PARLIAMENT
OF THE REPUBLIC OF SOUTH AFRICA

2026 SONA

SOCIAL SERVICES AND INFRASTRUCTURE CLUSTER

Implications of the 2026 State of the Nation Address for Cervical Cancer: Recommendations for Parliament

April 2026

PARLIAMENTARY RESEARCH UNIT (PRU)
WWW.PARLIAMENT.GOV.ZA

IMPLICATIONS OF THE 2026 STATE OF THE NATION ADDRESS FOR CERVICAL CANCER

Contents

Hannah Wolpe

ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
CANSA	Cancer Association of South Africa
DBE	Department of Basic Education
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
ISHP	Integrated School Health Programme
MSM	Men who Have Sex with Men
NDoH	National Department of Health
SSA	Sub-Saharan Africa
UNICEF	United National International Children's Emergency Fund
WHO	World Health Organization

Executive Summary

Cervical cancer is a major public health challenge and a **national health priority** in South Africa, with the National Department of Health recently adopting the World Health Organisation's (WHO) goal of **eliminating the disease by 2030**. Globally, the burden falls disproportionately on low- and middle-income countries where more than **80% of diagnoses and 90% of global deaths** occur, inflicting profound social and economic costs. In South Africa, cervical cancer is the leading cancer among 'Black' women and one of the top causes of cancer mortality. **HIV co-infection increases risk** substantially, which – alongside poor screening and treatment coverage – drives South Africa's high cervical cancer rates.

Cervical cancer is typically caused by the sexually transmitted **Human Papilloma Virus (HPV)**. Most sexually active South Africans are thought to have been exposed, but the majority clear the infection and never become symptomatic. Cancer of the cervix is **largely preventable** through HPV vaccination before puberty, regular screening, and early treatment. The national **school-based HPV vaccination programme**, launched in 2014, protects about 75% of all girls, according to the National Department of Health, though **WHO estimates are lower** (49% single-dose coverage by age 15). **Men and boys** are not included in the school-based programme despite also being at (relatively lower) risk of HPV-related genital warts and cancer. Meanwhile, the private sector offers vaccinations to anyone for about R1,000.

In 2024 South Africa adopted a single-dose HPV schedule and expanded vaccination to private and independent schools, aiming for 90% coverage in support of **WHO's 2030 elimination strategy.** Vaccine shortages, consent barriers, staff shortages, poor transport and administrative challenges remain obstacles.

Screening for early-stage cervical cancer is sub-optimal, with significant geographical disparities in access. Although free screenings are available for women in the public sector (at specified intervals), only about **56% of women aged 30–49 have ever been screened.** Barriers include lack of knowledge, stigma, misconceptions, inadequate privacy in clinics, and long waiting times.[1] Self-screening is highly promising, with high accuracy and acceptability, and could significantly increase screening uptake if scaled.[2]

Cervical cancer **treatment is highly inaccessible and uneven**. Diagnostic capacity is limited, waiting times may exceed a year, and late-stage treatment is concentrated in tertiary hospitals. Women face transport and accommodation costs, reinforcing inequities.

Some key recommendations for Parliament to consider include to:

- Monitor and promote increased coverage of **HPV vaccinations**.
- Promote cervical cancer **screening and early intervention**.
- Continue monitoring **HIV and AIDS efforts** and investigate the possibility of **prioritising** HPV vaccinations for women and girls living with HIV and AIDS.
- Conduct oversight to ensure adequate, protected **funding** for cervical cancer prevention and control efforts.
- **Promote** HPV-prevention measures through public outreach and **involve communities** in cervical cancer reduction efforts.

[1] Chitha et al. (2023); Ndubuisi et al. (2024); Petersen et al. (2022); Mantula et al. (2024).
[2] Taku et al. (2020).

1. Background

The prevention and control of cervical cancer was **highlighted in the 2026 State of the Nation Address**, with President Ramaphosa reminding South Africans that the government is "(…) working to end cervical cancer in our country by mobilising society to ensure that every young girl between the ages of 9 and 15 receives the human papilloma virus (HPV) vaccine.[3]" Cancer of the cervix[4] imposes a substantial health and social toll globally, particularly in low- and middle-income countries, despite being **almost entirely preventable**.[5] It is the fourth most common cancer worldwide, with 660,000 cases and 350,000 deaths recorded in 2022.[6] Statistics reflect global health inequities, with sub-Saharan Africa (SSA) suffering 80% of global diagnoses and **90% of related deaths**, making cervical cancer the **leading cause of cancer and disability** among women in the region.[7]

This high burden is partly driven by the region's **elevated HIV prevalence**. Cervical cancer is considered a defining illness of HIV and AIDS[8], as HIV accelerates the progression from HPV infection to cancer; women living with HIV are six times more likely to develop cervical cancer than HIV-negative women. [9] Yet it is ultimately limited and **uneven access to prevention, early diagnosis, and timely treatment** that leads to avoidable cases and deaths.[10]

This paper examines the causes and consequences of cervical cancer, reviews current efforts in South Africa to prevent and control the disease and assesses the country's progress toward the World Health Organisation's (WHO) **goal of eliminating cervical cancer by 2030** - a target South Africa has endorsed. It concludes with actionable recommendations for Parliament to support national efforts to combat this devastating but preventable disease.

1.1. CERVICAL CANCER IN SOUTH AFRICA

While breast cancer is the most commonly diagnosed cancer among South African women (23.2% of cases in 2018), cervical cancer tends to follow closely behind (15.9%) while proving **more lethal**.[11] **'Black'[12] women** shoulder a greater burden of disease in

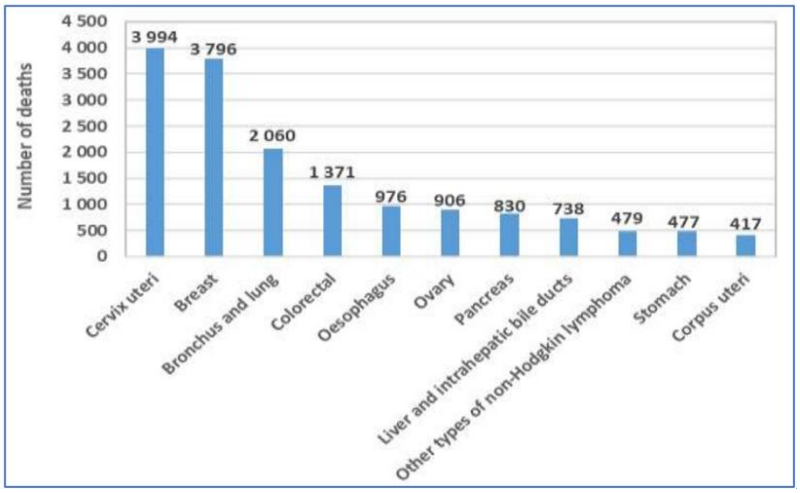

Figure 1: Cancer-related mortality by site among South African women in 2018 (Statistics South Africa 2023)

[3] Ramaphosa (2026).
[4] The cervix is the lowermost region of the uterus or birth canal.
[5] Aggarwal (2014).
[6] World Health Organisation (2025).
[7] Ginsburg et al. (2016); Soerjomataram et al. (2025).
[8] Statistics South Africa (2023).
[9] Stelzle et al. (2021).
[10] Ginsburg et al. (2016).
[11] Statistics South Africa (2023).
[12] Individuals of African population-affinity in South Africa trace their ancestry to Bantu-speaking sub-Saharan agropastoralists who migrated into southern Africa roughly 2,000 years ago (Liebenberg et al., 2015).

South Africa due to the increased prevalence of HIV and AIDS and constrained access to quality healthcare in this population, among other risk factors.[13]

1.2. CAUSES & CONSEQUENCES

The majority of cases of cervical cancer are caused by a small handful of the over 200 identified strains of the **human papillomavirus (HPV)**.[14] In South Africa it is estimated that most sexually active adults **have been exposed** to HPV, although most (~90%) clear the infection spontaneously and never develop symptoms.[15]

Cervical cancer has a profound **social and economic impact** through premature deaths and disability: health expenditure is increased to manage and treat cases, while labour and productivity is lost (effects that are often underestimated because much of women's domestic and care work is not captured in traditional economic measures).[16]

Text Box 1: Is HPV a Risk to Men and Boys?

Although women bear the brunt of HPV-related illness, men also carry the virus and are remain **vulnerable to HPV-related genital warts and cancers**: In 2019, HPV caused approximately 70,000 cancer cases in men – about 11% of the 660,000 HPV-related cancer cases recorded among women.[17] HPV is responsible for most anal and oropharyngeal cancers among men, with some such cancers **becoming increasingly prevalent in South Africa**.[18] The men at highest risk include those who are HIV-positive, smoke, use alcohol, or have multiple sexual partners without a barrier method of protection.[19] Men who have sex with men (MSM) are at particularly high risk of HPV-related cancers.[20]

HPV vaccination is the most effective method of preventing such diseases. However, **gender-neutral vaccination is not widely promoted** and remains under debate.[21] HPV vaccinations are not currently offered to men and boys in the public sector, although they may purchase vaccines in the **private sector for around R1,000** per dose. The Department of Health does not currently prioritise vaccinating males, citing the availability of other more cost-effective interventions.[22] Men who have sex with women do, however, gain some indirect protection through the mass vaccination – and ideally herd immunity – of women and girls.[23]

[13] Ibid.
[14] Ault (2007).
[15] Herbst (2025).
[16] Ginsburg et al. (2016).
[17] Del Martel et al. (2020).
[18] Shing et al. (2025).
[19] Lipsky et al. (2025).
[20] Machalek et al. (2025).
[21] Patra et al. (2025).
[22] Lesley Bamford (Acting Chief Director of Maternal, Child and Women's Health in the Department of Health), email message to author, March 6, 2026.
[23] Shing et al. (2025).

2. Prevention & Control of Cervical Cancer in South Africa

In 2017, the South African Department of Health published **comprehensive guidelines** on the prevention and management of cervical cancer.[24] This programme consists of three pillars:

- **Reducing HPV infections**: Raising awareness regarding cervical cancer prevention through male circumcision, the promotion of safe sex practises, and HPV vaccinations.
- **Detecting and treating pre-invasive lesions**: Strengthening screening and test-and-treat services in the public sector.
- **Timely treatment and palliative care** for invasive cancer.

The specifics of these three strategies will be unpacked below.

1.3. PREVENTION OF HPV INFECTION

The primary method of preventing cervical cancer is vaccination against high-risk HPV strains 16 and 18, which cause about 70% of call cervical cancer cases.[25] In South Africa, these vaccinations are available through:

1. **The national school-based vaccination programme**: Provides pre-pubertal girls in public schools with the Cervarix vaccine, which protects against the two dominant high-risk strains.
2. **The private sector:** Offers both Cervarix and Gardasil[26] (which also protects against genital warts) at approximately R1,000 per dose.

1.4. THE SCHOOL-BASED HPV VACCINATION PROGRAMME

South Africa has provided free HPV vaccines to girls in **government schools since 2014** (with consent required from parents or caregivers). This school-based programme is embedded in the broader Integrated School Health Programme (IHSP) and targets **pre-pubertal girls** since protection is greatest before any prior exposure to HPV.[27] As the vaccine is approved for use from age nine, grade-five learners (typically aged 9-12) were identified as the most suitable cohort.[28]

Research has found these vaccines to be **safe and highly effective** against HPV **strains 16 and 18**, with protection so far found to last many years:

- *Ceravix* (used in South Africa's school-based programme) lasts ***at least*** 5 years, with follow-ups still underway to determine when protection begins to wane.[29]
- *Gardasil* (available in the private sector) lasts at least 18 years.[30]

[24] South African Department of Health (2017).
[25] Statistics South Africa (2023).
[26] *Gardasil* is available in the private sector as both a quadrivalent (covering 4 strains of HPV) and 9-valent (covering 9 strains) vaccine.
[27] South African Government (2026).
[28] UNICEF (n.d.).
[29] Watson-Jones et al. (2025),
[30] Wu et al. (2026).

- While the durability of protection is still under study, re-vaccination (i.e. "booster shots") are not currently recommended.[31]

The programme is also **cost effective**,[32] with a single dose costing the South African government R400, compared to about R1,000 in the private sector.[33]

In 2024 the National Department of Health (NDoH) shifted to a single-dose schedule for the vaccine, supported by evidence showing that one dose is highly effective, reduces costs, simplifies delivery, and may ultimately increase coverage.[34] Vaccination has also been **extended to private and independent schools**, which account for approximately 5% of the eligible population.[35] This forms part of a new goal spearheaded by the WHO to cover 90% of the eligible population (see textbox 2 below).[36]

1.5. HPV VACCINE COVERAGE

In 2024, the NDoH estimated that **85-89%** of girls (aged 9-15) in *public* schools – and **75% of *all* South African girls** – had received at least one dose of the vaccine.[37] However, 2024 **estimates from the WHO** place coverage considerably lower at about **49% of all girls**.[38] Although reasons are unclear, this may be a result of the WHO utilising multiple sources of data (unlike the NDoH which relies on administrative data) and correcting for sub-optimal data quality.

Several factors have **hindered** South Africa's school-based vaccination efforts, including vaccine hesitancy among caregivers, disruptions caused by COVID-19, vaccine and staff shortages, and other technical constraints.[39] Key **facilitators**, by contrast, include ring-fenced funding, strong political will, social mobilisation, and effective monitoring and evaluation systems.[40]

Uptake in private and independent schools has also been relatively low since vaccinations were introduced there in 2024. According the Maternal, Child and Women's Health programme in the NDoH, this may reflect the high coordination costs of engaging individual private schools – work that in public schools is coordinated centrally by the Department of Education.[41]

Text Box 2: The World Health Organisation's Cervical Cancer Elimination Initiative
In August 2020 the World Health Organisation (WHO) adopted a global strategy for the elimination for cervical cancer by 2030.[42] 1. **Vaccinating 90%** of girls against HPV by age 15.

[31] World Health Organisation (2025).
[32] Li et al. (2015).
[33] Tomlinson (2024).
[34] Shing et al. (2025).
[35] Van Schalkwyk et al. (2025).
[36] Tomlison (2024).
[37] South African Government (2024).
[38] World Health Organisation (n.d.).
[39] Tomlison (2024); Shing et al. (2025); Denny & Kuhn (2017).
[40] Denny & Kuhn (2017).
[41] Lesley Bamford (Acting Chief Director of Maternal, Child and Women's Health in the Department of Health), email message to author, March 6, 2026.
[42] World Health Organisation (2020).

2. **Screening 70%** of women using high-performance tests by age 34, and again at age 45.
3. **Treating 90%** of women with pre-cancer and managing treatment of 90% of women with invasive cancer.

South Africa has recently committed to these 90-70-90 targets, but progress remains limited – especially in screening and treatment. The extent of policy and legislative alignment with the WHO's initiative is unpacked in Table 1 below.

1.6. CERVICAL CANCER SCREENING

Unfortunately, the HPV vaccine alone cannot prevent cervical cancer, underlining the importance of effective screening and treatment.[43]

Symptoms of cervical cancer may take **years, even decades to reveal themselves**. Detection of abnormal lesions during this pre-cancerous stage greatly improves chances of successfully preventing progression to fully-fledged cervical cancer. **Free cervical cancer screenings** are available at all primary care facilities in the country at specific intervals dependant on risk factors including HIV status (see textbox 3 below).

Text Box 3: South Africa's Cervical Cancer Screening Guidelines

According to South Africa's *Cervical Cancer Prevention and Control Policy* (2017):

- **HIV-negative women** are offered three free cervical cancers in their lifetimes.

Given that HIV increases the chances of developing cervical cancer after HPV infection, **women living with HIV** are offered screening at three yearly or annual intervals over the course of their lifetime (depending on the results of their previous screening).

1.7. CERVICAL CANCER SCREENING COVERAGE

Conventional cervical cytology **(i.e. Pap smears)** is the preferred screening method in South Africa. This involves a registered nurse collecting cervical cells by holding the vaginal walls open with a plastic or metal speculum.[44] In addition to being invasive, traditional Pap smears are **limited in their effectiveness**[45] and ability to reliably obtain quality samples, compared to more advanced screening methods.[46] More modern and effective screening methods do exist, but their use in South Africa is limited due to **financial and health system constraints**.[47]

Women with abnormal screening results are sent on for formal **diagnostic procedures** called colposcopies. [48] However, these tests generally require **specialists** to conduct them and are usually only available at **larger, higher-level facilities**.[49] **Decentralising** colposcopies from

[43] Van Schalkwyk et al. (2025).
[44] Meyer & Nqabeni (2021).
[45] Mayrand et al. (2007).
[46] Pankaj et al. (2018).
[47] South African Department of Health (2017).
[48] A medical diagnostic procedure used to closely examine the cervix, vagina, and vulva for signs of disease. It's often recommended when a Pap smear (Pap test) or HPV test shows abnormal results.
[49] Through a procedure called a colposcopy.

these more specialised facilities and into primary care facilities has been found to reduce waiting time and overall access to this service while upholding quality. [50]

According to NDoH data, **40.5% of women aged 30 and older** were screened in public facilities in 2023/24, with numbers gradually returning to pre-COVID-19 levels (see Figure 2).[51]

However, this national average masks **substantial provincial disparities**: coverage ranged from 72.3% in KwaZulu-Natal to just 24.7% in the North West. [52] However, independent research suggests official figures may be **overstated**; a 2020 academic study estimated that only 56% of women aged 30–49 had *ever* been screened, and just 44% had been screened within the previous three years.[53]

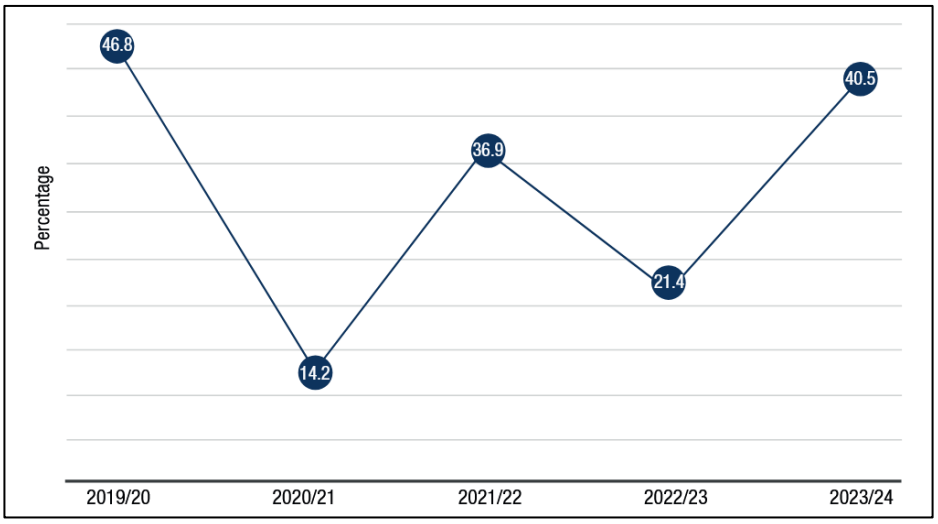

Figure 2: National Cervical Cancer Screening Coverage, 2019/2020 - 2023/24 – Official Government Data (District Health Barometer 2025)

Text Box 4: Causes of Low Screening Uptake

This low uptake of cervical cancer screening – despite its widespread availability in South Africa – is a result of:

- *Individual factors*:
  - Lack of **knowledge / awareness** about cervical cancer and screenings, among both healthcare professions and the general population; [54]
  - **Discomfort** with the invasiveness of the process.
  - **Misconceptions** about screening (e.g. pain, damage to uterus or cervix).
- *Social and cultural factors*:
  - **Stigmatisation** of cervical cancer (i.e. perception of it being a disease of promiscuity).
  - **Mistrust** of Western medicine.
- *Institutional / facility-based factors*:

[50] Maimela et al. (2019).
[51] Health Systems Trust (2025).
[52] Ibid.
[53] Yang et al. (2023).
[54] Chitha et al. (2023); Ndubuisi et al. (2024)

- Lack of **privacy** for screenings.
- Long **waiting times** and competing priorities for patients' time.[55]

According to the NDoH, **several efforts are currently underway** to improve screening rates.[56] **Self-screening** is one popular solution - this approach is explored in the textbox 5 below.

Text Box 5: Self-Screening for Cervical Cancer

HPV self-screening involves conducting a Pap smear (or similar test) without the direct involvement of a healthcare worker. These tests may be done **privately** at home, with samples sent to labs for processing. Self-screening can **help overcome barriers** associated with clinic-based Pap smears, including discomfort with invasive examinations, limited clinic access, and the stigma linked to sexually transmitted infections.[57]

Researchers have found HPV self-screening to be **highly acceptable** to South African participants due to its privacy, convenience, and autotomy.[58] Crucially, self-collected samples have **strong diagnostic accuracy** – approaching that of clinician-collected samples.[59] However, challenges remain: public awareness of self-screening is low,[60] with the logistics of test delivery and collection requiring development.[61]

Although HPV self-screening tests are available in the private sector, they are **not yet offered** in the public sector. However, a precedent exists for this in the rollout of HIV and AIDS self-test kits to targeted groups.[62] Between 2022 and 2025, over R38 million in the public health budget was allocated to cervical cancer prevention, including a self-screening pilot, and the South African National AIDS Council committed to distributing 10,000 HPV self-sampling kits.[63] The **outcomes of these initiatives have yet to be announced**.

1.8. LINKAGE TO TREATMENT

Even when cervical cancer is detected early, timely and effective treatment in South Africa may **not be guaranteed**. Research suggests that many patients never receive their results, book follow-up appointments, or are ultimately able access the treatment they need.[64] Treatment options include surgery, radiotherapy (where waiting times reach up to 15 months), and chemotherapy (which is costly and unevenly available).[65]

[55] Petersen et al. (2022); Mantula et al. (2024); Erin von der Heyden (HAST medical doctor), 1 September 2025.
[56] Lesley Bamford (Acting Chief Director of Maternal, Child and Women's Health in the Department of Health), email message to author, March 6, 2026.
[57] Department of Science, Technology and Innovation (2023).
[58] Taku et al. (2020).
[59] Ibid.
[60] Tiiti et al. (2025).
[61] Department of Science, Technology and Innovation (2023).
[62] Tomlinson (2025).
[63] Meyer & Nqabeni (2022).
[64] Jassat (2011).
[65] Ibid; Meyer & Nqabeni (2021).

Treatment places a significant burden on the government's healthcare system due to the high costs of staff, facilities, and therapy. Patients also incur substantial personal expenses for transport, accommodation, and other living costs during their treatment.[66] Efforts are underway to **decentralise** management of precancerous lesions to lower-level health facilities.[67]

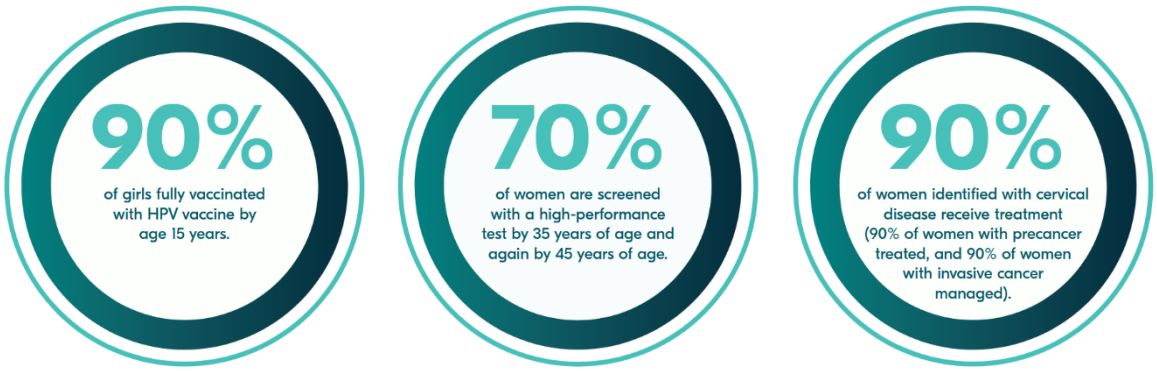

Figure 3: The World Health Organisation's Global Strategy to Eliminate Cervical Cancer (https://www.who.int/publications/i/item/9789240014107)

Table 1 below summarises South Africa's progress to achieving the WHO's targets for the elimination of cervical cancer by 2030.

[66] Statistics South Africa (2023).
[67] Lesley Bamford (Acting Chief Director of Maternal, Child and Women's Health in the Department of Health), email message to author, March 6, 2026.

Table 1: South Africa's Alignment with WHO's Cervical Cancer Elimination Targets		
WHO Target	**SA Progress & Policy Alignment**	**SA Legal Alignment**
90% Vaccination	*Strong Alignment* National school-based vaccination programme reaches ~85% eligible girls in public schools. Expanded in 2024 to reach girls in private and independent schools, with the vaccine regimen switched from double to single dose. Funding is secured.	No law mandating 90% coverage.
70% Screening	*Partial Alignment* Official government statistics[68] indicate screening rates are well **below the WHO's benchmark**, with drastic **disparities** between provinces. Numerous barriers to accessing screening must also be addressed. Although the cervical cancer prevention and control policy (2017) states that free screening will be offered to all eligible at government facilities as a national priority, it **does not mandate** WHO's 35/45-year schedule.	No law mandating screening at age 35 and 45.
90% Treatment	*Weak Alignment* Although all women diagnosed with cervical cancer in the public sector are eligible to receive free treatment, numerous barriers prevent this including persistent delays, uneven provincial capacity, and inadequate oncology resources.	No law mandating 90% treatment – depends on health system capacity.

2. Recommendations for Parliament

Parliament may play a pivotal role in the fight against cervical cancer in several ways:

2.1. MONITORING HPV VACCINATION EFFORTS

While the Department of Health consistently reports HPV vaccination coverage of 80% or more of girls in public schools, or 75% or more of *all* girls, independent estimates[69] suggest the true rate may be significantly lower. Parliament is well-placed to:

- Strengthen oversight over vaccination efforts by **interrogating official reports** and calling for **improved measurement**, including through the National Cancer Registry.
- **Oversee implementation** of the Integrated School Health Programme (in which the vaccination programme is embedded), the new single-dose HPV vaccination schedule,

[68] Health System Trust (2025).
[69] World Health Organisation (n.d.).

and the expansion of the programme into private and independent schools.[70] This may take the form of **joint oversight visits** with the Health and Basic Education committees.
- Monitor vaccine **coverage disparities** across provinces.
- **Promote coordination** among key stakeholders (NDoH, Department of Basic Education, WHO, and United National International Children's Emergency Fund (UNICEF)).[71]
- **Investigate logistical issues** including vaccine supply and cold-chain management.
- Identify and demand necessary **adaptations** to improve programme quality and reach.

2.2. ADVOCATING FOR INCREASED VACCINE COVERAGE

Increasing HPV vaccine coverage to 90% among girls could prevent an additional 5% of cervical cancer cases and reduce healthcare costs in South Africa.[72] Parliament could champion several approaches to strengthen vaccine coverage and immunity, including:

- Making free HPV vaccines **available at public healthcare facilities** for all eligible individuals. This may be more feasible and cost-effective than relying solely on the school-based programme.[73]
- Introducing 5-yearly **"catch-up" campaigns** so young women who were previously missed can be vaccinated. These could take place at secondary schools, clinics, or community venues, and research suggests they are cost-effective—and potentially cost-saving.[74]
- Extending HPV vaccination to **men and boys**, for example by including pre-pubescent boys in the school-based programme. Although still debated, this approach is supported by the Cancer Association of South Africa (CANSA) and evidence indicating it could be both effective and cost-saving. [75] **Rising rates** of anal and penile cancer in South Africa underscore the need to also protect males.[76] A more **targeted option** would involve vaccinating men who have sex with men (MSM), who face higher HPV-related cancer risks and do not benefit from herd immunity in girls-only programmes. [77]

2.3. IMPROVING ACCESS TO SCREENING & EARLY INTERVENTION

Screening for cervical cancer remains significantly under-utilised in South Africa. Parliament can help strengthen screening uptake – and thus early detection of cervical cancer – by:

- Overseeing current investigations into **self-screening** and, if found effective, advocating for its wider adoption.
- Monitoring South Africa's **alignment** with WHO screening targets, including efforts to reduce geographic disparities in coverage.
- Calling for improved availability of **diagnostic procedures**, which are currently limited to tertiary facilities.
- Overseeing the **decentralisation** of colposcopies diagnostic services and treatment for pre-cancerous lesions so that surgical management is available at lower levels of care.

[70] Vaccinations have been offered to private and independent schools since 2024, but uptake has been relatively low due to coordination difficulties.
[71] South African Government (2026).
[72] Van Schalkwyk et al. (2025).
[73] Mashele et al. (2023).
[74] Van Schalkwyk et al. (2025).
[75] Ibid; Herbst (2025).
[76] Shing et al. (2025).
[77] Machalek et al. (2012).

- Monitoring improvements in access to treatment for invasive cervical cancer, including **radiotherapy and chemotherapy**, which remains limited and subject to long delays.
- Promoting and overseeing **healthcare worker training** to strengthen knowledge of vaccination and screening, and reduce stigma and misinformation – ideally integrated into the Department of Health's existing cervical cancer training (if not already).[78]

2.4. HIV AND AIDS EFFORTS

Parliament can also address cervical cancer rates through rigorous monitoring of HIV and AIDS prevention and treatment since HIV and AIDS promotes the progression of HPV into cervical cancer,[79] with the cost-effectiveness of the vaccination program hampered in high HIV prevalence.[80] Parliament can thus:

- Ensure rigorous oversight over **HIV** and **AIDS prevention and treatment** efforts.
- Investigate the possibility of **prioritising vaccinations** for women living with HIV and AIDS up to age 45, which research finds to be cost-effective and capable of preventing an additional 10% of cervical cancer cases in this population.[81] This could take place through antiretroviral therapy clinics, maternal health services, or cervical screening programmes.

2.5. FINANCIAL OVERSIGHT

The funding of various segments of the nation's cervical cancer response requires protection through sustained oversight. Parliament can thus:

- Ensure **adequate, protected funding** for cervical cancer prevention and control (including monitoring). For example, oversight over the District Health Programme conditional grant is required to safeguard funds for the school-based vaccination programme.[82]
- Strengthen **budget scrutiny** to improve **equity** in access to prevention and treatment, as cervical cancer burden remains highest among 'Black' women and women living with HIV.[83]

2.6. PUBLIC PARTICIPATION AND KNOWLEDGE DISSEMINATION

Parliament can use its public participation role to promote HPV-prevention measures and involve communities in cervical cancer reduction efforts:

- **Outreach programmes** with constituency communities, especially youth, parents/caregivers, and other key stakeholders. These engagements can **counter misinformation, reduce stigma, and encourage uptake** of prevention measures (vaccination, screening, male circumcision, etc.).
- Promoting active and representative **community involvement** in cervical cancer prevention initiatives.

[78] South African Department of Health (2025).
[79] Stelzle et al. (2021).
[80] Li et al. (2015).
[81] Van Schalkwyk et al. (2025).
[82] South African Department of Health (2025).
[83] Statistics South Africa (2023).

- Building **partnerships with civil society** to strengthen public participation and share essential information on prevention and early detection. Potential partners include CANSA and the Cancer Alliance, both well-established advocacy and knowledge-sharing organisations.

Summary: Recommendations for Parliament

Monitoring HPV Vaccinations

- Demand better reporting and stronger measurement systems.
- Oversee implementation of updated school-based HPV programme.
- Monitor provincial disparities in coverage.
- Strengthen coordination among programme stakeholders.
- Identify and promote resolution of logistical issues.
- Support adaptations to improve programme delivery and reach.

Increasing Vaccine Coverage

- Support offering free HPV vaccines at public health facilities.
- Recommend 5-yearly catch-up vaccination campaigns.
- Advise extension of vaccination to boys or prioritise MSM as a targeted high-risk group.

Promoting Screening & Early Intervention

- Support inclusion of self-screening if evidence supports it.
- Monitor efforts to align national screening rates with WHO targets and reduce regional disparities.
- Recommend improved access to diagnostic procedures (colposcopy) and treatment for pre-cancerous lesions through decentralisation to primary care facilities, and expanded access to radiotherapy and chemotherapy.
- Promote and oversee strengthened healthcare worker training on screening and HPV.

HIV and AIDS Efforts

- Oversight over HIV and AIDS prevention and treatment.
- Investigate possibility of prioritising vaccines for women living with HIV and AIDS.

Financial Oversight

- Protect funding for cervical cancer prevention and control (including monitoring).
- Scrutinise budgets to promote equity in access to prevention and treatment.

Public Participation

- Conduct outreach with consistencies to counter misinformation and promote uptake of prevention measures.
- Ensure meaningful community involvement in HPV-related prevention efforts.
- Partner with civil society groups (e.g., CANSA, Cancer Alliance) to expand public awareness.

3. Conclusion

The elimination of cervical cancer by 2030 will remain elusive unless South Africa's makes significant strides in the prevention and control of the disease, particularly access to screening and subsequent linkage to intervention and treatment. Great inequities currently exist in access to these vital services, resulting in this largely preventable and treatable disease exacting a devastating toll on the nation. Parliament may play an influential role in reducing the burden of disease by monitoring and increasing access to vaccinations, promoting screening and early intervention, focusing on HIV and AIDS efforts, overseeing funding, and facilitating public participation. These parliamentary interventions are both impactful and cost-effective, and have the potential to make a cervical cancer-free future a reality.

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