

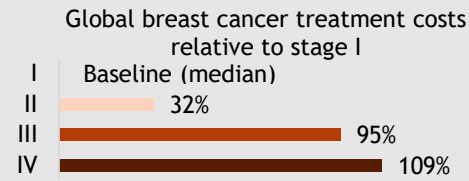




Women's cancers in sub-Saharan Africa

Total women (2024): 648 million
 Life expectancy (2023): 65 years
 Women's cancer cases (2022): 506,055
 Women's cancer deaths (2022): 328,762
 Sources: World Bank, IARC

Disease burden		Economic burden	
Breast cancer	Most common cancer among women in the region, accounting for 28% of all new cases and 22% of cancer deaths among women. Five-year survival rates hover around or below 70% across most countries.	Direct costs 	Early detection, timely diagnosis, and effective treatment significantly reduce expenses. For instance, pooled global estimates indicate that breast cancer treatment costs are approximately 109% higher at stage IV compared to stage I.
Cervical cancer	Second most common cancer among women representing 24% of all new cases and 22% of deaths - figures that are significantly higher than in other regions. Survival rates generally are below 60%, largely due to late-stage diagnosis and limited access to screening and treatment.		
Ovarian cancer	It causes 4% of new female cancer cases and 4% of female cancer deaths. In many low- and middle-income countries (LMICs), five-year survival rates range between 30% and 39%.	Indirect costs 	There is limited region-specific, comparable economic data, but available evidence shows substantial indirect costs from lost productivity. In high-income countries, indirect costs compose 32% to 70% of the total economic burden of women's cancers. Moreover, the World Ovarian Cancer Coalition's 11-country study estimated that indirect costs constituted 91% of ovarian cancer's socioeconomic burden - driven largely by the value of lives lost; the sample included Kenya, Malawi, and Nigeria.
Endometrial cancer	It accounts for 2% of new cases and 1% of cancer-related deaths among women. While robust data for sub-Saharan Africa are lacking, evidence from the United States (US) indicates that survival rates have declined since the 1970s.		



The case for investing in women's cancers

High returns

- In LMIC settings, a comprehensive cervical cancer elimination program (vaccination + screening + treatment) yields up to US\$3.20 in economic gains for every US\$1 invested by 2050.
- Scaling HPV vaccination and screening to WHO targets delivers per-capita savings of US\$215.3 in South Africa.

Strategic value of early investment

- Prevention through HPV vaccination requires decades before benefits fully emerge in terms of cancer reduction, but immediate benefits include preventing genital warts and precancerous lesions.
- Screening and early treatment lead to significant short- and medium-term cost savings, avoiding costly late-stage interventions.

Workforce and productivity impact

- In sub-Saharan Africa, where women are diagnosed with cancer at younger ages due to a relatively young population structure, investments in prevention and treatment reduce premature deaths and disability during the most productive years of life.
- This means more women remain active in the workforce, driving economic growth, while lowering social protection costs and avoiding the high expenses of late-stage care.

Evidence gap

- Investment cases overwhelmingly focus on breast and cervical cancer, while endometrial and ovarian cancer are under-studied.
- In sub-Saharan countries, as in other LMICs, this underinvestment risks perpetuating disparities and missed opportunities for cost-effective interventions.

Recommendations

Foundational enablers for women's cancer policy include universal health coverage, gender equity, a well-trained workforce, and robust data systems. These cross-cutting elements exhibit critical gaps in sub-Saharan Africa and are essential for effective, equitable cancer care. Building on these foundations, countries in the region should:



Advocate for women's cancers as a health priority



Strengthen and streamline cancer care delivery & workforce capacity



Focus on prevention and early detection efforts



Leverage innovation across the women's cancer care continuum

Prevention challenges

- **Low HPV vaccination rates:** Many countries still lack a national HPV program (e.g., Angola, Chad, Ghana, Somalia, Sudan, etc.), and among those with programs, coverage remains far below the 90% WHO target (e.g., last-dose by age 15: South Africa 44%; Nigeria and Ethiopia ~30%).
- **Information & awareness gaps on HPV and vaccination services:** Insufficient knowledge of HPV and its disease link is common. Limited information on where/how to access vaccination suppresses uptake.
- **Lack of genetic testing:** Genetic testing is largely unavailable or inaccessible in many sub-Saharan countries, even for women already diagnosed, with virtually no access for healthy high-risk women and a marked shortage of genetic counselors.
- **Rising overweight/obesity rates:** More and more women are overweight/obese, which are important risk factors for breast, ovarian, and uterine cancers.



Success story: **Rwanda** is a global HPV vaccination leader - first in Africa to launch a nationwide program (2011), achieving >90% coverage in year one and sustaining among the world's highest rates. The WHO reports Rwanda aims to reach the 90-70-90 cervical cancer elimination targets by 2027, years ahead of the global timeline.

Opportunities



Gender-neutral HPV vaccination and catch-up programs



School- & pharmacy-based HPV vaccination



Population-based genetic testing



New prevention strategies for gynecologic cancers

Detection and screening challenges

- **Lack of organized population-based screening programs for breast and cervical cancer:** Most countries still rely on opportunistic screening (women must actively seek it themselves).
- **Very low screening participation and late-stage diagnosis:** By 2019, 85% of women aged 30-49 in the region had never been screened for cervical cancer - far from the WHO target ($\geq 70\%$ screened by age 35 and again at 45). Many breast cancers present late; for example, in Uganda and Zimbabwe only ~8% are diagnosed at stage I-II, with many unstaged cases, signaling diagnostic and registry gaps.
- **Sociocultural barriers and fear:** Fear of cancer deters help-seeking in the region; in Nigeria, needing permission from male partners or elders to seek care and financial dependence further delay access.
- **Low health literacy:** Associated with lower screening participation, poorer adherence, and worse outcomes, especially among women facing socioeconomic, cultural, or language barriers.

Opportunities



Mobile screening



HPV self-sampling



Patient navigation



Integration of maternal health programs with screening programs



Leverage trusted voices

Diagnosis challenges

- **Severe specialist shortages:** Sub-Saharan Africa faces a documented scarcity of healthcare workers, including gynecologists, causing long waits and delayed diagnosis.
- **Pathology capacity is critically limited:** In parts of sub-Saharan Africa, very few pathologists serve millions; shortages are most pronounced in the public sector (e.g., in South Africa).
- **High out-of-pocket costs for basic services:** In Mozambique, even a core biopsy needle for breast cancer diagnosis can cost around one month's salary, delaying or preventing diagnosis.
- **Biomarker testing gaps:** Testing infrastructure is lacking in the region, with ovarian/breast samples often sent abroad, limiting access to BRCA/HRD and other tests needed to guide modern therapy. In Zambia, biopsies are frequently sent to India for immunohistochemistry/molecular tests due to local gaps, creating delays and out-of-pocket costs.
- **Treatment start before full diagnosis:** In a public hospital in South Africa, 10-15% of breast cancers were missing ER/PR/HER2 results, possibly leading to treatment decisions without full biomarker assessment.

Opportunities



Task-shifting in diagnostics by AI



Scaling diagnosis with telemedicine and telepathology



New molecular classifications



AI prediction of biomarker status



Gender-sensitive and cultural safe diagnosis

Treatment challenges

- **Fragmented care:** This leads to delays, higher costs, poor coordination, worse patient experience, and poorer cancer survival.
- **Severe oncologist & gynecologic oncologist shortages:** Many sub-Saharan countries have no clinical oncologists or extremely high patient loads; gynecologic oncology training is limited and depends on international collaborations.
- **Radiation therapy capacity gaps:** Many countries in the region lack LINACs; even when installed, machines are frequently non-functional (e.g., Zambia multi-year outages; Mozambique frequent downtime).
- **Limited access to new medicines:** Most novel treatments are never reimbursed; in Kenya, Rwanda, and Uganda, newer targeted therapies were not affordable for public funding.
- **Fertility preservation access is limited:** In sub-Saharan Africa, services focus on infertility rather than oncofertility; overall uptake is low, and discussions are often never conducted.



Success story: **Zambia's** expansion of multidisciplinary cancer care is an equity win. It began as a pilot tumor board and now has scaled across provinces, with clinicians holding MDT case discussions and using a mobile app to share diagnostic images/reports and trigger referrals. A cancer-hospital social worker uses the app to coordinate appointments, while clinicians help patients enroll in the national health insurance scheme, easing out-of-pocket costs.

Opportunities



Minimally invasive surgeries



More efficient use of radiation therapy



New cancer medicines



Link accessibility of medicines to clinical benefit



Patient-centered rehabilitation pathways



Gender-sensitive and cultural safe care



Infrastructure in remote/rural areas