Cervical Cancer

Improving Care and Driving Policy Change

The Dominican Republic

THE SWEDISH INSTITUTE FOR HEALTH ECONOMICS
ENABLING INFORMED DECISION MAKING

KEY TAKEAWAYS

600
DEATHS ANNUALLY

Cervical cancer causes over 600 deaths annually in the Dominican Republic, yet it is largely preventable through HPV vaccination, screening, and treatment.

90%
ACHIEVABLE TARGET

HPV vaccination for girls is progressing well and the 90% target is achievable; the recent expansion to boys and school-based delivery now require close monitoring and evaluation.

3-8
TIMES ITS VALUE

Every dollar invested in prevention, early detection, and treatment returns 3–8 times its value to society and the economy.

59%
LATE DETECTION

Screening remains opportunistic and inequitable, with poor follow-up and limited use of HPV testing, resulting in 59% of cervical cancer cases being detected late.

→|
RESTRICTION LIMITS

Restricted access to new cancer medicines, outdated clinical guidelines for cancer treatment, and shortage of radiation therapy machines and specialists in the public sector limit improvements in patient outcomes.

HIGH-LEVEL RECOMMENDATIONS

To accelerate the elimination of cervical cancer in the Dominican Republic, this policy brief proposes the following five recommendations.

Build a prevention-first culture

Empower health professionals as prevention champions

Strengthen data systems and accountability

Strengthen care integration to reduce waiting times and follow-up losses

Ensure access to innovative and up-to-date care

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BACKGROUND

In 2025, the Swedish Institute for Health Economics (IHE) published Bridging the Gap in Women's Cancer Care: A Global Policy Report on Disparities, Innovations, and Solutions. Endorsed by the Advanced Breast Cancer (ABC) Global Alliance, the International Gynecologic Cancer Society (IGCS), the International Gynecological Cancer Advocacy Network (IGCAN), and the World Ovarian Cancer Coalition (WOCC), the report outlines the unique challenges and opportunities in improving outcomes for women's cancers.

Building on the content and findings of this global report on women's cancers, this policy brief examines the situation of cervical cancer in the Dominican Republic (DR). It provides an overview of the societal burden and highlights priority areas for strengthening care and policy responses. Targeted literature searches were conducted to identify information on the state of care in the DR. In addition, a workshop with several local experts was held in October 2025 to verify and discuss challenges and opportunities specific to the care of cervical cancer in the DR.

WHAT IS CERVICAL CANCER?

Cervical cancer is a type of cancer that develops in the cervix, in the lower part of the uterus that connects to the vagina (1). It usually begins with abnormal changes in the cells lining the cervix called "precancerous lesions". Over time, if these changes are not detected and treated, they can grow uncontrollably and form a tumor.

The main cause of cervical cancer is persistent infection with certain types of human papillomavirus (HPV), a very common sexually transmitted virus. In early stages, cervical cancer often causes no symptoms. When symptoms do appear, they may include abnormal vaginal bleeding (i.e., bleeding after sex, between menstrual periods or after menopause) (2).

Cervical cancer is the second most common cancer among women in low- and middle-income countries (LMICs). Unlike most cancers, it is largely preventable through a combination of HPV vaccination, regular screening, and treatment. Yet, hundreds of thousands of women continue to be diagnosed and die from cervical cancer each year worldwide (3). In the DR, 45% of cases are diagnosed in women under 50 years old (3). Approximately 59% of cervical cancer patients in the DR are identified at late stages (III-IV) (4).

Global commitment to eliminating cervical cancer

In 2018, the World Health Organization (WHO) called for the elimination of cervical cancer, leading to the 2020 Cervical Cancer Elimination Initiative (CCEI), the first global pledge to eliminate a cancer as a public health problem (5). Elimination is defined as an age-standardized incidence rate (ASR) of below 4 cases per 100,000 women in every country. To reach this, the WHO sets the 90-70-90 targets until 2030: 90% of girls fully vaccinated against HPV by age 15; 70% of women screened with a high-performance test by ages 35 and 45; and 90% of women with disease receiving appropriate care (including 90% of precancers treated and 90% of invasive cancers managed). The DR has formally aligned with the WHO CCEI. In December 2021, the Ministry of Health (MoH) launched the National Plan for the Elimination of Cervical Cancer 2020-2030, developed with SNS and PAHO/WHO support and echoing the 90-70-90 goals (6).

WHO goals 2030

90% of girls fully vaccinated against HPV by age 15.

70% of women screened with a high-performance test by ages 35 and 45.

90% of women with disease receiving appropriate care.

[1]These estimates come only from the Oncology Institute (IOHP) 2023 and were recalculated excluding cases with unknown stage and stage 0, for a total of 111 cases.

DISEASE BURDEN

According to modelled estimates from the International Agency for Research on Cancer (IARC), the DR expected 967 new cervical cancer cases and 622 deaths in 2022, making cervical cancer the second most common cancer in women and the second leading cause of cancer death in women (3). As HPV is a highly infectious disease, all sexually active people are theoretically at risk of being infected. In the DR, 4.07 million women are estimated to be at risk of cervical cancer (7). The estimated lifetime risk is substantial, with around 1 in 46 women (2.2%) diagnosed with cervical cancer before age 84 and 1 in 56 women (1.8%) dying from it (3).

Monitoring progress remains difficult

Monitoring progress toward cervical cancer elimination remains difficult due to gaps in population-based cancer registries and inconsistent mortality data over time. Available estimates suggest declines between 2002 and 2018, yet the lack of continuous, high-quality surveillance, and the absence of a national cancer registry, limit confidence in true trends. Local experts highlighted that national incidence and mortality statistics likely underestimate the true burden, given the absence of a consolidated national cancer center and important underreporting. According to local experts, the Ministry of Health is currently developing a National Cancer Registry, with the first phase focusing on childhood cancers and plans to progressively incorporate other cancer types. A national registry is tentatively planned to start in 2026 (8).

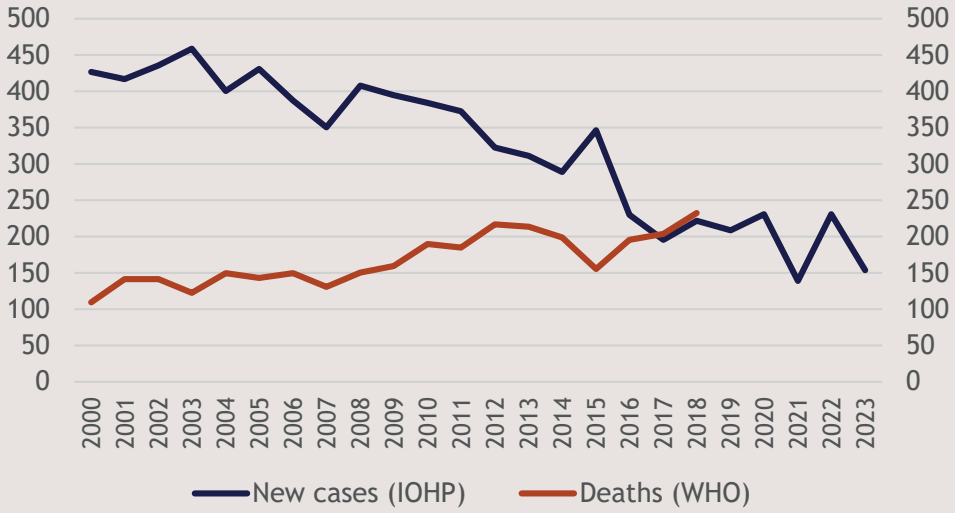

Figure title: Number of cervical cancer cases in IOHP and deaths in the WHO mortality database.

Notes: Please note that the numbers come from different sources and represent different levels of evidence. ***The new cervical cancer cases are institutional counts from IOHP*** *and thus reflect only patients seen at that center, not the total number of cases nationally.* ***The number of deaths comes from the WHO mortality database****. Deaths in the WHO database are registered in national civil/vital registration systems, coded by the national authority, and transmitted to WHO by the competent authorities. Source: (9,10).*

There is progress, but far from elimination and persistently high deaths

Estimated age-standardized cervical cancer incidence fell from 30.8 per 100,000 women in 2002 to 15.6 in 2022, probably reflecting gains from expanded screening, yet it remains well above the elimination threshold of 4 per 100,000. Mortality also declined markedly over two decades (from 17.3 to 9.9 per 100,000) but has plateaued in recent years (2018–2022). This recent stagnation might reflect the persistently high share of stage III–IV diagnoses noted above, limiting impact on deaths so far.

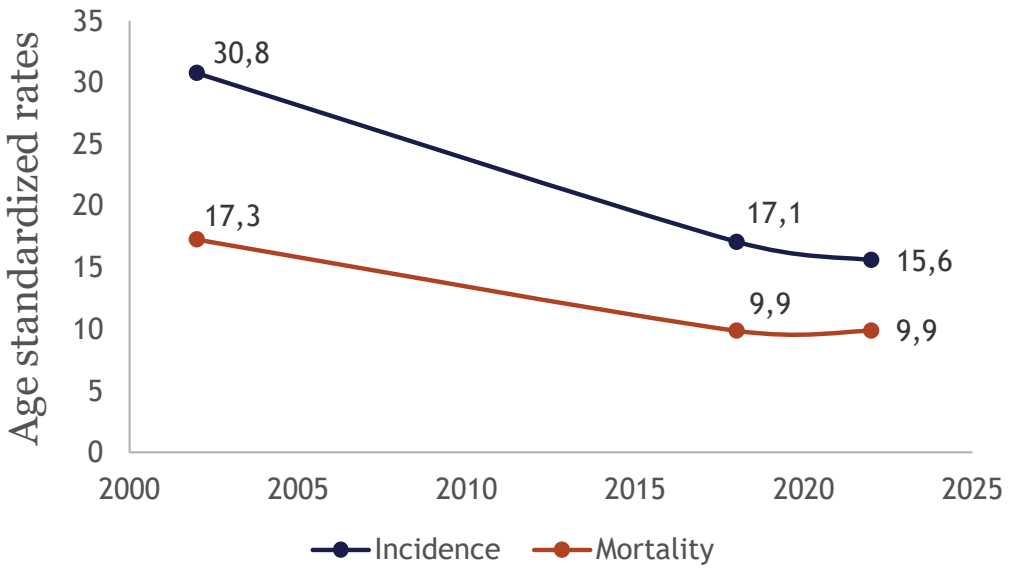

Figure title: Estimated age-standardized cervical cancer incidence and mortality rates over time in the Dominican Republic.

Notes: These figures are modelled estimates, not registry counts per 100,000 women. Source: (11). Originally from (12, 13) and (3).

RETURNS ON INVESTMENT

Evidence from multiple countries shows that every dollar invested in prevention, early detection, and treatment of cervical cancer can return 3–8 times its value in economic benefit (5). The WHO estimates that for every US$1 invested through 2050, an average of US$3.20 will be returned to the economy, primarily through increased women's workforce participation (14).

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ECONOMIC BURDEN

Cervical cancer places a considerable financial strain on health systems and societies.

The economic burden of cervical cancer in the DR is not well documented

There are no published analyses quantifying direct and indirect costs or government spending specifically for cervical cancer. However, global modelling estimates provide a useful approximation of the direct economic burden. According to a recent global analysis, the estimated direct economic burden of cervical cancer in the DR in 2021 was USD 1.01 million, with a cumulative burden of USD 10.15 million between 1990 and 2021 (15). These figures reflect direct healthcare expenditures only, excluding productivity losses and caregiving costs, and therefore likely underestimate the total societal burden. As observed in other Latin American countries, indirect costs can represent up to 80–89% of the total economic burden (16).

[2] Cost references come primarily from the official fee schedule of Ecuador's National Health System, only for services not listed were average prices from private institutions and local NGOs used.

The value of prevention and early detection

Evidence from Ecuador shows the large cost gap between prevention and late-stage treatment. An analysis based on the Ecuadorian national health system tariff schedule found that the cost of prevention per person ranges from USD 396 (vaccination + pap smear) to USD 761 (vaccination + HPV testing) (17). In contrast, the minimum treatment cost per patient with advanced cervical cancer (stages IIB-III-IV) is USD 28,560, more than 38 to 70 times higher than the cost of prevention. Treating in situ or very early invasive disease is also far less costly, averaging USD 685-3,465 per patient, than treating invasive stages (USD 23,762 for stage I-II and USD 28,560+ for stages IIB-IV).

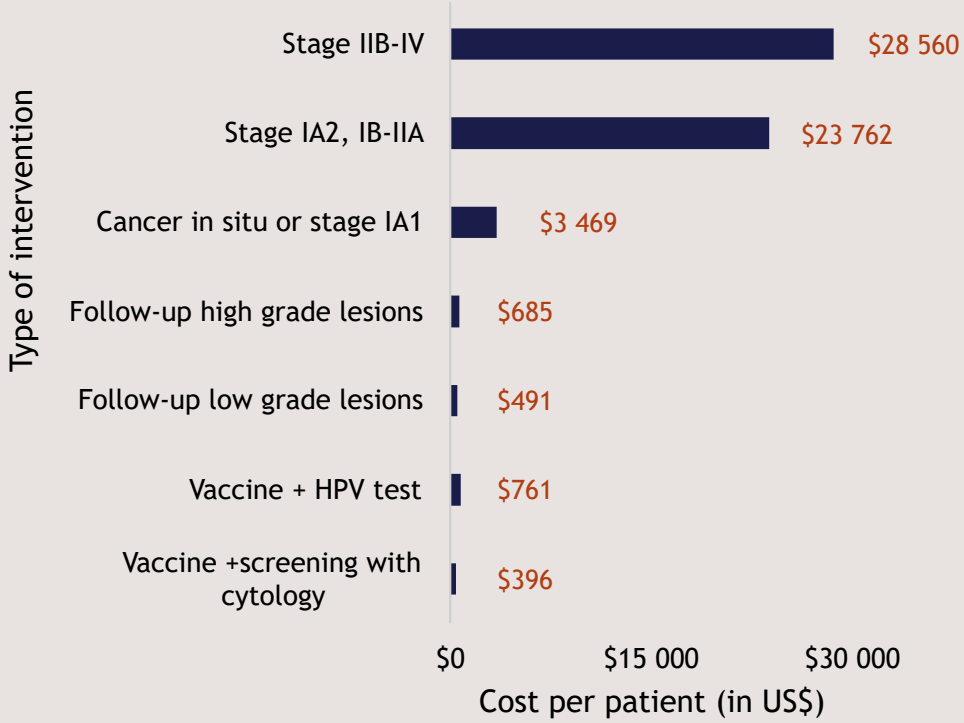


Figure title: Results from a comparative analysis of prevention and treatment costs associated with cervical cancer in Ecuador. Source: (17).

Notes: Cost references come primarily from the official fee schedule of Ecuador's National Health System, only for services not listed were average prices from private institutions and local NGOs used.

PREVENTION

Cervical cancer is one of the few cancers considered highly preventable, as persistent infection with high-risk HPV is the cause and effective vaccines are available (5). Primary prevention relies on HPV vaccination, which provides long-term protection against the most oncogenic HPV types. International recommendations prioritize immunization of girls aged 9–14 years, before the onset of sexual activity, but many countries are also adopting catch-up vaccination of older adolescent and young adult cohorts to accelerate reductions in cervical cancer burden. In addition, there is a growing switch toward gender-neutral vaccination, with boys increasingly included in national programs to enhance herd immunity and prevent other HPV-related cancers (18). As of September 2025, 83 countries vaccinate both boys and girls, including the DR (18, 19). The WHO Global Strategy to Eliminate Cervical Cancer calls for 90% of girls fully vaccinated by age 15 by 2030, a target endorsed by PAHO (20).

PREVENTION

HPV VACCINATION

WHO GOAL:
90% OF GIRLS FULLY VACCINATED AGAINST HPV BY THE AGE 15 BY 2030

HPV national vaccination program in the DR

The HPV national vaccination program in the DR was launched in 2017, targeting girls aged 9–14 years (21). In 2025, the DR expanded the program to include boys, thereby ensuring that all children aged 9–14 years are now covered (19). In 2024, the country transitioned to a single-dose HPV vaccine regimen, replacing the previous two-dose schedule, following recommendations issued by WHO's Strategic Advisory Group of Experts (SAGE) in April 2022 and subsequently endorsed by the World Health Organization (22, 23). This simplified schedule offers an opportunity to expand coverage in settings facing financial or logistical constraints; however, evidence on durability beyond 10 years, protection in boys, and non-cervical outcomes remains limited (24). Local experts noted that while the official national schedule follows the single-dose recommendation endorsed by PAHO, several medical societies (e.g., Infectious Diseases, Pediatrics) continue to recommend two doses for girls under 15 years of age and three doses for older age groups or special populations such as people living with HIV or immuno-compromised individuals.

Gender-neutral HPV immunization is increasingly used to strengthen progress toward elimination. It provides direct protection for men (penile, anal, and oropharyngeal cancers) and helps curb transmission, with population-level evidence of impact and herd effects from vaccination programs (25). Equity is also a key rationale, including boys and men helps protect groups who may benefit less from women-only herd effects or have higher risk and fewer screening options, such as men in general, men having sex with men, people living with HIV, and other underserved populations (25). In the Americas, adoption is growing, 28 countries now vaccinate both boys and girls, including the DR (18).

According to the WHO, vaccination coverage by age 15 among girls is about 80% for both the first and final dose in the DR; data for boys are not yet available (26). Coverage among girls has improved as the first-dose coverage reached ~65% in 2022 but sustained efforts are needed to raise completion under the new schedule and to monitor impact. HPV vaccination program coverage, which reflects the proportion of girls in the national target age group (9–14 years) vaccinated in a given year, was 45% in 2024, up from 21% (single dose) in 2022 (26).

Why HPV matters beyond cervical cancer?

High-risk HPV types are causally linked to anal, vulvar, vaginal, penile, and oropharyngeal cancers; see table below (27). HPV also causes genital warts and recurrent respiratory papillomatosis in adults and children (28). Globally, around 20% of HPV-related cancers occur at non-cervical sites (29).

Crude incidence rates per 100,000 people	Women	Men
Cervical cancer	19.8	
Anal cancer	0.09	0.20
Vulva cancer	0.09	
Vaginal cancer	0.52	
Penile cancer		1.86
Oropharyngeal cancer	1.16	1.96
Oral cavity cancer	0.98	1.42
Laryngeal cancer	1.12	4.30

Table title: Crude incidence rates of HPV-related cancers (per 100,000), by sex. Source: (7).

Misinformation and safety myths depress demand

Local professional bodies flag misinformation as a primary driver of vaccine myths in the DR; media and expert statements note the need to counter false beliefs about safety (30). Hesitancy has also been amplified by anti-vaccine mobilization during the COVID-19 period, including organized street protests against vaccination requirements, which likely reinforced distrust in some groups (31).

Lack of infrastructure for monitoring and evaluation

Reliable monitoring systems are indispensable for tracking progress, ensuring accountability, and building public trust. In the DR, HPV vaccination coverage rates (VCR) are primarily available through the WHO immunization database, as there is no publicly accessible national platform that systematically reports coverage data. These international figures are based on data submitted through standardized reporting mechanisms, but they do not provide disaggregated information by delivery strategy (e.g., school-based vs. primary health care), catch-up campaigns, or geographic region.

Parental hesitancy and consent hurdles

In the DR, hesitancy has been fueled by the belief among some parents that HPV vaccination at age 9 could "incite sexual activity" (30), though the current prevalence and impact of this belief are not well documented. Local professional bodies have also reported difficulty convincing parents of the vaccine's importance (32). Local experts noted that parental acceptance has increased in recent years, reflecting growing awareness and confidence in the vaccine. However, challenges remain in media outreach, as vaccination campaigns are not sufficiently visible on television and radio, limiting their reach and impact.

School-based vaccination in early stages

Some school-based HPV vaccination activities began in selected areas in 2022-2023, according to local experts. A national school-based vaccination campaign was officially launched in September 2025, coordinated by the Ministry of Health and the Ministry of Education, targeting children aged 9-14 years (33), a late start compared with many countries in Latin America (18). The campaign was announced as a nationwide effort and implemented through provincial health directorates across the country, though the extent of full school-level coverage has not been independently verified. This shift is promising, as local experts noted that vaccination coverage increased substantially following the adoption of the single-dose schedule and the inclusion of boys in 2025. However, as with many school-delivery programs, challenges such as parental consent bottlenecks, reaching out-of-school adolescents, and managing coordination and logistics (e.g., session planning, vaccine stock, and record-keeping) may slow coverage gains (34, 35).

EARLY DETECTION

Cervical cancer can be detected in two main ways: either when a woman experiences symptoms and seeks care, or through screening programs that identify precancerous lesions or actual tumors before symptoms appear. Early detection relies heavily on organized screening programs, traditionally using Pap smear (cytology) and, increasingly, HPV testing. Leading medical bodies like ASCO, ESMO, and European guidelines endorse HPV testing as the preferred approach, often using Pap smear only to triage HPV-positive cases (36,37). PAHO also recommends HPV DNA testing as the mainstay of effective cervical cancer screening across the Americas (20). The WHO CCEI calls for 70% of women to be screened with a high-performance test by ages 35 and 45 by 2030 (20). The local clinical practice guidelines in the DR recommend that women between the ages of 30 and 65 undergo HPV testing (38). However, the national screening program (Programa de Detección of the Servicio Nacional de Salud, SNS) currently provides screening for women aged 25–60 years, and it remains unclear whether HPV testing or Pap smear is being used as the primary method (39).

DETECTION

SCREENING PROGRAM WITH PRIMARY HPV TESTING (PREFERRED) OR PAP SMEAR

SELF-DETECTION OF SYMPTOMS

WHO GOAL:
70% OF WOMEN SCREENED WITH A HIGH-PERFORMANCE TEST BY AGES 35 AND 45 BY 2030

Opportunistic screening instead of a comprehensive, organized national program

According to WHO estimates (2019), between 79–85% of women aged 30-49 in the DR were screened within the past 3–5 years (40). However, this seemingly high coverage figure masks critical issues of quality and equity. Most screening is opportunistic, performed when women visit a clinic for other reasons, without an organized recall or follow-up system (27). As a result, women in rural and marginalized communities have far less access to consistent screening than those in urban areas (41). The Programa de Detección led by the National Health Service (SNS) operates in about 10 hospitals (39), but its reach in rural areas and underserved communities remains limited (39).

Lack of infrastructure for monitoring and evaluation

Comprehensive and complete data are important in monitoring and evaluation of the screening program. At present, the DR lacks a cervical cancer screening registry that captures screenings in both the public and private sector, or even one that covers only screening in the public sector.

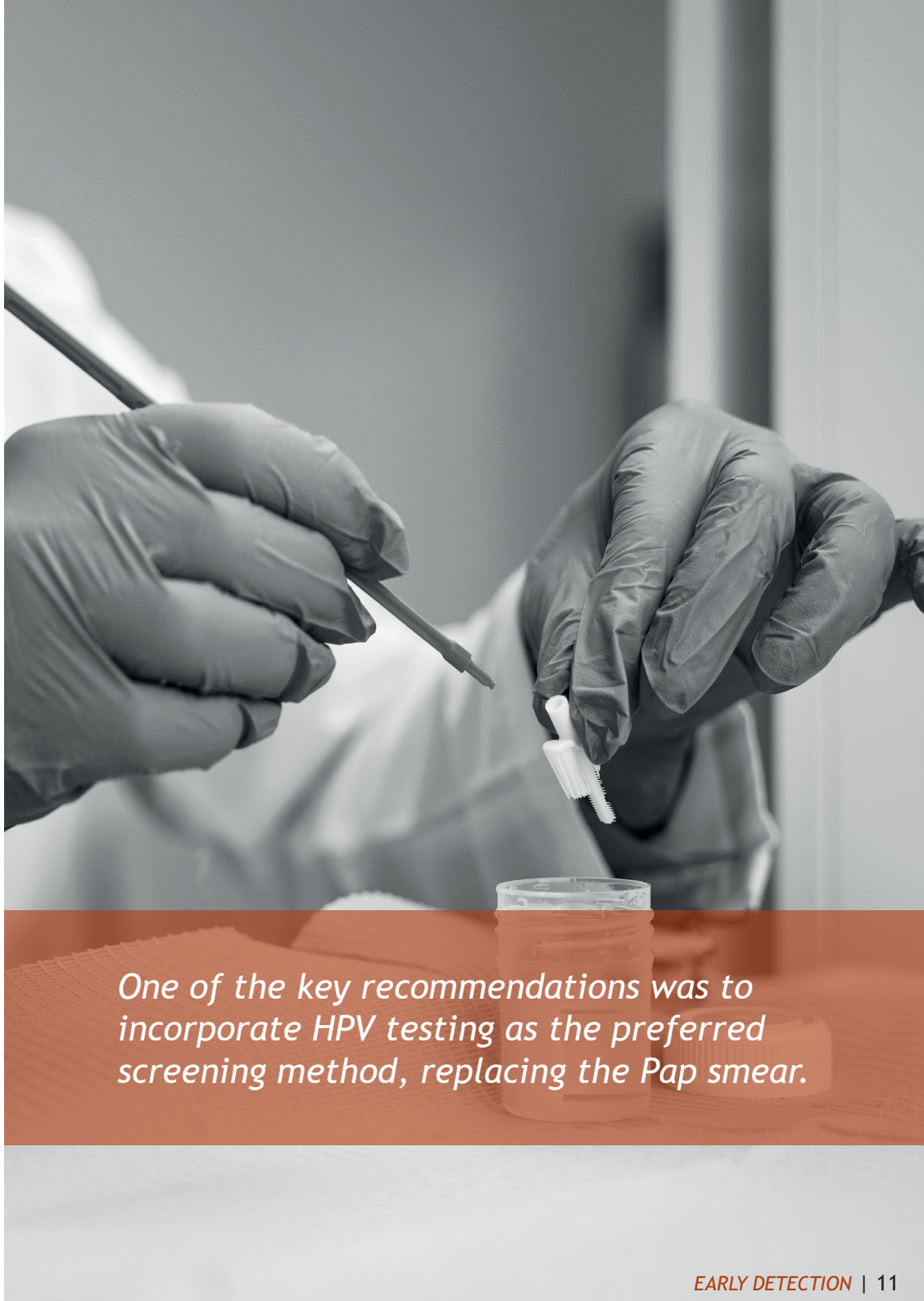
Limited public awareness of HPV and its link with cervical cancer

A qualitative study found that a key barrier to cervical cancer screening in the DR is the limited public awareness of HPV and its link to cervical cancer, compounded by stigma around HPV as a sexually transmitted infection (42). Cultural taboos and misconceptions, such as the belief that only women with multiple partners are at risk, discourage open discussion and create reluctance to seek screening or follow-up care after abnormal results. Another study with women from Paraiso revealed that although most women had undergone at least one Pap smear, their understanding of the purpose and recommended frequency of screening was limited, with many citing only vague reasons for the exam (43). This lack of accurate knowledge obscures the fact that HPV exposure is common, usually transient, and that only persistent infections carry the greatest risk. Local experts emphasized the need to strengthen public education on risk

factors, as many women are unaware of their personal risk and the importance of regular screening.

HPV testing is not yet routinely available

In March 2025, the Clinical Practice Guidelines for Screening, Detection, and Treatment of Precancerous Lesions for the Prevention of Cervical Cancer were updated. One of the key recommendations was to incorporate HPV testing as the preferred screening method, replacing the Pap smear (38). However, a 2018–2019 study found that most providers were familiar with HPV testing only as a complement to Pap smears, rather than as a stand-alone test (44). At the time, the Ministry of Health had not authorized its widespread use, limiting access primarily to the private sector and reinforcing inequities in screening. While providers generally recognized that combining HPV testing with Pap smears improves diagnostic accuracy, awareness of HPV self-sampling (self-collection for HPV testing) was very low: only 21.3% of providers were aware of this approach, and just 16.8% considered it a valid option. These findings reflect significant knowledge gaps in addition to systemic barriers to implementation. Further research is needed to assess the extent to which HPV testing is currently being conducted. For now, the guidelines continue to state that the Pap smear remains the primary detection method until HPV testing becomes broadly available in both the public and private sectors. Local experts noted that, in the public sector, nine prioritized centers currently offer HPV testing starting at age 30, in line with national and WHO guidelines. The test was included in the Basic Health Plan in 2023, and efforts are underway to integrate it into subsidized insurance schemes. Nevertheless, conventional Pap smears remain the main screening method nationwide.



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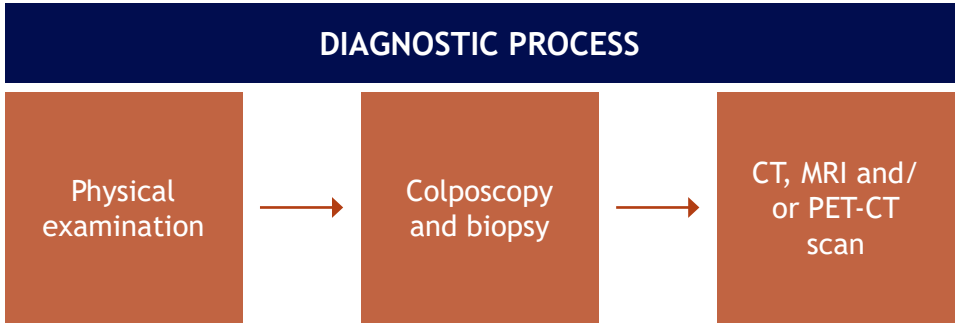
DIAGNOSIS

Cervical cancer diagnosis follows a structured, multi-step pathway. Positive screening results or suspicious findings are followed by physical examination, colposcopy, and biopsy to confirm the presence of precancerous lesions or invasive disease. Following this, images (through CT, MRI, or PET-CT scans) are taken to determine disease extent and guide staging. Accurate diagnosis and staging are critical for treatment planning. Strengthening access to timely diagnostic services and ensuring continuity across these steps remain essential for improving survival and advancing toward elimination goals.



Source: based on ESMO (45) and ESGO/ESTRO/ESP guidelines (46).

Follow-up of abnormal results

One of the most pressing challenges is ensuring timely follow-up after abnormal screening results (42). Women often encounter barriers such as the cost of additional tests, limited trust in providers, and doubts about the quality of care, which discourage them from completing further evaluations (42). Because the current system typically requires multiple visits, Pap test, receipt of results, diagnostic confirmation, and treatment, some women may be lost along the care pathway. Local experts noted that delays in receiving results can range from 15 to 30 days or more, particularly in rural areas, where transportation costs and distance often lead women to abandon follow-up altogether. They also emphasized the absence of systematic mechanisms to track and follow up on abnormal results, which contributes to further losses along the continuum of care. In addition, limited staffing and laboratory capacity can slow processing times, leaving screened women without timely results or appropriate management.

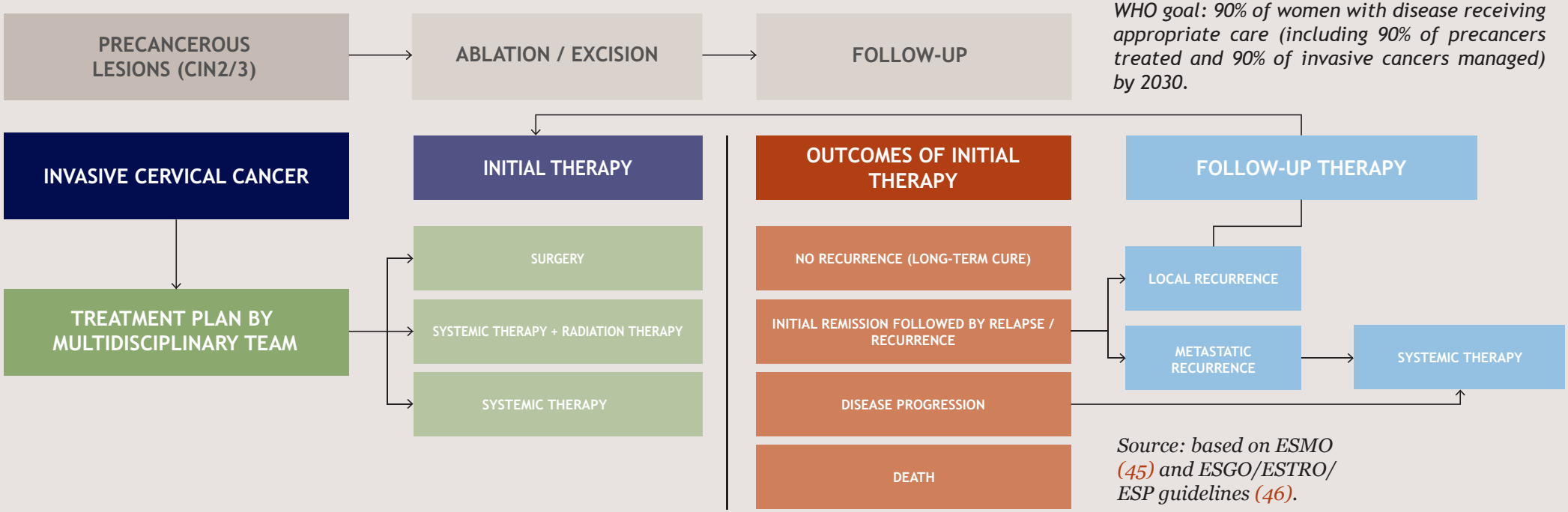
Pathology is limited outside the capital

A critical barrier to timely cancer diagnosis in the DR is the limited availability of pathology services beyond Santo Domingo (47). As reported by a news outlet in 2024, most provinces lack pathology laboratories, which creates inequities in access and forces patients in rural and regional areas to depend on the capital for diagnostic confirmation (47). Local experts clarified, however, that there are pathology centers operating outside the capital, although their capacity, distribution, and resources are often limited, which can result in delays and regional disparities in diagnostic services.

TREATMENT

Secondary prevention through screening and treatment of precancerous lesions plays a critical role in preventing progression to invasive cervical cancer. Early detection and timely management of cervical intraepithelial neoplasia (CIN) can interrupt the disease process (48), avoiding the need for more complex and costly cancer treatments later on. However, when cervical cancer develops despite preventive efforts or in the absence of such measures, comprehensive treatment strategies become essential to achieve cure or control of the disease.

Management of cervical cancer should be guided by a multidisciplinary team (MDT) (46), including oncologists, surgeons, radiologists, pathologists, and oncology nurses to ensure the most appropriate care for each patient. The stage at diagnosis determines therapeutic options; early detection allows for simple curative treatments, whereas advanced stages require complex and more costly approaches. Standard treatment typically involves surgery to remove the tumor and most often the entire uterus, radiation therapy, and systemic cancer medicines, alone or in combination depending on the stage (45,46). Early, operable disease is usually treated with surgery and often followed by radiation therapy with or without chemotherapy. For locally advanced cases, concurrent chemoradiation with brachytherapy used to be the curative standard, but nowadays immunotherapy may be added in selected high-risk settings (49). In recurrent or metastatic disease, chemotherapy regimens used to be the standard of care, but they have been extended to include immunotherapy in patients with a positive PD-L1 expression on their tumor (46). The updated WHO Essential Medicines List (EML) from September 2025, includes immunotherapy as a first-line monotherapy for metastatic cervical cancer (50). Equitable access to surgery, radiotherapy, systemic therapy, and novel agents, together with timely referral to specialized centers, is essential to improving outcomes. In IOHP in 2023, 7% of cases were diagnosed at stage I, 33% at stage II, 52% at stage III, and 7% at stage IV (4). As seen in the economic burden section, stages IIB-IV impose the highest costs on national health systems. In IOHP, 57% of patients received chemotherapy, 36% radiotherapy, and 10% surgery (4).



WHO goal: 90% of women with disease receiving appropriate care (including 90% of precancers treated and 90% of invasive cancers managed) by 2030.

Source: based on ESMO (45) and ESGO/ESTRO/ESP guidelines (46).

[3] These estimates come only from data from Oncology Institute Dr. Heriberto Pieter (IOHP) (2023) and were recalculated excluding cases with unknown stage and stage 0, for a total of 111 cases.

Outdated clinical guidelines

Although the Ministry of Health published updated clinical guidelines in 2025 for the prevention and early detection of cervical cancer, including the treatment of precancerous lesions but not invasive disease (38), the most recent national guidelines for the treatment of invasive cervical cancer, issued by the then Secretaría de Estado de Salud Pública y Asistencia Social (SESPAS, now the Ministry of Health), date back to 2010 (51). The risk of not having updated guidelines is that clinicians may rely on treatments that no longer represent the best available evidence (52), and clinical practice risks becoming inconsistent (53). However, local experts highlighted that a revision of the National Cervical Cancer Protocol is currently underway. This effort, led by the Ministry of Health, aims to unify diagnostic, treatment, and follow-up criteria in line with the most recent international guidelines.

Shortage of radiation specialists

A study estimated that by 2020 the DR would have needed approximately 31% more radiation oncologists, 35% more medical physicists, and nearly 47% more radiation therapists than it had in the early 2010s (54). The same study also highlighted as a problem the lack of comprehensive, local training programs for the radiation oncology workforce. Until 2010, the DR depended almost entirely on foreign training for radiation oncologists. In 2018, the only residency program produced 2 graduates per year, which is insufficient given the rise in cancer cases. For support staff (therapists, nurses, dosimetrists, medical physicists), there are no formal training programs at all, and they either learn on the job or must seek training abroad (54).

Geographic inequalities and limited access to radiation therapy

In 2018, there were 12 radiation therapy centers concentrated in 3 metropolitan areas (Santo Domingo, Santiago, and La Romana) (54). No centers existed in rural regions, meaning patients outside the cities had to travel long distances for treatment. Moreover, outside Santo Domingo, and to a limited extent Santiago, public hospitals do not provide radiation therapy, leaving most patients in other regions dependent on private facilities or referral to the capital (54). This urban concentration of services mirrors the general health system distribution: only about 35% of the population lives near or has direct access to major reference hospitals, which are primarily located in the metropolitan region (55). For the remaining ~65% of the population, accessing these hospitals can require more than three hours of travel time.

Shortage of radiation therapy machines relative to current and future demand

Despite being comparatively well positioned in Latin America and the Caribbean, the DR faces a persistent shortage of radiotherapy machines (56). In 2022, the country had 20 megavoltage (MV) units to serve nearly 19,500 cancer cases, falling short of the estimated demand of 25 units. By 2030, with cancer incidence projected to rise to almost 26,000 cases, the required number of MV units will increase to 33, leaving a projected deficit of 13 units if capacity does not expand (56). Since external beam radiation therapy, often combined with brachytherapy, is essential for treating locally advanced cervical cancer, this shortage has direct implications for access to timely and effective care. In addition, much of the recent expansion in equipment has occurred in the private sector, leaving public facilities comparatively under-resourced. For instance, most of the linear accelerators and HDR brachytherapy units installed after 2010 are located in private centers such as Oncoserv, CDD Radioterapia, and Radonic, while public institutions like the Instituto Oncológico Regional del Cibao still rely on older equipment, including a cobalt teletherapy machine from 1987 and a cesium LDR brachytherapy unit from 1995 (54).

Limited access to new cancer medicines

Local experts highlighted that, despite the availability of standard chemoradiation, access to innovative treatments such as immunotherapy remains limited. Broader analyses of the pharmaceutical landscape reveal that the DR exhibits a pronounced gap between regulatory approval and actual market availability of new medicines (57). Between 2014 and 2021, a total of 45 innovative molecules were approved locally (57). However, only one had full availability, ten were classified as having limited availability, and eighteen were restricted to the private market, while sixteen remained officially approved but unavailable. This pattern indicates that, although the regulatory approval process in the Dominican Republic is relatively efficient, the subsequent stages required to ensure reimbursement, inclusion in formularies, and broad public access remain significantly delayed or incomplete for most innovative therapies.

Waiting lists for the high-cost medicines program (PMAC)

Access to the high-cost medicines program (Programa de Medicamentos de Alto Costo, PMAC), managed by the High-Cost Medicines Directorate (Dirección de Acceso a Medicamentos de Alto Costo, DAMAC), is subject to budget-limited slots and centralized dispensing, creating a queue of patients awaiting inclusion. In August 2025, the president reported ~3,000 people still needed to enter the program (58). Ministry information reported by the press describes a process in which those not admitted immediately remain on a wait list, with approval times ranging from weeks to months and, in some cases, up to a year (59). Investigative reporting documents prolonged waits and treatment interruptions, including renewal delays every ~4 months and individual cases waiting around a year for first delivery (60).

Financial constraints: limited caps and copayments

Coverage rules further restrict effective access to high-cost cancer care. The annual coverage cap for high-cost diseases, including medical appointments, surgeries, chemotherapy, radiation therapy, and medications, was set at a maximum of RD$2,090,000 in 2022 (61). This is higher than the previous limit of RD$1,090,000, after numerous reports indicated the earlier amount was inadequate, often resulting in the halting of treatments (62, 63). This was particularly evident in advanced cancer cases, where some news outlets reported that patients exhausted their maximum coverage within four months while undergoing treatment (62). While the rise in the coverage limit is a step in the right direction for covering full treatment courses, its adequacy remains to be evaluated. In addition, the public health insurance system applies copayments that can further limit access for economically disadvantaged patients. Public coverage typically pays 80% of the costs for consultations, surgeries, radiotherapy, and chemotherapy, and 70% for outpatient medicines (62, 64). Consequently, patients must contribute the remaining 20% and 30% of these costs (62). Once they reach the annual coverage cap, they are responsible for all subsequent expenses, which can create a substantial financial burden and disrupt continuity of care.

RECOMMENDATIONS

Build a prevention-first culture

Maintain continuous, multi-channel education (TV, schools, supermarkets, community spaces), strengthen public understanding of risk factors, and invest in ongoing training for pediatricians, gynecologists, and other providers.

Strengthen care integration to reduce waiting times and follow-up losses

Set strict turnaround targets for HPV and biopsy results, deploy SMS/WhatsApp recalls for abnormal findings, and implement systematic tracking to prevent losses to follow-up.

Empower health professionals as prevention champions

Enhance continuous training for pediatricians, gynecologists, and other specialists, encourage active promotion of vaccination and screening, and leverage every clinical encounter as an opportunity for preventive education.

Ensure access to innovative and up-to-date care

Update national treatment guidelines regularly, expand public sector capacity for radiation therapy and systemic therapies, and strengthen financing mechanisms to improve equitable access to modern equipment, innovative cancer medicines, and evidence-based treatment options. Guarantee timely access to MDTs at diagnosis and during treatment planning.

Strengthen data systems and accountability

Establish comprehensive cancer and screening registries, strengthen HPV vaccination monitoring, and ensure routine collection and use of disaggregated data to guide policy, allocate resources efficiently, and track progress toward elimination targets.

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