

Background

In the Community of Latin American and Caribbean States (CELAC), the cancer burden is reflected by the age-standardized incidence and mortality rates of 178.4 per 100 000 person-years and 85.7 per 100 000 person-years, respectively, reported in 2020 [1]. Among the cancer types that are amenable to screening, breast cancer and cervical cancer are the first and third most common causes of cancer deaths, respectively, among women in the CELAC region. In 2020, the age-standardized mortality rate for breast cancer was 13.5 per 100 000 person-years and for cervical cancer was 7.6 per 100 000 person-years. Colorectal cancer is the third most common cause of cancer deaths among men (9.4 per 100 000 person-years) and the fourth most common cause among women (7.3 per 100 000 person-years) [1].

Cancer Screening in Five Continents (CanScreen5), a project of the

International Agency for Research on Cancer (IARC), was launched in 2019. CanScreen5 aims to collect information about the characteristics and performance of cancer screening programmes around the globe in a standardized manner, for effective programme evaluation and quality improvement [2]. More details about the project are available from the CanScreen5 website [3] and in recent publications [4, 5]. The CanScreen5/CELAC project is supported by an extramural grant from the Norwegian Research Council awarded to the Centre for Global Health Inequalities Research (CHAIN) at the Norwegian University of Science and Technology (NTNU). The objectives of the CanScreen5/CELAC project are to report on the status and performance of cancer screening programmes in CELAC countries and to assess the barriers to the implementation of quality-assured cancer screening in the region.

Of the 27 CELAC countries that participated in this project until 2023, 22 reported having a screening programme for cervical cancer and 16 for breast cancer. Large gaps were identified in the organization and quality of screening services. Only a few of the countries systematically invited the eligible population for screening: 4 countries for cervical cancer screening and 1 country for breast cancer screening. A colorectal cancer screening programme was implemented in only 7 countries [3].

Most of the countries with a cervical cancer or breast cancer screening programme reported collecting information about the screened population and the screening test results: 18 countries (86%) for cervical cancer screening and 12 countries (80%) for breast cancer screening. There was great variability in quality assurance, in terms of having a responsible individual or organization, documented

performance indicators, and a system for tracking screen-positive individuals and cancer cases. Few of the countries were able to provide quantitative data for analysis. For cervical cancer screening programmes, only 2 countries (10%) could provide the aggregate number of women undergoing further assessment, final diagnosis, and staging of the cancers detected. For breast cancer screening programmes, only 1 country (7%) submitted data on further assessment and only 2 countries (13%) could provide final diagnosis and cancer staging information of the women screened. Some of the explanations for the reported data gap were not having an effective information system, the inability to follow up the screen-positive women because of a lack of linkage between databases, insufficient human resources to perform this linkage, and/or a lack of clarity on the target population; this underscores the need for better quality assurance mechanisms within the programmes [5].

A survey was completed by staff members from the management and

leadership of the cancer screening programmes. The survey collected information about the policies, protocols, and organization of these programmes and provided valuable insights into some areas of inequality, such as out-of-pocket costs for screening, diagnosis, and treatment limiting access to services.

Although most of the countries reported that cervical cancer or breast cancer screening tests were provided free of charge in the public health system, women had to pay for diagnostic services for breast cancer in 7 countries (47%) and for cervical cancer in 9 countries (43%) and for treatment services for breast cancer in 6 countries (40%) and for cervical cancer in 8 countries (38%) [5]. This economic burden of health care among women with positive screening test results may cause them to forgo diagnosis or treatment because of unaffordable costs [6].

Although research has been conducted on barriers to accessing health services in the CELAC region from the population's perspective through household surveys [7], there

is a gap in the understanding of the country-specific barriers to accessing quality-assured cancer screening and ways of improving cancer screening programmes. One of the major objectives of the CanScreen5/CELAC project was to assess barriers to the cancer screening pathway from the health system perspective, and to identify evidence-based interventions that could help individuals to overcome those barriers and thus improve cancer screening programmes in the CELAC region.

This report covers the following information for each of the 27 participating CELAC countries:

- screening protocols for breast cancer, cervical cancer, and colorectal cancer in the country;
- mapping of barriers to the cancer screening pathway in the country; and
- identifying interventions that are already in place to improve cancer screening programmes in the country.