Annual LEEPs Performed	Minimal / High Backlogs	916 Procedures	Dramatically reduced patient wait times for precancer care
Clinical Autonomy Profile	100% specialist-dependent	~49% Independent Delivery (450/916) procedures by nurses/midwives	Shifted oncology load to decentralized clinics

THE METHODS: A STRUCTURED COMPETENCY-BASED MENTORSHIP PROGRAM FOR NURSES AND MIDWIVES



“Key Lessons Learned for Advocacy”

Rwanda’s experience demonstrates that **structured task shifting** can safely strengthen cervical cancer prevention services and offers a **scalable model for other low-resource settings**.

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Persistent Exclusion of Women Living with HIV from Cervical Cancer Trials in the Era of Novel Therapies

Larissa Emanuella da Silva Costa¹, Marlon Almeida Moreli².

Women living with HIV have a disproportionately high burden of HPV-associated malignancies, including cervical cancer, an AIDS-defining malignancy. Despite modern antiretroviral therapy transforming HIV into a manageable chronic condition for many patients, HIV status continues to be used as an exclusion criterion in contemporary oncology trials. This persists despite ASCO–Friends of Cancer Research and FDA recommendations stating that HIV infection alone should not justify trial exclusion when patients have controlled infection and adequate immune function.

This issue affects women living with HIV and cervical cancer, patients with HPV-associated tumors, oncologists, infectious disease specialists, clinical trial investigators, sponsors, ethics committees, regulators, and patient advocacy organizations. It is particularly relevant in regions where HIV and cervical cancer burdens overlap and access to innovative therapies is limited.

We reviewed eligibility criteria and published protocols from recent cervical cancer and drug-development trials. Contemporary studies such as INTERLACE and KEYNOTE-A18 illustrate the persistence of HIV-related exclusion in cervical cancer research. Similar concerns are emerging in trials evaluating antibody-drug conjugates, where eligibility criteria remain heterogeneous and may continue to restrict participation of patients living with HIV.

The exclusion of women living with HIV from cervical cancer trials limits generalizability, perpetuates stigma, and restricts access to innovation. Available evidence from immunotherapy cohorts and early-phase antibody-drug conjugate experience, including brentuximab vedotin-based treatment, suggests that selected patients with controlled HIV can receive novel cancer therapies without a consistent signal of excess toxicity or loss of virologic control. Trial eligibility should be based on CD4 count, viral load, antiretroviral therapy, opportunistic infection history, and drug interactions—not HIV serostatus alone.

El Zarif T, Nassar AH, Adib E, Fitzgerald BG, Huang J, Mouhieddine TH, et al. Safety and activity of immune checkpoint inhibitors in people living with HIV and cancer: a real-world report from the Cancer Therapy Using Checkpoint Inhibitors in People Living With HIV-International (CATCH-IT) Consortium. *J Clin Oncol*. 2023;41(21):3712-23. doi:10.1200/JCO.22.02459.

Uldrick TS, Ison G, Rudek MA, Noy A, Schwartz K, Bruinooge S, et al. Modernizing clinical trial eligibility criteria: recommendations of the American Society of Clinical Oncology-Friends of Cancer Research HIV Working Group. *J Clin Oncol*. 2017;35(33):3774-80. doi:10.1200/JCO.2017.73.7338

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PATIENT ADVOCACY: From Survivorship to System Change: Community-Led Gynecologic Cancer Advocacy and Patient Empowerment in Nigeria



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IGCS 2026
Annual Global Meeting
MONTRÉAL
October 1 - 3

BACKGROUND

Gynaecologic cancers remain a significant cause of morbidity and mortality in Nigeria, driven by late presentation, limited awareness, weak health systems, inadequate access to screening and treatment, and persistent social and cultural barriers.

As a breast cancer survivor, I transformed my own experience of cancer into a commitment to improving cancer awareness, early detection, patient empowerment, survivorship support, and advocacy. In 2016, I founded the Atinuke Cancer Foundation (ACF) to translate lived experience into community action and to ensure that patients and families have access to information, support, and a stronger voice in cancer control.

The Foundation's work has expanded from community awareness into survivor leadership, public education, media advocacy, partnerships, and policy engagement.

OBJECTIVES

The advocacy and community engagement approach seeks to:

- Increase awareness of gynaecologic cancers and promote early detection.
- Improve community understanding of cancer prevention and risk reduction.
- Empower women and communities with accessible, culturally relevant cancer information.
- Strengthen survivor and patient voices within cancer advocacy.
- Promote patient-centred approaches to cancer care.
- Advocate for policies and programmes that improve access to quality cancer services.
- Build partnerships among patients, survivors, healthcare professionals, government, civil society, media, and other stakeholders.
- Demonstrate how community-led advocacy can contribute to broader cancer-system strengthening.

METHODS & APPROACH

The Foundation's approach combines community-based interventions with advocacy, communication, survivor engagement, and strategic partnerships.

Key approaches include:

- Community cancer awareness campaigns.
- Educational programmes in schools and communities.
- Free cancer screening and health-check outreaches.
- Media engagement through television, radio, print, digital and social media.
- Survivor support and empowerment programmes.
- Patient and caregiver engagement.
- Community mobilisation.
- Policy dialogue and stakeholder engagement.
- Participation in technical working groups and cancer-control platforms.
- Collaboration with government agencies, healthcare institutions, NGOs, private-sector organizations and international partners.
- Monitoring of programme activities, beneficiary reach and media coverage.

RESULTS BETWEEN 2016-2026

200+
Cancer awareness campaigns and community education initiatives.

50+
Free cancer/health-screening programmes conducted through community outreach initiatives.

5,000+
Individuals reached through free screening and health-assessment initiatives.

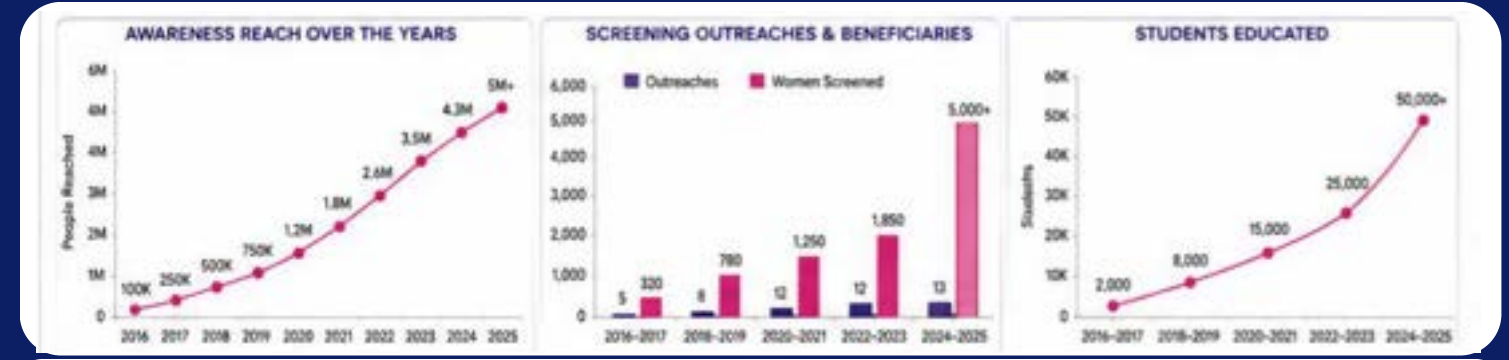
30,000+
Secondary school students reached through cancer education initiatives and competitions.

5 MILLION+
People reached through television, radio, print, digital and social-media engagement.

5000+
Cancer patients directly supported through treatment assistance, medications, food, transportation, counselling, psychosocial support and other interventions.

50+
Strategic collaborations with government, healthcare institutions, private-sector organizations, civil society, media and other stakeholders.

	KEY IMPACT AREA	IMPACT
COMMUNITY AWARENESS	The Foundation has reached diverse communities through, Television, Radio, Social media, Community meetings, Town halls, Market outreach, Religious communities, Schools, Corporate education programmes.	Increased cancer knowledge, attitudes towards early detection, and willingness to discuss cancer openly and seek appropriate care.
EARLY DETECTION	The Foundation has organized free screening and health-assessment outreaches, including breast and cervical cancer screening alongside other health checks.	Improved access and opportunities to screening among the underserved and increased early detection & referral.
SURVIVOR SUPPORT	The Foundation has developed survivor-centred activities focused on Peer support, Empowerment, Counselling, Survivor engagement, Patient education, Community participation, Leadership development.	Improved psychosocial support, reduced isolation, stigma, greater confidence among survivors to participate in advocacy.
POLICY ADVOCACY	Advocacy activities have included: Participation in policy dialogues, Promotion of patient-centred cancer policy, Patient representation, Engagement with government stakeholders, Advocacy for improved cancer services, Technical working groups	Greater visibility of patient and survivor perspectives in cancer-control conversations.
PARTNERSHIPS	The Foundation has collaborated with: Government agencies, Hospitals, Healthcare professionals, Private-sector organizations, NGOs, Academic institutions, Media organizations, International cancer organizations, Survivor networks.	Increased resource mobilisation, wider programme reach and stronger opportunities for sustainable cancer-control interventions.



SELECTED ADVOCACY AND PLATFORM/ INITIATIVES	POLICY ENGAGEMENT ROLE/CONTRIBUTION
NIGERIAN CANCER SOCIETY, LAGOS STATE	CHAIRMAN, LEADING ADVOCACY, AWARENESS AND CAPACITY
NATIONAL COALITION OF CANCER SURVIVORS	EXECUTIVE BOARD MEMBER, LEADING SURVIVOR VOICES
NONCOMMUNICABLE DISEASE, LAGOS MIN OF HEALTH	TWG MEMBER, CONTRIBUTING TO NCD POLICY IMPLEMENTATION
MIN. OF HEALTH NATIONAL CANCER CONTROL PLAN	TECHNICAL WORKING GROUP, MEMBER
RRI INTERNATIONAL BREAST CANCER ORG	REGIONAL REPRESENTATIVE

PARTNERSHIP/COLLABORATION

- Bet9ja Foundation
- FirstBank Women Network
- Fan Milk Nigeria
- Zaron Cosmetics
- DUFIL PRIMA Nigeria
- Colgate Nigeria
- Healthcare institutions
- Government agencies
- Media organizations
- Civil society organizations
- CODIX PHARMACEUTICALS

- CERBA LANCET LABORATORIES
- NIGERIAN INSTITUTE OF MEDICAL RESEARCH
- LAGOS UNIVERSITY TEACHING HOSPITAL
- NIGERIAN YOUTH SERVICE CORP NYSC
- LAGOS STATE TRANSPORT MANAGEMENT AUTHORITY
- LAGOS STATE GOVERNMENT

KEY ACHIEVEMENTS

- Built a credible survivor-led cancer advocacy organization with national reach.
- Expanded cancer advocacy beyond awareness into patient empowerment and policy engagement.
- Used media and strategic communication to challenge cancer myths and stigma.
- Mobilized communities around screening, prevention and early detection.
- Supported patients and caregivers facing financial and psychosocial challenges.
- Elevated survivor voices within national cancer conversations.
- Strengthened collaboration among survivors, healthcare professionals, government and civil society.
- Contributed to cancer-control conversations through national leadership roles.
- Built relationships with national and international cancer organizations.
- Demonstrated the potential of lived experience to become a driver of systems change.

LESSON LEARNED

1. Survivor voices drive empathy and action. People respond differently when cancer information is communicated by individuals who have experienced the disease themselves.
2. Community trust is fundamental to impact. Cancer education is more effective when information is delivered through trusted community, media and social networks.
3. Sustainable change requires partnerships. Community organizations cannot address complex cancer-system challenges alone. Collaboration with government, healthcare institutions, private-sector organizations, civil society and international partners is essential.
4. Awareness and early detection must remain priorities. Investment in cancer awareness and early detection can reduce late presentation and improve opportunities for timely intervention.
5. Survivor leadership can strengthen cancer systems. Survivors can contribute not only as beneficiaries of cancer services but also as educators, advocates, community mobilisers and policy partners.

CONCLUSION

A survivor's voice can become a movement.

Through community awareness, empowerment, partnerships and policy advocacy, the Atinuke Cancer Foundation demonstrates how lived experience can be transformed into sustained action for cancer control.

The Nigerian experience shows that patient advocacy is not separate from health-system strengthening. It is an essential component of it.

By connecting communities with knowledge, survivors with leadership opportunities, patients with support, and policymakers with lived experience, community-led advocacy can contribute to stronger and more equitable cancer systems.

Together, we can turn the tide on women's cancers



**I survived so others can live.
I advocate so change can happen.
I collaborate so no woman faces cancer alone."**

— Princess Oluseun Atinuke Sanusi

Utilizing Women’s Cooperative Contributions to Finance Cervical Cancer Screening in Igbotele, Osun State

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1. Department of Obstetrics and Gynaecology, Uniosun Teaching Hospital, Osogbo.

2. Department of Obstetrics and Gynaecology, Osun State University, Osogbo.

3.Local Government Health Authority, Odo-Otin Local Government, Okuku.

Introduction:

Cervical cancer causes high mortality in Nigeria, driven by late-stage presentations and low screening uptake in rural areas like Igbotele, Osun State, where out-of-pocket payments hinder access. While formal insurance rarely reaches these communities, women utilize stable, trust-based informal thrift cooperatives (*Ajo* or *Esusu*). Integrating a micro-health premium model into these existing frameworks could shift financing away from out-of-pocket costs, making preventative services sustainable. This study assesses the feasibility and impact of this integrated micro-premium model in Igbotele.

Stakeholders:

The community-financed micro-premium screening framework in Igbotele village operates through four interdependent stakeholder groups: rural women, traditional leaders, Community Health Extension Workers (CHEWs), and the Odo-Otin Local Government Area (LGA) Primary Healthcare Clinic. Rural women act as both consumers and funders, shifting to a stable, pre-paid model aligned with local *Ajo* or *Esusu* thrift schedules to avoid out-of-pocket costs. Traditional leaders provide essential social trust and governance, ensuring the program's legitimacy, while CHEWs drive demand through local-dialect communication and logistical support. The Odo-Otin clinic serves as the hub, ensuring affordable and accessible screening. The model leverages local infrastructure and social structures to remove financial and geographic barriers to care.

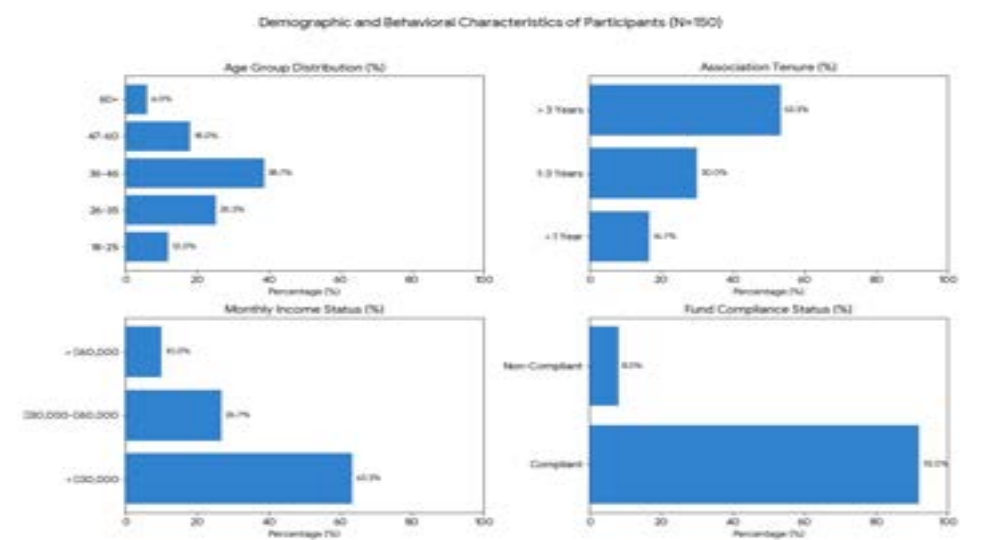


Table 1: Socio-Demographic Characteristics of Participants (N = 150)				Table2: McNemar’s Test Cross-Tabulation for Pre- and Post-intervention Screening Uptake.					Table 3: Point-Biserial Correlation Matrix for Social Variables and Fund Compliance				
Demo graphi c Variab le	Category	Frequency(n)	Percentage (%)		Post- Intervention Screening: NO	Post- Intervention Screening: YES	Total	Exact p-value.					
Age group s year.	25-35	42	28.0	Pre- Interventi on Screening: NO	68(Cell A)	65(Cell B)	133	<0.001	Peer Influence Score	Health Levy Compliance			
	36-46	58	38.7										
	47-57	35	23.3										
Associ ation Tenur e	58-65	15	10.0	Pre- Interventi on Screening: YES	3(Cell C)	14(Cell D)	17	<0.001	Peer Influence Score	Health Levy Compliance			
	<1 year	18	12.0										
	1-3 years	52	34.7										
Mont hly Incom e Status	> 3 years	80	53.3	Total	71	79	150	<0.001	Health Levy Compliance				
	< N30,000	95	63.3										
	N30,000-N70,000	43	28.7										
Fund Compl iance status	>N70,000	12	8.0	Net Statistical Increase: (+41.4%) (approximating to 43% increase)				<0.001	Health Levy Compliance				
	Non Compliant	12	8.0										
Fund Compl iance status	Fully Compliant	138	92.0										
	Fully Compliant	138	92.0										

References:

Adegbite, A. O., Alao, O. O., & Omisore, A. G. (2021). Harnessing indigenous social capital for health financing: The role of informal women micro-credit groups in Southwestern Nigeria. *Journal of Community Health Economics*, 14(2), 145-156.

Ezenwankwo, E. F., Osuchukwu, N. C., & Ibekwe, C. O. (2022). Out-of-pocket health expenditure and preventative cancer screening defaults among rural women in Nigeria. *African Journal of Primary Health Care & Family Medicine*, 14(1), 321-330.

Bello, T. O., & Akinyemi, O. O. (2022). Willingness to pay for health insurance among informal sector workers in Osogbo, Nigeria. *West African Journal of Medicine*, 41(4), 340-348.

World Health Organization. (2021). *Global strategy to accelerate the elimination of cervical cancer as a public health problem*. WHO Guidelines.

Engagement:

This 12-month participatory action study (Jan–Dec 2025) in Igbotele, Osun State, evaluated a micro-premium model using three *Esusu* associations. The cohort comprised 150 women contributing ₦2,000 monthly (₦500 weekly), pooling ₦300,000.

By restructuring the rotating credit framework, a 10% health levy (₦30,000) was combined with a 50% reserve interest match (₦15,000), generating a stable ₦45,000 monthly health fund.

At a negotiated rate of ₦3,000 per woman, the fund covered exactly 15 screenings monthly. This achieved 100% cohort coverage in 10 months, eliminating financial rollovers and finishing two months ahead of schedule. Peer-led advocacy and group solidarity were leveraged to maintain trust, while the association committee managed fund dispersal to cover screening costs. Data were analyzed using SPSS software.



Results and Conclusion

Participant Demographics and Compliance:

Table 1 presents the socio-demographic features of the 150-woman cohort. Most participants earned under ₦30,000 monthly (63.3%, n = 95). Despite financial constraints, health levy compliance was exceptionally high at 92.0% (n = 138).

Cervical Cancer Screening Uptake:

A McNemar’s test evaluated the Esusu health fund intervention among these 150 women (Table 2). Baseline screening was critically low at 11.3% (n = 17) but rose significantly to 52.7% (n = 79) post-intervention. Discordant pair analysis showed 48.9% of previously unscreened women (n = 65) accessed services after financial barrier removal, while only 2.0% (n = 3) reversed status. Yates's corrected McNemar’s test confirmed this shift was highly significant, $\chi^2(1) = 54.72, (p < 0.001)$,

Predictors of Fund Compliance:

Point-biserial correlation (Table 3) revealed a strong, significant positive relationship between peer influence scores and health levy compliance ($r_{pb} = 0.642, p < 0.001$), proving community trust drives financial adherence.

Conclusion:

Repurposing traditional Esusu cooperatives through fractional deductions eliminates financial barriers and expands screening utilization. Integrating health financing into existing social structures shifts preventative oncology from an individual burden to a shared communal priority, offering a sustainable pathway toward universal health coverage



MEETING RWANDA'S GROWING NEED FOR CERVICAL DYSPLASIA MANAGEMENT THROUGH TRAINING AND MENTORSHIP

SEBAZUNGU Theodomir¹, Caleigh Smith², Sabrina Bedell², Claire Dunlap²,
Eugene Ngabonziza¹, Eric Rusagura¹, Emmanuel Manirakiza³

¹ University of Rwanda | ² University of Utah Health | ³ Rwanda Biomedical Centre

BACKGROUND

- Cervical cancer remains a leading preventable cause of cancer death.
- HPV vaccination coverage **≈93%**.
- Screening remains only **25–30%**.
- Expanded screening increases dysplasia detection.
- More providers require colposcopy and treatment training.

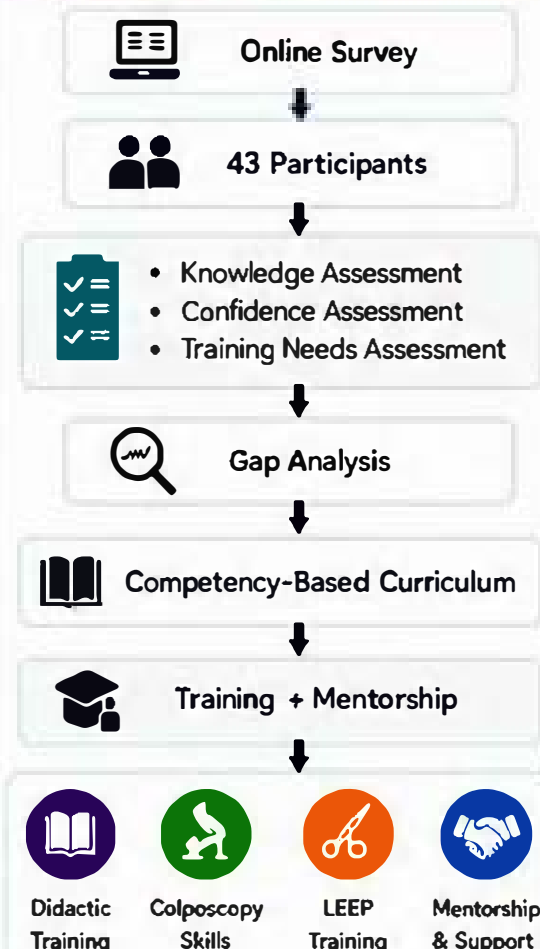
OBJECTIVE

Evaluate provider preparedness for cervical dysplasia management and identify training priorities to strengthen cervical cancer prevention services in Rwanda.

STAKEHOLDERS



METHODS

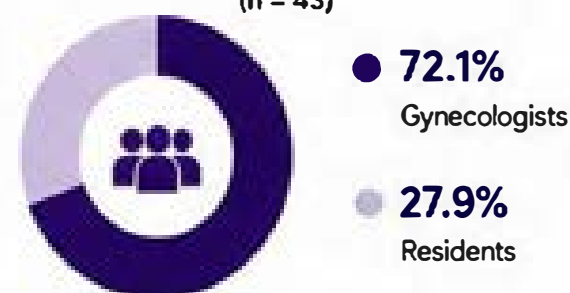


RECOMMENDATIONS

- Competency-Based Training Programs**
Standardized curriculum with hands-on practice.
- Mentorship & Supervision**
Ongoing mentorship and supportive supervision.
- Continuous Medical Education (CME)**
Regular CME and skills refreshers.
- Equipment & Infrastructure**
Ensure access to colposcopes, LEEP machines, and supplies.
- Strengthen the Workforce**
Invest in training more providers.

RESULTS

1. RESPONDENT CHARACTERISTICS (n = 43)



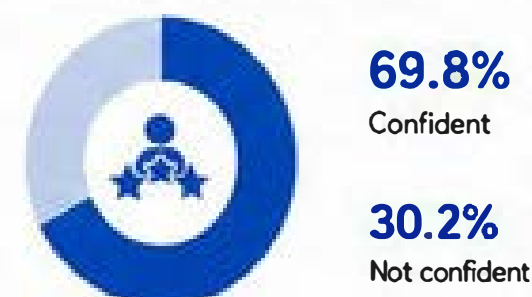
2. SCREENING PARTICIPATION



Most respondents are gynecologists (72.1%).

Only **48.8%** participate in cervical cancer screening.

3. CONFIDENCE IN MANAGING CERVICAL DYSPLASIA



4. ABILITY TO PERFORM PROCEDURES



69.8% feel confident managing cervical dysplasia.

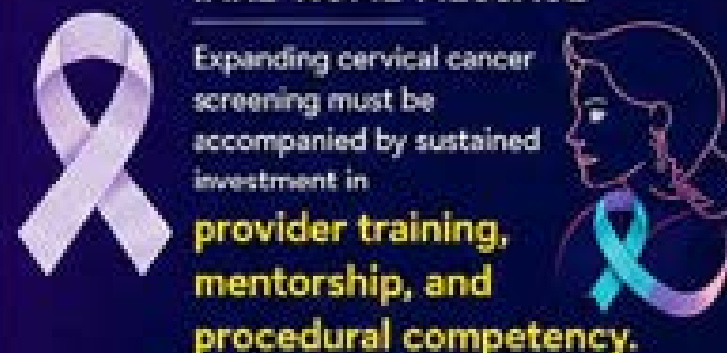
Only **32.6%** feel confident performing LEEP/CKC.



KEY FINDING: A substantial gap exists between identifying cervical dysplasia and providing definitive treatment.



TAKE-HOME MESSAGE



FUTURE DIRECTIONS



Scale up training programs across all districts.



Monitor outcomes and quality improvement.

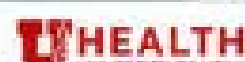


Strengthen data systems and research.



Sustain partnerships for long-term impact.

ACKNOWLEDGEMENTS:



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TEAL VERSE: THE POWER OF SPOKEN WORD IN CERVICAL CANCER ADVOCACY



Youth-led digital advocacy through creative expression



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BACKGROUND / PROBLEM

- Effective health advocacy requires messages that are engaging, relatable, and persuasive.
- With growing social media use among young people, digital platforms provide an opportunity to expand cervical cancer awareness.
- Innovative approaches are needed to sustain youth engagement and participation.

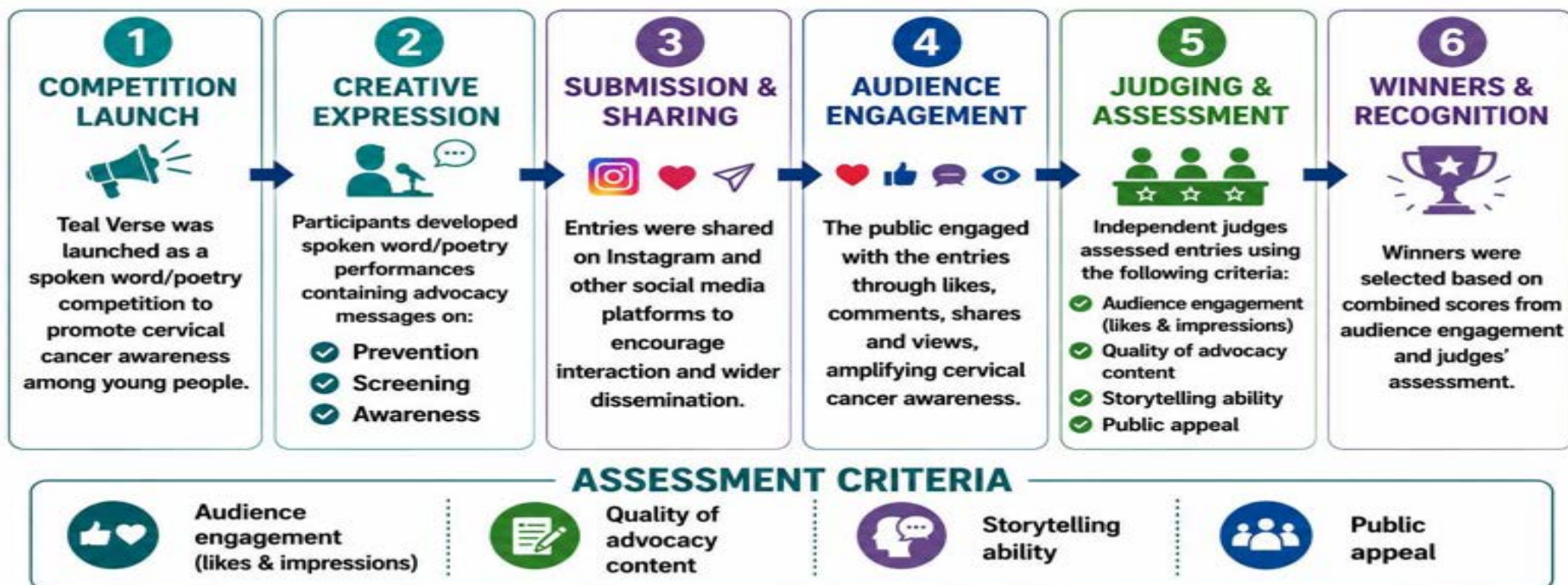
STAKEHOLDERS

- Youth advocates
- Students
- Cervical cancer advocates
- Social media users
- Independent content judges

These stakeholders supported and participated in the initiative.

ENGAGEMENT APPROACH

TEAL VERSE: STEPS OF THE SPOKEN WORD ADVOCACY COMPETITION



16

participants

RESULTS

>32,000

social media impressions & engagements

Key FINDINGS

- Judges rated most submissions as high-quality advocacy content, demonstrating creativity, relevance, and effectiveness in communicating cervical cancer awareness messages.
- The initiative promoted peer-to-peer dissemination of information and increased online engagement with cervical cancer advocacy content.

CONCLUSION

Social media remains a veritable tool for cervical cancer advocacy among young people because of its broad reach, interactive nature, and ability to amplify user-generated content.

TEAL VERSE | Youth engagement • Cervical cancer awareness • Digital advocacy

MANAGEMENT OF HPV DNA OR VIA POSITIVE CASES IN PRIMARY HEALTH CARE CENTRE: A REAL CHALLENGE TO PREVENT CERVICAL CANCER IN BANGLADESH

Anwar BR, Sultana CS, Afroz M, Habiba Z,Nazneen Ara, Afsara A,Tarannum T

Introduction

In Bangladesh, about 93% of eligible girls aged between 10-14 years received HPV vaccine during the nationwide campaign (1) which achieved remarkable progress in the implementation of primary prevention of cervical cancer by vaccination. Screening remains the most effective strategy to prevent cervical cancer in adult women, yet, it covers only 21% of women (2). Since 2005, Visual Inspection under Acetic Acid, (VIA) is the main method of cervical cancer screening method adopted by government of Bangladesh but HPV DNA test is available only in selected government and private sectors. Inadequate knowledge about VIA/HPV positive cases and lack of advocacy resource for positive cases among health professionals remains an important issue of concern. Our aim is to evaluate the gaps of management of precancerous lesions of cervix in primary health care centers.

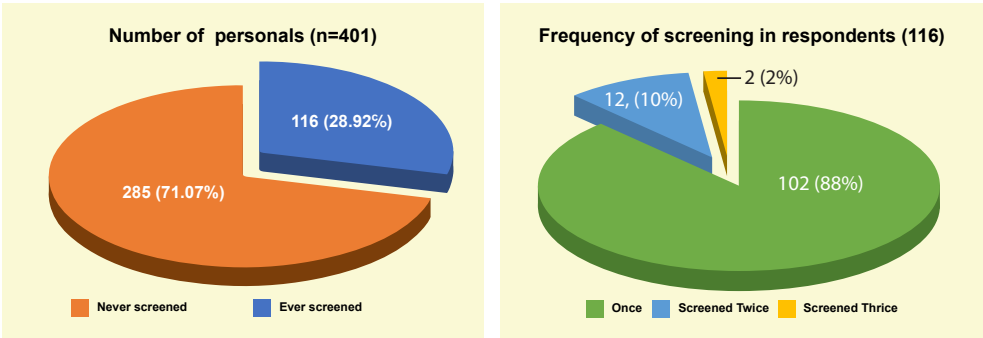
Methods

This prospective observational study was conducted in Duptora union of Araihasar upazilla of Narayangonj,district of Bangladesh. The study period was from January 2024 to June 2024. We assigned some personnel to inform and invite women to attend centres for screening. The information was circulated via microphone announcements. Vehicles were provided (Auto rikshaw) and expense was paid to the participants. Women over the age of 30 years were enrolled in the study. Total 401 participants were counselled by nurses to do screening by VIA, HPV DNA test and colposcopic examination simultaneously to identify lesions. Post-test counseling was done for surveillance of the biopsy proven positive cases. Cervical samples were collected from each participant using Digene PCR lab of National Institute of Cancer Research and Hospital (NICRH) on

the same day.At NICRH, DNA extracted from each sample using the ThainAmp viral DNA extraction kit and HPV genotyping was performed in a Bio-Rad CFX 96 touch real time PCR system. Histopathologically positive cases were referred to NICRH but patients were reluctant to visit referral centre for further management.

Results

Among 401 cases, 285 women were never screened and 116 were ever screened. Of the 116 women, only 2 women were screened thrice compared to 12 women who were screened twice an 102 women were only screened once in their life time. 90% women found HPV DNA test to be a suitable and comfortable test for rural area. In 54 (13.4%) cases, VIA as well as colposcopy was unsatisfactory but HPV DNA test showed positive report in 3 cases. It indicates that, HPV DNA test is a suitable primary screening test for rural area. It identified viral infection even in unsatisfactory VIA and colposcopy cases. Finally, histopathology report diagnosed 16(3.9%) cases of CIN-I and 3 cases of CIN-II (0.74%) Three CIN -II cases were referred, but they refused to go to higher centres. They were willing to take treatment in local centres. To overcome the challenge, to see and treat right away could be a better option to manage CIN cases in rural area.



Conclusion

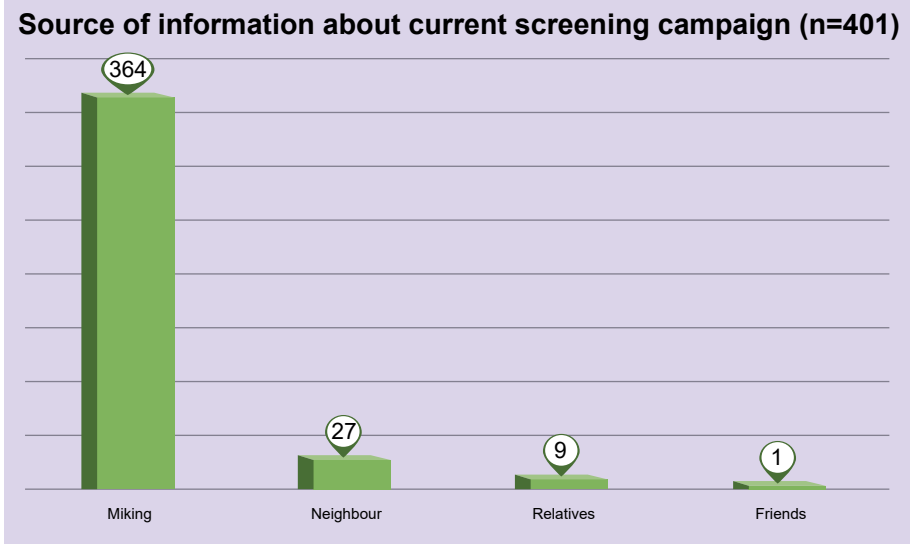
Future advocacy should focus more on positive counselling of screen positive cases to convince them to take treatment. Lesson learned from the study is that, policy makers should make treatment procedures available in the primary care centres under one umbrella.

References

UNICEF.93% eligible girls get vaccinated against Human Papilloma Virus across Bangladesh [internet]. UNICEF; 2024 Dec 11.Available from:<http://www.unicef.org/bangladesh/en/press+release/93-cent-eligible+girls-get-vaccinated-against-human-papilloma-virus-across>

Bangladesh Shongbad Shonsha (BSS) DHIS2 online data.

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GENETIC TESTING GAPS IN OVARIAN CANCER CARE

A MULTI-STATE PATIENT REPORTED ANALYSIS

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Core message: Testing gaps were more often linked to timing, provider discussion, education, and workflow than to patient refusal.

202	66.8%	20.8%	76.3%	5.6%
Ovarian Cancer Patients	Explicitly reported undergoing genetic testing	Explicitly reported not undergoing genetic testing	Tested among classifiable Yes/No	Gap theme comments reflected patient preference/declined

INTRODUCTION / PROBLEM

- Genetic testing is recommended for all patients with ovarian cancer because it informs treatment selection, familial risk, and cascade testing. Yet real-world uptake remains inconsistent.
- We used patient-reported data from a multi-state respondent cohort to identify where testing gaps occur and what system changes could improve uptake.

STAKEHOLDERS

Ovarian cancer respondents, caregivers and families affected by hereditary risk, gynecologic oncology teams, genetic counselors, patient navigators, advocacy organizations, and health systems responsible for equitable access to testing.

ENGAGEMENT

- Survey responses were collected through a national patient support program.
- Testing status was conservatively classified from free-text comments as Yes, No, Pending/In process, or Unclear.
- Gap themes were coded from comments among respondents not tested, pending/in process, or unclear.

RESULTS (INCLUDING ONGOING)

- We had 202 respondents fromstates
- 135 (66.8%) explicitly reported testing
 - 42 (20.8%) were not tested
 - 5 (2.5%) were pending/in process
 - 20 (9.9%) were unclear.
 - Among classifiable Yes/No respondents (n=177), 76.3% reported testing.
 - Testing did not differ significantly by age (p=0.287)
 - Patients with early-stage disease showed a non-significant trend toward lower early-stage uptake (p=0.066).

ADVOCACY AND PRACTICE IMPLICATIONS

- Findings suggest that genetic testing gaps are modifiable system-level problems.
- Ongoing advocacy should move testing from provider-dependent or patient-initiated workflows to closed-loop universal pathways.
- Priority actions include automatic referral at diagnosis, structured documentation of testing status, stage-neutral testing protocols, tele-genetics, and culturally responsive education.

LIMITATIONS

Testing status was inferred from free-text responses. The cohort is a respondent sample and should not be interpreted as population prevalence. Several subgroup analyses had small sizes, and stage/location data were missing or difficult to standardize for some respondents.

METHODS

- Cross-sectional analysis of 202 ovarian cancer respondents.
- Cohort included respondents from 29 identifiable U.S. states with location grouped into Northeast, Midwest, South, West, and Unknown for regional analysis.
- Available variables included age, self-reported stage, state/location, ethnicity, and free-text comments on genetic testing.
- Primary outcome was explicit self-reported testing.
- Secondary analysis examined classifiable Yes/No respondents.

OVERALL TESTING STATUS

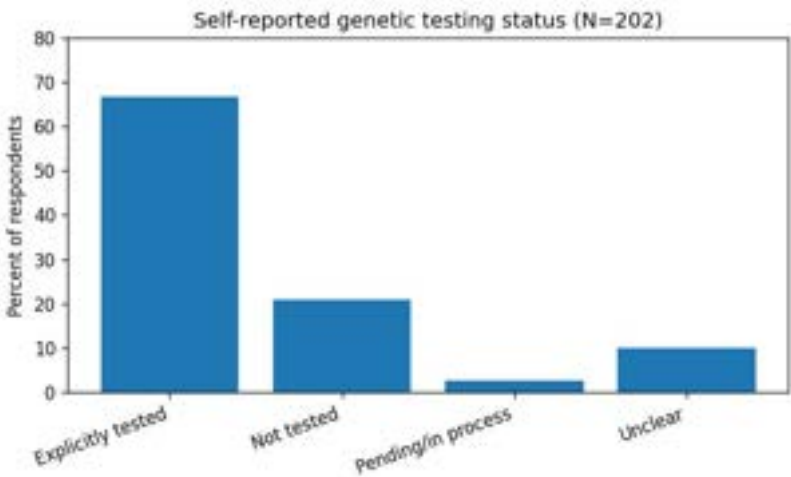


Figure 1. Self-reported genetic testing status among respondents (N=202).

REPORTED THEMES ASSOCIATED WITH TESTING GAPS

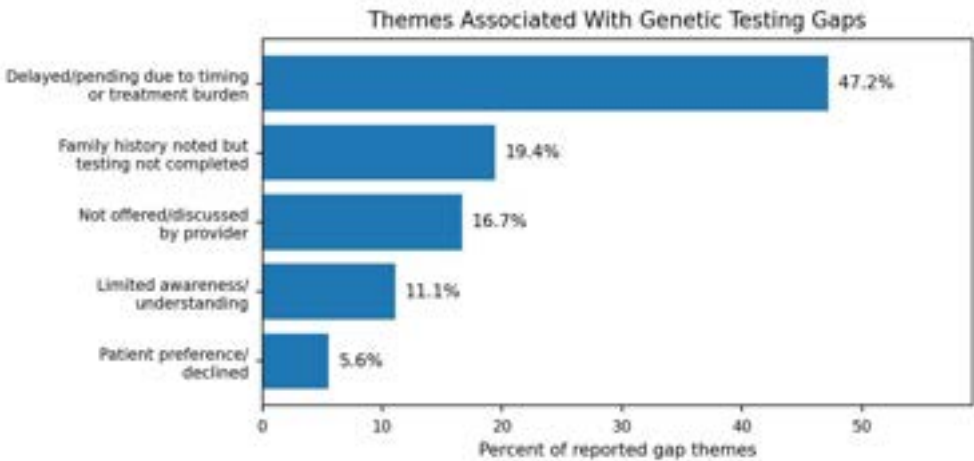


Figure 2. Percent distribution of gap-related themes from free-text responses (n=36 coded themes).

ACTIONABLE QUALITY METRICS

- ≥90% documented genetic referral within 30 days of diagnosis
- 100% structured testing status in oncology records
- <5% untested due to missed referral opportunities
- ≥80% tele-genetics offered when local access is limited
- Stratify dashboards by age, stage, location, and ethnicity

FINAL TAKEAWAY

The actionable focus is not convincing patients to accept testing; it is ensuring every eligible patient is consistently offered, referred, tracked, and supported through completion.

Sources: ASCO Guideline: Germline and Somatic Tumor Testing in Epithelial Ovarian Cancer; SGO clinical practice statements on genetic testing for ovarian cancer; respondent survey dataset, N=202.

LAPAROSCOPIC PRIMARY DEBULKING SURGERY IN ADVANCED-STAGE OVARIAN CANCER: A SYSTEMATIC REVIEW AND META-ANALYSIS

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Introduction

Primary debulking surgery (PDS) via open laparotomy is standard for advanced-stage (FIGO III-IV) ovarian cancer (EOC), but minimally invasive surgery (MIS) is increasingly used despite uncertain oncologic adequacy and safety. We compared MIS with open laparotomy for PDS via systematic review and meta-analysis

Stakeholders

Patients with advanced-stage EOC are the primary stakeholders, as surgical approach affects their morbidity and outcomes. Gynecologic oncology surgeons and trainees, hospital systems allocating training resources, professional societies translating evidence into guidelines, and researchers designing future trials are also key stakeholders.

Engagement

Our engagement strategy used rigorous evidence generation as advocacy for safer, equitable surgical care. We conducted a PRISMA-guided review, registered in PROSPERO (CRD420261381199), consolidating data from nine studies (649 patients) comparing laparoscopic and open PDS. Dissemination via conference and peer-reviewed publication is our outreach mechanism, showing where MIS access may be limited by uncertainty rather than evidence

Study Characteristics

Study	Design	Surgical comparison	MIS n	Open n	Dx. lap. first?	Conversion
Magrina et al. (2010)	Retrospective case-control	Robotic/laparoscopic MIS vs laparotomy	52	119	NR	1.9%
Van Trappen et al. (2022)	Retrospective cohort	Robotic IDS vs open IDS	21	20	No	NR
Nezhat et al. (2010)	Retrospective case series	Completed laparoscopy vs converted laparotomy	17	11	Yes	39.3%
Ceccaroni et al. (2023)	Retrospective single-center	Laparoscopy only	40	N/A	Yes	0%
Pereira et al. (2022)	Retrospective review	MIS vs laparotomy	21	76	Yes	NR
Liang et al. (2017)	Retrospective cohort	Laparoscopic vs open cytoreduction	64	68	Yes	3.1%
Andikyan et al. (2018)	Retrospective cohort	Completed laparoscopy vs laparotomy	23	26	Yes	51%*
Fanning et al. (2011)	Prospective database review	Laparoscopic-assisted cytoreduction only	25	N/A	No	8%
Ceccaroni et al. (2017)	Prospective cohort	Laparoscopic vs abdominal cytoreduction	21	45	Yes	0%

Results

Our synthesis of nine studies found complete cytoreduction (R0) rates of 79.7% with minimally invasive surgery versus 72.0% with open laparotomy, alongside lower blood loss, shorter operative time, and fewer bowel resections with the minimally invasive approach (all p<0.05). Conversion to laparotomy was low (2.5%). Three-year progression-free survival favored the minimally invasive group, though with no significant difference in overall survival, and we identified that patients selected for minimally invasive surgery tended to have less extensive baseline disease—a key source of selection bias that tempers any practice-changing conclusion.

MIS vs Open Surgery: Pooled Outcomes

Outcome	MIS	Open	P value
Patients, n	284	365	—
Age, years	57.6 ± 12.3	61.0 ± 12.9	0.0219
BMI, kg/m²	26.8 ± 9.1	23.9 ± 4.3	0.0047
Serous histology, %	75.7	75.0	0.979
FIGO stage III–IV, %	86.1	93.2	0.040
Ascites present, %	26.2	45.5	0.045
Omentectomy, %	100.0	98.3	1.000
Bowel resection, %	22.8	39.5	0.0029
EBL, mL	235.4 ± 269.3	747.3 ± 571.2	<0.000001
OR time, min	305.0 ± 117.4	368.4 ± 124.2	0.0011
R0 debulking, %	79.7	72.0	0.158
3-year PFS, %	62.1	38.0	0.0001
3-year OS, %	81.0	72.7	0.132

Lessons Learned and Future Implications

This work demonstrates that systematic, transparent evidence synthesis can itself function as an advocacy tool—surfacing where current practice may unnecessarily restrict patients from less invasive surgical options, while also being honest about the limitations (selection bias, heterogeneity across study designs) that prevent immediate practice change. The key takeaway for future advocacy-through-evidence projects is the importance of pairing favorable outcome signals with explicit acknowledgment of bias, so that the resulting advocacy message is credible to clinical stakeholders rather than overstated. Going forward, this evidence base supports advocacy for prospective, multicenter trials specifically designed to determine which advanced-stage EOC patients can safely access minimally invasive surgery—work that would directly expand safe surgical options for this patient population.