Women's integrated cancer services

A blueprint for the future of women's health in Africa

World Health Organization
African Region

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Foreword

Implementing transformative responses in health care

Cancer, particularly cervical and breast cancers continues to exact an unacceptable toll on women, families and health systems across the World Health Organization (WHO) African Region. This burden persists despite the availability of effective tools for prevention, early detection and treatment. Too many women are still diagnosed late, when survival is uncertain and the social and economic consequences are devastating. This reflects not a lack of knowledge, but persistent gaps in access, integration and continuity of care.

The Women's Integrated Cancer Services (WICS) initiative responds directly to this challenge. Anchored in primary health care (PHC), WICS offers a practical and scalable approach to delivering integrated cervical and breast cancer services alongside other essential health services. By bringing care closer to where women live and seek it, WICS advances equity, efficiency and people centred care—core principles of universal health coverage (UHC).

Phase I of WICS, implemented in Côte d'Ivoire, Kenya and Zimbabwe, demonstrated that integration within African health systems is not only feasible but transformative. It showed that women use services when they are accessible and respectful; that nurses, midwives and community health workers can be empowered to deliver high impact cancer interventions; and that integrated models strengthen health systems rather than burden them.

We now stand at a decisive moment. Phase I proved what is possible: cancers detected earlier, lives saved at the community level, and growing confidence that a cancer diagnosis does not inevitably mean death. The question before us is no longer whether WICS works—but how rapidly it can be scaled.

This moment demands urgency. Every delay means more women diagnosed too late, more families pushed into poverty and more health facilities overwhelmed by advanced disease that could have been prevented. The conditions for action are aligned: political commitment is growing, a proven integrated model exists, and global momentum is advancing through the cervical cancer elimination strategy and the Global Breast Cancer Initiative.

Scaling up WICS is both a moral imperative and a sound economic investment. Preventing disease and detecting cancer early saves lives—and costs far less than treating advanced illness.

The WHO Regional Office for Africa remains fully committed to supporting Member States to translate this integrated vision into reality. WICS represents a fundamental shift in how women's health services are designed and delivered in the Region. The women of Africa, who sustain families, communities and economies—deserve health systems that work for them.

WICS shows the way. Now is the time to act.

Dr Mohamed Yakub Janabi
WHO Regional Director for Africa

During a visit to a primary care clinic in Bungoma, Kenya, I met a woman named Judith. Like so many mothers across our continent, she had spent years balancing family and work, rarely finding a moment to think of her own health. When she finally sought screening through the Women's Integrated Cancer Services (WICS) initiative, her cervical cancer was detected early—at a stage where recovery isn't just a hope, it is a reality.

Judith's story is powerful, but it shouldn't be rare.

Across the Phase I countries – Côte d'Ivoire, Kenya and Zimbabwe – the Women's Integrated Cancer Services (WICS) has been truly transformative for women. More than just a programme, it is a living demonstration of how integrated, people-centred cancer services can be delivered through primary health care systems. In doing so, we are giving women a fighting chance and moving toward a reality where African women can expect the same global standards of care and survival outcomes as women anywhere else in the world.

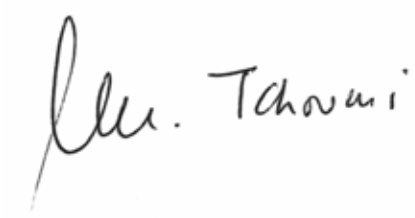
The beauty of WICS lies in its simplicity and its respect for the patient's reality. It is a practical, scalable model that meets women where they already are. By integrating cancer screening into these platforms, we are improving efficiency and ensuring that no opportunity to save a life is missed. Early results are tangible, with more than 11 000 women screened in Côte d'Ivoire.

Beyond its programmatic impact, WICS stands as an equity- and rights-based response to the persistent injustices in women's health. No woman should die of these preventable cancers because she is poor, rural or marginalized. By making essential cancer services accessible and integrated at the primary care level, it contributes to advancing universal health coverage while pointing to a broader pathway linking service integration with sustainable domestic financing. Governments are taking note and co-investing.

Yet, our work is far from finished. WICS cannot remain confined to pilot sites. To stop now would be to lose the momentum we have built, leaving too many women undiagnosed and still arriving with late-stage disease. The cost of inaction is too high—for our health systems, our economies, and our families. A healthier Africa is a wealthier Africa.

Looking ahead, in partnership with the WHO Regional Office for Africa, Roche and its partners will continue to support the scale-up of this initiative. Scaling WICS is not only a health and moral imperative—it is essential to securing the long-term wellbeing and prosperity of our communities.

Maturin Tchoumi
Area Head for Roche Africa



Abbreviations

HPV	human papillomavirus
NCD	noncommunicable disease
PHC	primary health care
UHC	universal health coverage
WICS	Women's Integrated Cancer Services

Investing in the future of women's health

Every year, thousands of women across Africa die from cervical and breast cancers, diseases that are preventable, treatable and highly survivable when detected early. Yet far too many women, particularly those who are poor, are living in rural areas or are affected by HIV, are never screened or diagnosed until it is too late. This is not a failure of medical science. It is a failure of health systems to reach women where they are when it matters most.

WICS offers a practical, scalable solution. Anchored in primary health care (PHC), WICS brings cervical and breast cancer prevention, screening, early diagnosis and referral directly to the points of care that women already use. By integrating services for cancer with those for noncommunicable diseases (NCDs), sexual and reproductive health and HIV programmes, and by leveraging task sharing and digital tools, WICS delivers a high-impact, cost-effective and women-centred model for improving health outcomes.

Phase I of WICS (2023–2026), implemented in Côte d'Ivoire, Kenya and Zimbabwe, demonstrated that this model works. With strong government leadership, technical guidance from WHO and support from partners including Roche Kenya, these **three countries implemented WICS across 19 health facilities, trained over 180 health workers, introduced new diagnostic capacities and screened thousands of women**, many of them for the first time.

Côte d'Ivoire offers a compelling example of progress through screening over 11 787 women and reaching over 3 million girls with WICS-supported community-based screening campaigns to strengthen cervical cancer prevention. Beyond service delivery, the initiative mobilized communities at scale, sensitizing thousands of women and their families on the disease, increasing awareness and reducing its stigma.

Senior Nursing Officer Divinza Ochela and patient Asha Akinyi review educational pamphlets distributed as part of WICS in Kenya
© WHO / Edmond N'Takpé

3 Countries engaged	**19** Health facilities supported as pilot sites	**180+** Health workers trained
17 587 Women screened for cervical and breast cancers	**Over 3 million** Girls protected from cervical cancer through HPV vaccination	**80+** Precancerous lesions treated

Strategic priorities for Phase II

WICS Phase I generated critical operational insights that now inform definition of a more deliberate and sustainable path to scale. These insights are essential to ensure that Phase II moves beyond pilots toward sustainable systems' change. With targeted investment, sustained leadership and strategic partnerships, WICS can become a cornerstone of Africa's cancer control and UHC strategies.

Converting political commitment into domestic financing

Political leadership proved essential in all three WICS Phase I countries but it must now be matched with dedicated domestic budget allocations. Phase II will focus on supporting governments to establish explicit financing for WICS within national and subnational health budgets, ensuring that integrated services transition from externally supported projects to durable, government-owned programmes.

Strengthening facility readiness

Phase I demonstrated that frontline facility readiness, that is adequacy of examination space, reliability of supplies and sufficiency of trained staff, is the strongest determinant of successful integration. Facilities meeting minimum readiness standards delivered one-stop services effectively. Phase II will prioritize operational readiness at the clinic level as a prerequisite for scale-up.

Completing the care pathway

Screening without effective referral and follow-up is incomplete care. Phase I highlighted the importance of formalized referral pathways, with Côte d'Ivoire developing a digital patient navigation system supported by a ministerial agreement spanning all three levels of care. Phase II will institutionalize such systems across all WICS countries to ensure every screened woman completes the care pathway.

“WICS Phase I generated critical operational insights that now inform definition of a more deliberate and sustainable path to scale.”

Scaling digital health systems

Where digital systems were deployed, particularly the DHIS2 tracker in Côte d'Ivoire, data quality, performance visibility and corrective action improved rapidly. Paper-based systems, by contrast, made it difficult to track outcomes or identify gaps. Phase II will embed digital tracking as standard practice across all WICS sites.

Investing in community engagement and demand generation

Community health workers played a vital role in mobilization, but they require structured support, incentives and clear mandates for cancer outreach. Phase II will move beyond facility-based service delivery by funding structured community education, engaging local leaders and positioning community health workers as trained navigators between communities and services.

> "Community health workers played a vital role in mobilization"

Call to action

If WICS remains confined to pilot sites the consequences will be severe. Momentum and political goodwill risk dissipating. Thousands of women who could be screened and treated early will remain undiagnosed, continuing to present with late-stage, incurable disease. Women will continue to navigate fragmented services, meaning they will deal with multiple care visits and facilities, plus costs for care that could be delivered in an integrated manner.

The economic cost is equally stark. Treating advanced cervical or breast cancer is exponentially more expensive than their prevention or early intervention. A single episode of cervical or breast cancer late-stage treatment or palliative care can cost families and health systems many times more than an HPV test or outpatient treatment of a precancerous lesion. WHO has consistently highlighted that underinvestment in NCDs, including cancers, represents a major economic risk, particularly for low- and middle-income countries.

Scaling up WICS offers exceptional value for money. WHO estimates that for every US$ 1 invested in proven NCD interventions, countries can expect a return of at least US$ 7 in economic benefits through increased productivity, reduced health care costs and longer, healthier lives *(1)*. Cancer prevention and early detection are among the highest-return components of this investment.

WICS operationalizes the return on investment by shifting care upstream, that is preventing disease, detecting cancer early and avoiding costly late-stage treatment. Beyond cancer outcomes, investments in training, equipment, referral coordination and digital health information systems benefit other programmes and services. Skilled nurses, functioning data systems and integrated service delivery models improve overall system resilience and accelerate progress toward UHC.

Togba Betti speaks to women as part of WICS outreach
© WHO / Edmond N'Takpé

WHO and the power of partnerships

The WHO's role in WICS extends beyond technical assistance. As the convening authority for health in the African Region, WHO provides the normative leadership, operational coordination and political leverage that make integrated programmes like WICS possible.

In Phase I, WHO contributions were decisive:

- Providing the evidence-based framework and operational guidance for integrated service delivery across cervical cancer, breast cancer, NCDs and mental health;
- Facilitating high-level political engagement, including the formal WICS launches by ministers of health in all three pilot countries;
- Leading structured South–South exchanges among Côte d'Ivoire, Kenya and Zimbabwe, accelerating cross-country learning and problem solving;
- Supporting the development and deployment of digital health solutions, including the DHIS2 tracker, to strengthen data quality and accountability;
- Convening partners and mobilizing catalytic resources to complement national investments;
- Elevating focus on WICS in regional and global policy platforms, including at the annual meetings of the WHO Regional Committee for Africa in 2024 and 2025.

Looking ahead,WHO's continued partnership remains indispensable. Phase II requires WHO to finalize and disseminate the WICS operational toolkit, accelerate digital integration across all sites, expand South–South learning networks and support governments in translating political commitment into sustained domestic financing. WHO presence ensures WICS quality, coherence and alignment with global strategies, including the WHO cervical cancer elimination strategy and the global breast cancer initiative.

WHO's continued partnership will enable:

- Expansion of WICS to additional countries and facilities across the African Region;
- Strengthening of digital health systems for real-time tracking and accountability;
- Investment in workforce capacity and training of trainers for sustainable scale-up;
- Deepening community engagement and demand generation to reach the most underserved women;
- Consolidation of referral pathways to ensure every screened woman receives complete care.

Donor investment through WHO amplifies impact

The WHO unique mandate, regional reach and trusted relationships with Member States mean that resources channelled through WHO achieve system-level returns that no single organization could deliver alone.

Côte d'Ivoire
© WHO / Edmond N'Takpé

Awu Marie's first visit
Côte d'Ivoire

Awu Marie, 34, received her first-ever cervical cancer screening through WICS.

During the same visit she also received a free diabetes test, something she had never imagined accessing in her community.

One visit gave her reassurance, knowledge and preventive care that many women go years without.

Cancer in Africa: a crisis in women's health

The burden we can no longer ignore

Cervical and breast cancers constitute an urgent women's health crisis in Africa. Together, they account for more than half of all cancers affecting African women. Cervical cancer, despite being almost entirely preventable and highly treatable, remains the leading cause of cancer-related death among women in the Region *(2)*. In 2022 Africa accounted for nearly one quarter of global cervical cancer deaths *(3)*, a stark reflection of global inequity.

Breast cancer outcomes are equally concerning. In many African countries, five-year survival after diagnosis is approximately 50% compared with over 90% in high-income countries *(4)*. This survival gap is driven primarily by late-stage diagnosis and limited access to timely, quality care. Across the continent, an estimated 60–70% of women's cancers are diagnosed at an advanced stage *(5)*, when treatment is more complex, costly and less effective.

These delays disproportionately affect women who are poor, live in rural or remote areas or face social stigma. Women living with HIV, who have up to a six-fold higher risk of cervical cancer *(6)*, face compounded vulnerability. Every woman who dies from cervical or breast cancer now when proven intervention tools are available represents an avoidable failure of the health system.

The consequences extend beyond the affected individuals' lives. Their families lose mothers and caregivers, communities lose productive members and countries lose human capital and economic potential. African women in the prime of their lives are dying from diseases that women elsewhere increasingly survive. Closing the cancer care gap for women is a moral imperative. Doing so will simultaneously strengthen health systems, advance UHC and uphold the right to health.

The response - WICS

WICS is an innovative, integrated approach designed to address cancers affecting women through PHC. At its core, WICS functions as a one-stop shop for women's health, replacing fragmented, vertical services with coordinated care delivered in a single visit.

In practical terms, when a woman attends a WICS-supported facility whether for maternal and child health, HIV care or another routine service, she can also receive cervical cancer screening via HPV testing or visual inspection, breast examination, screening for hypertension and diabetes, basic mental health screening, and counselling, referral and follow-up as needed.

This integrated model minimizes missed opportunities. The objective is simple: no woman should leave a health facility without being offered screening for major women's cancers and other NCDs.

WICS is delivered through PHC clinics and community outreach, aligning fully with countries' UHC agendas and global targets including the WHO 90–70–90 cervical cancer elimination strategy. By embedding cervical cancer screening into routine care, WICS helps countries move toward screening 70% of women by the time they are aged 35–45 years and toward ensuring 90% of women with precancer symptoms or cancer receive appropriate treatment.

Integration is WICS's greatest strength. Unlike siloed, single-disease programmes, WICS leverages existing health workers, infrastructure and community platforms to address multiple needs simultaneously. A woman may visit a health facility for a diabetes check and receive a cervical screening, or vice versa, saving time, reducing travel and lowering stigma by normalizing cancer prevention as part of routine health care.

Portrait of a patient

Janet Njaika, Kenya

Over the past two years, WHO has been supporting Kenya's Ministry of Health to implement WICS. This initiative combines screening for breast and cervical cancers with common NCDs, including diabetes, hypertension and mental health conditions, into a single, accessible health care visit.

In Kenya, WICS is being implemented in Bungoma and Nyandarua counties with a goal to reach 10 000 women. To date, over 5581 women have been screened, with 686 abnormal findings detected, enabling early intervention and treatment. This cost-effective, government-led approach addresses the problem of premature deaths from NCDs, projected to reach 3.8 million annually by 2030, improving both survival rates and quality of life for women across the Region.

The "portrait of a patient" shows Janet Njaika, highlighting the individual stories behind the statistics and representing the women who access life-saving screening and treatment services through the WICS initiative.

WICS: Phase I (2023–2026) at a glance

Phase I transformed an ambitious vision into concrete results. Across three pilot countries, that is Côte d'Ivoire, Kenya and Zimbabwe, WICS demonstrated that integrated women's cancer services can be delivered effectively through PHC even in resource-constrained settings. More importantly, it showed that when services are integrated, accessible and trusted, women use them.

Integrated services established

WICS successfully operationalized integrated women's health services across primary care clinics and district hospitals spanning urban, peri-urban and rural settings. For the first time in routine care in many of these facilities, women could access cervical cancer screening, breast cancer assessment and NCD checks in a single visit. Ministries of health formally designated pilot districts from Bungoma County in Kenya to Agboville District in Côte d'Ivoire, signalling high-level ownership and confidence in the model.

Women reached, lives protected

Thousands of women, many accessing cancer screening for the first time, benefited directly from WICS integrated services. Côte d'Ivoire led the way, exceeding its screening target and reaching over 11 000 women through a combination of facility-based integration and community HPV self-sampling campaigns that extended to hard-to-access populations. Across all three countries, integration of cervical cancer screening into maternal and reproductive health services increased its health services increased its uptake among high-risk women, including women living with HIV.

Implementation experience varied across the three countries, reflecting differences in system readiness, infrastructure and local context. These variations generated invaluable operational insights that are now directly informing the design of Phase II, ensuring that scale-up is grounded in practical realities and tailored to each country's starting point.

A health workforce equipped for integrated care

More than 180 providers including nurses, midwives, clinical officers and community health workers were trained across the three countries. Each pilot facility now has dedicated WICS focal staff, while national training-of-trainers approaches created lasting capacity. In Zimbabwe 46 national trainers of trainers were certified in 2025, creating a critical mass of skilled providers for scale-up. In Kenya, over 25 providers were trained as WICS trainers, enabling cascade training in integrated screening. Health workers consistently reported greater professional satisfaction from delivering comprehensive, people-centred care.

Diagnostic and treatment capacity brought closer to women

Phase I unlocked diagnostic and early treatment capacity by introducing HPV DNA testing platforms at the district level, portable thermal ablation devices to

enable same-day treatment of cervical precancers and ultrasound services to strengthen breast screening services. Critically, countries demonstrated ownership of the initiative by co-investing domestic resources: Zimbabwe allocated national funds to procure additional screening and treatment consumables, while Kenya used domestic resources to procure HPV test kits and speculums. This co-investment model reinforced sustainability and national commitment.

Digital health as a gamechanger

Côte d'Ivoire led the way by implementing a standardized WICS register within the DHIS2 tracker, capturing individual-level data across cervical cancer, breast cancer and NCD services. Early results demonstrated improved data quality, real-time performance visibility and stronger follow-up of referred women. Phase II will scale this digital model across all WICS sites, replacing paper-based systems with integrated digital tracking.

Political leadership and South–South momentum

WICS catalysed high-level political leadership across all three countries with ministers of health formally launching and championing the initiative. The model was elevated to the regional stage and showcased at the 2024 and 2025 WHO Regional Committee for Africa, where it was recognized as "a new standard of care rooted in equity and health justice". The WHO Regional Office for Africa facilitated structured peer exchange between countries, positioning Côte d'Ivoire as a regional implementation hub and accelerating cross-country learning.

The power of partnership

The role of partners in Phase I was instrumental not only in expanding access to diagnostics and treatment technologies through in-kind donations but also in demonstrating the power of well-governed public–private collaboration.

WICS partners invested in leadership, learning and scalable systems change, going beyond service delivery to advance cervical cancer elimination across the Region. This approach exemplifies how strategic private-sector engagement can amplify the impact of integrated health programmes.

Community health promoter Violet Kikaya consults with a patient inside her home during a community visit in Bungoma county, Kenya
© WHO / Yasin Abdullahi

Equity, rights and reaching the unreached

At its core, WICS is more than a health intervention; it is an equity- and rights-based response to one of the most persistent injustices in women's health. WICS is grounded in a simple principle: no woman should die from cervical or breast cancer because she is poor, rural or marginalized.

By anchoring services at the PHC level, WICS is deliberately pro-poor and pro-rural. The introduction of HPV self-sampling in community settings empowers women who face cultural, logistical or personal barriers to clinic-based screening. Integrated clinics that ensure privacy, respectful counselling and continuity of care help normalize cancer prevention, reducing stigma and fear.

Crucially, WICS corrects inequities created by vertical programmes. Standalone cervical cancer initiatives often reached only women already engaged in HIV or reproductive health services. By integrating services into general outpatient care and community outreach, WICS intentionally reaches women who are HIV negative, older women, women outside maternal health programmes and those rarely in contact with the health system.

> **"Crucially, WICS corrects inequities created by vertical programmes"**

The equity focus of WICS aligns strongly with global and donor priorities. It contributes directly to Sustainable Development Goals 3 (health) and 5 (gender equality) and advances UHC by reducing disparities in access to essential services. When a woman is spared advanced cancer, families remain intact, communities retain productive members and health systems avoid the high costs of late-stage care.

Judith's journey

Kenya

Judith is a 42-year-old mother from Bungoma, Kenya. Like many women balancing work, family and daily responsibilities, Judith rarely had time to think about her own health. But when she began noticing unusual blood discharge and other symptoms that didn't feel normal, she made a decision that would ultimately save her life.

Judith sought screening through WICS. What started as a precaution quickly became a turning point: her cervical cancer was detected early, at a stage when treatment is most effective and recovery is possible.

"Screening early helped me, and today I am undergoing treatment. I want other women to know the importance of going early for screening," Judith says, her voice steady with courage and determination.

Côte d'Ivoire
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Togba Betti's community approach

Moussadougou, Côte d'Ivoire

Togba Betti, a community health worker in Moussadougou, uses a culturally sensitive approach by starting with men – husbands, brothers and community leaders.

"When men understand, they convince their wives to go early," he says.

Across two districts, over 20 community health workers have been trained to break the silence and stigma surrounding women's cancers. His method has opened doors for hundreds of women who might otherwise have stayed home.

References

1. Saving lives, spending less: a strategic response to noncommunicable diseases. Geneva: World Health Organization; 2018. WHO/NMH/NVI/18.8. Licence: CC BY-NC-SA 3.0 IGO (https://www.who.int/publications/i/item/WHO-NMH-NVI-18.8).

2. Omotoso O, Teibo JO, Atiba FA, Oladimeji T, Paimo OK, Ataya FS, Batiha GE, Alexiou A. Addressing cancer care inequities in sub-Saharan Africa: current challenges and proposed solutions. Int J Equity Health. 2023 Sep 11;22(1):189. doi: 10.1186/s12939-023-01962-y. PMID: 37697315; PMCID: PMC10496173.

3. African health leaders, partners call for greater investment in integrated NCD services. Brazzaville: WHO Regional Office for Africa; 27 August 2025 (https://www.afro.who.int/news/african-health-leaders-partners-call-greater-investment-integrated-ncd-services, accessed 2 March 2026).

4. Three African countries pilot initiative to boost cervical and breast cancer care. Brazzaville: WHO Regional Office for Africa; 22 September 2023 (https://www.afro.who.int/countries/cote-divoire/news/three-african-countries-pilot-initiative-boost-cervical-and-breast-cancer-care, accessed 2 March 2026).

5. WHO releases new estimates of the global burden of cervical cancer associated with HIV. Geneva: World Health Organization; 16 November 2020 (https://www.who.int/news/item/16-11-2020-who-releases-new-estimates-of-the-global-burden-of-cervical-cancer-associated-with-hiv, accessed 2 March 2026).

Community Health Promoter Vugutsa Scholastica educates a group of women in Asha Akinyi's neighbourhood: Ladhifa Mutama, Christine Nafula, Redempta Wanguke, Salome Amugada, Juliet Nekesa, Christine Sande and Asha Akinyi and her daughter, about the importance of cancer screening. Following the session, they stand together holding hands, a powerful symbol of the unity and shared purpose fostered by this essential community education work in Bungoma.
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The WHO Regional Office for Africa

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Africa is one of the six regional offices throughout the world, each with its own programme geared to the particular health conditions of the Member States it serves.

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