



In
Collaboration
With



From Commitment to Action: Advancing Women's Cancer Elimination and Treatment in Sub-Saharan Africa

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This report draws on the discussions, insights, and commitments shared during the COWHA Roundtable, "From Commitment to Action: Advancing Women's Cancer Elimination and Treatment in Sub-Saharan Africa." The collective expertise, perspectives, and reflections of the participants have informed the key discussions and priorities presented throughout this report.

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Members



Technical Partner



Strategic Partners



List of Abbreviations

AfCFTA	African Continental Free Trade Area
AHB	Africa Health Business
AI	Artificial Intelligence
AMA	African Medicines Agency
AU	African Union
COWHA	Coalition for Women's Health in Africa
DHIS2	District Health Information Software 2
EAC	East African Community
ECA/UNECA	United Nations Economic Commission for Africa
ECOWAS	Economic Community of West African States
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
Gavi	Gavi, the Vaccine Alliance
GCO	Global Cancer Observatory
HPV	Human Papillomavirus
HIV	Human Immunodeficiency Virus
MSD	MSD (Merck Sharp & Dohme)
NCD	Non-Communicable Disease
REC	Regional Economic Community
ROI	Return on Investment
SADC	Southern African Development Community
SRHR	Sexual and Reproductive Health and Rights
SSA	Sub-Saharan Africa
TWG	Technical Working Group
UHC	Universal Health Coverage
UNFPA	United Nations Population Fund
WHO	World Health Organization
GLOBOCAN	Global Cancer Observatory (IARC/WHO)



Executive Summary

Sub-Saharan Africa (SSA) accounts for over 117,000 new cervical cancer cases and approximately 76,000 deaths each year, yet fewer than 6 per cent of eligible women have ever been screened.^[1, 2] The tools to change these outcomes exist: effective vaccines, validated self-sampling technologies, re-purposable HIV diagnostic platforms, and a clear WHO elimination framework. It has become increasingly apparent that the remaining gaps lie in the institutional, fiscal, and regulatory systems needed to deliver proven interventions at national scale, through integrated health systems and domestic financing.^[1, 2, 12]

HPV vaccines are effective and increasingly available through Gavi-supported programmes, which have protected 95 million girls in the past eight years in low-income countries.^[3] Self-sampling technologies enable screening in the privacy of a woman's home and in multiple cases have increased cervical cancer screening rates and demand especially in HIV clinics.^[4] Molecular diagnostic systems built through decades of HIV investment can be repurposed for HPV DNA testing. The WHO 90-70-90 elimination targets provide a clear framework.

Five interconnected barriers continue to prevent commitments from translating into outcomes: proven interventions remain fragmented across disconnected pilot programmes instead of being built into national systems; health investments are often framed differently from the way fiscal decisions are made; regulatory timelines can delay access to validated innovations across African markets by years; continental accountability mechanisms lack the political visibility needed to drive compliance; and patient voices and gender-responsive approaches remain insufficiently reflected in programme design.

Concrete pathways for addressing each of these barriers are emerging. Ethiopia has demonstrated what national ownership looks like in practice, achieving HPV vaccination coverage above 80 per cent, scaling screening to over 1,600 facilities, and subsidising 63 per cent of chemotherapy costs through federal financing.^[5] Evidence from Eswatini and Zimbabwe confirms that HPV vaccination can be integrated into existing HIV service platforms with uptake rates between 74 and 90 per cent.^[6, 7] The United Nations Economic Commission for Africa (UNECA) is piloting fiscal compacts between Ministries of Health, Finance, and Planning that embed cancer services within national budget lines.^[8] The African Medicines Agency (AMA) is advancing a continent-wide approach to regulatory harmonisation, building on earlier regional initiatives such as the East African Community Medicines Regulatory Harmonization programme, where joint scientific assessments reduced national registration timelines from approximately 24 months to 8–14 months for products assessed through the joint process.^[9, 10]

Multi-stakeholder platforms such as COWHA serve a critical function in this landscape: bridging the structural distance between a WHO-prequalified innovation and the woman in a rural health facility who needs access to it. No single government, company, or multilateral agency can address all the regulatory, financing, procurement, and delivery challenges involved in bringing these interventions to scale. Coalitions that bring these actors together around clear, measurable commitments and follow through on delivery are therefore an important part of the elimination effort, helping turn commitments into action.

Background

Women's cancers, principally cervical and breast, remain among the most urgent yet preventable health challenges in SSA. SSA bears a disproportionate share of the global cervical cancer burden, with over 117,000 new cases and approximately 76,000 deaths each year. Poor access to prevention, screening and treatment contributes to approximately 90 per cent of these deaths, while fewer than 6 per cent of eligible women in Sub-Saharan Africa have ever been screened. Eighteen of the 20 highest-burden countries globally lie within the African Region. Breast cancer incidence is rising sharply, driven by weak screening infrastructure, limited awareness, and scarce diagnostic capacity. In some settings, more than 70 per cent of breast cancer cases are diagnosed at an advanced stage.^[1, 10, 11]

A woman's chances of surviving cancer can vary significantly depending on where she lives. Differences in funding, infrastructure, health worker skill and availability, medicines, and diagnostics mean that survival can depend on the care available to a patient and not just the diagnosis. Fewer than half of women with cervical cancer in the region survive five years.^[12] Population-based registries record five-year breast cancer survival ranging from around 20 per cent in some settings to over 80 per cent in others.^[13] This data shows that differences in access to cancer care correlate to survival outcomes.

Many of the tools needed to improve these outcomes for survival, especially to women who live in less accessible settings, are already available and are in the market. HPV vaccination is expanding through Gavi-supported programmes and national immunisation platforms. The WHO Global Strategy to Accelerate the Elimination of Cervical Cancer sets clear targets through the 90-70-90 framework: vaccinate almost all girls against HPV before age 15, screen most women at least twice in their lifetime with an accurate test, and treat the great majority of those found to have precancer or cancer.^[14] Self-sampling technologies, AI-assisted screening platforms, and molecular diagnostic systems originally built for HIV and tuberculosis are available for repurposing. Agenda 2063 and the Africa Health Strategy 2016-2030 reinforce these aims through their calls for universal health coverage.^[15]

These global and continental frameworks are given operational specificity through the Sub-Saharan Africa Women's Cancer Elimination Roadmap (2026-2030), which provides a structured pathway for countries to translate elimination commitments into nationally owned implementation plans. Early adopters such as Kenya, which has already launched a national cervical cancer elimination plan aligned to the Roadmap, demonstrate that country-level operationalisation is both feasible and underway. The Roadmap serves as the principal accountability instrument against which national progress should be measured and reported.

Even with the policy roadmaps and the tools already in market, screening coverage remains below 10 per cent across much of the region.^[16] Radiotherapy, pathology, and specialist oncology services are concentrated in a few urban centres. Weak registries and fragmented data systems hamper planning and accountability. The main gaps are now in financing, implementation, and sustained political commitment.

Without faster action, SSA could see cervical cancer deaths remain high even as other regions make progress towards elimination. The tools and knowledge are available, but turning them into better outcomes will depend on how quickly they are put into practice.

The Implementation Gap: Why Commitments Are Not Yet Delivering Results

Changing the Narrative From Individual Action to Collective Action

Africa's health landscape has reached a point where no single actor, whether government, private sector, multilateral agency, or civil society, can alone deliver the systemic changes required to eliminate women's cancers. Tackling these challenges and providing accessible and equitable care for all women and children requires a fundamental shift from institutional competition to coordinated delivery. Companies can manufacture diagnostics but cannot build the regulatory pathways to market them across 55 jurisdictions. Governments can set policy but cannot generate the innovations that policy is meant to govern. Donors can finance pilots but cannot sustain the national systems that must eventually absorb them.

What is needed is a shift from institutions working towards their own goals to working together towards shared outcomes. Multi-stakeholder coalitions serve as the connective tissue between these actors, creating structured engagement platforms through which regulatory coordination, fiscal architecture, procurement alignment, and delivery infrastructure can be built and maintained simultaneously. Without this connective function, the components of an elimination strategy remain fragmented across institutional boundaries, each performing in isolation but failing to produce the integrated outcomes that women's cancer elimination demands.

This shift carries direct implications for how the private sector engages with health systems in Africa. The role of companies is no longer just to supply products, it is strategic technical and financial partnership with governments navigating complex reform agendas, including the construction of data-driven, bankable investment cases for presentation to Ministries of Finance. This repositioning moves the public-private relationship from only just procurement toward co-investment in health system architecture.

The Graveyard of Pilots: Why Proven Interventions Fail to Scale

Across the continent, promising demonstration projects are common but few develop into scaled national programmes. Multiple organisations pursue parallel pilot programmes in the same countries, often testing similar interventions without coordination, only for each to conclude when the initiating partner's funding cycle ends. The next organisation arrives, launches a new pilot, and the cycle repeats. The result is a continent with growing evidence of what works but few systems that are able to deliver at scale.

The problem is partly rooted in how pilots are designed and financed. Most are built to be fundable by donors, not scalable by governments. They lack integration plans, costed pathways into national benefit packages, and dedicated budget lines from inception. When a pilot concludes and the implementing partner approaches the government to request national scale-up, the response is predictable: there is no budget, no trained workforce at the required scale, and no institutional mechanism to absorb the programme into the routine health system.

Africa therefore has a scale-up problem as opposed to a pilot problem. The solution is not more evidence or more

demonstration projects. It is fiscal architecture from day one: every pilot should include an explicit transition plan that specifies the ministry responsible for absorption, the budget line that will finance continuation, and the timeline for handover. A declaration is a commitment without a map. A compact gives every commitment a clear owner, a budget line, and a timeline.

Sustainable Financing: Making Health Speak the Language of Treasuries

The Fiscal Translation Gap

There is also a persistent disconnect between how health investments are presented and how fiscal decisions are made. Ministries of Health frame investment cases in epidemiological and clinical terms: incidence rates, mortality burdens, disability-adjusted life years. Ministries of Finance respond to different metrics entirely: return on investment, cost avoidance, workforce productivity, macroeconomic impact, and debt sustainability. When cervical cancer elimination is presented only as a health priority, it has to compete for limited funding with proposals that make a clearer case for their economic value.

Cervical cancer elimination may be the most bankable proposition in global health. The tools are available. The targets are defined through the WHO 90-70-90 framework.^[14] The delivery pathway is clear. Every US\$1 invested is projected to generate an estimated US\$3.20 in economic returns through 2050 and beyond, largely driven by increased participation of women in the workforce. When the broader benefits of improved women's health for families, communities, and society are also taken into account, the estimated return rises to US\$26.00 for every dollar invested.^[17] A woman who dies of cervical cancer at 40 is not only a health statistic. She is a business that closes, a classroom that empties, a household that collapses. For the people making national budget decisions, the economic case is not separate from the health case. It is a central part of the case for investment and can lead to direct changes within policies and increasing access.

Building Fiscal Compacts Between Health, Finance, and Planning

The most concrete mechanism emerging to close this translation gap is the development of fiscal compacts: politically endorsed agreements between Ministries of Health, Finance, and Planning that embed specific health services within national budget lines. UNECA is building country-level fiscal diagnostics and investment cases that translate health outcomes into the fiscal language treasuries require, piloting these compacts in early-adopter countries with the aim of demonstrating a replicable model for the continent.

The compact model addresses a structural weakness in how health financing is currently governed. Too often, health services exist outside the formal fiscal architecture, funded through donor-supported parallel systems, off-budget project accounts, or discretionary allocations that can be withdrawn without institutional consequence. Compacts embed services such as HPV vaccination, cervical screening, and cancer treatment within the line-item budget structure, that both governments and their financing partners require when finalizing implementation decisions.

The Case for More Efficient Procurement

An estimated 40 per cent of health funds across African health systems are lost through procurement inefficiencies.^[18, 19] The immediate opportunity is not only to seek additional financing but to optimise existing resources. Savings recovered through improved procurement, reduced duplication, and more efficient supply chain management can be explicitly redirected toward women's health prevention and screening programmes. The real focus should possibly not be about attracting or funding but also how to best utilize the already existing funding in an efficient way.

Insurance mechanisms and contributory financing models also represent an underutilized pathway for cancer service sustainability. Where health insurance schemes are expanding, including in Kenya, Egypt, and Nigeria, explicitly covering cancer screening, diagnosis, and treatment within benefit packages can create a more reliable domestic source of funding. It also reduces reliance on external funding and links financing more directly to population needs.

Prevention and Early Detection: Reaching Women Where They Are

National Ownership at Scale: The Ethiopia Model

Ethiopia provides one of the most compelling demonstrations of what becomes possible when political commitment is matched by budget allocation and operational delivery. The country recognised cancer as a public health problem and established a national cancer control team in 2013, followed by a national cancer strategy plan in 2015. Since then, cervical cancer screening services have been scaled from a small number of facilities to over 1,600 nationwide, driven by decentralisation and task-sharing strategies that extend coverage beyond urban centres.^[5]

Self-screening has been adopted as an innovative tool for reaching women in hard-to-access communities, and within a single year, 4.5 million women were screened. Ethiopia introduced its first national breast cancer screening programme, extending early detection capacity into decentralised settings. On HPV vaccination, the country has achieved coverage above 80 per cent, compared with a global average of approximately 30 per cent and an African average of around 50 per cent.^[5] This was achieved in the second most populous country on the continent, across extraordinary geographic, linguistic, and cultural diversity.

On treatment financing, the federal government now subsidises 63 per cent of chemotherapy costs, complemented by insurance mechanisms designed to reduce out-of-pocket expenditure. The Ethiopia experience demonstrates that national ownership, when operationalised through legislation, budgetary allocation, and system-level delivery reform, produces results at a pace and scale that externally funded pilot programmes cannot replicate.^[5]

Leveraging HIV Infrastructure for Multi-Disease Cancer Prevention

26 years of sustained investment in HIV have built community health worker networks, testing platforms, laboratory infrastructure, and referral systems across Sub-Saharan Africa. These are not limited to one disease but with the right policy and regulatory support, they can also be used for other areas of diagnosis, screening, and prevention.

Evidence from integration pilots in Eswatini and Zimbabwe demonstrates that HPV vaccination can be delivered through existing HIV service platforms with uptake rates of approximately 90 per cent in Eswatini and 74 per cent in Zimbabwe, alongside high provider satisfaction.^[7, 6] Women living with HIV are approximately six times more likely to develop cervical cancer, making the integration of HPV prevention into HIV services both practical and important from a public health perspective.^[10] With these models already in place, the integration of HPV prevention into HIV services both practical and important from a public health perspective.

Molecular diagnostic platforms, originally deployed for HIV and tuberculosis testing, are capable of performing HPV DNA testing on the same equipment. Repurposing these platforms for multi-disease molecular diagnostics reduces per-test costs, improves platform utilisation, and avoids the capital expenditure required to build separate diagnostic infrastructure for cancer. This technology, like many others, is already compatible within the healthcare system, and the incremental cost of adding HPV testing to existing platforms is a fraction of building new ones.

Self-Sampling and Digital Screening: Putting Diagnosis in Women's Hands

HPV self-sampling represents one of the most significant innovations available for expanding screening coverage in settings where conventional clinic-based screening faces persistent cultural, logistical, and workforce barriers. Self-sampling enables a woman to collect her own HPV sample in the privacy of her home, addressing the cultural barriers that discourage conventional cervical examination in many African settings.

For many women, particularly in rural and underserved communities, self-sampling is the primary pathway to screening. Community health worker networks, already established across much of the continent through HIV and maternal health programmes, provide the distribution and collection logistics. The regulatory pathway should be streamlined so that a self-test kit approved in one African country does not require years of duplicative registration before it can reach women in another.

Digital tools are extending diagnostic reach further. AI-assisted cervical screening platforms are increasingly being deployed across Sub-Saharan Africa. Automated Visual Evaluation (AVE) tools, validated in prospective studies across multiple African countries, have demonstrated significantly higher sensitivity than conventional visual inspection in detecting high-grade cervical lesions, offering the prospect of specialist-level diagnostic accuracy delivered through accessible hardware at the primary care level.^[20]

Diagnosis and Treatment Capacity: Working towards interoperability

Regulatory Harmonisation

Innovations that are proven, WHO-prequalified, and available in other markets can face significant delays in reaching African patients, as manufacturers may need to navigate separate registration processes across national regulatory authorities.^[21] A diagnostic tool or pharmaceutical product registered in one African country may require full re-registration in a neighbouring market, imposing significant time and cost

burdens that structurally disadvantage African patients relative to their counterparts elsewhere.

The AMA represents the most significant structural reform available to address this barrier. AMA is advancing a model of one application, one scientific review, and access to multiple markets, while preserving the sovereignty of national regulatory authorities to make final registration decisions. AMA has established a Regulatory Innovation and Manufacturing Hub designed to support local manufacturers from the earliest stages of product development and is collaborating with Africa CDC on pooled procurement quality assurance and with the African Continental Free Trade Area (AfCFTA) Secretariat on product quality standards for continental trade.^[21]

Regulatory harmonisation and work-sharing mechanisms have demonstrated measurable gains in reducing registration timelines. Within the East African Community (EAC), the timeline for national assessment of medicinal product applications decreased from approximately 24 months in 2012 to 8–14 months by 2017 for products assessed through the joint assessment process involving two or more national medicines regulatory authorities. Since 2015, the initiative has conducted 10 joint product assessment sessions, considering 83 medicinal product applications and resulting in recommendations for the registration of 36 products by EAC Partner States.^[19, 22] Extending this model to self-sampling kits, molecular diagnostics, AI-assisted screening tools, and essential cancer medicines would materially accelerate the pace at which African women can access innovations that are already available elsewhere. The regulatory is the bottle-neck that determines whether innovations reach the women who need them in an efficient and timely manner.

Local Manufacturing and Continental Procurement: From Dependency to Sovereignty

Africa imports the majority of its diagnostics, vaccines, and essential medicines, a dependency that creates supply chain vulnerability, constrains national sovereignty over health decisions, and exports economic value that could be retained on the continent.^[23] The COVID-19 pandemic demonstrated that Africa is systematically deprioritised in global supply chains when global demand surges and need is greatest.

AMA's continental quality assurance architecture, working alongside Africa CDC's pooled procurement mechanisms and the AfCFTA's trade facilitation frameworks, is creating the conditions under which local manufacturing can be supported by predictable demand, assured quality standards, and access to continental markets. Products manufactured in Africa must be trusted to meet international quality standards, and that trust must be reflected in procurement policies that actively support local production rather than defaulting to imports.

The continent has committed to producing 60 per cent of its routine immunisation needs and other essential health products locally by 2040. Development finance institutions looking for predictable and well-governed investment opportunities could support a sector with a clear demand pipeline, a defined

regulatory pathway, and measurable economic returns. The trade-off is greater predictability, performance, and good governance which can support access to financing, technology transfer, and local production.

Accountability and Regional Cooperation: Tracking Progress

A Continental Women's Cancer Scorecard

Commitments are being made, but they are not always followed through. The most direct mechanism available to break this cycle is a continental women's cancer scorecard, designed with a focused set of health outcome indicators that heads of state can understand and act upon. The scorecard should measure outcomes, not just activities or processes: not how many women were invited for screening but how many were screened, treated, and survived. It should be submitted to the African Union Assembly of Heads of State on a biennial cycle, creating the political visibility and competitive dynamic that has proven effective in other health domains. The experience of malaria scorecards is useful. When heads of state can see how countries compare, they are better placed to hold health ministers accountable for progress and results.

COWHA is positioned to serve as the technical secretariat for the scorecard's development and operationalisation. The framework should be focused around six to eight outcome indicators with clearly defined data sources, drawn from GLOBOCAN estimates, WHO 90-70-90 targets, national DHIS2 reporting systems, and the SSA Women's Cancer Elimination Roadmap benchmarks. Critically, Coalition members hold valuable diagnostics, market, and supply chain data that governments do not always have access to, including screening volumes, self-sampling uptake, diagnostic platform utilisation, and HPV vaccine distribution intelligence. To safeguard commercial confidentiality, given that many Coalition members are competitors, private sector data contributions would be channelled through an aggregated, anonymised data-sharing protocol managed by the COWHA secretariat. This approach enables the scorecard to benefit from private sector intelligence on screening volumes, diagnostic utilisation, and supply chain performance without requiring direct disclosure between competing organisations. This would provide a credible and well-supported contribution to the evidence base, going beyond what public reporting systems can provide on their own. It would also strengthen the role of the COWHA scorecard in tracking progress and accountability.

The scorecard should be accompanied by civil society reports providing independent verification of government-reported data. Relying only on self-reported information limits accountability. Independent assessment can strengthen confidence in the data and help maintain the pressure needed to keep commitments on track.

Regional Economic Communities as the Implementation Layer

There is a gap between continental commitments and what happens at national level. Regional Economic Communities, including SADC, ECOWAS, and their counterparts, are well placed to help close this gap. Africa's implementation architecture depends on these bodies to translate continental frameworks into functional support at the country level: peer review, technical assistance, implementation schedule monitoring, and the facilitated learning exchanges that enable countries to adapt proven models from their neighbours. The establishment of a Regional Multi-Sector Coordination



Platform, as envisaged under the SSA Women's Cancer Elimination Roadmap, would provide the institutional architecture to support implementation, knowledge exchange, and accountability across RECs and their member states.

Engaging RECs requires more than just endorsement, it requires functional support directed at the specific barriers preventing progress in individual countries. Where a country's progress has stalled, the intervention should be diagnostic: what is preventing implementation, whether it is workforce capacity, procurement bottlenecks, regulatory delays, or financing gaps, and what targeted support can address the constraint. This level of engagement demands capacity within the RECs themselves. Investing in that capacity can strengthen their ability to support implementation across countries.

The Patient Voice and Gender-Responsive Design

No programme, financing model, or policy will succeed if it does not reflect the experiences and needs of the women it is intended to serve. Cervical cancer is not only a clinical condition. For women living with the disease, it can affect their dignity, relationships, livelihoods, and ability to access care. These challenges are often greatest for women with the least power and resources to advocate for better services.

HPV vaccination communication provides a concrete example. Current messaging strategies focus predominantly on parents and caregivers, failing to engage the young people who are the intended recipients of the vaccine. The messaging focuses on girls while omitting the fact that HPV affects boys as well, and that the current prioritisation of girls reflects resource constraints rather than the full epidemiology of the virus. Investing in inclusive, culturally appropriate communication now can support wider vaccination programmes in the future and help address the misinformation that continues to affect uptake.

Gender and social norms operate as structural barriers to care across the continent. Laws, cultural practices, and community expectations continue to require women to seek permission before accessing health services, to endure symptoms in silence, and to regard their own health needs as secondary. Until these norms are addressed directly, through comprehensive approaches that include community engagement, sexuality education, midwife-led outreach, and private sector employee health accountability, the downstream investments in diagnostics, treatment, and financing will continue to benefit mainly women who are already able to navigate the health system.

Women's health needs to be addressed across the full course of life, not only during pregnancy and childbirth. Health data systems and benefit packages that capture only pregnancy-related care render invisible the cancers, cardiovascular conditions, and other NCDs that disproportionately affect women throughout their lives. Moving to a lifecycle approach does not necessarily require new infrastructure. It requires using existing contact points more intentionally: when a woman attends an antenatal clinic, that visit is an opportunity

for breast cancer screening, cervical screening, blood pressure assessment, and glucose testing. The additional cost of providing these services during an existing visit is relatively small. Missing a diagnosis, however, can have a much greater cost for the woman and for the health system later.

Conclusion

The gap between what is possible and what is being delivered for women's cancer in SSA is not a lack of knowledge, technology, or stated political commitment. The main gaps are in implementation, scaling up proven approaches, and securing sustainable financing.

Countries such as Ethiopia are showing that national ownership, supported by budget commitments and effective implementation, can deliver results at scale. Health platforms developed through decades of HIV investment can be used for broader diagnostic services and cancer prevention. New financing approaches are being developed to help make the economic case for health investments and secure national budget support. The African Medicines Agency is working to reduce duplication and delays in regulatory processes, while digital screening tools are already being used and are ready to be expanded.

These efforts will not deliver their full potential unless they are brought together through clear and accountable action. Pilot programmes need to be incorporated into national systems from the outset, with a clear plan for long-term financing and scale-up. Financing discussions need to speak directly to the priorities of Ministries of Finance. Accountability needs to reach the highest political level, supported by scorecards that track health outcomes. Regulatory cooperation needs to move faster. Patient voices, including the social, cultural, and gender-related factors that affect access to care, also need to be part of programme design from the beginning.

The commitments made by participating organisations during the session are documented in the accompanying



Commitments Register annex. The register identifies the responsible organisation, a measurable indicator, and a review date for each commitment. Subject to Board endorsement, COWHA proposes to track progress over the next 12 months, with an interim update at six months and a full review at the next COWHA convening.

Key Recommendations

The following implementation framework translates the report's findings into specific, accountable actions. Each recommendation is mapped to a responsible party, an entry point, a progress measure, and a target date, reflecting the session's core principle that meaningful commitments require a clear owner, an accountable institution, and a timeline.

Recommendation	COWHA Role	Implementation Party	Entry Point	Progress Measure and Target Date
Aggregate pilots into national systems with fiscal architecture from the outset	COWHA NCD and Cancer TWG to map existing pilots across focus countries and produce an advocacy brief identifying candidates for national adoption.	National Ministries of Health (implementation); UNECA (fiscal architecture support)	UNECA fiscal compact framework; national health sector plans	Mapping completed by Q3 2027; advocacy brief circulated to MoHs in focus countries by Q4 2027
Accelerate regulatory harmonisation through the African Medicines Agency	COWHA NCD and Cancer TWG to map the regulatory status of priority women's health technologies across focus countries and share findings with AMA to inform its work programme	AMA (regulatory action); national regulatory authorities (registration decisions)	AMA Regulatory Innovation and Manufacturing Hub	Regulatory landscape mapping completed and shared with AMA; number of priority technologies flagged for expedited review. Q4 2027
Develop a continental women's cancer scorecard	COWHA to lead the technical design of 6-8 outcome indicators drawing on member data, GLOBOCAN, WHO 90-70-90, and DHIS2; produce a draft scorecard and present to AU Commission for adoption	AU Commission / Africa CDC	AU Comprehensive Monitoring, Reporting and Accountability Framework; SSA Women's Cancer Elimination Roadmap	Draft scorecard produced by Q2 2027; presented to AU Commission for consideration between Q4 2027-Q2 2028
Establish a Regional Multi-Sector Coordination Platform	COWHA to advocate for the establishment of the platform through engagement with AU Commission and RECs; produce a proposed term of reference	AU Commission / RECs / Africa CDC (establishment and governance)	Existing REC health coordination mechanisms; AU Health Strategy implementation architecture	Terms of reference drafted by COWHA by Q4 2027 and submitted to AU Commission in 2028
Engage Regional Economic Communities as the implementation layer	COWHA to engage REC health desks with advocacy materials and scorecard data; facilitate peer-learning exchanges between focus countries	RECs (SADC, ECOWAS, EAC) / AU Commission (implementation)	REC health sector coordination mechanisms; existing peer review frameworks	Number of RECs engaged by COWHA on women's cancer agenda; peer-learning exchange convened; Q4 2027
Adopt a lifecycle approach to women's health, including breast cancer	COWHA SRHR and NCD/Cancer TWGs to produce a technical brief on integrating multi-condition screening at existing health contact points; advocate with MoHs in focus countries and facilitate exchanges between focus countries	National Ministries of Health (policy adoption and service delivery)	Antenatal care platforms; primary healthcare systems; national NCD strategies	Technical brief produced by Q3 2027; presented to MoHs in at least 2 focus countries by Q4 2027
Advocate for fiscal compacts between Ministries of Health, Finance, and Planning	COWHA NCD and Cancer TWG to produce a Finance Ministry-facing brief on the economic returns of cervical cancer elimination; support UNECA's compact piloting with advocacy in focus countries	UNECA (compact development); national Ministries of Health, Finance, and Planning (adoption)	UNECA Sustainable Health Financing initiative; Conference of Ministers of Finance	Fiscal brief produced by Q3 2027; COWHA advocacy conducted in at least 2 focus countries alongside UNECA between Q4 2027-Q2 2028

Recommendation	COWHA Role	Implementation Party	Entry Point	Progress Measure and Target Date
Leverage HIV infrastructure for multi-disease cancer prevention	COWHA to advocate for integration through policy briefs and convening; highlight EGPAF evidence from Eswatini/ Zimbabwe at ministerial engagements	EGPAF / Abbott / Gavi / National Ministries of Health	Existing HIV service platforms; GeneXpert networks; community health worker systems	Advocacy brief produced citing integration evidence; presented at COWHA convenings and to MoH counterparts by Q3 2027
Centre the patient voice and gender-responsive design in programme architecture	COWHA SRHR TWG to develop gender-responsive design guidance for cancer prevention programmes; COWHA to include patient representatives in future convenings	UNFPA (gender norm programming); civil society partners (community engagement); national MoHs (service delivery)	UNFPA country programmes; antenatal care platforms	Gender-responsive guidance produced by Q3 2027; patient voice represented at next COWHA convening
Advocate for redirecting procurement efficiencies toward women's health investment	COWHA to produce an advocacy brief quantifying the opportunity from procurement reform and present to MoH/MoF counterparts in focus countries	National Ministries of Health and Finance (procurement reform); Africa CDC (continental procurement)	Africa CDC continental procurement initiative; national procurement reform agendas	Advocacy brief produced and circulated by Q4 2027
Scale self-sampling and digital screening technologies	COWHA to advocate for regulatory harmonisation of self-sampling kits through AMA engagement; highlight validated technologies in policy briefs and convenings	Abbott / Hologic / National MoHs / AMA (product registration and deployment)	AMA regulatory harmonisation pathway; community health worker networks	Self-sampling included in COWHA regulatory mapping and AMA engagement; technologies highlighted in COWHA advocacy materials by Q4 2027





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