ABSTRACT BOOK

ELIMINATING CERVICAL CANCER 2026

HYBRID CONFERENCE

25-27 NOVEMBER 2026
SOFITEL, MELBOURNE



NHMRC Centre of Research Excellence in Cervical Cancer Control

This is a multi-institutional agreement in partnership with:

The University of Sydney – Cancer Elimination Collaboration

UNSW Kirby Institute

Australian Centre for the Prevention of Cervical Cancer

The University of Melbourne

Australian National University

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Join us in 2026

Dear Colleagues

On behalf of the ECC2026 Organising Committee, we are delighted to invite you to partner with us for the Eliminating Cervical Cancer Conference (ECC2026), taking place from 25–27 November 2026 in Melbourne, Australia (with a cocktail reception to kick off proceedings on the 24th). We have already received strong interest from previous conference participants and new stakeholders alike, reflecting the growing momentum and global commitment to this important cause.

For the first time in history, the elimination of a cancer is within reach. On 17 November 2020, the World Health Organization (WHO) launched its Global Strategy to eliminate cervical cancer as a public health problem by the end of the century. Central to this vision is a comprehensive, triple intervention approach —vaccination, screening and treatment—designed to place every country on a clear pathway towards elimination by 2030.

ECC2026 will bring together leading researchers, policymakers and health sector leaders from Australia, New Zealand, the Indo Pacific and across the globe. Together, we will share evidence, insights and collaborative approaches to accelerate our journey towards a future free from cervical cancer.

Your partnership will play a vital role in shaping ECC2026 as our most innovative, engaging and impactful conference to date. As a Partner and/or Exhibitor, you will be supporting global efforts to eliminate a preventable disease while showcasing your expertise and contributing meaningfully to discussions that will inform policy, practice and research.

We invite you to be part of ECC2026 and to work with us in advancing this historic global health agenda.

Warm regards



Professor Marion Saville AM
Executive Director
Australian Centre for the Prevention of Cervical Cancer



Professor Karen Canfell AC
Lead
Cancer Elimination Collaboration
The University of Sydney

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ECC2026

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A collaborative equilibrium approach to co-design of cervical cancer patient education in resource-poor settings: A case study from Indonesia

Linda Bennett, Mitha Eka

Nossal Institute for Global Health, University of Melbourne

Introduction: In high-resource settings patient education is typically established as an essential component of cancer care. However, in lower-resource settings with very high cervical cancer burdens such as Indonesia, formalised patient education is lacking, which negatively impacts quality of care, treatment delays and outcomes, and patients' rights.

Methods: A co-designed intervention was undertaken with cancer survivors and patients, treating clinicians, hospital management, professional medical associations and government representatives. Priorities for content, communication mediums and accessibility were determined, and two sets of education resources were developed, a flip chart for use at point-of-diagnosis and take-home fact sheets. A training module for clinicians on delivery of patient education was developed and facilitated, and the education resources were piloted in four hospitals over six months in 2026. Evaluation of the pilot by patients and clinicians was undertaken qualitatively and quantitatively.

Results: Key challenges included: ensuring readability by using colloquial language rather than medical terminology; time pressure due to short consultation windows and high patient load; removing judgmental or stigmatising language from clinician-patient interactions; encouraging two-way communication; and the need to address misinformation.

Patient satisfaction was either high or very high among all patients who participated in the evaluation. Clinicians reported higher confidence in delivering patient education and addressing myths, and observed greater patient participation in decision making, less anxiety among patients, and faster treatment uptake. Clinicians requested the training be adapted into an online module to allow ongoing training of new residents.

Conclusions: The co-design process enabled development of education resources and training that overcame prior barriers and was a realistic fit with low levels of cancer-related health literacy and the low-resource setting. Collaboration was key to achieving equilibrium between patients' needs and clinicians' capacities, and fostered strong joint ownership, which has translated into a commitment to upscaling the intervention.

To be presented on Day 3, in the 11am-12:30pm Scientific session – Pillar 3

Socioeconomic disparities in HPV vaccination coverage using the Person Level Integrated Data Asset

Samrawit Fetene[1], Claire Vajdic[1], Julia Brotherton[2], Rebecca Guy[1], Zoe Aitken[2], Adrian Walker[3], Hamish McManus[1]

[1] *Kirby Institute, University of New South Wales, Sydney*

[2] *Melbourne School of Public Health, The University of Melbourne, Melbourne.*

[3] *Centre for Big Data Research in Health, University of New South Wales, Sydney*

Introduction: In Australia, people of lower socioeconomic status experience a higher burden of cervical cancer and lower HPV vaccination coverage. Existing HPV vaccination coverage estimates derived from the Australian Immunisation Register have methodological limitations. Firstly, subpopulations with socioeconomic disadvantage are identified using the area-level ABS Socio-Economic Indexes for Areas (SEIFA). Secondly, coverage estimates do not censor individuals who emigrate from Australia. Thirdly, residential location is derived from one dataset at a single point in time. The Australian Bureau of Statistics (ABS) Person Level Integrated Data Asset (PLIDA) allows each of these limitations to be addressed.

Methods: Using a vaccination coverage tool developed in PLIDA, we examined HPV vaccination coverage among annual cohorts of adolescents turning 15 years from 2020 to 2024 stratified by indicators of socioeconomic status. These indicators include self-reported household equivalised income, time-updated parental income, and parental receipt of social services. Adolescent HPV vaccination coverage was estimated using these indicators and the area-level indices, and also estimated with and without censoring at emigration and with and without reference to the most up-to-date residential location information. Socioeconomic inequalities were assessed using absolute differences, prevalence ratios, and relative risks estimated from Poisson regression models with robust standard errors.

Results: We will report trends in sex- and age-specific HPV vaccination coverage using these individual- and area-level socioeconomic measures and compare estimates against current national estimates over the study period. We will assess whether temporal declines have been steeper among more disadvantaged groups, indicating widening socioeconomic inequalities.

Conclusions: The availability of linked, person-level health and social data has the potential to advance our understanding of socioeconomic disparities in HPV vaccination and how they have changed over time. Such evidence has important policy implications for targeted interventions, which will be increasingly relevant as progress is made towards elimination.

To be presented on Day 1, in the 11am-12:30pm Scientific session – Pillar 1

Exploring Indonesian midwives' training experiences and knowledge related to cervical screening and HPV DNA testing in East Nusa Tenggara province

Sandra Frans[1], Ariane Utomo[2], Linda Bennett[1]

[1] *Nossal Institute for Global Health, Melbourne School of Population and Global Health, The University of Melbourne*

[2] *School of Geography, Earth and Atmospheric Sciences, The University of Melbourne*

Background: Indonesia has the highest rates of cervical cancer (CC) mortality in Southeast Asia, mainly due to poor access to and low uptake of cervical screening. Indonesian midwives are primarily responsible for conducting cervical screening, yet there is very limited research on their relevant knowledge, training and capacity to provide screening.

Objective: This study explored midwives' experiences of cervical screening training and their knowledge related to CC, cervical screening using Visual Inspection with Acetic Acid (VIA), and Human Papillomavirus (HPV) DNA testing in East Nusa Tenggara, Indonesia.

Design: A qualitative study design was employed, based on primary data collected through fieldwork using semi-structured interviews and supplemented by a knowledge assessment questionnaire.

Methods: Twenty-four midwives across two districts, one semi-urban and one remote, participated. Qualitative data were analysed using a codebook thematic analysis approach, and questionnaire data were descriptively analysed.

Results: Midwives' mean knowledge score was 75%, with midwives trained in cervical screening scoring higher than untrained midwives. Our findings highlighted inequitable access to training, with midwives in the more urban district having more access to training and higher knowledge. Midwives emphasised that adequate training and continuous practice of the VIA were crucial to building confidence in service delivery. Key knowledge gaps included poor understanding of the relationships between HPV infection, pre-cancer lesions, CC and its prevention. Midwives' poor knowledge of CC aetiology and asymptomatic pre-cancer lesions resulted in only recruited women who came with associated symptoms.

Conclusions: Geographical inequality in human resource investment in remote areas limits women's access to quality cervical screening and impedes progress towards CC elimination. Supporting midwives through thorough and up-to-date training, including HPV DNA testing, is essential to increase screening access and uptake, and for the transition to HPV DNA testing.

To be presented on Day 2, in the 11:15am-12:30pm Scientific session – Pillar 1

Reaching women for cervical screening through antenatal care in hospitals: assessing implementation and impact of 'Screening During Pregnancy' across New South Wales

Sarah Gerritsen[1], Corinne Avery[1], Mandy Wang[2, 3], Therese McGee[2, 3], Gina Papandony[1], Kidest Nadew[1], Alison Jones[1], Megan Varlow[1], O'Brien Tracey[1]

[1] *Cancer Institute NSW*

[2] *Department of Obstetrics and Gynaecology, Westmead Hospital*

[3] *Westmead Clinical School, University of Sydney*

Introduction: The National Cervical Screening Program encourages cervical screening as effective and safe at all stages of pregnancy. Offering an HPV test in pregnancy has the potential to considerably improve outcomes for never- and under-screened women. This study assessed implementation of screening during pregnancy (SDP) in hospitals and pilot data to estimate the potential impact of SDP statewide implementation.

Methods: Data were National Cancer Screening Register (NCSR) HPV primary cervical screening tests (CST) collected in NSW hospitals 2019–2025 from women aged 25–49, and participation rates in local health districts (LHD). Perinatal Data Collection provided annual number of mothers of the same age giving birth in hospitals. eMaternity data from an 18-month pilot of SDP at Westmead hospital measured acceptability and achievable SDP rate. The SDP rate was then used to estimate number of additional women tested if SDP was implemented statewide, accounting for LHD's different due/overdue and current CSTs collected in hospitals.

Results: CSTs collected in hospitals across NSW were low in 2020-22 but increased to over 6,000 by 2025, with self-collection dominant. Only 2/15 LHDs had strong adoption of SDP, with 19% and 12% of women giving birth screened in 2025. Five LHDs had higher proportions of women due/overdue for CST (>20%) but low rates of SDP (2-7%). In the Westmead pilot, 48% (2492/5190) of eligible pregnant women were due/overdue, 70% were offered and 94% accepted (65% of eligible women tested). If all LHDs offered SDP, an additional 5,020 women would have a CST annually (>50% of whom would be from three LHDs).

Conclusions : SDP is an acceptable and effective method for reaching women due for cervical screening and has the potential to make a strong contribution to the elimination of cervical cancer. Implementation in hospitals with low SDP rates in LHDs with higher due/overdue rates could be impactful.

To be presented on Day 2, in the 11:15am-12:30pm Scientific session – Pillar 2

What is the optimal screening strategy to achieve cervical cancer elimination in Ethiopia: Implications for national strategy

Muluken Gizaw[1, 2], Diep Nguyen[2], Daniela Rivas Romero[2], Michael Caruana[2], Kate Simms[2], Karen Canfell[2]

[1] *Department of Epidemiology and Biostatistics, School of Public Health, Addis Ababa University, Addis Ababa, Ethiopia*

[2] *Cancer Elimination Collaboration, School of Public Health, The University of Sydney, Sydney, Australia*

Introduction: Cervical cancer is the second most common cancer among women in Ethiopia (20.2/100,000). HPV vaccination began in 2018 for 14-year-old girls, with variable reported coverage. Screening, introduced in 2015 using VIA, has limited coverage (~26%) and is further constrained by high loss to follow-up across the care continuum, resulting in limited program effectiveness. Radiotherapy capacity meets only ~5% of treatment needs. The 2025–2029 national guideline prioritizes HPV-based screening. This study therefore aims to assess effectiveness, cost-effectiveness, and elimination timelines of screening strategies with vaccination and treatment scale-up to guide MoH elimination planning.

Methods: The study uses a co-design approach involving national stakeholders to develop context-specific and policy-relevant scenarios. The Elimination Planning Tool (EPT) is used to evaluate the health impact, cost-effectiveness, and budget implications of alternative HPV-based screening strategies, screen-and-treat for rural settings and screen-triage-treat for urban settings, combined with HPV vaccination and treatment scale-up. Model inputs are derived from national data sources and complemented by primary costing data collected at Tikur Anbessa Specialized Hospital(TASH).

Results: Consultations with national stakeholders have been conducted to identify country needs and inputs to finalize scenarios for modelled evaluation. A desk review of information on national HPV vaccination, screening, and treatment has been conducted. The collection of cervical cancer treatment costs is ongoing at TASH by the research team at Addis Ababa University in Ethiopia. Model simulation will be performed by the modelling team at the Cancer Elimination Collaboration, University of Sydney (CEC). The EPT indicates that if the current HPV vaccination program could reach and maintain 90% coverage from 2023, over 1 million lives could be saved by 2120. Preliminary results on the additional impact of screening and treatment scale-up will be available for presentation at the conference.

Conclusions: This study will provide critical evidence to inform national strategies on cervical cancer screening, optimize resource allocation, and accelerate progress toward cervical cancer elimination.

To be presented on Day 2, in the 11:15am-12:30pm Scientific session – Pillar 2

Expanding the Cervical Screening Workforce Through HPV Screening Kaimahi: A New Approach to Reducing Barriers and Improving Equity in Aotearoa New Zealand

Jane Grant

Health New Zealand I Te Whatu Ora

Introduction: Aotearoa New Zealand's transition to HPV primary screening created new opportunities to improve participation through self-testing. However, inequities in access persist for Māori, Pacific peoples, rural communities, and people not enrolled with primary care. The National Cervical Screening Programme (NCSP) recognised that the clinical workforce alone could not achieve equitable access or support cervical cancer elimination goals. NCSP developed a workforce expansion model enabling trained unregistered health workers, known as **HPV Screening Kaimahi**, to facilitate HPV self-testing within a structured professional partnership model.

Methods: The HPV Screening Kaimahi role was developed through co-design with kaimahi, nurses, managers, and screening support services. Six focus groups and workshops explored workforce capabilities, implementation requirements, cultural safety, and participation barriers. Findings informed a national competency framework, learning pathway, quality framework, and professional partnership model with responsible clinicians. The initiative was piloted with Screening Support Services, expanded to NCSP regional coordination teams, and is now being tested within Primary Health Organisation/Hauora to inform wider primary care implementation.

Results: Participants identified kaimahi as trusted navigators who bring community relationships, language skills, cultural understanding, and flexible ways of working. These strengths can improve participant experience, reduce clinical barriers, strengthen engagement, and support culturally safe screening for priority populations.

Implementation has created a new non-clinical screening workforce able to support HPV self-testing, supporting specialist clinicians to focus on complex care, follow-up, and diagnostic and treatment pathways. The model is scalable, aligns with Te Tiriti o Waitangi principles, and supports sustainable delivery through trusted community-based providers.

Conclusions: The HPV Screening Kaimahi initiative shows how workforce innovation can support cervical cancer elimination by addressing barriers beyond clinical service availability. Embedding trained community-based kaimahi in cervical screening delivery provides a culturally responsive approach to improving access, strengthening engagement, and supporting equitable participation.

To be presented on Day 2, in the 8:30am-10am Australia and New Zealand session – Pillar 2

Co-designing the ideal cervical screening program with and for people with disability

Nicola Hofler, Francis Townsend, Mariana Galrao

Sexual Health Quarters

Introduction: The Australian cervical cancer screening program invites eligible people to participate in this free program, every 5 years. It is estimated that only one third of people with a disability, participate in the program. Low participation has been attributed to barriers, such as inaccessible services, stigma, and poor communication with health professionals. Sexual Health Quarters is seeking to co-design the ideal cervical screening program with and for people with disability.

Methods: Between March and August 2025, SHQ consulted with 98 individuals with disability, 11 carers of people with disability and 18 service providers, to explore barriers and enablers of participation in cervical screening and the components for the ideal model of care. Data were collected via surveys, interviews, and focus groups, and analysed using descriptive statistics and thematic analysis.

Results: Four key themes emerged: 1) previous experiences with cervical screening tests; 2) knowledge of importance of screening; 3) recommendations for a home-based outreach model; and 4) elements of the ideal model of care. While most participants called for outreach screening due to increased comfort and accessibility, others expressed some concern about privacy in shared accommodation, safety of home visits, and the need for culturally sensitive care. Overall participants recommended provision of trauma-aware, person-centred care; flexibility in appointment location; use of accessible and inclusive communication formats; female clinicians; interpreter availability; and allowance for support persons during procedures.

Conclusions: The findings indicate strong recommendation for an outreach service, provided it is designed around individual needs and community preferences. This consultation represents the first stage of a co-designed program and offers practical guidance for developing equitable and scalable cervical screening services for people with disability. A pilot program to trial this service delivery model is due to commence in mid-June 2026.

Global Cervical Cancer Elimination and Control Policy Analysis

Amelia Hyatt[1, 2, 3], Claire Bavor[3], Karen Canfell[4], Rob Moodie[3], Claire Nightingale[3], Telma Costa[4], Carol Naidu[4], Sanchia Aranda[2]

[1] *Centre for Health Services Research, Peter MacCallum Cancer Centre*

[2] *Department of Nursing, University of Melbourne*

[3] *School of Population and Global Health, University of Melbourne*

[4] *Cancer Elimination Collaboration, School of Public Health, University of Sydney*

Introduction: As countries progress towards the World Health Organization's (WHO) 2030 cervical cancer elimination targets, many countries have developed policies to translate commitments into action. Despite this political priority-setting, it is unknown whether policies are adequate to support feasible and sustainable elimination planning activity. This study aimed to analyse all current global policy, strategy and plans associated with the control and elimination of cervical cancer to determine their coverage of essential information.

Methods: Analysis was completed using the Policy Accelerator for Cervical Cancer Elimination (PACE) tool developed by our team, which operationalised WHO cervical cancer elimination guidance literature into core domains for assessment. A mixed-methods approach was employed to analyse policies. Policy data were extracted using Covidence, then exported into Microsoft Excel for analysis. Descriptive statistics (frequencies and proportions) were employed to quantitatively summarise and score individual policy alignment against PACE items. Scoring was also aggregated both across and within policies, and plans compared against human development index (HDI) category.

Results: A total of 30 plans were identified globally, inclusive of 24 national policies and 6 regional plans. Notably, aggregate policy data demonstrated that less than 50% of policies included all recommended information components within the policy context, cancer control or health system domains. On average, plans included greater details regarding screening and prevention programs and services than information on treatment, palliative care, or survivorship. Overall, national policies commonly scored high for reporting of goals, however routinely excluded information necessary to support implementation.

Conclusions: Assessment of national and regional cervical cancer elimination and control plans revealed important patterns in reporting of key information, including gaps in core cervical cancer control and actions to support implementation. Comparison of individual policies identified differences in scope and focus, potentially associated with level of health system development. Findings will support improved policy development.

To be presented on Day 3, in the 11am-12:30pm Scientific session – Pillar 3

It Starts With Me, supporting Aboriginal health workforce to become Certified Cervical Screening Providers

Debbie Mars[1], Bridget Sampson[2], Laura-May Willems[1], Susan Cadman[2], Michelle Cornelius[1], Lauren Temminghoff[1], David Hawkes[3], Alice Bastable[1]

[1] *Cancer Council Victoria*

[2] *Victorian Aboriginal Community Controlled Health Organisation*

[3] *Australian Centre for the Prevention of Cervical Cancer*

Introduction: Inequities in cervical screening participation among Aboriginal and Torres Strait Islander peoples contribute to delayed progress towards cervical cancer elimination. In Victoria, certification pathways for non-medical Cervical Screening Providers have traditionally been promoted to nurses and midwives, with known barriers for Aboriginal Health Practitioners (AHPs). *It Starts With Me* is a partnership between VACCHO, CCV and ACPCC, supported by the Australian and Victorian Governments in alignment with the National Strategy for the Elimination of Cervical Cancer, to expand certification pathways through a culturally safe, self-determination driven training model for the Aboriginal health workforce.

Methods: Co-design was used to adapt the existing cervical screening certification pathway for AHPs. A Cultural Governance Group led decision-making across project design, implementation and evaluation. The program includes a culturally safe training course, wraparound supports for workforce and their workplaces, alongside adaptation of state certification and endorsement processes. Evaluation intends to measure workforce feedback and screening outcomes in the Aboriginal Community.

Results: The first of three courses have been delivered. Participants reported high satisfaction with course content, cultural safety, and wraparound supports. Early findings indicate increased confidence and readiness to progress toward certification, and willingness to act as ambassadors for their peers. The self-determination led approach was identified as critical to ensuring cultural safety and workforce engagement.

Conclusions: This project strives to address the challenge of how a largely non-Indigenous project team can ensure a self-determination driven approach through co-design and cultural governance to address workforce barriers and improve access to culturally safe screening. Early project implementation has highlighted the importance of system flexibility and initial workforce support of a new and sustainable screening workforce. Lessons from this model have broader relevance for strengthening equitable screening access and accelerating progress toward cervical cancer elimination.

To be presented on Day 2, in the 11:15am-12:30pm Scientific session – Pillar 2

Implementation and Coverage of the Human Papillomavirus (HPV) Vaccination Program in Western Highlands Province, Papua New Guinea: August 2024 – June 2026

Carolynne Masakai[1], Paulus Ripa[1]

[1] *Western Highlands Provincial Health Authority*

[2] *Kirby Institute, UNSW*

Background: Human Papillomavirus (HPV) vaccination is a key public health intervention aimed at preventing cervical cancer among adolescent girls. Western Highlands Province introduced the HPV vaccination program as part of a donor funded cervical cancer elimination program, targeting girls aged 9–14 years through school-based and community outreach approaches.

Methods: A descriptive review of program implementation data from August 2024 to June 2026 was conducted across the four districts of Western Highlands Province: Hagen Central, Tambul-Nebilyer, Mul-Baiyer Lumusa, and Dei. Data were analyzed on vaccination coverage, school reach, health worker training, community engagement activities, and adverse events following immunization (AEFI).

Results: A total of 28,828 eligible girls received HPV vaccination, achieving 96% of the provincial target of 30,000 doses. School-based delivery accounted for 95% of all vaccinations. Hagen Central recorded the highest number of vaccinated girls (13,481), followed by Tambul-Nebilyer (8,049), Mul-Baiyer Lumusa (4,585), and Dei (2,713). Of the 507 registered schools, 370 schools (73%) were reached by the end of Quarter 2, 2026. Community awareness activities included 481 information sessions reaching 76,072 participants. A total of 97 non-serious AEFI cases were reported, mainly dizziness, headache, and fainting, with no serious AEFI documented. The program also vaccinated girls with disabilities and eligible HIV-positive girls, although follow-up for subsequent doses among HIV-positive recipients remained a challenge.

Conclusion: The HPV vaccination program in Western Highlands Province achieved high coverage and is now progressing to integrating HPV vaccine into routine immunisation and school health programs. Collaboration between the Provincial Health Authority, Department of Education, WHO, UNICEF, and community stakeholders contributed significantly to program success. Continued efforts are needed to improve coverage in hard-to-reach districts, strengthen health facility reporting, and enhance strategies for vaccinating out-of-school girls, girls with disabilities, and HIV-positive adolescents. This presentation will explore the challenges and key drivers of success of the program and consider learnings for the impending national introduction of HPV vaccine in Papua New Guinea in September 2026.

To be presented on Day 1, in the 1:30-2:50pm International session – Pillar 1

Health impacts, cost-effectiveness and budget estimates to support the introduction of HPV vaccine into the national immunization program in Viet Nam

Diep Nguyen[1], Kate Simms[1], Shu Chen[3], Due Ong[2], Xuanchen Tao[3], Xinyu Zhang[4], Kristine Macartney[3], Phuong Khanh Nguyen[2], Shenglan Tang[4], Karen Canfell[1]

[1] *Cancer Elimination Collaboration, School of Public Health, The University of Sydney (CEC USYD)*

[2] *Health Strategy and Policy Institute, Viet Nam Ministry of Health*

[3] *Australian National Centre for Immunization Research and Surveillance (NCIRS)*

[4] *Duke University*

Introduction: In collaboration with Viet Nam Ministry of Health, DUKE University, and NCIRS, we aimed to evaluate the health impact, cost-effectiveness and budget estimate of national roll-out of HPV vaccination at a range of prices to support the National Immunisation Program plan.

Methods: The extensively validated dynamic Policy1-Cervix modelling platform was calibrated separately to urban and rural regions' data of Viet Nam. Input costs were informed by analysis of systematically collected data from local hospitals and immunization programs. Routine girls-only HPV vaccination for 11-year-olds was evaluated assuming quadrivalent(Gardasil4) or nonavalent(Cecolin9/Gardasil 9) vaccines at 2-dose schedule. We considered vaccine price-per-dose for Gardasil4, Cecolin9, and Gardasil 9, respectively at UNICEFF prices of US$20, US$ 24, and US$34, and at market prices of US$69, US$70, and US$115. Due to planned phased introduction sub-nationally, we assumed 90% national coverage either by 2030 (WHO target), or by 2035.

Results: Scaling-up quadrivalent vaccine to 90% by 2030 is predicted to reduce cancer rates below the elimination threshold of 4-per-100,000 by 2090 and prevent 86,000 deaths by 2100. If nonavalent vaccine is used instead, cancer rates fall below the elimination threshold by 2078 and 109,000 deaths will be averted by 2100. Delaying scale-up by 5-years will delay elimination by 5 years and prevent 15,000 fewer deaths. At UNICEF prices, if Gardasil4 is available at $20per-dose, then Gardasil9 or Cecolin9 are cost-effective options for prices up-to $34per-dose (ICER=$4,115/HALY) (at WTP: 1XGDPper-capita of US$4,717). The estimated 5-year budget for HPV vaccination is US$152M for Gardasil4, US$172M for Cecolin9, and US$235M for Gardasil9. At market prices, if Gardasil4 is available at $69 per dose, then Cecolin9 ($70 per-dose) is cost-effective (ICER=US$882/HALY), but Gardasil9 is not likely to be cost-effective at $115per-dose; the budget for vaccination is $456M for Gardasil4 and US$464M for Cecolin9. Conclusions

With Gavi's new approach and new vaccines on the market, it is important that countries can access technical support to re-assess options for obtaining the best value for money and dose-schedule.

To be presented on Day 1, in the 11am-12:30pm Scientific session – Pillar 1

Timely initiation of cervical screening at age 25 in Australia: findings from Australia's national cervical screening program

Monjura Nisha, Ya-Lun Liang, Karen Canfell, Megan Smith

Cancer Elimination Collaboration, Sydney School of Public Health, Faculty of Medicine and Health, The University of Sydney, NSW, Australia

Introduction: Modelling in 2019 used to predict elimination timing in Australia assumed timely initiation of screening at the recommended age of 25 (74% attended by age 26), but as at end-2024, only 50% of those aged 25-29 years were up-to-date with screening. To assess whether individuals are initiating HPV screening as recommended in Australia, we estimated the proportion of screen-eligible individuals who had an HPV test before their 26th birthday.

Methods: Using National Cancer Screening Register data, we estimated the proportion of individuals turning 25 between December-2017 and June-2023 who initiated screening on-time (defined as ≥1 HPV test between age 24 years 9 months and <26 years). Estimates were calculated as a proportion of those previously unscreened (true first-time screeners) and of all individuals turning 25 (regardless of prior screening), and stratified by demographic variables.

Results: Timely attendance rates for an HPV test in the 2023 cohort were 27.4% (20,497/74,934) by true first-time screeners and 25.0% (24,149/96,476) among all 25-year-olds. Timely initiation showed a clear socio-economic gradient, with substantially higher rates in the least versus most disadvantaged areas (true first-time: 34.1% vs 21.6%, all 25-year-olds: 30.7% vs 20.4%). Timely initiation rates were lower in those living in ACT (true first-time: 24.1%, all 25-year-olds: 23.0%), NSW (true first-time: 25.5%, all 25-year-olds: 23.4%), and major cities (true first-time: 26.5%, all 25-year-olds: 24.5%), while rates were relatively higher in those living in Tasmania (true first-time: 37.0%, all 25-year-olds: 32.5%) and inner regional areas (true first-time: 32.1%, all 25-year-olds: 28.1%).

Conclusions: Concerted action is needed to achieve initiation near the recommended age, as this is very low throughout Australia. Disparities were observed by area-level socio-economic status, state/territory, and (to a lesser extent) by remoteness, sometimes differing from those seen in broader screening participation measures. These data emphasise the need for updated modelling to understand the effect on elimination timing and new interventions to increase timely initiation.

To be presented on Day 2, in the 11:15am-12:30pm Scientific session – Pillar 2

A Small Island, A Big Step: Launching the Niue Cervical Screening Programme

Ebony Pulu[1], Margot McLean[2], Tokasa Muakisuva[1], Grizelda Mokoia[1], Jane Lohrey[2], Shannon Trebble[3], Vanessa Price[4], Le May Thai[4]

[1] *Niue Foou Hospital-Women's Health Services*

[2] *New Zealand Ministry of Health*

[3] *Family Planning, Australia*

[4] *Kirby Institute, University of New South Wales*

Introduction: In April 2026 Niue launched its national cervical screening programme, offering Human Papillomavirus (HPV) testing using self-collected samples and on island GeneXperts®. Previously screening had been opportunistic, based on speculum examination for liquid-based cytology (LBC) specimens.

Niue is a self-governing island country with a population of less than 2000 people. Niuean people are New Zealand (NZ) citizens with the right to access free secondary and tertiary care in NZ, including pathology services not available in Niue.

Because of frequent travel between Niue and NZ, local and visiting clinicians expressed preference for the Niue screening pathway to be similar to New Zealand's.

This presentation describes the steps involved in implementing the programme and early results.

Method: This work utilised a mixed approach methodology, integrating both qualitative and quantitative methods to ensure the proposed screening programme is evidence-based, contextually appropriate, and feasible within Niue's health system.

This approach ensures that the programme is informed by evidence and data, while grounded in local context, stakeholder input, and system capability, supporting effective and sustainable implementation in Niue. The steps included:

1. Scoping and Evidence Review (Quantitative and Document Analysis)
2. Stakeholder Engagement (Qualitative)
3. Health System and Resource Scoping (Mixed)
4. Programme Design and Clinical Pathways (Mixed)
5. Workforce Capacity Building (Qualitative and Implementation Focused)
6. Scoping of Diagnostic Technology and Service Delivery (Quantitative/Technical)

Results

The presentation will describe the screening model developed and implemented.

Early implementation has demonstrated increased screening participation and acceptability of self-collected sampling.

Screening results for the first five months of the programme will be presented.

Conclusion: The implementation of an HPV-based cervical screening programme represents a critical step toward cervical cancer elimination in Niue. Early findings suggest that incorporating a self-collected sampling model with same day local HPV testing can improve access and participation as well as increasing local agency, reducing cancer incidence and inequities.

To be presented on Day 2, in the 11:15am-12:30pm Scientific session – Pillar 2

Role of fluorodeoxyglucose positron emission tomography/computed tomography in addition to standard staging in early-stage cervical cancer: a systematic review identifying an evidence gap

Dana Stefanovic[1], Telma Costa[1], Susan Yuill[1], Denise Campbell[1], Tracey Muir[2, 3, 4], Aravind Ravi Kumar[5, 6], Glen Lo[4, 7, 8], Jim Nicklin[9, 10], Yee Leung[11, 12]

[1] *Cancer Elimination Collaboration, The University of Sydney, Sydney, Australia*

[2] *Fiona Stanley Hospital, Perth, Australia*

[3] *Royal Perth Hospital, Perth, Australia*

[4] *Envision Medical Imaging, Perth, Australia*

[5] *Princess Alexandra Hospital, Brisbane, Australia*

[6] *Sir Peter MacCallum Department of Oncology, University of Melbourne, Melbourne, Australia*

[7] *Sir Charles Gairdner Hospital, Perth, Australia*

[8] *Curtin University, Perth, Australia,* [9] *Royal Brisbane and Women's Hospital, Brisbane, Australia*

[10] *University of Queensland, Brisbane, Australia*

[11] *King Edward Memorial Hospital for Women, Perth, Australia*

[12] *University of Western Australia, Perth, Australia*

Introduction: Accurate staging in early-stage cervical cancer is essential for guiding treatment decisions. MRI is the standard imaging modality for local staging, while FDG PET/CT provides complementary metabolic and anatomical information, particularly for nodal and distant staging. The incremental value of PET/CT relates to detection of additional disease and avoidance of multimodality therapy, balanced against potential false-positive findings and other clinical and resource considerations.

Methods: This systematic review was part of the development of Australian clinical practice guidelines. A comprehensive literature search aimed to identify studies evaluating the additive value of PET/CT beyond standard initial staging (including MRI) in early-stage (FIGO 2018 IA2–IB2) cervical cancer before surgery. Where direct evidence was lacking, a structured synthesis of indirect evidence was undertaken for contextualisation and to support the guideline recommendations.

Results: No studies met the predefined inclusion criteria and directly assessed the incremental benefit of PET/CT beyond standard staging in strictly defined early-stage disease. Broader literature review suggests that PET/CT may have high specificity and prognostic value in this setting. However, evidence is limited by small sample sizes, heterogeneous populations and sparse reporting of disease detected uniquely by PET/CT (see Figure 1 in Appendix 1: Evidence map for FDG-PET/CT in early-stage cervical cancer staging.).

Conclusion: No direct evidence supports the incremental value of PET/CT beyond standard staging in FIGO IA2–IB2 cervical cancer, highlighting a relevant evidence gap. Current selection of early-stage patients for additional PET/CT imaging relies on extrapolation of limited indirect data and clinical reasoning. Evidence with well-defined populations is needed to define which patients benefit from addition of PET/CT.

To be presented on Day 3, in the 11am-12:30pm Scientific session – Pillar 3

Expanding Access to Cervical Screening: Outcomes and Consumer Acceptability of a Telehealth Self-Collection CST Model in South Australia

Kelly Stegmeyer

Shine SA

Introduction: Improving access to cervical screening remains critical to achieving cervical cancer elimination, particularly among under-screened and priority populations.

In July 2025, SHINE SA in partnership with Preventive Health SA and with funding from the Australian Government, implemented a telehealth Cervical Screening Test (CST) program enabling self-collection through structured eligibility screening and medical oversight.

Methods: Eligible clients were assessed via telehealth, with kits supplied by VCS Pathology and outcomes tracked in a database to support follow-up. Data from July–December 2025 were analysed for demographics, screening outcomes, and HPV detection. Consumer feedback was collected via 38 anonymous surveys assessing satisfaction, acceptability, and barriers.

Results: Of 207 consultations, 180 were eligible. Priority groups included under-screened clients (43%) and rural/remote residents (19%). 147 swabs were processed and 88% were HPV-negative, 11% had non-16/18 HPV, and 1% HPV 16. One test was invalid and there was an 18% lost to follow-up rate. Client satisfaction was high, with 97% rating ≥8/10 and 92% highly likely to recommend. Reported barriers to prior screening included access difficulties, fear, stigma, and competing responsibilities.

Conclusion: Telehealth CST self-collection is a feasible, acceptable, and scalable model that reduces barriers and improves engagement. Strengthening follow-up pathways will optimise outcomes and support cervical cancer elimination.

To be presented on Day 2, in the 11:15am-12:30pm Scientific session – Pillar 2

Implementation of self-collected cervical screening in an under-screened, culturally and linguistically diverse antenatal population: a quality improvement study

Mandy Wang[1, 2], Therese McGee[1, 2], Alison Brand[2, 3], Kim Kaddour[1], Lynette Samany[1], Martin Plymoth[4]

[1] *Department of Obstetrics and Gynaecology, Westmead Hospital*

[2] *Westmead Clinical School, University of Sydney*

[3] *Department of Gynaecological Oncology, Westmead Hospital*

[4] *Department of Clinical Microbiology, Umeå University*

Eliminating cervical cancer requires high screening participation levels. Pregnancy is an opportunity to reach under-screened women, but clinician-collected speculum examination is a barrier to uptake. Patient self-collected cervical screening tests (SC-CST) using a vaginal swab for detection of human papillomavirus (HPV) may offer a solution. The objective of this study was to evaluate the outcomes and implementation of a comprehensive program embedding SC-CST into antenatal care.

This is a prospective quality improvement study in a tertiary hospital servicing a population with one of the lowest cervical screening rates nationally. Pregnant women attending public maternity care and eligible for screening under national guidelines were included. Screening histories were obtained from the national registry to identify screen-overdue or never-screened women for SC-CST offer. Staff education and patient information encouraged participation. Test packs facilitated specimen collection. Referral pathways were created for abnormal results. Main outcome measures include reach, effectiveness, implementation, and maintenance of quality improvement.

From 19/2/2024 to 31/7/2025, 48.1% (2492/5190) of eligible pregnant women required a CST, 69.7% were offered SC-CST, and 93.7% accepted. Cervical screening rates increased 22-fold from 3.0% prior to the program to 65.3%. Parous women were offered SC-CST at lower rates than nulliparous women (66.5% vs 74.1%; p=0.024). Women residing in the lowest socioeconomic quintile had lower acceptance rates (91.9% vs 94.8%; p=0.024). Being overseas-born and need for interpreter were not barriers to SC-CST offer or acceptance rates. Results were high risk HPV-negative in 88.1%, HPV 16/18 positive in 1.9%, HPV non-16/18 positive in 9.1%, and invalid in 0.9%. Colposcopy was performed for 41 women, with 7 cases of biopsy-confirmed high-grade squamous intraepithelial lesion requiring treatment.

Introduction of SC-CST into antenatal care is an effective strategy to improve cervical screening rates and was highly acceptable to pregnant women. Program sustainability requires additional resources, staff engagement, and timely follow-up.

To be presented on Day 2, in the 11:15am-12:30pm Scientific session – Pillar 2

Impact of HPV vaccination on rates of cervical precancer treatment and preterm births in women giving birth in NSW, Australia, 2000-2020

Susan Yuill[1], Megan Smith[1], Louiza Velentzis[1], C. David Wrede[2], Deborah Bateson[3], Karen Canfell[1]

[1] *Cancer Elimination Collaboration, Sydney School of Public Health, University of Sydney*

[2] *Oncology and Dysplasia Unit, Royal Women's Hospital, Melbourne, Victoria*

[3] *Cancer Elimination Collaboration, Sydney Medical School, University of Sydney*

Introduction: Excisional cervical precancer treatment is associated with increased risk of subsequent preterm birth (PTB). Human papillomavirus (HPV) vaccination has been shown to reduce cervical precancer and is thus predicted to reduce excisional cervical treatments and hence reduce PTB rates. We assessed the impact of HPV vaccination and vaccination age on excisional cervical treatment and future PTB rates.

Methods: Using individually-linked data for Australian-born women who gave birth in NSW (1-January-2000 to 30-June-2020), we estimated rates and odds ratios (ORs) for (i) excisional treatment by 1+dose-HPV vaccination status and vaccination age; (ii) PTBs in women with spontaneous singleton liveborn deliveries by (a) previous excisional precancer treatment and (b) HPV vaccination status (1+ dose-HPV vaccine ≥1 year pre-delivery) and vaccination age. We adjusted for maternal age, delivery year, parity, smoking, socio-economic status and remoteness of residence, plus PTB risk factors (excluding excisional treatment) in PTB analyses (Table). We restricted the analysis to Australian-born women to reduce misclassification (overseas-born women may have been vaccinated/treated overseas).

Results: Among 1,285,877 births, compared to unvaccinated women, previously vaccinated women had lower pre-delivery treatment odds (adjusted OR [aOR]:0.62,95%CI:0.59-0.64) (Table).

Among 670,137 spontaneous live singleton births, 6.2% were preterm. Mothers treated pre-delivery had increased PTB odds (aOR:1.50,95%CI:1.43-1.57). After adjustment, no significant difference in PTBs was found in vaccinated compared to unvaccinated mothers (aOR:0.99,95%CI:0.95-1.02). Vaccination age had an overall effect on PTBs (p=0.03), with a slight decrease in those vaccinated aged 16-19 years compared to unvaccinated mothers (p=0.04) (both adjusted). (See Appendix 2: HPV vaccination, cervical precancer treatment and preterm birth outcomes.)

Conclusion: We confirmed an increased PTB risk in previously treated women and found HPV vaccination reduced excisional treatment risk. While we found no difference in PTBs in vaccinated compared to unvaccinated mothers, we identified a protective effect in those vaccinated aged 16-19. As many factors contribute to PTB, pooling international data may be needed to detect an impact of HPV vaccination.

Immunotherapy for locally advanced cervical cancer: a systematic review to inform the first Australian Cervical Cancer Management Guidelines

Susan Yuill[1], Denise Cambell[1], Telma Costa[1], Dana Stefanovic[1], Kathryn Middleton[2], Jim Nicklin[3, 4], Yee Leung[5, 6]

[1] *Cancer Elimination Collaboration, Sydney School of Public Health, University of Sydney, Sydney, Australia*

[2] *Mater Hospital, Brisbane, Australia*

[3] *Royal Brisbane and Women's Hospital, Brisbane, Australia*

[4] *University of Queensland, Brisbane, Australia*

[5] *King Edward Memorial Hospital for Women, Perth, Australia*

[6] *University of Western Australia, Perth, Australia*

Introduction: Despite Australia approaching cervical cancer elimination, some women will continue to be diagnosed with locally advanced disease (LACC). Concurrent chemoradiation with brachytherapy (CCRT+BT) remains the standard of care, yet 30–35% of patients experience disease progression. Immunotherapy has demonstrated benefit in metastatic disease and is now being evaluated for LACC. We conducted a systematic review (SR) and GRADE Evidence-to-Decision assessment to inform the first Australian Cervical Cancer Management Guidelines (ACCMG).

Methods: A SR was undertaken following PRISMA 2020 guidelines comparing immunotherapy in combination with CCRT (I+CCRT) with CCRT in women with LACC (FIGO 2018 stage IB3, IIA2-IVA). We included randomised controlled trials or SRs thereof. Outcomes of interest included overall survival (OS), progression-free survival (PFS), grade 3-4 adverse events (AE) and quality of life (QoL). Searches using MEDLINE, EMBASE, and Cochrane databases identified one previous SR (Zhao 2024), which we updated. In consultation with the ACCMG Working Party (WP), 3+-year (preferably 5+-year) OS and QoL were identified as critical outcomes to inform the recommendation process.

Results: Two trials met inclusion criteria: CALLA (durvalumab) and ENGOT-cx11/GOG-3047/KEYNOTE-A18 (pembrolizumab) (Table). Only KEYNOTE-A18 reported both critical outcomes. Three-year OS was significantly higher in the pembrolizumab (82.6%) versus the control arm (74.8%) (hazard ratio 0.67, 95% confidence interval: 0.50–0.90, p=0.00). No significant difference in QoL between the two arms at 36 weeks was observed. (See Appendix 3: Immunotherapy trial evidence for locally advanced cervical cancer.)

Conclusion: The ACCMGWP conditionally recommended the addition of pembrolizumab to CCRT+BT for patients with 2018 FIGO III/IVA disease regardless of PD-L1 status, noting that shared decision-making should include discussion of immunotherapy-related AEs and patient preferences. Government subsidisation of pembrolizumab for LACC has since been announced ensuring equitable access. Recommendation and subsidisation decisions were based on improvement in 3-year OS (5-year OS data are pending). Further research exploring biomarker-guided patient selection is warranted.

To be presented on Day 3, in the 11am-12:30pm Scientific session – Pillar 3

Appendix 1

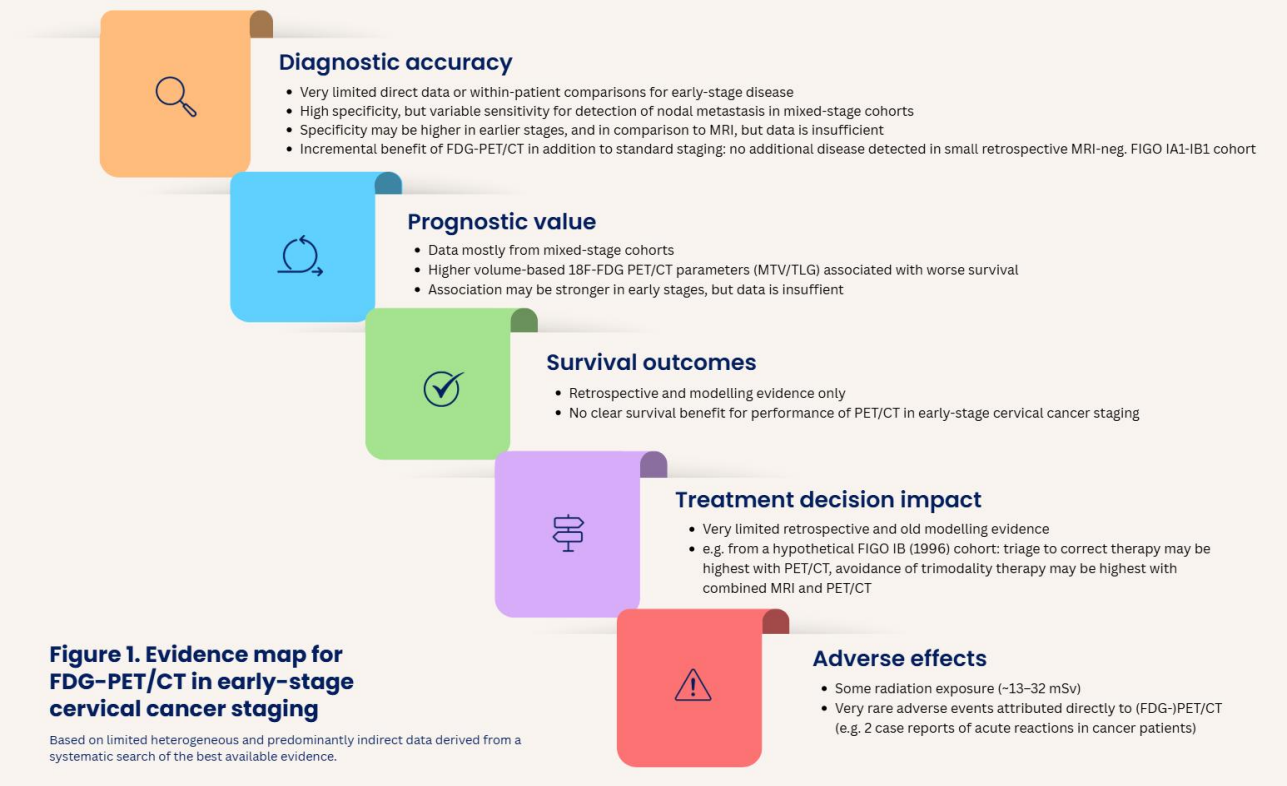


Figure 1. Evidence map for FDG-PET/CT in early-stage cervical cancer staging

Based on limited heterogeneous and predominantly indirect data derived from a systematic search of the best available evidence.

Appendix 2

Table: Rates and odds ratios for (i). excisional cervical treatment pre-delivery by HPV vaccination status (1+ dose ≥1 year pre-delivery and age at vaccination) and (ii). preterm births (PTBs) in spontaneous singleton live births by: (a). excisional cervical treatment pre-delivery and (b). HPV vaccination status (1+ dose ≥1 year pre-delivery) and age at vaccination in Australian-born women who gave birth in NSW between 1-January-2020 and 30-June-2020

	n/N (%)	Unadjusted OR#	Adjusted OR#*
Excisional treatment pre-delivery			
Maternal HPV vaccination status: 1+ dose HPV vaccine ≥1 year pre-delivery‡			
No	42,805/995,948 (4.3)	1.00 (reference)	1.00 (reference)
Yes	8,251/289,929 (2.9)	0.65 (0.63-0.67)	0.62 (0.59-0.64)
p-value		***<0.001***	***<0.001***
Maternal HPV vaccination status: 1+ dose HPV vaccine ≥1 year pre-delivery by age at vaccination‡			
No history vaccination prebirth	42,805/995,948 (4.3)	1.00 (reference)	1.00 (reference)
Vaccinated prebirth aged ≤13 years	170/33,272 (0.5)	0.11 (0.10-0.14)	0.28 (0.23-0.33)
Vaccinated prebirth aged 14-15 years	456/38,624 (1.2)	0.27 (0.24-0.30)	0.37 (0.33-0.42)
Vaccinated prebirth aged 16-19 years	1,794/66,636 (2.7)	0.62 (0.58-0.66)	0.64 (0.60-0.69)
Vaccinated prebirth aged ≥20 years	5,831/151,397 (3.9)	0.89 (0.86-0.93)	0.65 (0.62-0.68)
p-value		***<0.001***	***<0.001***
Total	51,056/1,285,877 (4.0)		
Preterm births in spontaneous singleton live births			
Excisional treatment pre-delivery			
No	39,008/642,202 (6.1)	1.00 (reference)	1.00 (reference)
Yes	2,517/27,935 (9.0)	1.53 (1.46-1.60)	1.50 (1.43-1.57)
p-value		***<0.001***	***<0.001***
Total	41,525/670,137 (6.2)		
Maternal HPV vaccination status: 1+ dose HPV vaccine ≥1 year pre-delivery‡			
No	32,673/522,813 (6.3)	1.00 (reference)	1.00 (reference)
Yes	8,514/143,565 (5.9)	0.95 (0.92-0.97)	0.99 (0.95-1.02)
p-value		***<0.001***	***0.37***
Maternal HPV vaccination status: 1+ dose HPV vaccine ≥1 year pre-delivery by age at vaccination‡			
No history vaccination prebirth	32,673/522,813 (6.3)	1.00 (reference)	1.00 (reference)
Vaccinated prebirth aged ≤13 years	1,309/17,736 (7.4)	1.20 (1.12-1.27)	1.07 (1.00-1.15)
Vaccinated prebirth aged 14-15 years	1,215/19,989 (6.1)	0.97 (0.91-1.04)	0.98 (0.91-1.04)
Vaccinated prebirth aged 16-19 years	1,889/33,595 (5.6)	0.89 (0.85-0.94)	0.94 (0.89-1.00)
Vaccinated prebirth aged ≥20 years	4,101/72,245 (5.7)	0.90 (0.87-0.94)	0.99 (0.95-1.03)
p-value		***<0.001***	***0.03***
Total (without treatment pre-vaccination)	41,187/666,378 (6.2)		

HPV: human papillomavirus; N: number preterm; N: total number of births.

We accounted for clustering of >1 delivery per women.

*Adjusted for maternal age, year of delivery, parity, smoking during second half of pregnancy, remoteness of residence, area-level socio-economic status; PTB analyses were additionally adjusted for diabetes, hypertension, complications in previous pregnancy (preterm birth, small for gestational age, pregnancy-induced hypertension, stillbirth) previous caesarean section, baby's sex.

‡ Birth(s) excluded in woman with a history of excisional treatment pre-vaccination.

Appendix 3

Table: Study characteristics and results of included studies of randomised controlled trials comparing immunotherapy plus concurrent chemoradiation to concurrent chemoradiation for women diagnosed with locally advanced cervical cancer.

	CALLA (Monk 2023, AstraZeneca 2024)		ENGOT-cx11/GOG-3047/KEYNOTE-A18 (Larusso 2024a, 2024b)	
	Intervention	**Control**	**Intervention**	**Control**
Population	Untreated locally advanced adenocarcinoma, squamous, or adenosquamous cervical cancer; FIGO 2009 stage IB2–IIB LN positive or FIGO 2009 stage ≥III any LN status		Newly diagnosed, FIGO 2014 stage IB2–IIB with node-positive disease or stage III–IVA regardless of nodal status histologically confirmed, squamous cell carcinoma, adenocarcinoma, or adenosquamous cervical cancer	
Arms	1500 mg durvalumab intravenously every 4 weeks with and following CRT for up to 24 cycles N=385	Placebo intravenously every 4 weeks with and following CRT cycles N=385	200 mg pembrolizumab every 3 weeks with CRT for 5 cycles, followed by 400 mg pembrolizumab every 6 weeks for 15 cycles N=529	Placebo every 3 weeks with CRT for 5 cycles, followed by placebo every 6 weeks for 15 cycles N=531
Follow-up Median (IQR)	18.5 months	18.4 months	29.9 months (23.3-34.3)	29.9 months (23.3-34.3)
Overall survival (OS)				
Median: n/N (%)	326/385 (84.7%)	311/385 (80.8%)	454/529 (85.8%)	422/531 (79.5%)
Hazard ratio (95%CI); p-value	0.78 (0.55-1.10); p=0.16		0.67 (0.50-0.90); p=0.00	
36-month OS (%) (95%CI)	**NR**	**NR**	**82.6% (78.4-86.1)**	**74.8% (70.1-78.8)**
Progression-free survival (PFS)				
Median: n/N (%)	273/385 (70.9%)	257/385 (66.8%)	68% (62-73)	57% (51-63)
Hazard ratio (95%CI); p-value	0.84 (0.65-1.08); p=0.18			0.68 (0.56-0.84); p=0.00
24-month PFS (%) (95%CI)	65.9% (59.8-71.4)	62.1% (56.2-67.4)	68% (62-73)	57% (51-63)
Grade 3-4 adverse events*				
Overall: n/N (%)	199/385 (51.7%)	196/384 (51.0%)	413/528 (78.2%)	371/530 (70.0%)
Treatment-related: n/N (%)	160/385 (41.6%)	166/384 (43.2%)	365/528 (69.1%)	325/530 (61.3%)

FIGO: International Federation of Gynecology and Obstetrics; LN: lymph node; CRT: chemoradiation; N: number (total); n: number; IQR: interquartile range; HR: hazard ratio; CI: confidence interval; NR: not reported.

*CALLA: Adverse events included up to 90 days after the last study treatment; ENGOT-cx11/GOG-3047/KEYNOTE-A18: Adverse events are included if they occurred during treatment period or within 30 days after the treatment period.

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