Cervical Cancer

Improving Care and Driving Policy Change

Hong Kong

THE SWEDISH INSTITUTE FOR HEALTH ECONOMICS
ENABLING INFORMED DECISION MAKING

KEY TAKEAWAYS

Cervical Cancer in Hong Kong

170

DEATHS ANNUALLY

Cervical cancer causes over 170 deaths annually in Hong Kong, yet it is largely preventable through HPV vaccination, screening, and treatment.

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.

92%

FULLY VACCINATED

The introduction of HPV vaccination in girls has been a success with high coverage rates surpassing the WHO target of 90%.

45%

DETECTED LATE

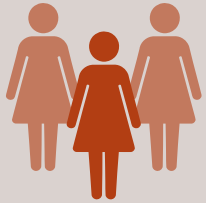
Screening effort can be further strengthened, as only 38% of women report having been screened during the last five years, well below the WHO target of 70%.

UNEQUITABLE ACCESS

Image-guided brachytherapy and immunotherapy recommended by international guidelines are currently not uniformly available or reimbursed.

HIGH-LEVEL RECOMMENDATIONS

To accelerate the elimination of cervical cancer in Hong Kong, this policy brief proposes the following recommendations.



More effort in promoting cervical cancer screening

Raise awareness of cervical cancer prevention and early detection among underserved populations

Strengthen diagnostic and treatment capacity

Improve equitable access to new therapeutic technologies

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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 (1). 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 Hong Kong (HK). 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 HK. In addition, two interviews with local clinical oncologists were held in November 2025 to verify and discuss challenges and opportunities specific to the care of cervical cancer in HK.

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 (2). 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 that almost all sexually active people will be infected with at some point in their lives (3). 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) (4).

Cervical cancer is the fourth most common cancer among women globally (5). 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 (5).

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 (6). 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 Hong Kong SAR Government committed to reducing the burden of cervical cancer in a strategic document from 2022 (7), which continues on initial actions foreseen in the Hong Kong Cancer Strategy 2019 (8). This includes the addition of HPV vaccination in the Hong Kong Childhood Immunisation Programme starting from the 2019/20 school year and the improvement in participation in the Cervical Screening Programme that was already introduced in 2004 (8). In addition, the Hong Kong College of Obstetricians and Gynaecologists published revised guidelines for cervical cancer prevention and screening in 2024 to reflect advances in HPV vaccines and HPV testing since the 2016 version (9).

Many high-income regions with well-developed healthcare systems have achieved substantial declines in both incidence and mortality over recent decades (10, 11). The same pattern is visible in HK (see section 'Disease Burden') (12). High coverage of HPV vaccination in schoolgirls in HK can be expected to drive down incidence over the longer term (likely 10-20 years, as vaccinated cohorts reach the ages at which cervical lesions and cancer typically emerge), with these benefits accumulating as vaccinated cohorts age. In the meantime, there is a need to strengthen early detection through screening and to provide effective treatment.

In European countries where HPV vaccination programs, including catch-up programs, were introduced early at the end of the 2000s, and where vaccination rates have been high, a decrease in cervical cancer incidence is already visible. In Sweden and Denmark, a significant decrease started in 2017 and 2018 respectively, when the first cohort of vaccinated girls reached the age of 25-29 (13). Similarly, in England, a lower incidence of cervical cancer and precancerous lesions (CIN3) is found in the cohort of women who were offered vaccination at a young age, compared to those never offered vaccination, and by mid-2020 HPV vaccination had prevented an estimated 687 cervical cancers and more than 23,000 CIN3 cases (14).

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] CIN3 = severe cervical intraepithelial neoplasia; abnormal growth of cells on the surface of the cervix that can lead to cervical cancer.

DISEASE BURDEN

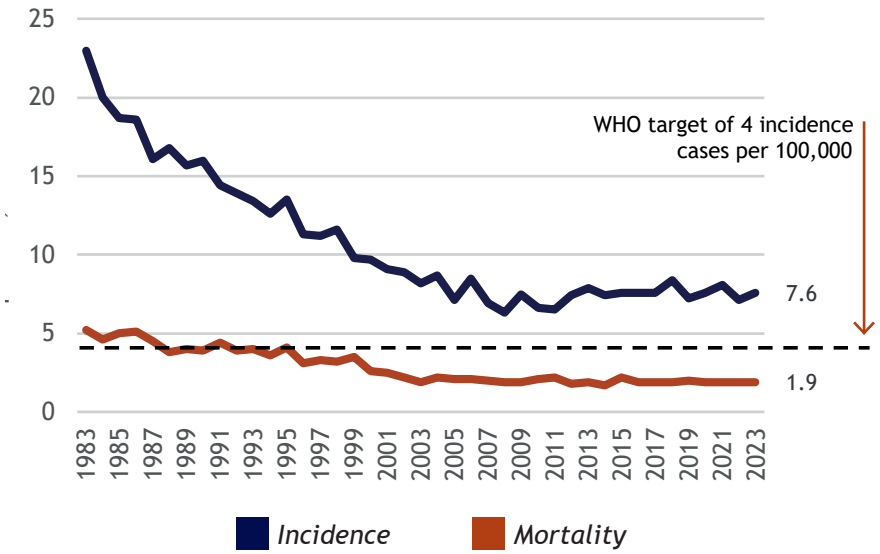
In 2023, HK registered 576 new cervical cancer cases and 173 deaths, making cervical cancer the seventh most common cancer and the ninth leading cause of cancer death among women (12). A woman's lifetime risk of developing cervical cancer before age 75 is 1 in 128, while the risk of dying from it is 1 in 503 (12). The five-year relative survival rate was 65.8% for women diagnosed in 2010-2018 (12).

Cervical cancer largely affects women of reproductive age and working age. Some 70% of new cases were diagnosed in women aged 20-64 years in 2023 (15), and cervical cancer was the fourth most common cancer among women aged 20-44 (16). The median age at diagnosis was 56 years and at death 65 years in 2023 (12).

Despite progress, incidence rates remain above the WHO elimination target

Official statistics from the Hong Kong Cancer Registry show that the age-standardized incidence rate has declined greatly since the 1980s, falling from over 20 cases per 100,000 women to below 10 per 100,000 (15). However, this downward trend has levelled off in the past two decades, with very stable numbers of around 7 cases per 100,000 since around 2005, meaning that incidence is still almost twice as high as the WHO elimination target of 4 cases per 100,000. Mortality has followed a similar trend - decreasing from around 5 deaths per 100,000 women in the 1980s to a stable level of around 2 deaths per 100,000 in the last 20 years (15).

Incidence and mortality of cervical cancer in Hong Kong (1983-2023)



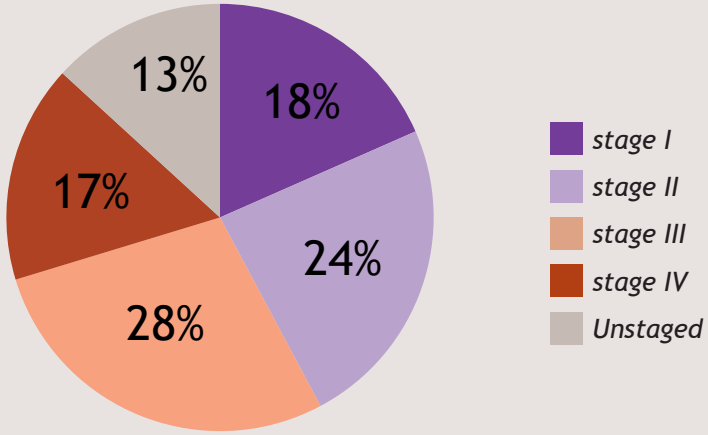
Title: Age-standardized incidence and mortality rate of cervical cancer per 100,000 women in Hong Kong in 1983-2023.

Note: Age standardization according to World population (Segi 1960).
Source: (15).

A substantial proportion of cases are diagnosed at advanced stages

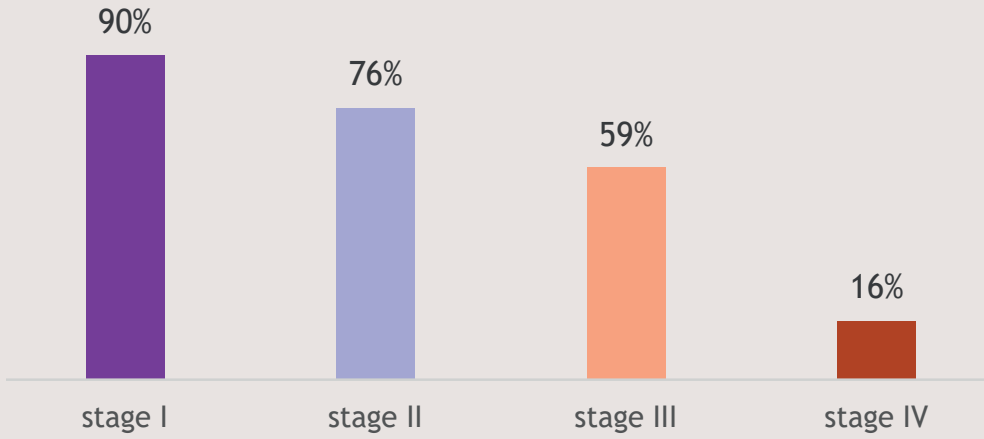
In 2023, 18.4% of cases were diagnosed at stage I, 23.8% at stage II, 28.1% at stage III, and 16.5% at stage IV (12). This means that almost 45% of cervical cancer cases in HK were identified at an advanced stage (III-IV), which is concerning given the disease is largely curable if detected early. By comparison, the Netherlands in 2023 reported a higher proportion of diagnoses at stage I (46%) and a lower proportion at advanced stages (III-IV, 40%), indicating earlier detection overall (17). Five-year survival rates deteriorate in more advanced stages; while they were 90.2% in stage I, 75.6% in stage II, and 58.9% in stage III, they fall sharply to just 16.2% in stage IV for patients diagnosed in HK in 2010-2018 (12).

Stage at diagnosis of cervical cancer in Hong Kong in 2023



Title: Stage at diagnosis of cervical cancer in Hong Kong in 2023. Source: (12).

5-year relative survival rate of cervical cancer in Hong Kong in 2010-2018



Title: Five-year relative survival of cervical cancer by stage at diagnosis in 2010-2018. Source: (12).

[2] 13.2% of cervical cancer cases in HK were recorded as unstaged, which is why the stage-specific percentages do not add up to 100%.

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 (1). 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 (18).

Every dollar invested in prevention, early detection, and treatment of cervical cancer can return **3–8 times** its value.

ECONOMIC BURDEN

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

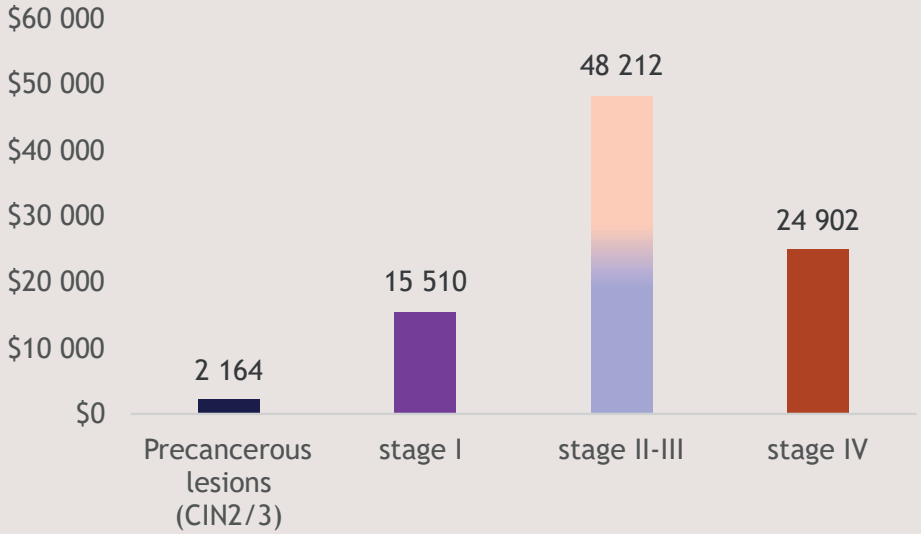
The economic burden of cervical cancer is not well documented, but indirect costs are likely substantial

The economic burden of cervical cancer in HK remains unquantified, as no cost-of-illness studies have been published. Insights from a province in eastern China provide a useful reference. There, the average direct medical costs were estimated at US$ 4,314 for outpatient care and US$ 12,007 for hospitalizations (19). Yet the indirect costs far outweighed direct medical costs as each cervical cancer death was linked to nearly 28 years of life lost and an estimated US$ 95,000 in productivity loss. The high indirect costs are a consequence of the high proportion of new cervical cancer cases and deaths that occur in women of working age (see section "Disease burden"). These costs could be alleviated through better prevention, early detection, and timely treatment and management of precancerous cervical lesions and cancer cases.

Managing advanced cases costs more

Early detection of cervical cancer has important cost implications. Managing precancerous lesions is much cheaper than treating invasive cases, while treating early-stage invasive cases is less costly than advanced cases. Evidence from HK indicates that treatment costs for precancerous lesions are seven times lower than for stage I disease. Stage II-III disease is about 2.2 to 3 times more expensive to treat than stage I, while stage IV disease is roughly 1.5 times more costly than stage I (20, 21). Recurrence of disease after initial treatment further magnifies the burden, as each relapse typically requires more intensive and expensive care, compounding both the clinical and economic impact (22, 23).

Treatment costs of precancerous lesions and cervical cancer in Hong Kong

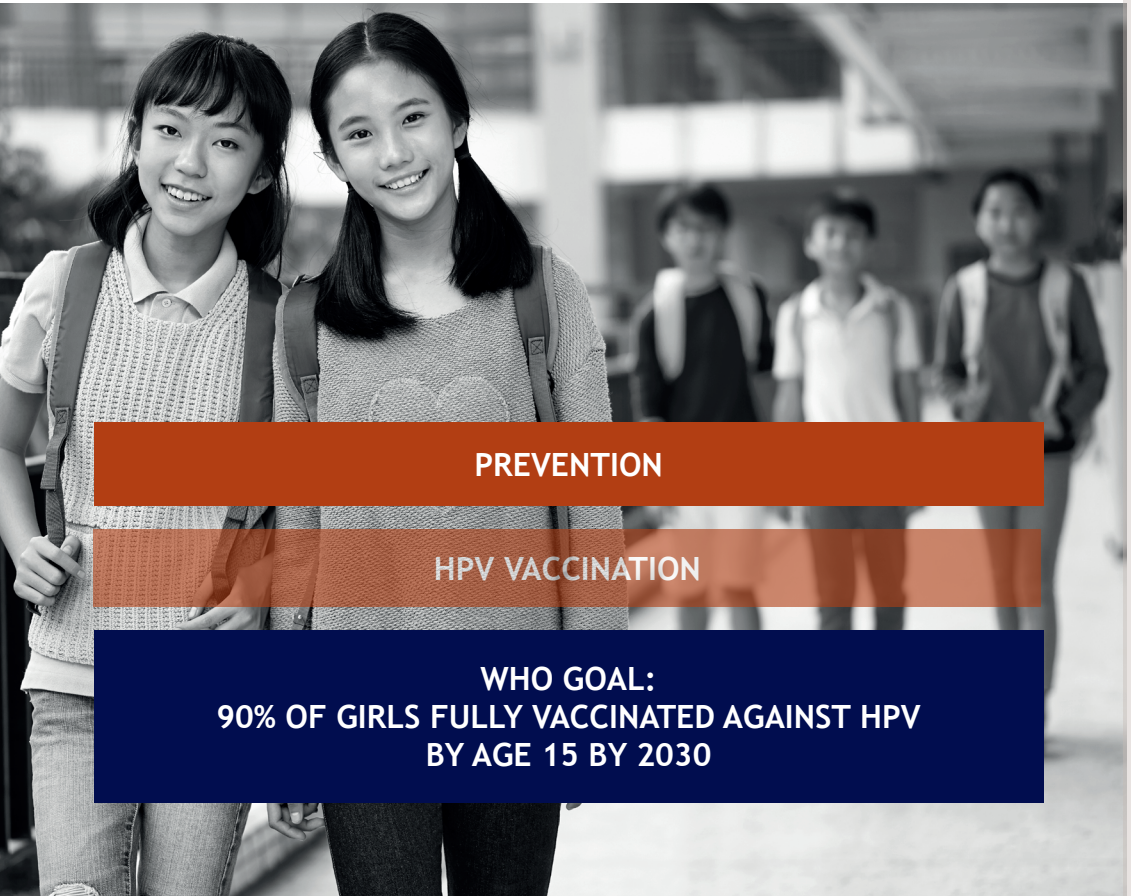


Title: Treatment per stage in Hong Kong in US$ 2022.

Note: Treatment for precancerous lesions includes loop electro-surgical excision procedure (LEEP), for stage I Wertheim's hysterectomy, for stage II–III radiation therapy + chemotherapy + brachytherapy, for stage IV radiation therapy + chemotherapy. Source: (20).

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 (1). 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. Including boys can enhance herd immunity by lowering overall transmission of vaccine-type HPV across sexual networks, indirectly protecting people who are unvaccinated, under-vaccinated, or less likely to mount a strong immune response, while also preventing other HPV-related cancers (24). As of November 2025, 85 countries vaccinate both boys and girls (24). The WHO CCEI calls for 90% of girls fully vaccinated by age 15 by 2030 (1).



HPV vaccination rates are high

HK has made clear progress in the primary prevention of cervical cancer through HPV vaccination. The government introduced a free vaccination program for girls (but not for boys) in the fifth grade in the school year 2019/20 (25, 26), and by 2022/23 the coverage rate for the second dose (for girls in the sixth grade) had reached a remarkable 92% (26), above the WHO target of 90%. Vaccinations are administered by School Immunisation Teams of the Department of Health (27). To further close gaps, a one-time catch-up program was launched in late 2024 to provide free HPV vaccination for older adolescent girls who had missed the initial roll-out (26). This initiative, running until 2026, targets women born between 2004 and 2008.

Given that HK started vaccinating girls in fifth grade (11-12 years old) in the schoolyear 2019/20, it will take at least a decade to see the very first signs of an impact of the HPV vaccine on the incidence of cervical cancer. This is because, e.g., in 2023 in HK, the earliest cases of cervical cancer were diagnosed in the age group 25-29 and the median age at diagnosis was 56 years (12), meaning that vaccinated cohorts will not enter the highest-risk age groups for a few decades.

Why does HPV matter beyond cervical cancer?

There are 12 high-risk HPV types that are causally linked to anal, vulvar, vaginal, penile, and oropharyngeal cancers (3, 28). More commonly, HPV causes precancerous lesions in the cervix and genital warts in both sexes (3). HPV also causes a rare disease called recurrent respiratory papillomatosis in adults and children that affects the vocal cords in the larynx (29). Globally, around 20% of HPV-related cancers occur at non-cervical sites (30).

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. While the benefits of high HPV vaccine uptake are expected to be reflected in lower cervical cancer incidence over the next 1–2 decades, early detection through screening remains important for all unvaccinated women who have ever been sexually active. Screening programs traditionally used Pap smear (cytology) to detect cancer but this is nowadays increasingly replaced by HPV testing. Leading medical bodies like ASCO, ESMO, and ESGO endorse HPV testing as the preferred approach, often using Pap smear only to triage HPV-positive cases (31-33). The WHO CCEI calls for 70% of women to be screened with a high-performance test by ages 35 and 45 by 2030 (1).

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

The Cervical Screening Programme in HK was established in 2004 (8). Since 2023, HPV testing has been adopted as primary screening method (34). The HK Cancer Expert Working Group recommends that women aged 25 to 64 who have ever been sexually active undergo regular screening (34). Those aged 25 to 29 should have a Pap smear every three years, while women aged 30 to 64 may opt for a Pap smear every three years, HPV testing every five years, or co-testing every five years (34).

Ongoing need to optimize the screening program

Despite the Cervical Screening Program having been available territory-wide since 2004, further effort is needed to optimize the program and encourage more women to initiate enrollment (35). Screening is offered at subsidized rates via Maternal and Child Health Centers (HK$ 100 per test), with fee waivers for women receiving Comprehensive Social Security Assistance and some other groups (34). According to the Population Health Survey 2020–2022, 52.1% of women aged 25–64 have ever been screened and only 38.4% were screened in the last 5 years (34), well short of the WHO's 70% target. In comparison, several European countries achieve cervical screening coverage at or above 70% within the recommended interval (e.g., Sweden 78%, Czechia 75%, Slovenia 75%, Ireland 74%, and Finland 73%) (36). Notably, only around 2% of women in HK cited participation in the organized program as their reason for screening, underscoring limited program reach (37). The most common reasons for undergoing screening were medical necessity (38.8%), being offered the test during a routine visit (32.8%), and inclusion in a general health check-up (19.2%) (37). Local experts noted that, in the absence of a strong primary care system, preventive care is rarely integrated into routine consultations, which constrains uptake. This is consistent with an analysis by the OECD highlighting the importance of population-based (organized) screening approaches – supported by systematic invitation practices, screening data systems, and quality assurance/monitoring, and free-of-charge screening visits – to improve program performance and equity (38).

Low prioritization of preventive measures among women

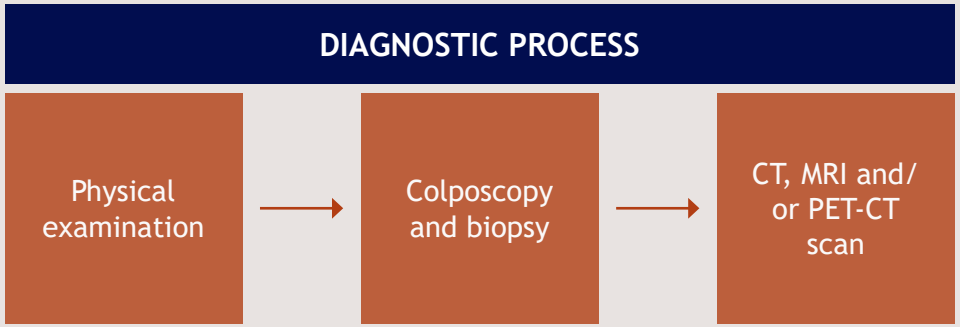
Among women who had not been screened, the most common reasons were no physician recommendation (33.3%); no symptoms (30%); and perceiving no need (14.6%) (37). These patterns are consistent with expert observations that most people in HK seek care only when symptomatic, often at walk-in clinics or specialist services. Finally, 6.1% of women cited a lack of time as their reason for not being screened. To address these challenges, research in HK has highlighted HPV self-sampling as a promising alternative. Studies show that self-testing achieves high uptake rates, ranging from 62% to 73%, particularly among under-screened and never-screened women, with strong acceptability and willingness to repeat the test (39, 40). Evidence from HK also suggests face-to-face outreach to underserved groups yields substantially higher kit return than social-media or school outreach.

Limited health literacy

Findings from the Population Health Survey 2020–2022 show that 9.3% of women who had not undergone cervical cancer screening believed they were too young or had not yet reached the appropriate age, despite all respondents being within the eligible age range (37). Research among ethnic minority women, who make up around 8% of HK's population, highlights similar gaps in understanding and awareness (41). Misconceptions included thinking that screening was unnecessary if they were not currently sexually active or if they had no symptoms. Local experts also identify foreign domestic helpers as a particularly vulnerable group: many come from countries without widespread HPV vaccination or screening activities, and they tend to have lower awareness of symptoms and often present late with advanced disease.

DIAGNOSIS

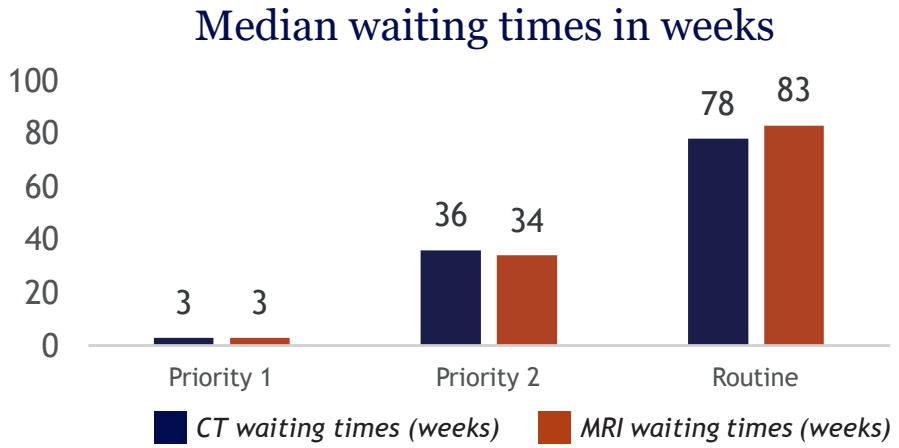
Cervical cancer diagnosis follows a structured, multi-step pathway. Positive screening results or suspicious findings are followed by physical examination, colposcopy, and biopsy to confirm the presence of precancerous lesions or invasive disease. Following this, images (through CT, MRI, or PET-CT scans) 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 (42) and ESGO/ESTRO/ESP guidelines (33).

Addressing the capacity for timely access to imaging and outpatient services

Demand for diagnostic imaging outstrips supply in HK's public system, particularly for routine cases, creating long waiting times for services. Median waits for patients triaged as semi-urgent face waits of 6-8 months for advanced imaging in the public system (43). The accessibility of PET scans, often needed for precise staging or assessment of metastasis, is also challenging (44). This situation has prompted the Hospital Authority to set up a Private Healthcare Info Desk to refer patients to private providers (44). According to local experts, this public-private collaboration scheme helps patients with histologically proven cancer to receive CT or MRI scans at private centers with costs covered by the government at considerably shorter waiting times. Specialist clinics triage referrals by urgency: while urgent referrals (Priority 1) are typically seen within 2 weeks and semi-urgent within 8 weeks (targets generally met) (45). According to local experts, patients with suspected cervical cancer are generally prioritized: those with squamous cell carcinoma on Pap smear are usually seen by a gynecologist within around 2 weeks, and high-risk abnormalities within about 8 weeks, with subsequent oncology appointments typically scheduled within 4 weeks. Waiting times also vary across Hospital Authority clusters, and patients are generally required to attend hospitals within their residential catchment area, limiting their ability to choose centers with shorter waiting lines.



Title: Median waiting times in weeks for CT and MRI in Hong Kong 2023-2024. Notes: Numbers are provisional figures. Source: (43).

Strengthening access to timely diagnostic services and ensuring continuity across these steps remain essential for improving survival and advancing toward elimination goals.

Growing demand for healthcare workforce

HK faces shortages of healthcare professionals in the public system across multiple specialties critical to cervical cancer care, reflecting broader workforce challenges across the health system as in other advanced economies. These shortages affect every step of the care pathway, from gynecologists who perform colposcopies and surgeries, to radiologists who interpret imaging, to pathologists who provide diagnostic confirmation. In 2021, HK had 2.1 registered physicians per 1,000 population, well below the OECD average of 3.6 and lower than high-income countries such as South Korea (2.6) and Japan (2.7) (46). Within the Hospital Authority, key specialties including obstetrics and gynecology, pathology, and radiology report high attrition rates (46). Obstetrics and gynecology recorded the second-highest attrition of all specialties in 2022 (9.8%), followed by pathology (9.6%). According to one news outlet, the pathology workforce is particularly strained, with only about 260 practicing pathologists for a population of 7 million, equivalent to one pathologist per 26,500 people (47). This ratio is markedly worse than in countries such as Australia, which has approximately one pathologist per 15,500 people and still considers pathology to be facing an important workforce shortage. Local experts noted that, although the situation has improved slightly in recent years, vacancies remain widespread, and experienced physicians frequently move to the private sector in search of better remuneration, further eroding expertise within the public system.

TREATMENT

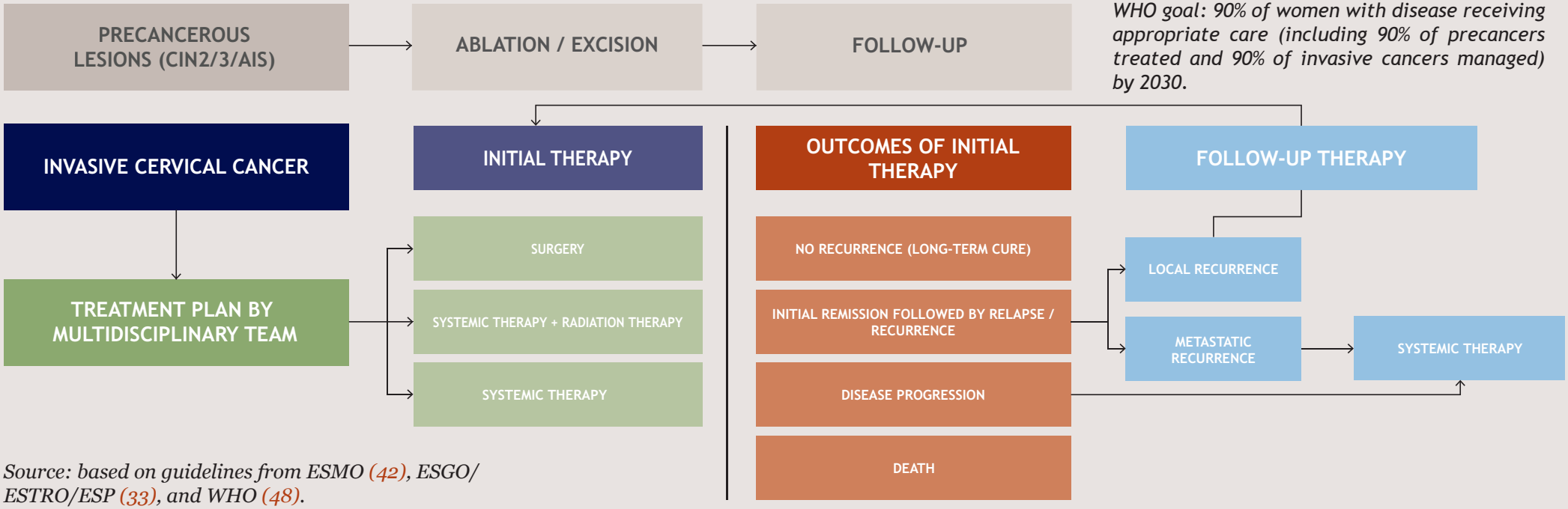
Early detection and timely management of precancerous lesions (CIN) can interrupt the disease process of developing invasive cervical cancer (48), avoiding the need for more complex and costly cancer treatment later on. Yet in all instances when cervical cancer does develop, access to effective treatment strategies is essential to achieve cure or control of the disease.

The management of cervical cancer should be coordinated by a multidisciplinary team (MDT) of oncologists, surgeons, radiologists, pathologists, and oncology nurses to ensure the most appropriate care for each patient (33). Treatment approaches vary by disease stage and typically involve surgery, radiation therapy, and cancer medicines used alone or in combination (33, 42).

In general, the therapeutic approaches are as follows:

- **Early-stage cases:** Surgery, often involving removal of the entire uterus, and often followed by radiation therapy with or without chemotherapy (33).
- **Locally advanced cases:** Concurrent pelvic external-beam radiation therapy and chemotherapy (chemoradiation) followed by brachytherapy used to be the curative standard (33), but nowadays immunotherapy may be added to chemoradiation in selected high-risk cases (49).
- **Recurrent or metastatic cases:** Chemotherapy used to be the standard of care but should now be combined with immunotherapy in patients with a positive PD-L1 tumor expression (33). The latest WHO Essential Medicines List (EML) from September 2025, includes immunotherapy as a first-line monotherapy for metastatic cervical cancer (50).

Relapse rates after initial treatment increase markedly with disease stage: around 10% for early-stage cervical cancer, approximately 17–23% for stage II, about 42% for stage III, and up to 74% for stage IV (51, 52). Ensuring equitable access to these treatments and timely referral to specialized centers remains critical for improving outcomes.



Source: based on guidelines from ESMO (42), ESGO/ESTRO/ESP (33), and WHO (48).

Need to standardize actual practice with common clinical guidelines

According to local experts, oncology centers in HK mainly refer to international clinical guidelines (by ESMO or ESGO/ESTRO/ESP) but adapt them into their own in-house protocols based on available equipment and medicines. Therefore, actual practice may vary across centers.

Varying availability of image-guided brachytherapy

Local experts noted how resource and capacity constraints particularly affect the availability of advanced radiation therapy techniques such as image-guided brachytherapy (IGBT), which is now considered the global standard of care for locally advanced disease and is associated with substantially better outcomes than conventional "point A" brachytherapy (33). In HK, access to MRI-guided IGBT is currently limited to some of the six public oncology centers, reflecting shortages of anesthetists and general anesthesia slots, limited staff expertise with IGBT workflows, inadequate hardware and theatre layouts, and high patient volumes. Other centers have to rely on more conventional two-dimensional planning techniques and non-image-guided brachytherapy.

Bottleneck in affordability of novel and essential cancer medicines

Although immunotherapy for metastatic cervical cancer is included in the WHO EML, in HK, it is only available through the Hospital Authority as a self-financed item as of November 2025. Without government funding, immunotherapy remains largely inaccessible to underprivileged patients, according to local experts. In locally advanced cervical cancer, immunotherapy which is already included in NCCN guidelines, is not yet enlisted at the Hospital Authority Drug Formulary as of November 2025.

Optimize evaluations of evidence to enhance predictability of formulary decisions

HK's Hospital Authority has set up its own system to review and evaluate different medicines for enlistment and reimbursement. Recently, the statutory body introduced cost-effectiveness evaluation and simplified the process to shorten the enlistment and reimbursement timeline. Unlike many other developed health systems in the region (Australia, South Korea, Taiwan), structured health technology assessment (HTA) is not routinely applied in formulary decisions (53, 54). In a 2024 survey on barriers, 71% of stakeholders cited lack of expertise and resources, 57% data collection and integration challenges, and 52% both lack of transparency and poor alignment with existing processes (54). Three priorities were identified to move forward: greater transparency in methods and decision-making, capacity building given that HK lacks a dedicated HTA body, and stronger data infrastructure since existing health data lack itemized costs and rely heavily on Western populations limiting local applicability. For cervical cancer, where new treatment options are becoming available, the absence of a formal HTA process may limit timely patient access and predictability around how clinical benefit, affordability, equity, and system priorities are balanced in decisions on medicine enlistment and reimbursement.

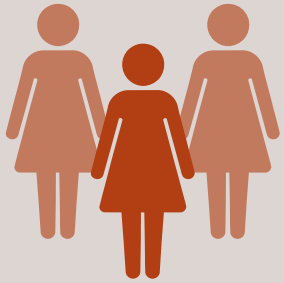
Strengthen gynecologic oncology workforce capacity

Most early-stage cervical cancer cases are managed by gynecologists who perform surgery. Early-stage cases needing subsequent radiation therapy or cancer medicines as well as advanced cases are usually managed by clinical oncologists. Gynecologic oncologists in HK are scarce, similar to other advanced economies. As of recent figures, there are 24 practicing gynecologic oncologists serving a population of 7.4 million, equating to roughly one specialist per 300,000 people (55). Local experts describe this shortage as particularly acute in the public system. HK's certified subspecialty training program, which began in 2007, produces just 1 to 3 newly certified gynecologic oncologists each year (55). While the program is rigorous, spanning 2-3 years and includes multi-disciplinary rotations, formal surgical skills assessments, and a mandatory research component, the output may not be sufficient to offset retirements, attrition, or the rising demand driven by an aging population. Local experts explained that most cervical cancer surgeries are therefore performed by general gynecologists rather than subspecialists.

RECOMMENDATIONS

With high HPV vaccination coverage among schoolgirls, cervical cancer incidence is expected to decline over the coming decades as vaccinated cohorts age. The switch to HPV testing as primary screening method in 2023 can also be expected to help accelerate the elimination of cervical cancer through early detection of precancerous lesions. In the meantime, strengthening screening uptake, timely diagnosis, and access to effective treatment remains essential. This is particularly true for current high-risk groups, including women who were not vaccinated or have not been regularly screened.

More effort in promoting cervical cancer screening



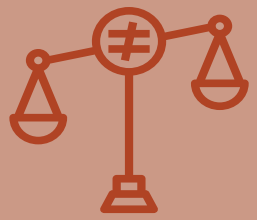
Transition to an organized HPV-based screening program with active invitations/recall mechanisms. Integrate HPV self-sampling as a core component of the program – either universally or as a targeted option for women who do not respond to invitations – to improve coverage and equity.

Strengthen diagnostic and treatment capacity

Continue expanding and optimizing CT, MRI, and PET capacity, including through public-private schemes, to ensure timely access to imaging. In parallel, continued efforts are necessary to attract and retain healthcare professionals in the public system to guarantee timely delivery of care services.

Raise awareness of cervical cancer prevention and early detection among underserved populations

Partner with stakeholders to develop targeted education and outreach initiatives for populations with higher cervical cancer burden, including unvaccinated and never-screened women. Improve awareness of cervical cancer symptoms, the importance of screening, and the availability of HPV vaccination and preventive services.



Improve equitable access to new therapeutic technologies

Accelerate equitable access to advances in cervical cancer treatment across all public oncology centers to improve patient outcomes. This includes wider implementation of image-guided brachytherapy (IGBT) and investment in associated infrastructure and training as well as reimbursement of essential and cost-effective novel medicines, including immunotherapies, following international treatment guidelines and the WHO Essential Medicine List.

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