RESEARCH POSTERS

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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"The information out there helps a lot": Evaluating web-based information on self-collection for cervical screening in Australia

Authors: Alysa Azryn, Maleeha Ashfaq, Tessa Saunders, Ana Machado Colling, Julia Brotherton, Claire Nightingale
Affiliation: Evaluation and Implementation Science Unit, Department of Health Systems, Policy and Economics, Melbourne School of Public Health, The University of Melbourne

Background

- Since 2022, the Australian National Cervical Screening Program (NCSP) guidelines state that women and people with a cervix should be offered a choice between a clinician-collected or self-collected cervical screening test.
- Previous research suggests that screen-eligible people have various unmet information needs when making decisions about cervical screening.

Aim

To evaluate web-based information on self-collection and the extent to which it meets the information needs of people with a cervix.

Methods

PHASE 1: THE *CHECKLIST*

RESEARCH QUESTION: What information do people with a cervix want in websites containing information about self-collection?

- **1A: INTERVIEW DATA ANALYSIS**
  - INPUT: Secondary analysis of *Understanding Choice* interview data (HREC Project ID 27551)
  - OUTPUT: Themes identified in relation to information needs
- **1B: CHECKLIST DEVELOPMENT**
  - INPUT: Themes identified in 1A; A review of NCSP guidelines, existing health literacy measures and relevant literature
  - OUTPUT: Finalised checklist developed into a data extraction tool using REDCap: 1) Content 2) Accessibility 3) Inclusivity *Accessibility domain used validated measures e.g. SHeLL editor and CDC Clear Communication Index*

PHASE 2: THE *SEARCH*

RESEARCH QUESTION: To what extent can websites which contain information about self-collection be found through an online search?

- **2A: SEARCH STRATEGY**
  - INPUT: Exploratory survey taken by Consumer and Community Advisory Panel (n=12)
  - OUTPUT: Most common terms and search engine identified
- **2B: SEARCH EXECUTION**
  - INPUT: Search informed by 2A results; Search executed using Incognito browser
  - OUTPUT: Websites screened and selected based on eligibility criteria (outlined below)

PHASE 3: THE *EVALUATION*

RESEARCH QUESTION: To what extent do these websites meet the information needs of people with a cervix?

- INPUT: REDCap data extraction tool was used to evaluate each website
- OUTPUT: Data extracted from each website was analysed

Results

Phase 1

Eligible screeners wanted more information relevant to:

The screening journey
- Options available for cervical screening
- Potential need to return for a speculum examination
- Costs
- Process of receiving test results

The test itself
- Accuracy of self-collection vs clinician-collection
- Self-collection as a vaginal swab
- Importance of getting a cervical screening test

Self-efficacy
- Clear instructions on how to perform the test
- Depth of swab insertion
- Length of time required for swab rotation

People also wanted information about self-collection to be:
- Available in **plain language**
- **Gender-inclusive**
- Available in **multiple languages**

Phase 2

Search

using Google as the search engine

self-swab cervical screening test

Included:
- About self-collection
- Consumer-facing
- Available in English
- Published by an Australian-based organisation

Excluded:
- Not consumer-facing
- Published by a clinical service provider
- Academic papers, advertisements, news reports, social media pages, online discussion forums, blogs or articles

10 websites included in the evaluation

Phase 3

24-item checklist across three domains

Content 15 items
- The journey
- The test itself
- Self-efficacy
- Additional resources

Accessibility 6 items
- Health literacy
- Information design

Inclusivity 3 items
- Availability in languages other than English
- Gender-inclusive language
- Inclusive representation

100% Met all key information design criteria

100% Used gender-inclusive language

100% Included information about eligibility, cervical screening options, booking a test, self-collection as a vaginal swab, and the importance of testing

90% Provided additional resources for consumers

60% Provided information in languages other than English

0% Met the recommended readability level of Grade 8 or lower

Information Gaps & Inconsistencies Implications of Findings

Websites varied in the information provided, with several key content areas inconsistently reported or absent

Costs of testing
Only four websites had information about costs, stating that cervical screening is free for eligible people but consultation fees may apply.

Transparent cost information can help people make informed screening decisions amid rising living costs.

The need to return for a speculum examination
Eight websites mentioned the need for a clinician-collected sample following a positive self-collected test, but only two specified the likelihood (reporting a 10% chance of HPV being detected).

This information helps people make informed screening decisions, as returning for a clinician sample may be a barrier for some.

Flexible access
Only half of the websites provided information about flexible access options, such as self-collecting at home and telehealth.

Given people value the convenience and flexibility of self-collection, websites should acknowledge available options and direct consumers to relevant services.

Self-collection instructions
There was inconsistent guidance on swab insertion depth and duration of insertion and rotation.

Clear and consistent instructions support self-efficacy and help build confidence in performing self-collection.

Conclusion

- Australian-based websites on self-collection include many key content areas, are well-designed and use inclusive language, but fall short on readability and meeting some practical informational needs.
- Organisations should ensure online information meets the content, accessibility and inclusivity needs of people with a cervix.
- Accessible and actionable information can support informed screening decisions and help progress towards the elimination of cervical cancer in Australia.

Ready to put your website to the test?
Scan to access the checklist and assess your website!



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Mixed-methods evaluation of a nurse-led telehealth cervical screening service

AUTHORS: Claire Bavor[1], Sarah Harwood[2], Catherine Kirby[1,2], Claire Nightingale[1]
AFFLIATIONS: 1. Melbourne School of Public Health, University of Melbourne, Australia; 2. Sexual Health Victoria, Melbourne, Australia

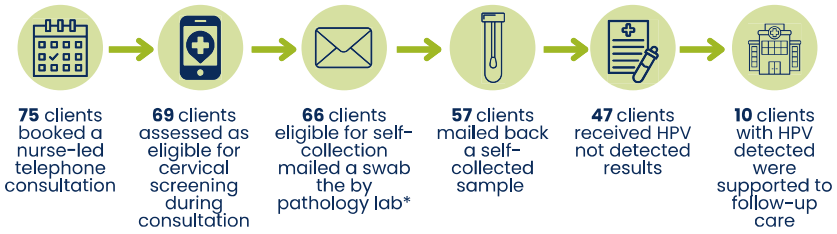
Introduction

- Telehealth is increasingly being used to improve access to healthcare services in Australia
- Healthcare providers have played a long-standing role in supporting access to cervical screening, as it is typically delivered in-person in primary care
- However, there are logistical, practical and financial barriers to accessing in-person care that the use of telehealth could address

Aim

To evaluate the **acceptability, safety, sustainability** and **scalability** of a **nurse-led telehealth cervical screening** service in Victoria, Australia.

Results



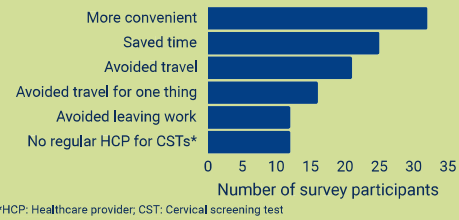
*Three clients required co-tests

Methods

- Mixed-methods evaluation
- Clients completed an online survey (N=36) followed by an interview (N=15)
- Service staff (N=2) & pathology provider staff (N=2) completed an interview
- Findings synthesised using the **client perspectives, organisational aspects** and **safety domains** in the **Model Assessment of Telemedicine Framework**

Client perspectives

Client reasons for using the service (N=36):



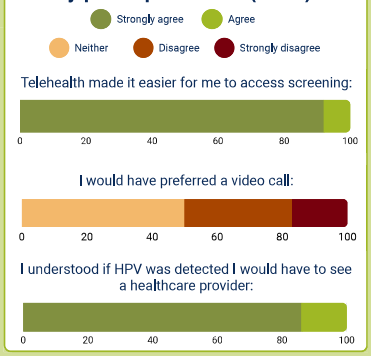
*HCP: Healthcare provider; CST: Cervical screening test

"I feel quite uneasy about it [cervical screening], being able to **talk about it in my own home**, in my own space where I already feel comfortable is **definitely better than** being in a **clinical setting**." (C14, overdue screener)

Interview participants discussed (N=15):

- How telehealth made it **easier** to access cervical screening and how they valued its **convenience, privacy** and **flexibility**
- The **acceptability** of discussing cervical screening over the phone, especially if they had negative prior screening experiences
- The need for **clear information** prior to the consultation explaining how and when they would receive a swab for self-collection

Survey participants said (N=36):



Organisational aspects

Service and pathology staff said:

Implementation enablers

- Organisational values that supported the role of nurses in providing cervical screening
- The use of nurse-doctor task-sharing and collaboration provided clinical oversight and improved the efficiency of service delivery

Implementation barriers

- Lack of funding for nurse cervical screening providers
- Required to charge clients out-of-pocket costs to reimburse nurse time
- Limited capacity of staff to expand service

Safety

- The nurse's use of an autofill (shortcut text on clinical software) to structure consultations facilitated consistent prompting for symptoms and management of follow-up care
- Staff felt video calls (rather than telephone) would enable them to use non-verbal communication cues to better gauge client understanding
- Staff documented client plans for follow-up care and had local knowledge of appropriate follow-up services if the client was unable to return to the service (e.g. women's health hubs)

"There's a risk this consultation is quite information giving and yes/no answers... there's a chance if people are not super clear from a health literacy perspective or language is a barrier, that they may have symptoms and you not pick it up." (S1, clinical staff member)

Conclusions

- Accessing a cervical screening consultation via telehealth and receiving a swab in the mail is highly acceptable
- Nurse-doctor task sharing facilitated clinical oversight and efficient service delivery
- Funding and policy changes are needed to sustainably deliver and scale nurse-led telehealth services in Australia

Eliminating Cervical Cancer Conference November 2026

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'It's just another opportunity where gaps can be closed' Leveraging engagement with telehealth medical abortion services to increase access to cervical screening

AUTHORS: Ana Machado Colling[1], Shelly Makleff[1], Tessa Saunders[1], Claire Nightingale[1], Emma Boutlon[2], Joanne Mountford[2], David Hawkes[3], Marion Saville[3,4], Deborah Bateson[4], Julia Brotherton[1]

AFFILIATIONS: 1. Melbourne School of Public Health, The University of Melbourne 2. Clinic 66 Online 3. Australian Centre for the Prevention of Cervical Cancer 4. Cancer Elimination Collaboration, Sydney Medical School, The University of Sydney

Introduction

- Since July 2022 there has been alignment between the universal access to self-collection for cervical screening and Medicare-funded telehealth for sexual and reproductive health.
- Clinic 66 online (a private national telehealth medical abortion service) leveraged this opportunity to implement a bulk-billed model of cervical screening, via mail-out within the context of tele-abortion care.

Aim

To evaluate the reach, acceptability, implementation and sustainability of the **integration of cervical screening into a telehealth medical abortion** service in Australia.

Methods

Mixed methods evaluation (March 2026 - current) including:

- A retrospective review of service records
- Client and service provider interviews
- Thematic analysis, triangulation of data
- Descriptive analysis of quantitative data

Preliminary Results

Uptake of self-collection in the first year of service implementation

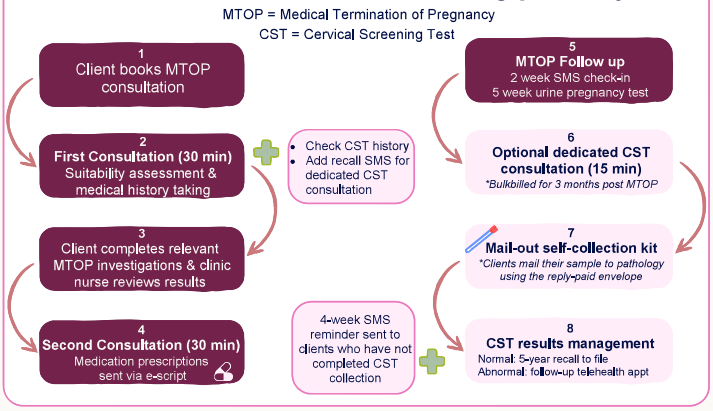
(April 2025 to March 2026)

- Increase in the number of clients (from 46 to 120) who consented to have SMS 'cervical screening appointment reminder' sent at baseline (April - July 2025) compared to endline (Dec-March 2026), but limited number of dedicated cervical screening appointments booked.
- A total of 26 self-collection kits were mailed to clients in the first year, but only 7 samples were returned.
- All self-collection kits had a follow up period of at least 3 months.

Interviews n=15

- Service clients (n=6) • Service providers (n=9)

Overview of Clinic 66's telehealth medical abortion and cervical screening pathway



Theme 1. Navigating care, choice and agency

- Variation in what clients knew and understood about abortion and cervical screening
- A favourable policy environment enabled service providers and clients to exercise greater agency
- Clinic 66 plays a key role in addressing anticipated and experienced stigma along the abortion pathway

"They [Clinic 66 doctors] were just fantastic with making sure that I was aware of those screenings and those sorts of things.. **I think that's the biggest thing for me is it [self-collection] is easy and accessible, and that I can do it at home**"

ID07, Client

"**I've got a lot of investment in destigmatising abortion**...I'm hyper vigilant for internalised stigma comments... we're not going to get attitude change in Australia, unless the very people who are having these services start to talk about it more... I'm full of random facts...like, "every third woman's had an abortion. So you know, why wouldn't you tell your friend?"

ID06, Service Provider

Theme 2. Integrating cervical screening in practice

- Amongst tele-abortion clients there is opportunity to engage a cohort who may otherwise be under screened
- Strong client acceptability of model and receptivity to discussing topics beyond abortion care
- Integrating screening is congruous with the care provided and service ethos
- Flexibility in when and how screening is offered was supported by system processes accounting for diverse client needs

"We know that women who seek abortion care have got a higher prevalence of other adverse health indicators, such as domestic violence or, financially disadvantaged... this is **an opportunity for us to get those people because they're highly motivated, and in other circumstances, you wouldn't engage with them at all**"

ID01, Service Provider

"**I think the [3-month cervical screening bulk billing] time period is definitely good**, and especially like you know after that first month [after an abortion], your body's returning back to being itself, and yeah, over a lot of the hormonal changes that happen with it, and over a lot of the emotional ups and downs too, so **I think definitely communicating that you know, you don't have to make the decision right now**"

ID03, Client

Theme 3. Optimising the wider policy environment to reach people equitably

- Service providers called for a centralised telehealth follow up and referral system and greater government investment in SRH services
- Clients and service providers identified opportunities beyond abortion care to improve access to cervical screening care (e.g. maternity, mental health, domestic violence and homelessness services)

"The Medicare rebates associated with it [service model] has to be looked at, because **clinics are absorbing the cost... we keep our prices low so that we're accessible**...there's quite a bit of an administrative role in the background."

ID04, Service Provider

"**I'd be an advocate for it [cervical screening] to appear at any given conversation point, especially with relation to women's health and managing women's health**... people in crisis, you know, we aren't always going to consider the grand scheme, so **to even just have that option become available could be the first time in years someone was asked that question or had that realisation that that may have been neglected**"

ID02, Client

Conclusions

- Teleabortion services can be leveraged to support cervical screening and improve awareness and access for underserved populations.
- Implementation challenges remain, demonstrated by only 26% (7/26) of self-collected samples returned.
- A range of strategies are needed along the client pathway to support uptake.
- Wider policy and system improvements are needed to support service sustainability and scalability.

Project funding gratefully received from C4



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NHMRC Grant ID: 2049748
Poster created 28 October 2026 for ECC Conference



From Awareness To Action

Improving Cervical Screening Participation Through LGBTQ+ Pop-Up Screening and Targeted Campaigns

INTRODUCTION

While Australia is on track to eliminate cervical cancer by 2035, LGBTQ+ people with a cervix face ongoing barriers to screening

Common gaps in prevention and care for LGBTQ+ people include discrimination, misinformation, and exclusion from mainstream health services

To address these, ACON combined targeted communications through the '**Own It**' campaign with pop-up cervical screening at major community events

RESULTS

'Own It' Campaign:

An 18% increase in awareness of the self-collection option in the LGBTQ+ audience, rising from 55% before the campaign to 67% during

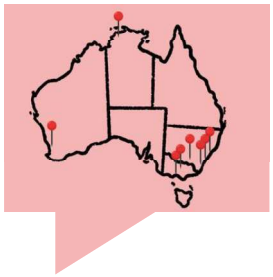
89% of LGBTQ+ people who saw the campaign intended to self-collect their next test

Across 10 LGBTQ+ events:

More than 200 self-collected tests

200+ conversation starting lip glosses distributed at each event

METHODS



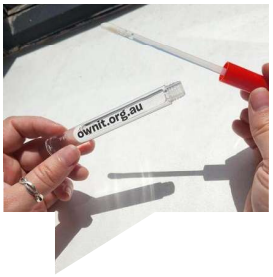
Pop-up screening at major LGBTQ+ events

10 Events



Tailored, inclusive campaigns

'Own it'



Creative educational tools

CST Lip Gloss



Specialised training for clinicians

LGBTQ+ inclusion

CONCLUSION

Combining **targeted communications** with **accessible screening** improved participation from LGBTQ+ people

Communications campaigns are more effective when paired with **inclusive service delivery** and outreach

Community-led engagement can reduce long-standing barriers to cervical screening

Authors: L Copland[1], E Goodlet[1], S Walsberger[1], A Varua[1], A Guo[1], E Spencer[1], E Lee[1], J Dueñas[1], M Vaughan[1], A Gordon Heinrich[2], E Bingham[2], K Bogg[2], A Zhao[2]

1. ACON 2. Australian Government Department of Health, Disability and Ageing

Australian Government | NATIONAL CERVICAL SCREENING PROGRAM

CAN WE | acon

Advancing equity in cervical cancer prevention among multicultural populations: qualitative insights from General Practitioners in NSW

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1. General Practice Clinical School, Faculty of Medicine and Health, The University of Sydney
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3. Kirby Institute, University of New South Wales

Introduction

The elimination of cervical cancer through vaccination, screening, and treatment is a global health priority. Despite organised cervical screening and an HPV vaccination program in Australia, inequities persist particularly for multicultural communities with lower rates of vaccination and screening. GPs are crucial for delivering cervical cancer prevention services and have the potential to reduce inequities.

Methods

- Purposive sampling
- One-on-one semi-structured interviews
- Interviews focused on all cervical cancer prevention activities (HPV vaccination, cervical screening including self-collection), GPs role and engagement with multicultural populations
- Inductive thematic analysis
- Iterative data collection and analysis

Aim

To examine and understand the role of general practice in facilitating cervical cancer prevention among multicultural populations within metropolitan Sydney and rural New South Wales (NSW)

Results

Participant Characteristics



31 GPs interviewed



7 male



24 female



28 metropolitan Sydney



3 rural NSW

- **42%** born overseas
- **71%** spoke a language other than English
- **45%** used a language other than English in consultations

"I didn't think that I would have been the one to change her mind, but it did. And I think that's because we made the time for it." (GP01, male)

Themes



1) Core business of general practice with proactive discussions critical



2) Strong GP-patient relationships lead to action



3) GP practice stronger in cervical screening compared to HPV vaccination



4) GPs restricted by time, funding, competing priorities



5) Technology and system support important for care

Conclusions

Cervical cancer prevention is core business for general practice, and GPs are central in achieving equitable elimination in Australia. GPs' expertise in tailored health education and health literacy support can help engage multicultural patients, who were perceived as receptive when prevention was proactively discussed. Trusted GP–patient relationships helped translate these conversations into action. However, the role of general practice in catch-up HPV vaccination needs to be strengthened, with GPs supported to discuss and offer vaccination as early as possible. Effective reminder and integrated information systems, together with public health education and awareness, are crucial to support this role.

Literature cited

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Further information

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Understanding the colposcopy pathway for multicultural populations: qualitative perspectives from General Practitioners and colposcopists in NSW

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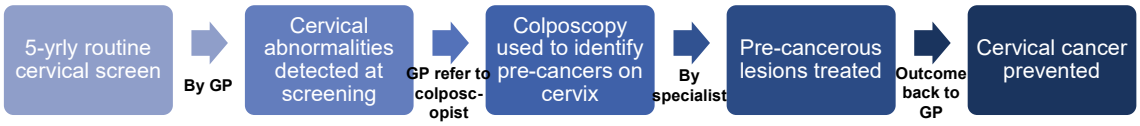
2. Specialty of Obstetrics, Gynaecology and Neonatology, Sydney Medical School, Faculty of Medicine and Health, The University of Sydney
3. Kirby Institute, University of New South Wales

Introduction

Eliminating cervical cancer through vaccination, screening and treatment is a global health priority. Despite Australia's progress, inequities persist particularly for multicultural populations with higher cervical cancer rates and lower rates of treatment compared to the general population. Timely colposcopy after screen-detected abnormalities is essential for histological diagnosis and preventive treatment, with GPs and colposcopists essential for this pathway.

Preventive Colposcopy Pathway



Aim

To explore the roles and interactions of GPs and colposcopists in facilitating colposcopy access and cervical cancer prevention for multicultural populations in metropolitan Sydney and rural New South Wales (NSW)

Methods

- Purposive sampling
- One-on-one semi-structured interviews exploring experiences and role of GPs and Colposcopists from start to end of the colposcopy pathway for multicultural populations
- Inductive thematic analysis; iterative with data collection

Results

Participant Characteristics



31 GPs
15 colposcopists



7 male GPs
3 male colposcopists



24 female GPs
12 female colposcopists



41 metropolitan Sydney



5 rural NSW

- Colposcopist training: **67%** O&G, **13%** Sexual health practitioner, **13%** Nurse Practitioner, **6%** GP
- Colposcopist primary setting: **60%** public hospital, **27%** community clinic (e.g. FPA), **13%** private O&G rooms
- GP background: **42%** born overseas, **71%** spoke a language other than English, **45%** used a language other than English in consultations

Themes

1) Patients and clinicians experience navigational barriers with colposcopy

2) Education and trusted GP relationships support attendance and ease anxiety

3) Effective GP and colposcopist communication is essential for care

4) Willingness to engage, but socioeconomic barriers limit access and attendance

5) Language barriers significantly affect colposcopy delivery

Conclusions

Colposcopists and GPs have important interconnected roles in facilitating colposcopy pathways among multicultural patients. Difficult-to-navigate processes, socioeconomic constraints and language barriers must be addressed through streamlined pathways, effective communication between GPs and colposcopists, and identification of the need for language support. Strengthening coordination and culturally responsive patient education may reduce anxiety, support attendance and help ensure multicultural patients are not lost along the pathway to cervical cancer prevention. These novel findings about the colposcopy pathway will help inform policy and practice to help improve multicultural patient care.

Literature cited

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Further information

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Enhancing Equity in Cervical Screening for people with disability: the role of a lived experience Cervical Screening Advocates Program in co-designing for equity

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[1] Centre for Disability Studies, Research Affiliate of The University of Sydney
[2] Cancer Elimination Collaboration, The University of Sydney
[3] Trinity College Dublin [4] The University of Melbourne

BACKGROUND

- People with disability face barriers to the National Cervical Screening Program.
- Educational materials rarely centre their lived experience.
- Workers and family carers have limited practical guidance.

AIM Explore how lived experience Advocates could co-design and co-deliver cervical screening education.



Advocates brought diverse lived experience from across Australia.

METHODS

1 Screening Advocates Program

Ten Advocates with lived experience of disability were recruited from across Australia.

2 2025-2026 training and co-design program

6 learning sessions on cervical screening, the National Cancer Screening Register, its Personal Representative function and advocacy strategies. 5 co-design sessions created webinar role plays.

3 Further co-design in 2026

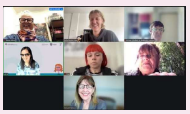
Advocates and support workers co-designed the four-module eLearning course and scripts for training videos.

4 Co-delivery and consultation

Advocates co-delivered the webinar series. Consultation and a modified Delphi process informed a Cervical Screening Practice Alert for NDIS providers.

FINDINGS

NATIONAL WEBINAR SERIES



4 webinars
152 sign-ups
52 live attendees

SCREEN ME! ELEARNING COURSE



A four-module cervical screening course co-designed with Advocates and support workers, including filmed role plays.

CERVICAL SCREENING PRACTICE ALERT

NDIS Quality and Safeguards Commission

Created for NDIS providers. Consultation and a modified Delphi process informed the content.

REPORTED OUTCOMES

- Advocates gained confidence and co-design and presentation capability.
- Webinar participants reported greater awareness of self-collection, the Personal Representative function and access to screening.

CONCLUSIONS

- The Cervical Screening Advocates Program positioned people with disability as partners who shaped and delivered education about cervical screening drawing on their lived experience.
- Their involvement made the resources more relevant to the barriers experienced by people with disability and those who support them.

"I learnt a lot when I joined here and listened to everyone sharing and discussing."

SCREENING ADVOCATE

KEY MESSAGE **Educational resources about people with disability are stronger when people with disability help design and deliver them.**

Lani Dinh • lani.dinh@cds.org.au

Barriers and enablers to implementing self-collected HPV cervical screening in Australian hospital-based antenatal care : an implementation evaluation

AUTHORS:
Jordan Dixon[1,2], Ana Machado Colling[1], Daniel Rolnik[2], David Hawkes[3], Alice Bastable[4], Marion Saville[3], Megan Smith[5], Claire Nightingale[1], Julia Brotherton[1]

AFFILIATIONS:
1. Centre for Health Policy, Melbourne School of Population and Global Health, University of Melbourne, Victoria, Australia
2. Monash Health, Obstetrics and Gynaecology department, Womens and Newborn, Victoria, Australia
3. Australian Centre For Prevention of Cervical Cancer, Melbourne, Victoria, Australia
4. Cancer Council Victoria, Melbourne, Victoria, Australia
5. The Cancer Elimination Collaboration (CEC), Sydney School of Public Health, University of Sydney, New South Wales, Australia

1. Introduction

Australia is set to be the first country to eliminate cervical cancer by 2035, building on its successful National Cervical Screening Program and human papillomavirus (HPV) vaccination program. However, significant disparities persist, with 70% of cervical cancer cases occurring in under-screened or never-screened individuals. Despite HPV-based cervical screening being recommended during routine antenatal care, there remains a significant gap between guidelines and practice. The introduction of universally available self-collection (using a low vaginal swab) in July 2022 marked a critical step toward increasing participation among under-screened populations. While showing promising acceptance rates in primary care, its implementation in routine pregnancy care and tertiary sevices remains unexplored.

2. Aim

To evaluate barriers and enablers to sustainable integration of HPV-based cervical screening, including self-collection, into Australian antenatal care, with a focus on equity and system readiness.

3. Methods

- Key stakeholders across maternity services and non-govermnet orgnaisations were identified
- Recruited arcoss three Australian States, from metropolitan and Regional locations
- Doctors, nurses, midwives and NGO staff were invited to participate
- Implementation evaluation was conducted using semi-structured interviews
- Analysed using Proctors Framework and Theroectical Framework of Acceptability

4. Results

16 participants

7 Obstetricians / gynaecologists, 1 general practitioner, 2 nurses, 4 midwives and 2 NGO staff
Thematic analysis identified key barriers and enablers to embedding cervical screening in antenatal care

Preliminary findings identify antenatal care as an effective setting to reach under-screened or never-screened populations, particularly when screening is embedded within existing clinical workflows. Prior to self-collection, screening was not routinely offered, highlighting a gap between guidelines and clinical practice. Leveraging innovative screening tools such as self-collection can address some of the barriers identified. Results management, IT systems, funding, clinican workload along with knowledge and awareness were identified by all participants as major barriers that would need to be addressed to sustainably offer cervical screening within pregnancy care. Integration into clinical workflows and knowledge and awareness about the safety and accuracy of self collection was key to the succesful provision of screening in pregnancy care and was an important factor across all domains

Proctors implementation outcomes



Feasibility
- ✓ Self-collection reduced barriers and enabled screening to be offered opportunistically within routine care.
- ! Workflow constraints at booking, limited access to screening histories, and unclear follow-up processes reduced feasibility in practice.

Adoption
- ✓ Early adopters of self-collection routinely incorporated screening into antenatal care.
- ! Adoption was inconsistent across providers, with many clinicians not routinely offering screening.

Sustainability
- ✓ When integrated into workflows combined with education and auditing, cervical screening was seen as sustainable.
- ! Sustainability was unlikely without system-level supports, including IT integration, workforce training, and clear clinical governance.

Acceptability
- ✓ Self collection was acceptable to clinicians and patients, seen as less invasive, reducing barriers and increasing access.
- ! Clinician collected cervical screening was seen as less acceptable by clinicians due to risk of bleeding in pregnancy. Patients rarely chose clinician collected it offered a choice.

Penetration
- ✓ Self-collection was successfully embedded in some services, demonstrating potential for integration within maternity models of care.
- ! Overall penetration remained low, with screening not yet standardised or routinely delivered across services.

Appropriateness
- ✓ Antenatal care is an appropriate and strategic setting for screening, given high service contact and access to priority populations
- ! Some clinicians perceived screening as secondary to pregnancy-focused care, limiting prioritisation during time-constrained visits.

Facilitators to providing cervical screening in pregnancy

Improves uptake

There's a big gap [in cervical screening in pregnancy] that we want to address actively rather than passively. [Self-collection] improves uptake by both patients and clinicians because it's so easy to do.
Obstetrician

Self-collection has really improved things [cervical screening provision]
Midwife

Streamlined Screening Pathway

There's just so many women that we need to utilise the touch points within healthcare to actually capture them in cervical screening, and self collection reduces so many barriers that you can actually engage them in [the screening pathway].

This is a game changer [self-collection]. This is a life saving, and we [Australia] lead the world in this. So finding innovative ways to capture more and more women into care and save more and more lives, it's just super important.
Nurse colposcopist

Opportunistic screening

I think pregnancy is a perfect opportunity to capture people, particularly in my population where half are not current. Their median age is 33, so they're not 26yo who just haven't had it. 1/4 of our women are never screened and the other 1/4 are more than 12 months overdue. So it's not just that we're doing it for someone who is going to get it done anyway, a lot of these women weren't going to get it done.
Obstetrician Gynaecologist

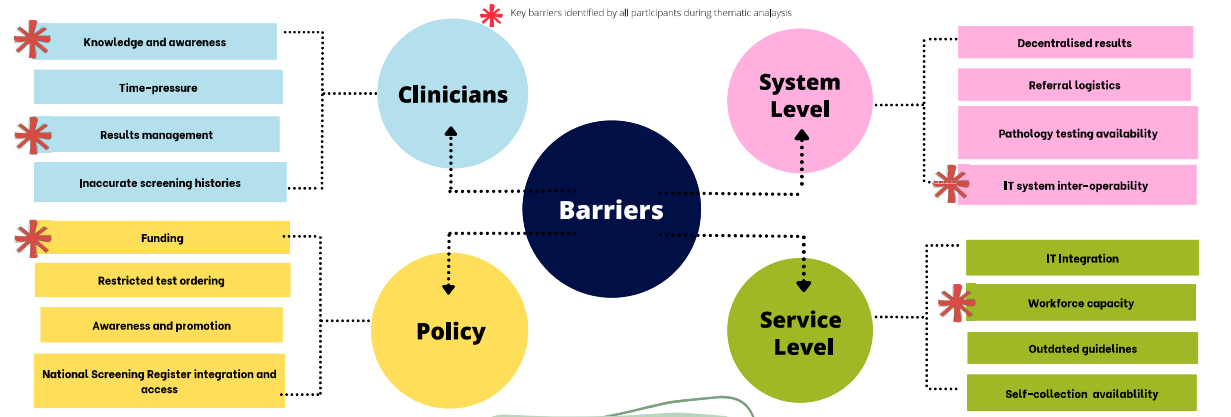
Sustainability

There are many things in my hospital that are not sustainable long term, but cervical screening in pregnancy is.
Obstetrician Gynaecologist



Barriers to providing cervical screening in pregnancy

Key barriers identified by all participants during thematic analysis



Cervical screening using a speculum was one of the biggests barriers for both patients and clinicians.

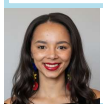


I think one of the concerns is that they [obstetricians] don't feel like it's their role and it's just one more thing to do. But it's such a simple test and the consequences...the stakes are very high if a woman presents late. It's such a preventable disease and it's just a shame that we can't incorporate it [cervical screening] into normal antenatal care.
Nurse colposcopist

There's just no CST champion. There's nobody that it matters to that much. There's an incredible amount of workload and not enough staff. There is lack of education about the importance of cervical screening and the safety of cervical screening in pregnancy. On the patient facing side and the practitioner facing side, there is lack of personnel to actually chase and enact the results. I think it's a multi system level barriers. There is a barrier at every level.
O&G Registrar

5. Conclusion

Self-collection within antenatal care represents an opportunity to improve equitable access for under-screened populations contributing to national efforts to achieve equitable elimination of cervical cancer. Although Australia's National Cervical Screening Program recommends routinely checking cervical screening history and offering screening to eligible pregnant women, screening provision within hospital-based antenatal care remains limited. Self-collection in pregnancy is acceptable and feasible but constrained by modifiable system- and service-level barriers. Addressing these barriers is essential for sustainable implementation within the maternity care system.



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HREC approval from Monash Health
[Project ID Number: 116005]

THE INCLUDE STUDY

Socioeconomic disparities in HPV vaccination coverage in Australia: a population-based linked national dataset

Samrawit Mihret Fetene[1], Claire M. Vajdic[1], Rebecca J. Guy[1], Zoe Aitken[2], Adrian R. Walker[3], Hamish McManus[1], Julia M. L. Brotherton[2]
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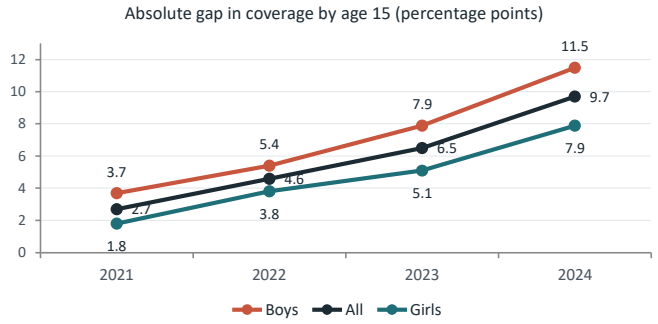
Area-level measures can hide who is missed by HPV vaccination. Linked national data let us measure socioeconomic position for every individual and/or household, every year.

1 Background

- Australia aims to eliminate cervical cancer as a public health problem by 2035
- Target: 90% HPV vaccination by age 15, for girls and boys, by 2030
- Since 2021, coverage has declined each year, and the socioeconomic gap has widened



Quintiles are area-based (SEIFA). Source: Smith et al., 2025 Cervical Cancer Elimination Progress Report.

2 Evidence gap

Most Australian studies use the area-level Socio-Economic Indexes for Areas (SEIFA).

Misclassification
one value for everyone in an area hides household differences

Static
fixed at one Census, held every five years

Composite
cannot show which dimension of disadvantage matters

Gap No population-based Australian study has assessed HPV vaccination disparities using measures of individual- or household-level socioeconomic position.

3 Methods

Research questions How large are socioeconomic disparities in HPV vaccination at the individual and household level? Do area-level measures under- or over-estimate them?

Other linked data

- Health
- Education
- Disability & ageing
- Migration
- Income & taxation

PLIDA
~40 million people since 2006
40 datasets · updated yearly

Used for socioeconomic position

- **Core Income** tax and Centrelink income
- **Core Relationships** parent–child, partner links
- **DOMINO** government income support
- **2021 Census** education, occupation, housing

Population

15-year-olds resident in Australia, 2021–2025

Outcome

- At least one HPV dose by age 15
- Australian Immunisation Register

Socioeconomic position

- Household income
- Government income support
- Parental education
- Parental occupation
- Housing tenure

Analysis

- Coverage by each indicator
- Absolute and relative gaps
- Compared with SEIFA

Constructing household income from tax and Centrelink records

Age group	Step 1: identify (Core Relationships)	Step 2: household income (Core Income)
Under 15	Linked parents	Sum of parental income
15–21	Partner and parents	Own + partner, or parental income
22 and over	Partner	Own + partner income

Limitation: co-residence is not confirmed; 2021 Census household income is used alongside.

4 Results

Pending ABS output clearance

Our results have been submitted to the ABS for output clearance but were not ready in time for this conference. We look forward to sharing them soon.

5 Conclusions

- Area-level measures are known to misclassify individuals
- PLIDA enables the use of individual and household-level measures of socioeconomic status for the whole population
- We developed a method for deriving time-updated household income from administrative data that other PLIDA researchers can apply

Funding Australian Government Department of Health and Aged Care, 2021 MRFF Primary Health Care Digital Innovations (INCLUDE project).
References National Strategy for the Elimination of Cervical Cancer in Australia (2023). Smith M, et al. 2025 Cervical Cancer Elimination Progress Report. Samuels et al., Int J Epidemiol 2026.

Elimination of cervical cancer, implementation of WHO 90/70/90 targets in a LMIC setting, Western Highlands Province in Papua New Guinea

J. Gabuzzi[1], P. Ripa[1], J. Tonny[1], G. Munnull[1], J. Koim[1], J. Pere[1], A. Vallely[2], V. Price[2], R. Smith[2]
[1] Western Highlands Provincial Health Authority
[2] Kirby Institute, University of New South Wales, Sydney, Australia

Introduction

Papua New Guinea has the highest cervical cancer incidence and mortality rates in the Western Pacific which attributes to 1500 deaths annually.[1] The Western Highlands Provincial Health Authority (WHPHA) is the first LMIC in the Pacific to successfully implement the WHO global strategy targets at a population level.

The screening program began in May 2022 targeting eligible women aged 30-59 years using the 'hub-and-spoke' approach – a fixed clinic, as well as day and rural outreach in four districts.

Screening Approach

Point-of-care HPV screen-and-treat



Results

To date a total of 32,669 women were screened (78% of target of estimated 42,000 eligible women). 21% of women screened were HPV positive (n=6736), 85% had same day treatment with thermal ablation (n=5689) and 2% of women were referred (n=734).

Implementation Lessons

Health Education supports same day treatment

- To encourage same day treatment, the clinic team strengthened messaging so women understood the full service: self-collection, results within one hour and same day treatment for women who tested HPV positive.
- Staff offered pre-treatment counselling, addressing concerns about the procedure and aftercare. This information also supported women who wished to have further discussions with their husbands.
- Women were encouraged to return when they felt ready, and bring their husbands to the clinic for support.
- The team reported fewer treatment refusals after strengthening this approach.

90% girls fully HPV vaccinated by 15 years

70% screened using a high-performance test

90% pre-cancer treated or invasive cancer managed

Strengthening Referrals

- The team identified referral completion as a point where women could be lost to follow-up.
- Some women referred for further gynaecological review did not attend. To address this, the hospital O&G doctor began holding sessions at the clinic.
- This allows women to see the doctor in a familiar setting, reducing the need to navigate a separate service and supporting timely review.

canSCREEN digital registry helps target outreach

- canSCREEN is used to review where women screened are located. When screening activity is lower in a particular area, this information helps to prioritise outreach locations.
- canSCREEN also helps staff identify women who are due or overdue for their follow up or review, supporting timely contact.

Community follow-up helps maintain contact

- For women requiring follow-up or repeat screening, the team use locator forms organised by village and district.
- They first try to reach women by phone. When this is unsuccessful, outreach teams visit the villages to locate women.
- Alongside individual follow-up, health staff and volunteers reinforce health messages through local media and awareness at markets and bus stops. This combines direct contact with broader awareness to support women to attend screening and follow-up.

Conclusion

- The Western Highlands program demonstrates how screening and treatment can be delivered in a provincial LMIC setting.
- The team adapted its approach in response to implementation challenges, including strengthening education and community follow-up, using canSCREEN to target outreach, and bringing O&G review closer to the clinic to support referral follow-through.
- Sharing these practical lessons may help other programs adapt screening and treatment services to their own settings and inform future opportunities to integrate cervical cancer services with other health programs.

Acknowledgements
- Minderoo Foundation
- Kirby Institute, UNSW
- ACPCC
- EPICC
- WHPA Management
- VCS
- Well Women's Clinic staff
- The participants

References
[1]Bray F., et al. 2020

WHPHA has received support for its cervical cancer elimination program via the ECCWP Project funded by the Minderoo Foundation and donations of equipment and consumables from Cepheid and Copan, with in-kind and additional funding support from partner health authorities and governments. From 2025, support has been provided via the DFAT-funded EPICC Program. Technical support under these projects is provided by the Kirby Institute, UNSW.

Cervical Cancer Prevention in individuals experiencing Severe Mental Illness (SMI):

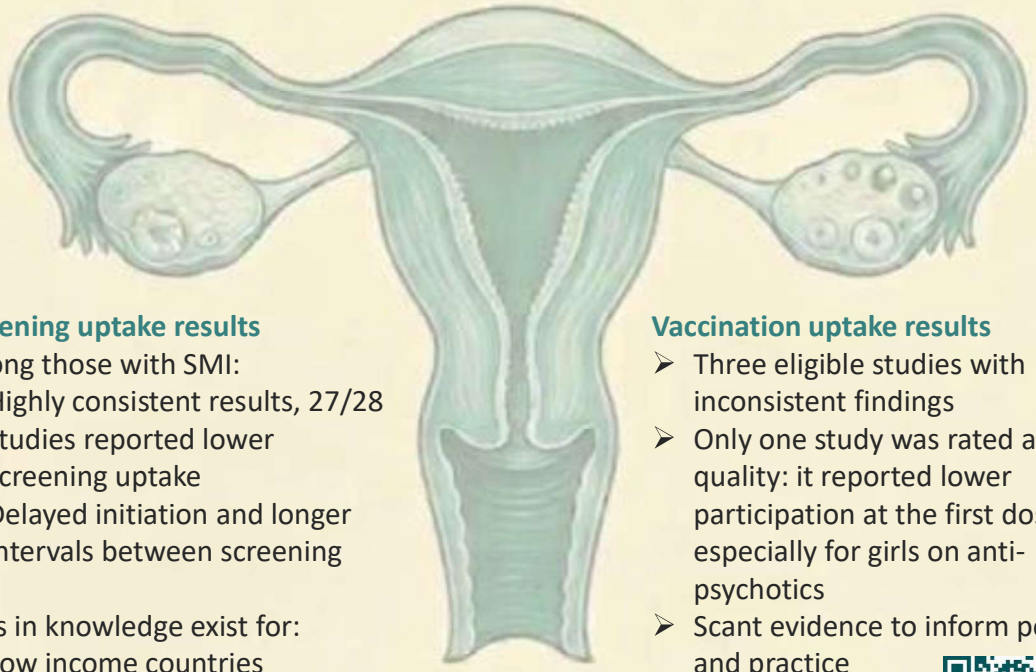
A Systematic Review of HPV Vaccination and Cervical Screening Uptake

Hayes L, Enticott J, Saville M, Galbally M

Background Cancer outcomes are significantly worse for people with severe mental illness, who experience later diagnosis and higher mortality. Multiple barriers contribute to lower participation in cervical screening. The full benefits of cervical cancer prevention programs may not be reaching this population (Aggarwal et al., 2013; Grassi et al., 2023; Pillai et al., 2026; Solmi et al., 2020).

Aim To compare HPV vaccination and screening uptake among people with and without severe mental illness (SMI).

Method Systematic review of English language studies (2008 onwards) reporting vaccination or screening uptake by mental illness status



Screening uptake results

Among those with SMI:

- Highly consistent results, 27/28 studies reported lower screening uptake
- Delayed initiation and longer intervals between screening

Gaps in knowledge exist for:

- Low income countries
- After screening, results and care
- Newer innovations, such as self collection

Vaccination uptake results

- Three eligible studies with inconsistent findings
- Only one study was rated as high quality: it reported lower participation at the first dose, especially for girls on anti-psychotics
- Scant evidence to inform policy and practice

So what? As we progress towards elimination, population gains may mask persistent inequities. Cervical cancer prevention programs work, the challenge is ensuring people with SMI can access appropriate supports. If this population group misses prevention opportunities, disparities in cervical cancer outcomes may persist or worsen.

What next? Towards a new model of care…

Data linkage for local insights → Interviews for implementation determinants → Delphi for sustainable recommendations

MONASH University · Safer Care Victoria · Monash Health

Eliminating Cervical Cancer Conference 2026

Real-time data linkage for cervical cancer screening in Naoero

Naoero Ministry of Health + BES International

Background

Effective cervical cancer elimination programs depend on timely, structured data linking screening, visual assessment, and treatment services. Naoero's Ministry of Health uses canSCREEN as its national cervical cancer screening data system, while frontline clinical data is captured in Tamanu, the country's electronic health record. Bridging these systems required an automated, low-friction data pipeline rather than a traditional point-to-point integration.

Method how the data moves

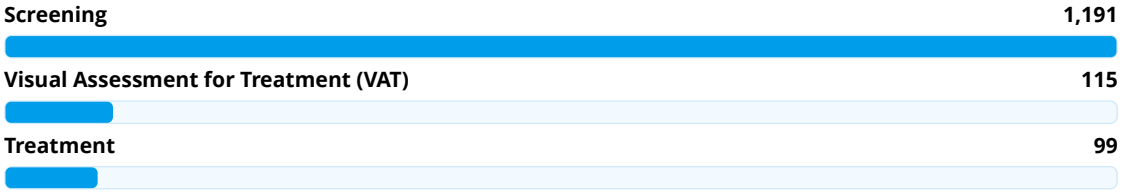
1. **Daily automated pipeline**
   Built with Dagster, operating on a replica of Naoero's Tamanu database.
2. **Three clinical survey forms extracted**
   Cervical Screening, Visual Assessment for Treatment (VAT), and Treatment.
3. **Demographics joined to clinical data**
   Each row combines patient demographics (name, date of birth, village/district, contact details, nationality, tribe, and related fields) with form-specific data: WHO functional-difficulty responses, sample identifiers, transformation-zone classification, ablation and referral details, and treatment type and outcomes.
4. **Data minimization**
   Internal patient identifiers and raw submission timestamps are excluded.
5. **Uploaded for canSCREEN**
   One Excel file per survey per day goes to a dedicated Azure Blob Storage container for consumption by canSCREEN.

Results 1 Sep 2025 – 30 Sep 2026

1,036 unique patients linked to canSCREEN

across 1,405 forms submitted from Tamanu

1,191	115	99
Screening forms	Visual Assessment for Treatment (VAT) forms	Treatment forms



1,405 total forms submitted across all three survey types

Conclusion

This automated export architecture demonstrates a scalable, low-maintenance model for connecting frontline EHR systems to national screening registries in resource-constrained settings. By prioritizing simplicity, data completeness, and privacy-conscious design, the approach supports Naoero's progress toward WHO cervical cancer elimination targets and offers a replicable framework for other Pacific Island nations building similar surveillance capacity.

FROM TRAINEE TO TRAINER

The Evolution of a Sustainable Cervical Screening and Train-the-Trainer Program in Malawi

Kimberley Ivory[1,2] · Gillian McDowell[4,5] · Graham Carey[4,5] · Eva Bryer[4,6] · Melissa Miskell[3]

INTRODUCTION

Limited access to trained providers is a major barrier to scaling up cervical cancer screening in Malawi.

PINCC has provided cervical cancer screening and treatment training in high-prevalence, under-resourced countries for over 21 years. In 2025, PINCC was invited to Malawi, which has one of the highest incidences of cervical cancer morbidity and mortality in the world.

OBJECTIVE: *To build sustainable local capacity by moving from clinical training to a competency-based train-the-trainer (TTT) program.*

MALAWI



SOUTHEAST AFRICA

- Lilongwe, Malawi's capital
- 3 sites visited by PINCC in 2025
- 2026 TTT held at Child Legacy International

21+ years of PINCC training experience. **Since 2023:** 7,600+ women screened across 4 countries 1,360+ women treated, and 33 devices donated.

500K+ women and girls living with HIV in Malawi face a sixfold higher risk of cervical cancer.

9 Women die every day, on average, from cervical cancer in Malawi

PROCESS

2025: SETTING THE FOUNDATION

- A multidisciplinary PINCC team visited 3 sites near Lilongwe, Malawi
- 17 practitioners trained in VIAA and thermocoagulation
- 691 women screened for HPV and 54 women treated for cervical pre-cancer



2026: BUILDING LOCAL CAPACITY

- Competency-based TTT program delivered at Child Legacy International
- 3 nurses selected by the hospital as trainers, based on their 2025 experience with PINCC
- Trainers ran a supervised screening clinic to train 6 fellow healthcare workers



THE TRAIN-THE-TRAINER CURRICULUM

Cervical cancer

- Natural history
- Prevention: vaccination and education
- Risk & disease progression

Screening

- HPV screening with point-of-care tests
- Visual inspection with acetic acid (VIAA)

Treatment & referral

- Appropriate use of thermo-ablation
- Referral for LEEP and cancer treatment

Teaching skills

- Clinical teaching
- Supervised screening clinic
- Competency assessment

RESULTS

COMPETENCY ACHIEVED

VIAA certified 6 / 6

Thermo-ablation certified 3 / 6

Between PINCC visits, Child Legacy International staff continued to screen and treat local women.

THE MULTIPLIER EFFECT

17 practitioners trained (2025) › **3** local trainers (2026) › **6** additional workers trained





85 Women screened for HPV using mRNA point-of-care testing

34 Women examined with VIAA

8 Women received thermo-ablation based on testing & VIAA

6 Additional healthcare workers trained by the new trainers

CONCLUSIONS

Train-the-trainer is a promising strategy for expanding cervical cancer screening capacity in resource-poor settings. As facilitators, we learned a great deal about structuring a TTT curriculum and continue to improve on it. By reducing reliance on external trainers, this model offers a means to strengthen cervical cancer prevention programs.

LESSONS FOR FUTURE TTT PROGRAMS

- **Select trainers with clinical experience and leadership potential**
- **Combine theoretical learning with supervised clinical teaching**
- **Work within country's guidelines while advocating for change when appropriate**

KEY TAKEAWAY: TRAINING LOCAL HEALTHCARE WORKERS IS ESSENTIAL FOR OVERCOMING BARRIERS TO CARE AND ESTABLISHING APPROPRIATE SUSTAINABLE HPV AND CERVICAL CANCER PREVENTION PROGRAMS.

[1] Board Member, PINCC (Preventing Cervical Cancer Globally, NGO)
[2] Honorary Senior Lecturer, Sydney School of Public Health, University of Sydney, Australia
[3] Executive and Medical Director, PINCC; Board Certified Gynecologist, USA
[4] Volunteer Clinician, PINCC
[5] FRACGP
[6] Certified Nurse Midwife, USA

PINCC
PREVENTING CERVICAL CANCER GLOBALLY

ECC2026

Efficacy of Photodynamic Therapy at improving clearance of Premalignant High-risk Human Papillomavirus Cervical Infections: a literature review

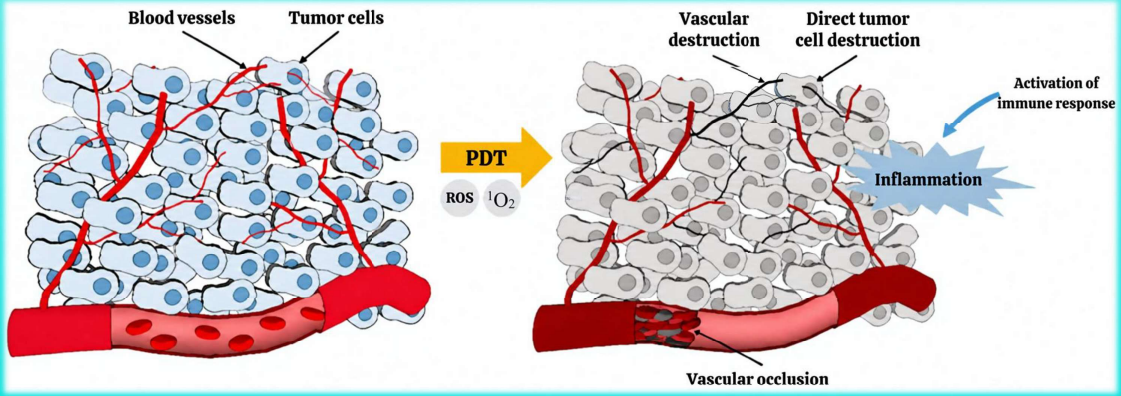
Robert Kibuuka, Hunter New England Local Health District

INTRODUCTION

Persistent high-risk human papillomavirus (HPV) infection can be a significant risk factor for progression of premalignant cervical lesions to a malignant state. Photodynamic therapy (PDT) could potentially be a relatively well-tolerated and non-invasive means of proactively preventing disease progression.

METHODS

A literature search was performed in Embase and Medline using the following terms; photochemotherapy, papillomavirus infections, photodynamic therapy, cervix uteri, uterine cervical neoplasms, uterine cervix disease, uterine cervix carcinoma in situ, uterine cervix carcinoma, uterine cervix disease, uterine cervix and viral clearance.



Source: Correia et al, https://doi.org/10.3390/pharmaceutics13091332

RESULTS

Multiple recent studies have demonstrated increased clearance of HPV in patients receiving PDT compared to routine follow-up/ observation. A 2025 retrospective study showed PDT to have better HPV clearance than loop electrosurgical excision procedure (LEEP) for patients with HPV-associated cervical intraepithelial neoplasia while avoiding the potential effects to fertility and risks to pregnancy associated with the latter procedure. However, a 2024 retrospective study demonstrated similar HPV clearance rates between PDT and LEEP with PDT still maintaining a safer adverse effect profile.

Side effects noted with PDT included abdominal pain, increased vaginal discharge, vulvar pruritus, cervical stenosis, vaginal bleeding, vaginal pain and focal oedema. HPV clearance rates after PDT were noted to be worse with postmenopausal status, type III transformation zone, no previous HPV vaccination and prior cervical surgery.

Notably, majority of prospective studies on the efficacy of PDT had a small sample size (<100) with a follow-up period of 0.5 to 2 years.

CONCLUSION

PDT could potentially be an upcoming minimally invasive option to promote clearance of high-risk HPV in patients with premalignant cervical lesions. However, larger scale prospective studies and/or clinical trials with a longer period of follow-up are needed to further solidify the evidence for its clinical benefit and applicability.

What a great opportunity, getting ACT women back on track with cervical screening, Apr 2025 — Apr 2026.



Connor S, Knight A, Shuck J | Canberra Sexual Health Centre, Canberra Health Services ACT

Background:

Despite Australia's progress towards cervical cancer elimination, some priority populations continue to experience lower screening participation, delayed diagnosis, and poorer outcomes.

Through a Commonwealth Federation Funding Agreement — Expanding access to cervical screening services, Canberra Sexual Health Centre (CSHC) implemented targeted approaches to increase awareness, engagement, and participation in cervical screening across the ACT prioritising culturally and linguistically diverse (CALD) communities, LGBTQIA+ people, Aboriginal and Torres Strait Islander peoples, sex workers, and other priority groups.

Methods:

The Cervical Screening Test (CST) Catch-Up Project expanded access to screening through a nurse-led model delivered by CSHC, a publicly funded multidisciplinary health service. The program offered appointment-based clinic screening and community outreach "pop-up" services. CSHC partnered with community leaders and organisations to promote and deliver culturally safe education sessions and flexible outreach screening opportunities tailored to community needs. CSHC followed up clients with abnormal results in accordance with national guidelines and supported continuity of care through primary healthcare providers by sending GP letters for all consenting clients. The first reporting period was from 1 April 2025 — 30 April 2026.

Results:

During the reporting period, 576 CSTs were completed for 572 individuals.

Key Outcomes

44 women who were 5 — 22 years overdue were successfully re-engaged and had their CST updated through the program.

62 outreach activities delivered, resulting in:

807 People reached

181 Cervical screen tests completed

207 STI screens completed

Table 1. Participant characteristics

Characteristics	n	(%)
Aged 25-44 years	424	73.6%
CALD (from a non-main English speaking country)	251	43.6%
Aboriginal and/or Torres Strait Islander	19	3.3%
LGBTIQA+	65	11.2%

Table 2. Screening history and re-engagement outcomes (n=576 CSTs)

Outcome	n	(%)
No previous screening history recorded on the NCSR	276	47.9%
- Aged ≥30 years*	122	44.2%
Overdue for screening (>2 years)	257	44.6%
HPV positive result	141	24.5%

*Percentage of participants with no previous screening history recorded on the NCSR (122/276)

Table 3. Participants with no previous cervical screening history on NCSR by priority population group

Priority group	n	(%)
CALD (n=251)	170	67.7%
Aboriginal and/or Torres Strait Islander (n=19)	7	36.8%
LGBTIQA+ (n=65)	24	36.9%

Conclusion:

The CST Catch-Up Project demonstrates that nurse-led, community-based screening models can successfully engage priority populations, reduce barriers to participation, and re-engage individuals long overdue for screening. These findings support the value of targeted outreach and culturally sensitive care in reducing inequities and advancing Australia's goal of cervical cancer elimination.

Acknowledgement of Country
Canberra Health Services acknowledges the Ngunnawal people as traditional custodians of the ACT and recognises any other people or families with connection to the lands of the ACT and region. We acknowledge and respect their continuing culture and contribution to the life of this region.

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Eliminate 38

Cervical cancer elimination research and advocacy in Aotearoa New Zealand: Community, NGOs, researchers and government working together.

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Introduction

Elimination of cervical cancer in our lifetime is within reach. We have the evidence, the proven interventions, and the capability to achieve this through equitable human papillomavirus (HPV) vaccination, screening, early diagnosis, and timely treatment.

Aotearoa's National Cervical Screening Programme (NCSP) offering an HPV self-test to everyone eligible was introduced in September 2023. Cervical screening coverage has increased from 69.1% in May 2023 to 77.0% overall in May 2026 with all ethnicities seeing increased coverage. (1)

However, the next steps of diagnosis and treatment are affected by poor planning and workforce shortages, resulting in long wait times. In addition, national HPV vaccine coverage for 14-year-olds in the 2025 April/June quarter was 49% for indigenous Māori and 63% for Europeans. (2)

Methods

Te Tātai Hauora o Hine research group recently partnered with the Cancer Society of New Zealand, advocating with policy makers, government, and the health system to eliminate cervical cancer in Aotearoa by 2038.

The partnership collaborates with stake-holders in the field of HPV and cancer to advocate for change. These include non-governmental organisations (NGOs) like Smear Your Mea, a Māori-led health campaign launched in 2017 by the late Talei Morrison to raise awareness about cervical cancer, the National Kaitiaki Group which upholds Māori data sovereignty within the NCSP and the Royal Australian and New Zealand College of Obstetrics & Gynaecology (RANZCOG). We organised two cervical cancer elimination summits in 2026 including all stakeholders in discussing a collaborative way forward.



Nicola Coom, CE of Cancer Society and Prof Bev Lawton, Director of Te Tātai Hauora o Hine join forces in the 'Elimination of cervical cancer' partnership.

Objectives

To collaborate with NGOs, the Ministry of Health, the National Screening Unit, immunisation specialists and other stakeholders in a united call for:

- a cross-party commitment to extend free cervical screening as the two other government funded screening programmes (breast and bowel screening) are free to all those eligible.
- an action plan paired with funding to eliminate cervical cancer in Aotearoa NZ by 2038



The teams at Cancer Society of NZ and Te Tātai Hauora o Hine join forces to advicate for free cervcial screening and a funded elimination plan from government.

Results

The outcome has resulted in our collaborative extending the World Health Organisation's three pillars to four for Aotearoa:

1. Vaccination
2. Screening
3. Diagnosis (including early colposcopy diagnosis)
4. Treatment.

Underlying these four pillars are the principles of innovation, transparency, accountability, monitoring and evaluation, cross-party agreement and, of course, equity.

As a collaborative we strongly advocated for these pillars to be included in the upcoming Te Aho o Te Kahu Cancer Control Agency New Zealand Cervical Cancer Elimination Action Plan 2026 to 2040.



Representatives from NZ government, Te Aho o Te Kahu Cancer Control Agency, National Screening Unit, immunisation advisors , head and neck cancer experts, RANZCOG, Te Tātai Hauora o Hine, Kaumātua (elders), the Cancer Society of NZ, Australian colleague and HPV epidemiology expert, Prof Lisa Whop, meet together in Wellington

Conclusions

We called for a cross-party commitment to extend free cervical screening as the two other government funded screening programmes (breast and bowel screening) are free to all those eligible. The current government announced free cervical screening to all those eligible on the 1st of September 2026. A government backed cervical cancer elimination strategy was also announced but with no increased funding attached.(3) the government plan states elimination by 2040. Our advocacy partnership continues to push for more funding for colposcopy services to address the bottleneck in diagnosis and more access and strategies to increase HPV vaccination among school children. This E38 partnership will be holding the govt and sector to account for equitable outcomes.

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Improving Cervical Screening Awareness and Participation in Under-Screened Populations in South East Melbourne

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Background

- Cervical screening is a public health priority for the South East Public Health Unit (SEPHU) as cervical screening rates are below the Victorian average across several of the 11 Local Government Areas (LGAs) in the SEPHU catchment, particularly in priority populations.
- SEPHU collaborated with Women's Health in the South East (WHISE) and Bayside Health-Peninsula, to deliver cervical screening sessions.

Objectives

- Increase awareness of cervical screening via self-collection and support participation in under-screened priority groups.

Methods

Partner → Educate → Offer → Evaluate

- Partnership between SEPHU, WHISE and Bayside Health delivered place-based sessions incorporating HPV vaccination, screening and women's health education, with on-site self-collection.
- A total of 10 sessions (1 in each LGA) were held, October 2025 – May 2026.
- Women and people with a cervix aged 25-74, from culturally diverse and First Nations communities attended education sessions delivered by trusted nurses.

What worked well

'welcoming, supportive, and safe'

- Safe spaces and one-on-one chats with trusted nurses on sensitive women's health issues.
- Bilingual interpreters, Multicultural, First Nations and LGBTQIA+ resources on self-collection.
- Welcoming, familiar community environments to support engagement and participation.

Results

177 Attendees

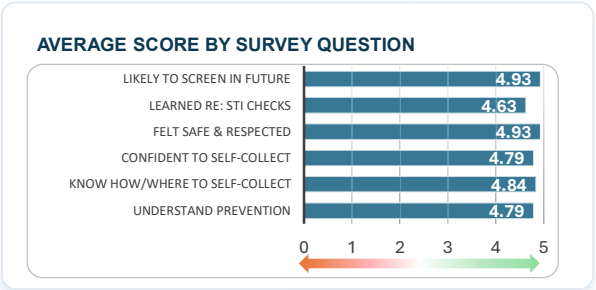
74 self-collections completed

Evaluation

88
Responses
9 locations

81%
Self-Collection Uptake
42 of 52 eligible participants

4.8/5
Average score
Experience questions



Lessons learned

- Develop trust in tailoring sessions to ease into culturally sensitive topics.
- Effective engagement requires flexible delivery and ability to pivot to meet audience needs.
- Value Lived Experience and Storytelling.
- Partnerships share skills, extend reach and access to trusted services.

Conclusion

Collaboration between trusted partners and practitioners, working in local settings, meeting people in their communities, make cervical screening easier to access.

Contact details

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Springvale Service for Children-Greater Dandenong
Group session



St Kilda Library-Port Phillip
L-R Melissa M (SEPHU), Cathy H (Bayside Health-Peninsula), participant, Laura R (WHISE)



Grattan Gardens-Stonnington
L-R Robyn H (Bayside Health-Peninsula), Laura R (WHISE), Melissa M (SEPHU)

Monash Health South East Public Health Unit · whise Women's Health in the South East · Bayside Health

Quantifying the opportunities for cervical screening during pregnancy and postpartum care: a population-based analysis

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THE UNIVERSITY OF SYDNEY — Cancer Elimination Collaboration

Introduction

Pregnancy provides a key opportunity to assess cervical screening history and offer screening, particularly for women with limited healthcare contact

It is not yet known:

- how many never/under-screened women could be screened if they were routinely offered screening during antenatal check-ups or postpartum
- the extent to which screening already occurs during pregnancy or postpartum
- factors associated with being screened during pregnancy and postpartum

Objectives

- To quantify the proportion of women overdue for cervical screening immediately prior to pregnancy
- To assess if this reduces over the course of pregnancy or first year post-birth (first year postpartum)
- To investigate factors associated with cervical screening during pregnancy and first year postpartum

Methods

Data source:

NSW Perinatal Data Collection and NSW Pap Test Register (linked data)

Cohort eligibility:

Women who gave birth in NSW between 2007-2015 and were aged 25-49 years at estimated LMP date

↓

% overdue for cervical screening (no cytology test in previous 3 years) at LMP

↓

- % screened during antenatal period
- % screened by first year postpartum

*Estimated LMP = baby's date of birth minus gestational age in weeks; proxy for beginning of pregnancy

Data analysis:

Descriptive analysis, stratified by key characteristics

- Socio-demographic factors
- Maternal characteristics
- Health service-related factors

Univariable and multivariable logistic regression analyses

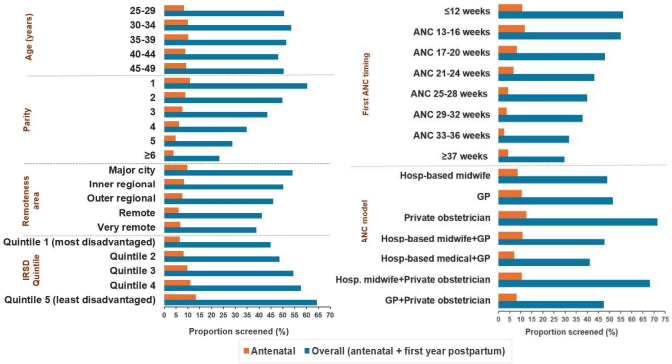
Results

Cohort selection

Eligible pregnant women: 685,120

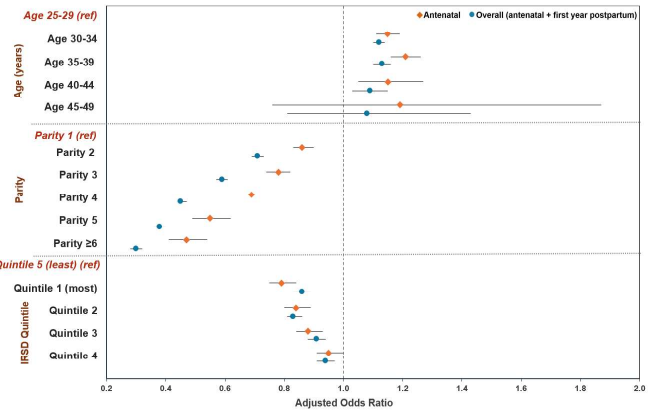
32.0% (219,108)	9.2% (20,171)	42.5% (93,141)	51.7% (113,312)
Overdue at LMP	Screened in antenatal period	Screened in first year postpartum	Screened in antenatal+first year postpartum

Cervical screening during pregnancy and up to first year postpartum by key characteristics

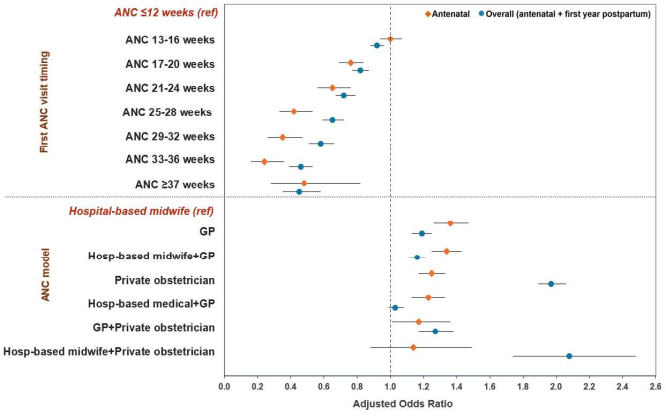


*ANC: Antenatal care; IRSD: Index of Relative Socio-economic Disadvantage

Socio-demographic and maternal characteristics associated with cervical screening during pregnancy and up to first year postpartum



Health service-related factors associated with cervical screening during pregnancy and up to first year postpartum



Screening participation during pregnancy and up to first year postpartum also varied significantly across NSW Local Health Districts (results not shown)

Key findings

Very few women in NSW received cervical screening during pregnancy

Many of those missed during pregnancy were still not screened by first year postpartum

The odds of being screened during pregnancy or up to first year postpartum were

LOWER among women with:

- higher parity (vs parity 1)
- living in more (vs least) disadvantaged areas
- later gestational age at first ANC visit (vs ≤12 weeks)

and HIGHER among women who

- were aged 30-34, 35-39 or 40-44 years (vs 25-29 years)
- received ANC through GP or obstetrician models (vs hospital-based midwifery care)

Conclusions

- A missed opportunity exists for catch-up screening in antenatal and postpartum care
- Although these data relate to Pap tests, failure to catch-up screening during extended postpartum period remains relevant to HPV-based screening
- Factors identified as being associated with missed screening opportunities around pregnancy could guide development of targeted approaches for populations most in need
- Strategies to systematically offer screening during antenatal care, now further enabled by self-collection, are needed

Acknowledgments

The Centre for Health Record Linkage (CHeReL) for the record linkage, the Secure Unified Research Environment (SURE) for the provision of secure data access and the Cancer Institute NSW and NSW Ministry of Health for the use of their data; Funding: NHMRC Centre of Research Excellence in Cervical Cancer Control (C4) (APP2015739), NHMRC Leadership Fellowship (Prof Karen Canfell's fellowship APP1194679)

Further information

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Pacific Against Cervical Cancer (PACe) Project: Approaches to Cervical Cancer Screening in Diverse Pacific Island Settings

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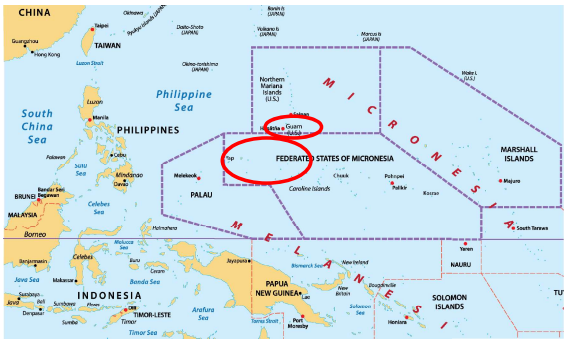
Introduction

The United States Affiliated Pacific Islands (USAPI) have among the highest cervical cancer (CC) incidence rates globally, ranging from 11 to 62.4 per 100,000 women. These island nations have populations dispersed across more than 100 small islands, are health resource-constrained, lack screening, and have limited advanced healthcare infrastructure, resulting in high cervical cancer mortality.

Methods

The Pacific Against Cervical Cancer (PACe) Project developed a high-quality, resource-appropriate screening and treatment program in the lower-middle-income, sovereign island nation of Yap, Federated States of Micronesia and the high-income U.S. territory of Guam.



Through a participatory co-development strategy, a multidisciplinary team (medical/laboratory, community engagement, data/registry, and modeling experts) established tailored approaches for CC screening and treatment in Yap and Guam, while navigating diverse regulatory, economic, and geographic contexts. Guam must follow U.S. regulatory requirements, while Yap follows World Health Organization guidance.

Results

	Islands	Goal	# HPV DNA Tests	Provider collected	Self-collected	HPV +	HPV 16	HPV 18	HPV 45	Other hrHPV	Treated
Yap	Main + 18 outer	1600	1892	274	1618	306 (16%)	15	52	52	261	85%
Guam	Main	100	59	59	0	12 (20%)	0	0	1	11	100%

-Yap challenges included developing on-island HPV DNA testing capacity and follow-up with women on outer islands reachable only by ship.

-Guam integrated hrHPV DNA testing into its CC screening program, which previously relied on Pap smear. Challenges included navigating the Pap smear medical culture, modifying insurance pathways, utilizing off-island laboratories, meeting FDA regulatory requirements, and developing risk-based management protocols.

Conclusions

The PACe project established a sustainable screening model for diverse Pacific Island settings. A systems-based approach to operationalize and implement cervical cancer screening and treatment across diverse and distinct geographic, regulatory, health policy, and health care resource environments is possible. The methods are described in a CC Screening Implementation Guide for the Pacific.

For more information, visit: www.pacificcancer.org

Acknowledgments

Special thanks to Mona Saraiya, MD, MPH, Jin Qin, ScD, MS, Virginia Senkomago, PhD, MPH, the Centers for Disease Control and Prevention, Pacific Island Health Officers' Association, Yap Community Advisory Board, Yap State Department of Health Services, Wa'ab Community Health Clinic, Guam Department of Public Health & Social Services, and Guam Community Advisory Board.

Accelerating Cervical Cancer Elimination in Nepal

Progress, Innovations, and Challenges Across the Three WHO Elimination Pillars

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Background

Nepal has demonstrated strong political commitment to the WHO Global Strategy for the Elimination of Cervical Cancer as a Public Health Problem. Through strengthened policies, expanded service delivery, and strategic partnerships, the country has accelerated implementation across all three pillars: HPV vaccination, screening and treatment of precancerous lesions, and management of invasive cervical cancer.

What efforts exist in Nepal?

- HPV Vaccination included in the National Immunization Program
- National screening programme
- Referral system
- Cancer management guidelines and strategies
- Cancer registry program
- Surgery, chemotherapy and radiotherapy services
- National trainings on VIA, Cryotherapy, LEEP/Colposcopy to service providers

Nepal at a Glance: Burden and Baseline

Source: WHO Cervical Cancer Country Profile, Nepal (2021)

16.4	2,000	2025	10%	4 / 1	No
Age-standardized incidence per 100,000 women (2020)	Cervical cancer deaths (2019)	HPV vaccine introduced; it was not in the national schedule in 2020	of women aged 30–49 ever screened; only 6% in the last 5 years (2019)	Radiotherapy / brachytherapy units per 10,000 cancer patients (2021)	Palliative care in primary health care or community-based care (2021)

NEPAL'S 90–90–90 ELIMINATION TARGETS

by 2030

- **90%** **HPV vaccination** (girls fully vaccinated by age 15)
- **90%** **Screening** (women screened by 35 and 45)
- **90%** **Treatment** (identified cases managed)

PILLAR 1 HPV Vaccination

- Nationwide HPV vaccination campaign launched on World Cancer Day (4 February 2025)
- Targeted approximately 1.68 million girls aged 10–14 years
- School- and community-based delivery strategies
- HPV vaccine introduced into the routine immunization programme, ensuring long-term sustainability

HPV VACCINE • SCHOOL + COMMUNITY

PILLAR 2 Screening and Pre-cancer Treatment

- National screening guideline revised and HPV DNA SOP developed (2023/24)
- HPV DNA testing is the preferred screening method for women aged 30–49 years
- Pilot in 11 districts, followed by phased scale-up
- Services integrated into reproductive health outreach and primary health care
- Laboratory expansion, health-worker training, thermal ablation and LEEP strengthen screen-and-treat

HPV DNA TESTING • SCREEN & TREAT

PILLAR 3 Cervical Cancer Treatment

- Access expanded through specialized oncology centres in federal and provincial referral hospitals
- Referral pathways strengthened for women identified through screening
- Surgery, chemotherapy, radiotherapy, pathology and multidisciplinary care increasingly available
- Government financial support exists but is not sufficient for tertiary treatment

DIAGNOSIS • REFERRAL • TREATMENT

Nepal's Policy Provisions

- National commitment to eliminate cervical cancer as a public health problem, aligned with the WHO Global Strategy and the 2030 targets
- National Cervical Cancer Screening Guideline endorsed in 2010; revised and supported by a Standard Operating Procedure for HPV DNA-based screening (2023/24)
- HPV DNA testing adopted as the preferred screening method for women aged 30–49 years, piloted in 11 districts and then scaled up
- Annual Policies and Programmes (FY 2023/24): free cervical cancer screening at state-run health facilities
- HPV vaccine introduced into the routine immunization programme after the 2025 nationwide campaign for girls aged 10–14 years
- Government financial support for cancer treatment; screen-and-treat services with thermal ablation and LEEP

Challenges in Nepal

- Late diagnosis: more than half of cervical cancer patients present at an advanced stage
- Limited funding: free screening reached only a few local units in 11 districts; treatment support is not sufficient for tertiary care
- Low screening uptake: limited awareness and perceived risk, cost of services, distance to facilities, and women's limited decision-making power
- Geographic inequities and shortages of trained health workers and HPV DNA laboratory capacity
- Earlier national guidelines were not fully implemented; data systems and follow-up need strengthening
- Sustainable financing is needed to scale up vaccination, screening and treatment

Conclusion Nepal has made substantial progress across all three pillars through high-level political commitment, HPV vaccination, transition towards HPV DNA-based screening, and expansion of treatment services. Continued investment in equitable service delivery, laboratory capacity, workforce development, data systems, and sustainable financing will be essential to achieve WHO elimination targets and ensure access to prevention, early detection, and quality treatment.

A cervical cancer-free Nepal is within our reach.

Beyond Screening: Culturally Responsive Communication Across Vaccination, Screening and Follow-up in the Northern Territory

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Introduction

Aboriginal women in the NT experience higher cervical cancer mortality despite comparable incidence (9.8 vs 8.0 per 100,000 women).[1]

Aim: To develop culturally responsive resources to inform understanding of vaccination, screening and follow-up for Aboriginal women through audio-visual resources.

2.6×
Cervical cancer mortality Aboriginal vs non-Indigenous women 2018–2022[2]

***67%**
Barkly Age-standardised screening participation[2]

***64%**
East Arnhem Age-standardised screening participation[2]

* Participation figures reported April 2026.

Methods

- **Evidence-based foundation** → Nationally developed, co-designed resources
- **Script development** → Clinicians • Nurses Aboriginal Health Practitioners
- **Stakeholder review** → ACCHOs • Language centres • NGOs Community-based organisations
- **Iterative adaptation** → Scope • Content • Message framing Language • Cultural appropriateness

Continuous resource refinement and adaptation

Results - Four communication priorities from iterative stakeholder consultation

Culturally appropriate prevention messaging

Stakeholders described cancer associated with illness and death, discouraging uptake of preventive initiatives when people feel well.

→ Impact: Emphasise positive messaging around health, family and future generation

Role of vaccination and screening is not always understood

Limited understanding as to how vaccination can prevent cervical cancer or why screening matters

→ Impact: Explain vaccination and screening purpose clearly.

Informed choice supports ongoing engagement

People need to understand screening options, their rights and what a positive screening result means.

→ Impact: Prioritise awareness, informed choice and preparedness.

Communication must reflect local cultural context

Language, culture and communication preferences vary, including voice, visuals and delivery of sensitive information.

→ Impact: Adapt message framing, language, visuals, voice and dissemination locally.

Implementation Progress



Indicative locations only; not language boundaries.

Languages confirmed for translation

- **Tiwi** (Tiwi Islands)
- **Kunwinjku** (western Top End)
- **Burarra** (north-central Top End / Arnhem-adjacent coast)
- **Eastside Kriol** (primarily Katherine region)
- **Alyawarr** (Barkly region)
- **Western Arrarnta** (Central Australia around Alice Springs)
- **Pintupi-Luritja** (southwest Central Australia near the WA border)

Additional languages

- **Yolŋu Matha** (East Arnhem)
- **Anindilyakwa** (Groote Eylandt / Gulf area)



Current Scripts

01 Why HPV vaccination matters
02 Cervical screening: choices and rights
03 Understanding a positive HPV result

Discussion & Implications

1. **Broader resource scope covering screening & vaccinations**
2. **Local adaptation requires more than language translation**
3. **National and local resources should be complementary**[4]
4. **Extending the approach for other priority populations**
   21.8% of NT residents were born overseas[3].

Limitations and next steps

Findings based on stakeholder consultation only; Next steps include visual and dissemination formats with stakeholders and continue consultation with CALD communities.

Equitable elimination starts with locally relevant messaging

Locally relevant, culturally responsive communication can strengthen understanding and informed consent across HPV vaccination, screening and follow-up.

Acknowledgements: We acknowledge Aboriginal Health Practitioners, Aboriginal language centres and other stakeholders whose cultural, linguistic, clinical and local knowledge is driving the development and local adaptation of these resources for Aboriginal communities across the Northern Territory.

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NORTHERN TERRITORY GOVERNMENT

Viral Fingerprints in the Tumour Transcriptome: HPV-Driven Immune Reprogramming in Cervical Cancer and the Search for Druggable Targets

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Eliminating Cervical Cancer Conference 2026 · Digital Poster

KEY FINDING: Myeloid dendritic cells depleted 13× in HPV⁺ tumours vs HPV⁻ ($p < 0.001$) — a hallmark immunosuppressive signature

5,395	13×	487	61
Differentially Expressed Genes	mDC Depletion (HPV⁺ vs HPV⁻)	GO Biological Process Terms	KEGG Pathways Enriched

Background

Cervical cancer kills ~1 woman every 2 minutes; HPV drives >99% of cases

HPV reshaping of the immune microenvironment remains incompletely characterised at the transcriptomic level

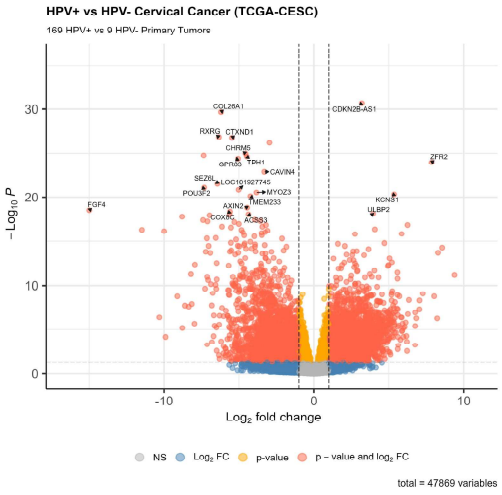
Aim: Identify HPV-driven transcriptomic signatures and novel, computationally validated drug targets in TCGA-CESC

Methods

Dataset: TCGA-CESC — 178 primary tumours; 169 HPV+, 9 HPV−
DEA: DESeq2 · padj<0.05 · $|\log_2 FC|>1$ · VST normalisation
Enrichment: GO BP + KEGG via clusterProfiler (R)
Immune: quanTIseq deconvolution — 11 cell types · Wilcoxon test
Druggability: DGIdb GraphQL · top 30 DEGs screened · candidate identified for further study

Differential Expression — Volcano Plot

DESeq2: 5,395 DEGs (2,847 up ↑ · 2,548 down ↓). $|\log_2 FC| > 1$, padj < 0.05.

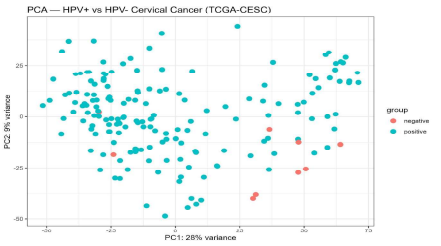


Top up: CDKN2B-AS1 ($\log_2 FC=3.2$) — lncRNA, HPV E7-mediated p16 suppression

Pathway Enrichment Analysis

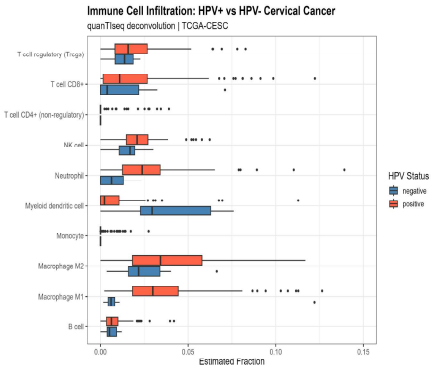
Leukocyte-mediated immunity (GO BP · padj=1.6×10^{-24})
Cytokine–cytokine receptor interaction (KEGG · padj=2.3×10^{-14})
Viral protein–cytokine interaction (padj=9.1×10^{-5})
Cornified envelope / keratinocyte differentiation (padj=9.2×10^{-13})

PCA — HPV⁺ vs HPV⁻ Transcriptomes



Immune Deconvolution (quanTIseq)

11-cell quanTIseq panel. Myeloid DCs: 13× depleted in HPV⁺ ($p < 0.001$). M2 macrophages elevated — consistent immunosuppression.



Novel Drug Target Identified — Wnt/β-catenin Axis

AXIN2 — Novel Drug Target
$\log_2 FC = -2.9$ | padj = 3.2×10^{-18}
DGIdb screen: 0 known drug interactions — completely undrugged
DIX domain (PDB: 1DK8) selected for target-based discovery

- AXIN2 is a negative regulator of Wnt/β-catenin signalling, disrupted in HPV oncogenesis
- Identified as most significantly upregulated in top-30 DEG DGIdb screen with zero known inhibitors
- Represents a first-in-class target opportunity for cervical cancer drug discovery

Wnt/β-catenin Pathway

WNT Ligands
Frizzled + LRP5/6
Dishevelled
AXIN2 Degradation ↑
β-catenin nucleus
Target Gene Activation

DGIdb Druggability Screen — Top DEGs

Gene	log2FC	Interactions
CDKN2B-AS1	+3.2	12
FGF4	−15.0	8
RXRG	−4.1	5
POU3F2	−3.8	2
AXIN2 ★	−2.9	**0**

★ AXIN2: 0 known inhibitors — first-in-class target

Future Directions

01 Validate AXIN2 dysregulation in African patient cohorts — address representation gap in genomic data

02 In vitro AXIN2 knockdown / overexpression in HPV+ cervical cancer cell lines (HeLa, SiHa)

03 Structure-based drug discovery targeting the AXIN2 DIX domain — computational screening pipeline underway

04 Characterise DC depletion mechanism — HPV E5/E6 mediated MHC-I downregulation vs. direct DC apoptosis

Conclusions

1. DESeq2 identified 5,395 HPV-associated DEGs linked to immune evasion, DNA repair, and Wnt signalling
2. quanTIseq revealed a 13× depletion of myeloid DCs — a hallmark immunosuppressive signature in HPV⁺ tumours
3. AXIN2 emerges as a highly upregulated, completely undrugged Wnt/β-catenin target with first-in-class potential

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From HPV Self-Testing to Follow-Up Care: Screening Outcomes and Patient Experiences Among Women Living with HIV in Malaysia

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BACKGROUND

Women living with HIV (WWH) are at increased risk of high-risk human papillomavirus (HR-HPV) infection and cervical cancer[1]. While HPV self-testing may improve screening participation, understanding patient experiences is essential to inform implementation. This study integrated quantitative screening outcomes and qualitative findings to guide the implementation of integrated cervical cancer prevention services within HIV care.

METHODOLOGY

Explanatory sequential mixed-methods study

Infectious Diseases clinic, Universiti Malaya Medical Centre

November 2025 - August 2026

Eligibility Criteria of WWH
- Aged 30–65 years.
- No history of cervical cancer.
- Not currently pregnant.
- Have not undergone a total abdominal hysterectomy.
- No documented negative HPV test within past 3 years



1. Eligible patients approached during follow-up at clinic
2. Patient completed HPV pre-screening survey
3. Patient educated on HPV and cervical cancer
4. Patient performed HPV self-testing
5. Patient completed HPV self-testing satisfaction survey
6. HPV swab samples sent to UMMC Microbiology Lab for processing
7. HPV results communicated to participants via WhatsApp
8. HR-HPV positive patients referred to O&G for colposcopy
9. Conducted in-depth interviews for selected patients

Descriptive analyses summarised uptake, HR-HPV prevalence, genotype distribution, and follow-up outcomes. Thematic analysis explored experiences explaining quantitative findings on screening and care linkage.

RESULTS: PARTICIPANT CHARACTERISTICS

60 WWH **approached** during follow-up visits at ID clinic

70% (n= 42) WWH **participated**

Age Median: **47 years**

59.5% had no prior HPV testing

9 WWH **interviewed**

2 WWH declined HPV self-testing

4 WWH tested HR-HPV negative

3 tested HR-HPV positive & completed colposcopy

ACCEPTABILITY OF HPV TEST

Quantitative

76.2% (n= 32) felt good about self-sample collection

85.7% (n= 36) found the procedure **easy**

81.0% (n= 34) **preferred self-sampling** over Pap smear

97.6% (n= 41) Willing to do regular HPV self-testing if it is the only available screening option

Qualitative

1. Perceived benefits: personal control over self-sampling

"..it's a bit more personal and you don't have to come into the clinic or somebody else looking at you, touching you or feeling you..." (52 years, Negative HPV test)

Greater privacy

"Easy. Like you said, doing it ourselves feels more comfortable than having someone else do it. When we do it, like you said, just insert it. So, it's okay, nothing much." (57 years,HR-HPV+, colposcopy completed)

Greater comfort

"Because, well, it's usually women who do it. But there's still some embarrassment because it's our... (vagina). Better if we do it ourselves, much better." (39 years,Negative HPV test)

Less embarrassment

2. Barriers to testing

"They made me lie down and then they assured me that it'll be okay, you know. When they put that thing in, it's actually very painful." (56 years, Rejected HPV test)

Previous painful screening experiences

"Inserting it myself, felt squeamish. I wasn't sure if I was doing it correctly." (56 years, Rejected HPV test)

Discomfort with genital sampling

LINKAGE TO CARE & INTEGRATED HPV CARE

Quantitative

Out of **33** HPV samples,**HR-HPV** was detected in **16.7%** (n= 7/42)

95.2% (n= 40) expressed **willingness to attend follow-up care** if results were positive

6/7 WWH completed colposcopy

Qualitative

1. Facilitators of follow-up: Clear counselling, reassurance, and trust in HIV healthcare providers

"Yeah, at that time, I felt scared because it was positive. Then you said, 'It's okay, a positive result for the first test (HPV test) doesn't necessarily mean a positive result for the second (cervical cancer). We need to wait for the second test.' So, I felt okay, a bit relieved." (41 years, HR-HPV+, colposcopy completed)

"They explained, like the doctor earlier. Okay, I need to see the gynaecologist, I need to see the dietitian. So, they looked at everything comprehensively...So, doctor also guide. It's very good actually." (48 years, Negative HPV test)

2. Integrated HIV care: Coordinated care reduced the need for multiple hospital visits.

"It's more convenient. No need to go to two different places. It takes me more than an hour to get here. Since my ID appointment and screening are done here, I can go straight home afterwards." (52 years, Negative HPV test)

"I think it's okay to have HPV at the clinic, right? Yes, it's convenient when everything is combined." (39 years, Negative HPV test)

CONCLUSION

HPV self-testing demonstrated high acceptability among WWH and facilitated engagement across the cervical screening pathway. Integrating self-testing within trusted HIV care services, alongside patient-centred counselling, may enhance cervical cancer prevention among WWH in Malaysia.

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Turning the tide!

Mapping Kenya's journey towards cervical cancer elimination through targeted screening, treatment of precancerous lesions and HIV integration

Duke Sangara[1], Joan-Paula Bor[2], Lilian Genga[2], Emily Fitzgerald[3], Ana Refinetti[4], Mila P. Salcedo[4], Sharmeen Virani[4], Melissa Varon[4], Kathleen Schmeler[4], Kevin Massoudi[5], Kevin Massoudi[5]

1. Lvcthealth 2. Kenya Ministry of Health, National Cancer Control Program
3. World Economic Forum 4. UT MD Anderson 5. Siemens Healthineers 6. Xenco Medical

Introduction: Cervical cancer remains a leading cause of cancer morbidity and mortality among women, despite being preventable through screening and early treatment of precancerous lesions. An estimated 662,301 new cases and 348,874 deaths occurred worldwide in 2022, making it the fourth most commonly diagnosed cancer among women globally. In Kenya, cervical cancer is the leading cause of cancer-related mortality among women, accounting for nine deaths daily. Women living with HIV face a six-fold increased risk relative to the general population. Kenya has therefore prioritized population-based screening as a pillar of its elimination strategy.

Methods: A retrospective analysis of aggregate national programmatic data in the District Health Information Software 2 (DHIS2) platform was conducted covering five reporting periods (April 2021–March 2022 through April 2025–March 2026). Data included visual inspection with acetic acid (VIA), Human Papilloma Virus (HPV) testing, Pap smear, and precancerous lesion treatment (cryotherapy, thermocoagulation, and loop electrosurgical excision procedure (LEEP), alongside screening uptake among HIV-positive clients.

Results: A cumulative 2,114,548 women were screened nationally. VIA accounted for the majority of screening volume (89.0%), while HPV testing and cytology contributed 5.6% and 5.3%, respectively. Annual screening volume increased from 112,278 in 2021–2022 to a peak of 556,357 in 2023–2024, followed by a decline to 505,368 in 2025–2026. Test positivity varied substantially by modality: 3.2% for VIA, 16.1% for HPV testing, and 6.3% for cytology; 18,008 clients presented with lesions suspicious for malignancy. Among 22,206 clients receiving treatment, thermocoagulation was the predominant modality (78.2%), followed by cryotherapy (12.0%) and LEEP (9.8%). HIV-positive clients constituted 35.7% (n=754,359) of the total screened population, with a corresponding test positivity of 7.1%.

Kenya MOH 745 Cervical Cancer Screening Program Data DHIS2

Period	Country	Number of clients who received VIA or VIA/ VILI Screening	Number of clients who received HPV Test	Number of clients who received Pap smear	Total Screened	Number of clients with Positive VIA or VIA/VILI result	Number of clients with Positive HPV result	Number of clients with Positive Cytology result	Number of clients with suspicious cancer lesions	Number of clients treated using Cryotherapy	Number of clients treated using Thermocoagulation	Number of clients treated using LEEP	Total Treated	Number of HIV positive clients screened	Number of HIV positive with positive screening results
April 2021 - March 2022	Kenya	105,667	3,353	3,258	112,278	4,610	366	205	1,096	303	389	109	801	46,180	4,998
April 2022 - March 2023	Kenya	378,677	22,833	21,729	423,239	12,775	2,857	1,557	3,390	821	2,168	607	3,596	149,367	14,827
April 2023 - March 2024	Kenya	509,244	20,777	26,336	556,357	15,343	3,770	3,331	5,154	637	5,031	605	6,273	202,095	11,730
April 2024 - March 2025	Kenya	457,640	26184.39	33,481	517,305	14,082	5170.3	1,006	4,425	380	5,355	390	6,125	185,531	11068.1
April 2025 - March 2026	Kenya	431,418	46,181	27769.3	505,368	13,586	7,034	1,010	3,943	532	4,417	462	5,411	171,186	10,563
Total		**1,882,646**	**119,328**	**112,573**	**2,114,548**	**60,396**	**19,197**	**7,109**	**18,008**	**2,673**	**17,360**	**2,173**	**22,206**	**754,359**	**53,186**
Percentage		**89.0%**	**5.6%**	**5.3%**	**100.0%**	**3.2%**	**16.1%**	**6.3%**	**1.0%**	**12.0%**	**78.2%**	**9.8%**	**36.8%**	**35.7%**	**7.1%**

Figure 1: Aggregate data for MOH 745 from DHIS2 platform

Conclusion: Kenya has demonstrated substantial growth in cervical cancer screening coverage, diagnostic capacity, and treatment of precancerous lesions over the past five years, with a notable pivot toward HPV testing and thermocoagulation. Reliance on VIA over HPV-based testing suggests an important opportunity to strengthen molecular screening infrastructure. The elevated positivity observed among HIV-positive clients underscores the imperative for sustained integration of cervical cancer screening within HIV care platforms. Sustained investments will be critical to achieving national and global cervical cancer elimination targets by 2030.

CerviGrade:

A Clinician-in-the-Loop Decision-Support Workflow for Cervical Screening Triage and Referral Management

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Dr Ehsan Ullah
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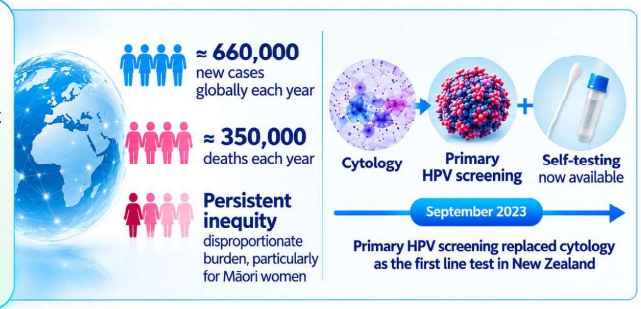
University of Otago, Dunedin, New Zealand

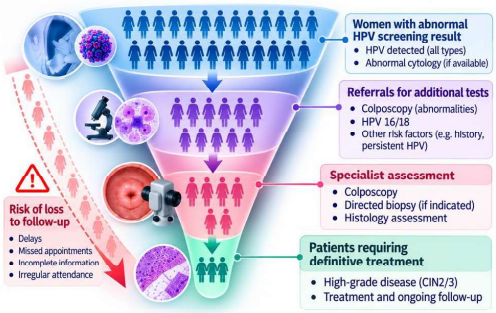
1 HPV primary screening

improves sensitivity for cervical disease but creates **increasingly complex, risk-based follow-up pathways.** Clinicians and screening coordinators must reconcile current HPV and cytology results with screening history, self-testing status, test-of-cure requirements, referral context, and incomplete data across multiple systems. We developed **CerviGrade** to support consistent, auditable triage while preserving clinical judgement.



2 Current Triage Challenge





3 CerviGrade: Integrated Decision Support



4 CerviGrade changes the workflow

From manual pathway interpretation to automated, consistent triage

Current manual triage

- Multiple results and history
- Complex guidelines
- Incomplete data
- Time pressure



Prioritised Triage Queue

Cases are automatically prioritised based on guideline-aligned rules, with urgent and mandatory-review cases flagged for clinician assessment.

Higher risk

- **Urgent review**
  - High-risk results
  - Safety triggers
  - Guideline-mandated review
- **Mandatory review**
  - Abnormal results
  - Complex history
  - Requires clinician judgement
- **Routine review**
  - Lower-risk results
  - Standard follow-up
  - Outside routine surveillance
- **Auto-action**
  - Negative / low risk
  - Routine follow-up
  - Consistent with guidelines

Lower risk

5 Methods (in brief)

A functional proof-of-concept was developed using synthetic cases modelled on Aotearoa New Zealand cervical screening pathways. CerviGrade ingests simulated data from laboratory, eReferrals and screening-register sources and applies a deterministic, guideline-aligned rules engine.

6 Results (in brief)

Early evaluation showed that a stand-alone, single-case calculator demonstrated feasibility and potential operational value. The batch workflow correctly prioritises higher-risk cases, produces transparent decision logic and integration-ready outputs.

7 Conclusions

CerviGrade demonstrates the feasibility of a clinician-in-the-loop workflow layer for cervical screening triage and referral management. Formal clinical validation, usability testing, interoperability assessment, privacy and security review, and prospective pilot evaluation are required to determine effects on triage time, decision consistency, timely escalation, auditability, and equity.



Cervical cancer screening experiences and awareness and acceptability of HPV self-collection among lesbian, bisexual, and queer (LBQ+) cisgender women ages 50 and above

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Background

- Cervical cancer screening uptake is low among LBQ+ cisgender women and in people aged 65+
- Self-Collected HPV may increase screening uptake.
- The study aims:
  - Understand older LBQ+ cisgender women's experiences with cervical cancer screening.
  - Explore older LBQ+ cisgender women's knowledge and acceptability of HPV self-collection.

Methods

- August – November 2025: Semi structured interviews with 27 participants in Metropolitan Chicago (Illinois)
- Recruitment through:
  - A large university health system
  - LGBTQ+ community-based organizations
  - Snowball sampling
- Thematic analysis using inductive and deductive coding

Results

Participants viewed regular cervical cancer screening as an important component of being proactive about their own health, despite the near-universal depiction of physical discomfort and pain.

"**Just because something's uncomfortable doesn't mean you shouldn't do it**...and [cervical cancer screening is] a good thing. 'Cause it's **good to catch cancer early on**. That always takes precedence over anything discomfort." – Alex, lesbian, 60s

Participants had mixed perceptions about HPV self-collection, but noted how it could increase access and convenience for those who cannot or refuse to access screening

Autonomy

"I think it's a very attractive method because **it's taking more control over a part of your body** that often in medical settings is not in your control… especially the histories of medicine." – Kathleen, lesbian, 50s

Lack of Confidence

"I…wouldn't trust it, because **I'd probably not get the right area** anyhow. I think that is **something that needs to be done professionally**, regularly."- Jacqueline, lesbian, 60s

Access

"For a lot of people who **might not have the ability to get to a clinic or the means to pay** for a doctor's visit or the lab, this could **make a lot more people have access** to, really basic, good healthcare." - Erin, Gay, 60s

Takeaway Message: Framing HPV self-collection as a **reliable, accurate option that enhances autonomy, comfort, convenience, and access** to cervical cancer screening may increase uptake of screening in LGB+ and other under screened populations.

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Funding Statement

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UIC UNIVERSITY OF ILLINOIS CHICAGO

CRWG CENTER FOR RESEARCH ON WOMEN AND GENDER

Vaccination to prevent cancer: a gift for our children

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Introduction

Aotearoa New Zealand's (NZ) human papillomavirus (HPV) vaccination programme is failing our children. Aotearoa NZ has very low HPV vaccination coverage overall, with inequitable access for tamariki Māori and children in rural areas.

National vaccine coverage for 14 year-olds in the 2025 April/June quarter was 49% for Māori and 63% for Europeans.[1] In comparison, Australia's 2024 vaccine coverage was 79% for First Nations females (83% overall) and 73% for First Nations males (81% overall).[2]

The health and economic cost of not addressing poor vaccination coverage is high. The economic burden of preventable HPV-related cancers in NZ was estimated at $140,400,000 between 2019-2022.[3] The HPV vaccine is safe and proven to prevent cervical cancer. There is an urgent need to examine why the vaccination programme is failing and to trial community driven models to increase coverage equitably and prevent morbidity and mortality from HPV cancer.

We hypothesise that community co-designed interventions will increase HPV vaccination coverage with the goal of eliminating HPV related cancers.

Methods

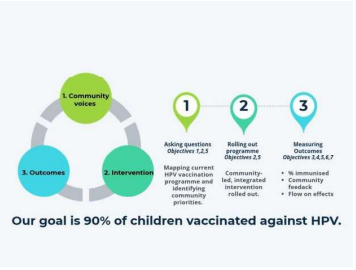
This community partnership will use a mixed methods design,[4] underpinned by Kaupapa Māori Research (KMR) methodologies.[5-7] Guided by kaumātua (elders), we will identify priorities, supports and enablers for informed whānau vaccination participation.

Together, we will co-design, test, analyse and quantify integrated models of vaccine delivery that harness community knowledge. We will assess whether HPV vaccination coverage increases after implementation of co-designed interventions and Identify community responses to trialling new approaches to HPV vaccination information and delivery.

Research Objectives

1. Identify community priorities, supports for informed whānau participation in HPV vaccination across three sites
2. Develop and test community-led approaches working with schools, public health nurses and primary care to increase vaccination participation
3. Identify baseline HPV vaccination coverage at each of the three sites
4. Examine vaccination coverage after implementation of co-designed interventions
5. Hold meetings with community experts and policymakers.
6. Identify community responses after trialling new approaches to new vaccine-delivery interventions
7. Describe flow-on effects for whānau such as increased coverage of other childhood immunisations or cervical screening.

Figure 1: Study Design







Community Partners

Te Hiku Hauora is a comprehensive, community-based health and wellbeing service established in 1995 by Tangata Whenua o Muriwhenua to serve the health needs of whānau, hapū, Iwi and communities in the Far North of Aotearoa.



The population in the Muriwhenua region which is served by Te Hiku Hauora is 30 000 with 58% identifying as Māori.

"Thirty years deep into the delivery of comprehensive primary care community- based services, we are well positioned to support this research."
Dr Maria Baker, CEO.

Turuki Health Care Charitable Trust was founded in 1995 by a visionary group of Maaori midwives, Te Putea o Pua Trust. The original kaupapa was to overcome health and wellbeing inequities for waahine Maaori.



The health centre managed by Turuki Health Care has two large South Auckland GP clinics in Maangere and Panmure, serving a population of around 15000 people.

"Whaanau have high aspirations for themselves and their communities and are clear about how they want to work with us to make these aspirations a reality… findings will assist us to deliver our own services in ways that continue to response to what whānau tell us works best."
Rachael Scully, Executive Lead Primary Care.



These photos are reproduced with permission. Ngā mihi nui

Conclusions

If successful, this KMR research will increase HPV vaccination coverage, leading to reduced preventable harm and death from HPV related diseases and substantially reduced public health costs.

Building on community expertise, our research will gather knowledge to positively influence health delivery policy, practice, and systems.



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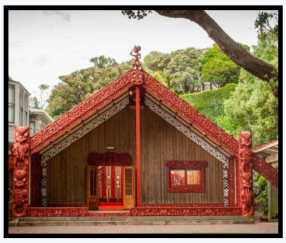

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CAPITAL THINKING. GLOBALLY MINDED.
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National Centre for Women's Health Research Aotearoa
VICTORIA UNIVERSITY OF WELLINGTON
TE HERENGA WAKA

Australian Government | NATIONAL CANCER SCREENING REGISTER

Monitoring self-collection in the National Cervical Screening Program

Recognising progress and addressing challenges

Farhana Sultana[1,2], Melanie Matheson[1,2], Lesley Rowlands[1], Jack Davies[1], John Lee[1], Nicole Willmott[1] and Dorota Gertig[1,2]

[1] Telstra Health, National Cancer Screening Register [2] University of Melbourne

Background

DEC 2017 Self-collection restricted to people aged ≥30 years who were never-screened or overdue by at least two years

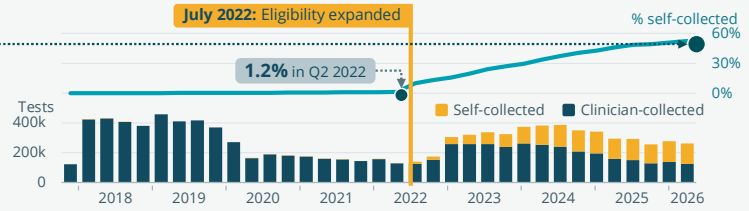
JUL 2022 Eligibility expanded to all screen-eligible people (aged 25–74)

Results

1 National uptake over time

52.3%
of HPV screening tests were self-collected in Q2 2026

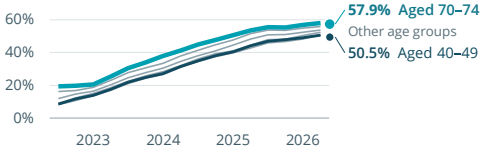
HPV screening tests by collection method and self-collected share, by quarter



2 Patterns of uptake since July 2022

Self-collected share of HPV screening tests | National: 52.3%

Age



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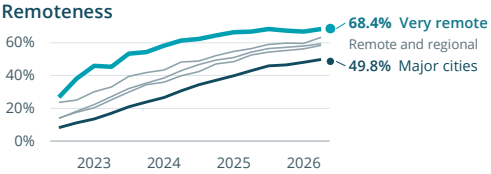

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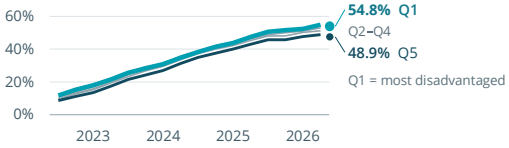
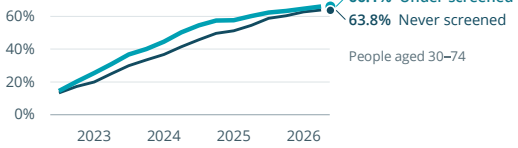
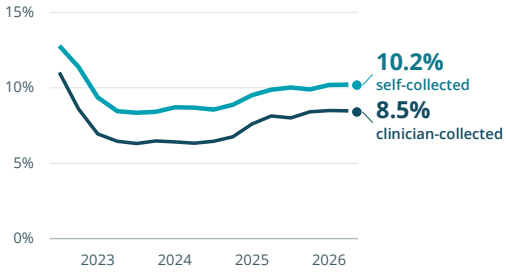


Screening history



3 HPV positivity by collection method

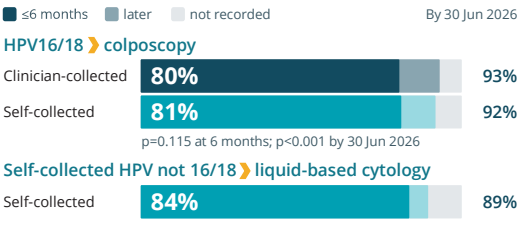
Valid primary screening tests • unadjusted



4 Follow-up after HPV detection

First colposcopy/LBC after positive primary screening test, 1 Jul 2022 – 30 Jun 2026

~4 in 5 people with HPV16/18 had colposcopy within 6 months, similar by collection method.



Conclusions

PROGRESS Expanded self-collection represents important progress towards equitable access to screening.

CHALLENGE Timely and appropriate follow-up after HPV detection remains essential for cervical cancer elimination.

Methods

DATA
National Cancer Screening Register (NCSR) data
1 Dec 2017 – 30 Jun 2026
Extracted 21 Jul 2026

UPTAKE
Proportion of HPV screening/follow-up tests that were self-collected • age 25–74
Screening-history analyses: age 30–74

FOLLOW-UP
First positive primary screening test
HPV16/18 to first colposcopy
Self-collected HPV not 16/18 to any LBC
Follow-up to 30 Jun 2026

ARIA: remoteness categories • SEIFA: socioeconomic quintiles • LBC: liquid-based cytology

Acknowledgements: Department of Health, Disability and Ageing • Self-collection Implementation Committee • NCSP Quality and Safety Monitoring Committee
Reference: NCSR Monitoring of self-collection in the NCSP: summary pack, Q2 2026. Australian Government Department of Health, Disability and Ageing; 2026



Twelve month follow-up after thermal ablation in Southern Highlands Province, Papua New Guinea

Authors: T Traima, R Smith

Background

Loss to follow-up after treatment for cervical precancer is a major challenge, particularly in high-burden and resource-constrained settings, such as Papua New Guinea.

The Well Women's Clinic in Southern Highlands Province, was established in June 2024, through a partnership between the Southern Highlands Provincial Health Authority, Santos Foundation and the Kirby Institute (UNSW). During its first year, the clinic screened more than 2600 women, many travelling from remote and rural communities across the province.

The services offered at the clinic include:

- HPV screening
- Same-day thermal ablation

Methods

Women who tested positive for HPV and received thermal ablation were advised to return for routine follow-up at 12 months after treatment, as per the Clinical Guidelines for Cervical Screening and Cancer Prevention in PNG (2021).

The clinic incorporated the following strategies to strengthen follow-up rate:

Health Education:

- Culturally adapted health education material in local languages
- Targeted counselling during initial visit on importance of follow-up

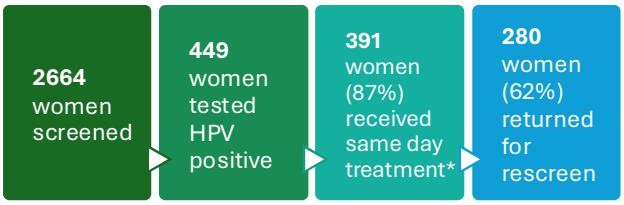
Tracking and reminders:

- Ongoing review of women due for follow-up through the canSCREEN
- SMS reminders and calls for those with mobile phones and network access

Community engagement:

- District-level awareness activities promoting screening and rescreening
- Engaging with local, Village Health Attendants (VHAs) for hard-to-reach women/communities

Results



Screening outcomes at Southern Highlands Well Women's Clinic 2024-25

**thermal ablation*

Several challenges remain for women due to return to the clinic for rescreen:

- Missing or changed phone numbers
- Limited network coverage
- Geographic isolation
- Travel costs and financial constraints

Conclusion

- High follow-up rates were achieved in a remote, high-burden setting where retention after treatment is often challenging. The findings suggest that culturally adapted health education, active patient tracking, reminder systems, and community engagement may contribute to improved retention following treatment. Further research is needed to identify the key factors associated with successful follow-up and to inform sustainable scale-up across PNG.

- To date, more than 7800 women have undergone HPV screening in Southern Highlands Province, with approximately 20% testing HPV positive. Sustaining high follow-up rates will be essential to maximise the benefits of HPV screen-and-treat programs and support PNG's progress towards the WHO goal of cervical cancer elimination.

Ways forward for Well Women's Clinic:

- Expand women's health services beyond screening
- Strengthen district outreach and community engagement
- Enhance data management and review of canSCREEN tracking
- Prepare for national HPV vaccination rollout
- Introduction of LLETZ procedures

Santos Foundation

UNSW Kirby Institute

Cervical screening among Australian women who receive medically assisted reproduction treatments

Claire Vajdic[1], Signe Opdahl[2], Christos Venetis[2], Louisa Jorm[2], Neville Hacker[3], Michael Chapman[3], Antoinette Anazodo[4], Robert Norman[5], Catharyn Stern[6], Ursula Sansom-Daly[3], Georgina Chambers[2], Adrian Walker[2]

[1]Kirby Institute, UNSW Sydney; [2]Centre for Big Data Research in Health, UNSW Sydney; [3]School of Clinical Medicine, UNSW Sydney; [4]Kids Cancer Centre, Sydney Children's Hospital; [5]Robinson Research Institute, Adelaide University; [6]Melbourne IVF

Introduction

Australian women are advised to be up-to-date with their cervical cancer screening prior to conception.

There are no published data on screening by women using **medically assisted reproduction (MAR)**, in Australia or elsewhere.

Such data would aid interpretation of the cancer incidence profile for this population group and indicate whether women presenting for MAR are receiving guideline-based pre-conception healthcare.

Aims

Do women who receive MAR have the same rate of participation in organized cervical screening compared to matched control women unexposed to MAR?

Methods

Using linked population-based Australian health registries and administrative datasets, we compared organised publicly funded cervical screening episodes for women aged 21-55 years who received one of three types of MAR (n=313,432) and matched women who did not (n=1,017,761) between 1991 and 2016 .

Matching factors were birth year, parity at first MAR, age at first birth and remoteness. We modelled the proportion of women screened in the three years before and after first MAR treatment, adjusting for age, remoteness, parity, socio-economic disadvantage, cancer history, and breast cancer screening attendance.

Results

After adjustment, a greater proportion of women who received MAR than women who did not had cervical screening before MAR (77.3%-84.1% vs 57.5%-62.0%, depending on MAR treatment type) and after MAR (77.0%-78.5% vs 68.1%-68.3%, depending on MAR treatment type).

MAR-treated women showed an increase in cervical screening the year immediately prior to MAR that was not seen in untreated women.

Women who received MAR were also more likely than untreated women to be screened in the three years after MAR treatment (77.0%-78.5% vs 68.1%-69.5%).

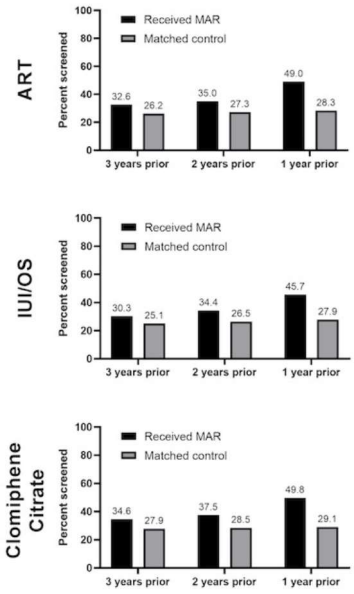


Figure: Proportion of each cohort screened for cervical cancer one to three years prior to first MAR treatment (or matched date)

ART = Assisted reproduction technology, like in-vitro fertilisation

IUI = Intrauterine insemination

OS = ovarian stimulation

Conclusion

Cervical cancer screening is more common in women who received MAR compared to matched women who did not. This accords with their lower incidence of cervical cancer compared to the general population.

However, **1-in-4 to 1-in-6 women were not up-to-date with screening prior to MAR**, identifying missed opportunities for the prevention of cervical cancer during the clinical workup for MAR.

Consultations with GPs and fertility specialists about possible infertility are an opportunity for cervical cancer prevention, and RACGP and RANZCOG guidelines could highlight this group of women.

ACKNOWLEDGEMENTS: We acknowledge and thank the staff at the Australian Institute of Health and Welfare (AIHW) Data Linkage Unit, the Data Access and Assurance Unit, Data Services Branch, Queensland Health, the NSW Centre for Health Record Linkage, the Tasmanian Data Linkage Unit, the Centre for Victorian Data Linkage, and the Linkage, Data Engineering Outputs and ISPD Client Services teams at Western Australia Data Linkage Services for supporting the project and undertaking data linkage. We thank the Australian Institute of Health and Welfare and the population-based cancer registries of New South Wales (NSW), Victoria, Queensland, Western Australia, South Australia, Tasmania, the Australian Capital Territory (ACT) and the Northern Territory for the provision of data from the Australian Cancer Database. We thank the following data custodians for providing the datasets used for this project: Australian Department of Health and Aged Care (Medicare Benefits Schedule, Pharmaceutical Benefits Scheme); AIHW (National Death Index); the NSW Ministry of Health, the Department of Health Victoria, the Data Services Branch Queensland Health, the Department of Health Western Australia, Preventive Health South Australia, the Department of Health Tasmania, HealthInfo ACT (perinatal data including the Midwives Notification System dataset); the jurisdictional Registries of Births, Deaths and Marriages (birth data); and BreastScreen Victoria, BreastScreen NSW, BreastScreen Queensland, BreastScreen WA, BreastScreen Tasmania and BreastScreen SA. We are grateful to the Victorian Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM) for providing access to the data used for this project and for the assistance of the staff at Safer Care Victoria. The conclusions, findings, opinions and views or recommendations expressed in this paper are strictly those of the authors. They do not necessarily reflect those of CCOPMM.

ELIMINATING CERVICAL CANCER 2026

HYBRID CONFERENCE

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eva Grupo Brasileiro de Tumores Ginecológicos



From Brazil to Australia:

The EVA Gynecologic Cancer Group as a National Platform for Cervical Cancer (CC) Elimination Through Education, Advocacy, and Global Collaboration

Carolina Martins Vieira — Presenting author

Co-authors

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All authors: EVA – Grupo Brasileiro de Tumores Ginecológicos, Brazil

Introduction

- Persistent disparities in access to cervical cancer prevention and care in Brazil, despite the incorporation of technologies into the public healthcare system.
- Vaccine hesitancy and barriers to workforce engagement as additional challenges.
- Aim: describe EVA's contribution to WHO 90-70-90 targets and Brazil–Australia collaboration.

Methods

Descriptive review of EVA institutional activities, based on publicly available data and reports from 2010 to 2026.

Results

1,232
EVA members across Brazil Group established in 2010

>700
EVA members linked through the IGCS Strategic Alliance Partnership

10,000
professionals in the International Gynecologic Cancer Society (IGCS) global network

Education and research

- Runs annual meetings and continuing education.
- Hosts tumor boards, webinars, and podcasts.
- Educates patients and raises awareness.
- Advances oncology through scientific collaboration.

Advocacy and public engagement

- "Brazil Without Cervical Cancer" Movement: medical societies, patient groups, policymakers and clinicians.
- Advocacy for HPV vaccination, organized screening and equitable treatment access.
- Christ the Redeemer illumination on cervical cancer Elimination Day to raise awareness.

Brazil–Australia collaboration

Australia's progress toward elimination offers lessons for Brazil. Collaboration between EVA, Australian institutions and IGCS may support shared initiatives.

Conclusion

The EVA model illustrates how a national professional society can support cervical cancer elimination through education, advocacy, research and international engagement. Brazil-Australia collaboration may accelerate progress toward WHO targets and more equitable prevention and care.

Design methodologies can complement and strengthen public health innovations

Authors Imogen Webb[1], Adam Bulley[1], Kate Baker[1], Jennie Haarsager[1], Glenn Austin[1], Kara Lilly[1], Shelley Peardon[2], Christina Webber[2], Evita Shoostovian[2], Wendy Jordan[2]

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[2]Health Contact Centre, Queensland Health

Title Applying a design thinking approach to development of a new cervical screening self-collection kit for underserved people in Queensland

Introduction

Novel approaches are required to engage underserved populations and remove barriers to screening

We used a hybrid of Design Thinking and the Double Diamond to develop a consumer-centred self-collection kit for a new nurse-led telehealth cervical screening service

Methods

We delivered short, structured workshops of up to 90 minutes and broad stages were shared in advance to secure leadership support and align schedules

Workshops followed design thinking stages as follows:



Empathise

consumer insights, comparable services, literature



Define

empathy mapping, barrier mapping



Ideate

rapid brainstorming to address barriers, solution sorting



Prototype

mock-ups, assessed concepts against user needs



Test

desktop walkthroughs, implementation and launch

Results

We used established, best practice design principles to meaningfully integrate consumer insights

By centring the experiences of participants, the methodology ensured that user perspectives informed key kit design decisions, while remaining responsive to system constraints and requirements

Our approach demonstrated flexibility under changing conditions, for example, moving timelines and system needs

This meant activities could be adapted as insights emerged

Conclusion

Design methodologies can complement and strengthen public health innovations

In turn, this can break down barriers for underscreened people, contributing towards a 70% screening target for 5-yearly participation by 2035

DELIVERING FOR QUEENSLAND | Queensland Government

Diagnostic Outcomes at a Tertiary Colposcopy Unit for Women Aged 50-74 years Referred After Detection of Oncogenic HPV at Primary Cervical Screening

C David Wrede, Estefania Vicario, Antonia Jones, Angela Steele, Orla McNally and Jeffrey HJ Tan

The Royal Women's Hospital Oncology & Dysplasia Unit, Melbourne, Australia

Background

More than ninety percent of cervical cancer is caused by persistent infection with genital oncogenic HPV types. Australia moved to primary cervical cancer screening using HPV DNA PCR in December 2017. Historically during the era of Pap Test screening by cytology, there was no significant control in the observed increase in incidence of invasive cervical cancer in women over the age of 70 years. We have seen an increase in the number of women referred to our unit over the age of 50 since the advent of HPV testing, many with previously negative Pap Test histories.

Aim

To examine outcomes in women aged 50–74 years after detection of oncogenic human papillomavirus (HPV) at cervical screening.

[We have previously reported and published on an earlier & smaller cohort; of 464 women seen in the Royal Women's Hospital Colposcopy Clinic from 1 January 2018 to 31 July 2020, 292 (62.9%) were positive for HPV16/18 and 172 (37.1%) for HPV (not 16/18). Aust N Z J Obstet Gynaecol 2023 Aug;63(4):564-570.]

Methods

A retrospective observational study of 1612 women seen in the Royal Women's Hospital Colposcopy Clinic from 1 January 2018 to 31 July 2025. Informed consent was obtained for participation in the audit and permission was granted to access results from the cervical screening register. 807 (50.1%) were positive for HPV16/18 and 805 (49.9%) for HPV (not 16/18). Data were extracted and cleaned from our locally designed Colposcopy data system embedded in the precinct-wide EPIC electronic medical record.

Results

One hundred & fifty-four women (9.6%) had histologically proven CIN2+ including twenty cancers, up to two years after first colposcopy visit (FCV): 137 (90%) detected at FCV or at excisional treatment(Excision) arranged after no CIN2+ detected at FCV. There was no significant difference ($P = 0.14$) in proportion of CIN2+ detected between the two groups, 'HPV16/18' (9.3%) or 'HPV (not16/18)' (9.8%), nor with reflex cytology types. The positive predictive value (PPV) of high-grade impression at colposcopy was 60.6% falling to 25% if referral cytology was negative. There were 901 (55.9%) who had Type 3 transformation zone (TZ3) when no visible lesion 21 CIN2+ detected, at FCV, including *all three cancers and five at Excision*. There were 584 (72.4%) with positive HPV16/18 who had reflex negative cytology, of which eighteen had CIN2+ (3.1%) including four cancers. 439 had a repeat negative LBC at Colpscopy with 6 (1.4%) CIN2+ at FVC or diagnostic LEEP. A further five cases including one cervical cancer plus one endometrial cancer were detected with two years of follow up.

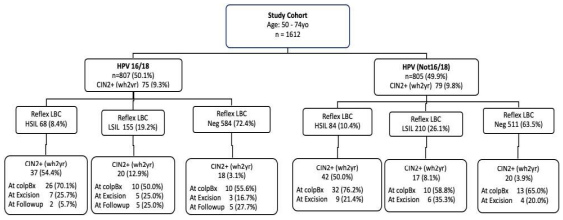

Figure 1. Outcomes from Primary HPV screening in Women 50 – 74 years old seen at Royal Women's Hospital Colposcopy Clinic.

CIN2+ includes CIN2, CIN3, adenocarcinoma-in-situ (AIS) and cancer. LBC: Liquid based cytology; In LBC: HSIL includes possible HSIL or worse; LSIL includes possible LSIL and LSIL; Neg: Negative. Colp Bx: Histology from First Colposcopy Biopsy; Excision: Diagnostic excisional treatment planned after first colposcopy when no CIN2+ on Colp Bx. wh2yr: worst histology at Colp Bx or Excision and Follow up to 2 years after first colposcopy when no CIN2+ detected in first 2 encounters. .

* Total of 27 had inadequate colposcopy or no documentation of Transformation zone.

	Cancer	AIS	HSIL (CIN3)	HSIL (CIN2)	CIN2+
Biopsy at FCV	10 (50.0%)	4 (66.7%)	34 (55.7%)*	55 (82.1%)*	103 (66.9%)
Excision after FCV[#]	7 (35.0%)	2 (33.3%)	23 (37.7%)	2 (3.0%)	34 (22.1%)
FollowUp 2years[¥]	3 (15.0%)	0	4 (6.6%)	10 (14.9%)	17 (11.0%)

Figure 2. Histopathology detected at colposcopy, excisional treatment or follow up to two years from first colposcopy visit.

Figure 3. Colposcopy prediction and Histopathology at first colposcopy (FCV) or Excision arranged after no CIN2+ at FCV in '50 – 74yo' cohort.

'50 – 74yo' cohort								
Colposcopy (FCV)	Cancer	AIS	HSIL	LSIL	Negative	No histology	Total	CIN2+ (%)
Malignancy	9 (90.0%)	0	1	0	0	0	10 [0.6%]	10 (100%)
Glandular Atypia	0	1 (50.0%)	0	0	1 (50.0%)	0	2 [0.1%]	1 (50.0%)
HSIL	2 (2.4%)	1 (1.2%)	43 (52.4%)	22 (26.9%)	10 (12.2%)	4 (4.9%)	82 [5.1%]	46 (56.1%)
LSIL	2 (0.5%)	2 (0.5%)	35 (9.1%)	160 (41.6%)	135 (35.1%)	51 (13.2%)	385 [23.9%]	39 (10.1%)
Normal	0	0	18 (4.5%)	59 (14.8%)	115 (28.9%)	206 (51.8%)	398 [24.7%]	18 (4.5%)
NVL*	4 (0.5%)	2 (0.3%)	17 (2.3%)	77 (10.5%)	128 (17.4%)	507 (69.0%)	735 [45.6%]	23 (3.1%)
Total	17 (1.1%)	6 (0.4%)	114 (7.1%)	318 (19.7%)	389 (24.1%)	768 (47.6%)	1612	137 (8.5%)
HPV16/18_LBCNeg								
Colposcopy (FCV)	Cancer	AIS	HSIL	LSIL	Negative	No histology	Total	CIN2+ (%)
Malignancy	2 (100%)	0	0	0	0	0	2 [0.3%]	2 (100%)
HSIL	0	1 (5.6%)	2 (11.1%)	9 (50.0%)	5 (27.8%)	1 (5.6%)	18 [3.1%]	3 (16.7%)
LSIL	0	1 (0.9%)	1 (0.9%)	48 (41.4%)	54 (46.6%)	12 (10.3%)	116 [19.8%]	2 (1.7%)
Normal	0	0	3 (2.0%)	20 (13.5%)	52 (35.1%)	73 (49.3%)	148 [25.3%]	3 (2.0%)
NVL*	1 (0.3%)	2 (0.7%)	2 (0.7%)	36 (11.9%)	64 (21.2%)	197 (65.2%)	302 [51.5%]	5 (1.7%)
Total	3 (0.5%)	4 (0.7%)	8 (1.4%)	113 (19.3%)	175 (29.9%)	283 (48.3%)	586	15 (2.6%)

HSIL: high-grade squamous intraepithelial lesion; LSIL: low-grade squamous intraepithelial lesion.
AIS: adenocarcinoma-in-situ; CIN2+ includes CIN2, CIN3, AIS and cancer.
No histology: No biopsy taken when colposcopy abnormal; Colp-N: Normal colposcopy and no biopsy taken.
*No Visible Lesion with Type 3 Transformation zone at colposcopy.

Discussion

The majority (89%) of CIN2+ found over the first two years of presentation were detected within six months, either at first colposcopy or diagnostic excision arranged after results review or after an MDM, with 17 cancers and all 6 cases of AIS identified with colposcopic impression of HSIL or cancer. PPV for HSIL colposcopy prediction was 60.6%, similar to the NCSP monitoring report[6] of 63.1% for all people aged 25–74 years, although they had a higher CIN2+ detection of 19.3%. Colposcopic PPV improved considerably with increasing reflex cytological abnormality, ranging from 25% with normal cytology to over 90% with reports of HSIL.

At colposcopy, 55.9% of Transformation zones were type 3, However, 72.2% of all CIN2+ were detected at FCV due to our high biopsy rate at colposcopy of 82% for any colposcopy abnormality, and an overall biopsy rate of 52.4% for all colposcopies, higher than the 41.6% reported by NCSP.[6] The low rate of CIN2+ detected in excisions arranged for women after colposcopy with no CIN2+ on biopsy at FCV, at less than 20% confirms the need to be highly selective when deciding to treat these women with discrepant colposcopic findings.

Further investigation of new adjunctive tests and technologies including dual stain and methylation studies may assist in the selection of patients in this group requiring excision for diagnosis and therapy.

Conclusion

The large majority of CIN2+ were detected at first colposcopy or at subsequent diagnostic excision. We would encourage high biopsy rates at colposcopy, including endocervical curettage and vigilance in selection for excisional treatment in TZ3 cases if there is no significant suspicion of high-grade abnormality. There is a need to refine the algorithm for management of persistent HPV16/18 infections with reflex negative cytology to reduce colposcopy referrals in women aged 50 and above. This group of women will need careful longitudinal follow up and audit to determine the long-term risks of CIN2+ as they age up to and beyond the completion of routine screening at 75y

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the women's
the royal women's hospital