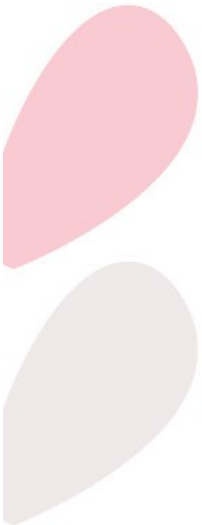


Cervical Screening Program UPDATE

Dr. Caroline Wewengkang MBBS, FRANZCOG

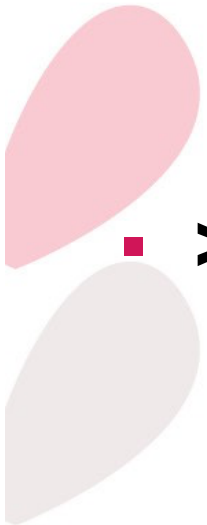
Contents:

1. Incidence of cervical cancer
2. Cervical screening program in Australia - Update
3. 2020 WHO global strategy
4. 2023 Australia national strategy
5. Patient's questions



CERVICAL CANCER

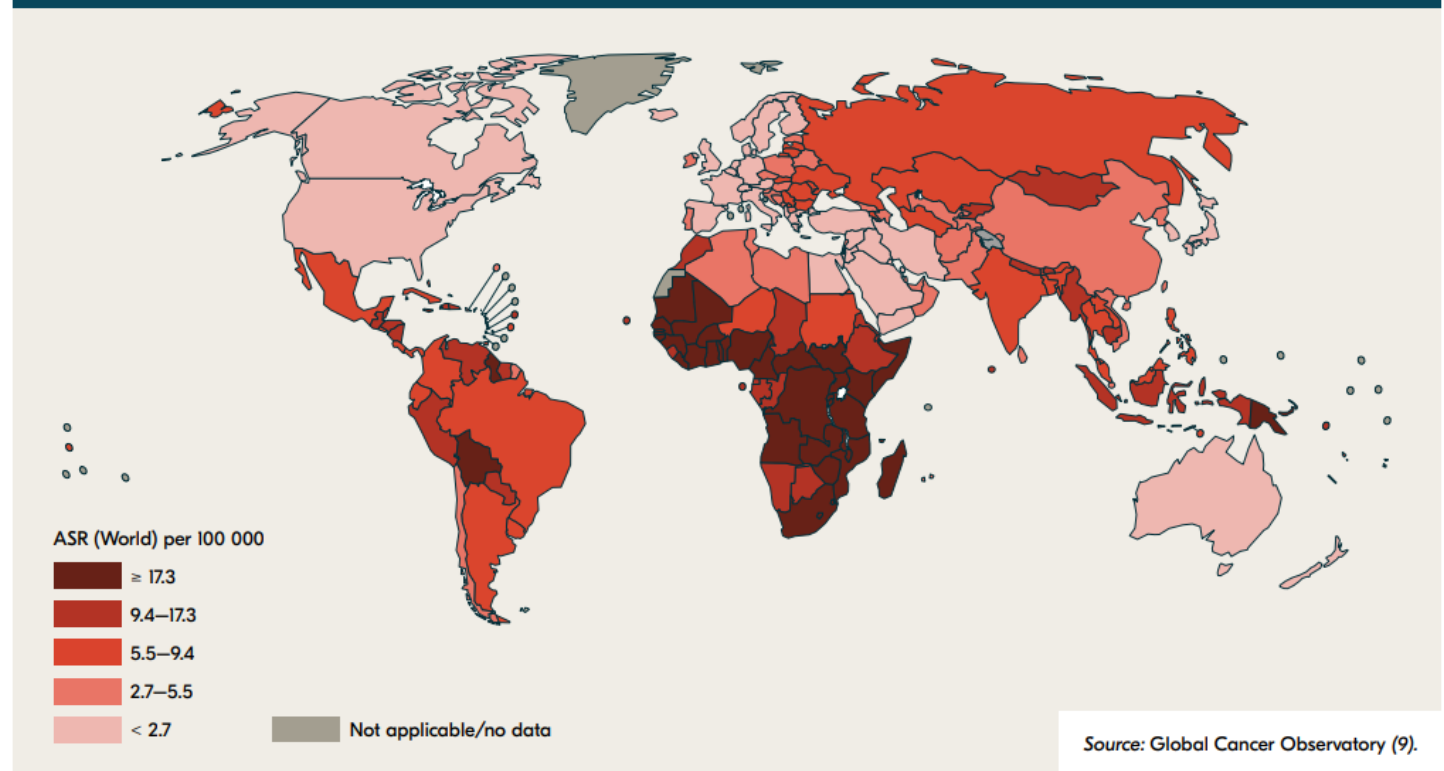
- Preventable disease !
- **4th** most common cancer globally
- 2022
 - **660,000** women diagnosed with cervical cancer
 - **350,000** women died from cervical cancer
- **>99.7%** associated with persistent HPV infection



CERVICAL CANCER

90% of death from cervical cancer is in low- and middle-income countries

Fig. 2. Estimated age-standardized cervical cancer mortality, 2018

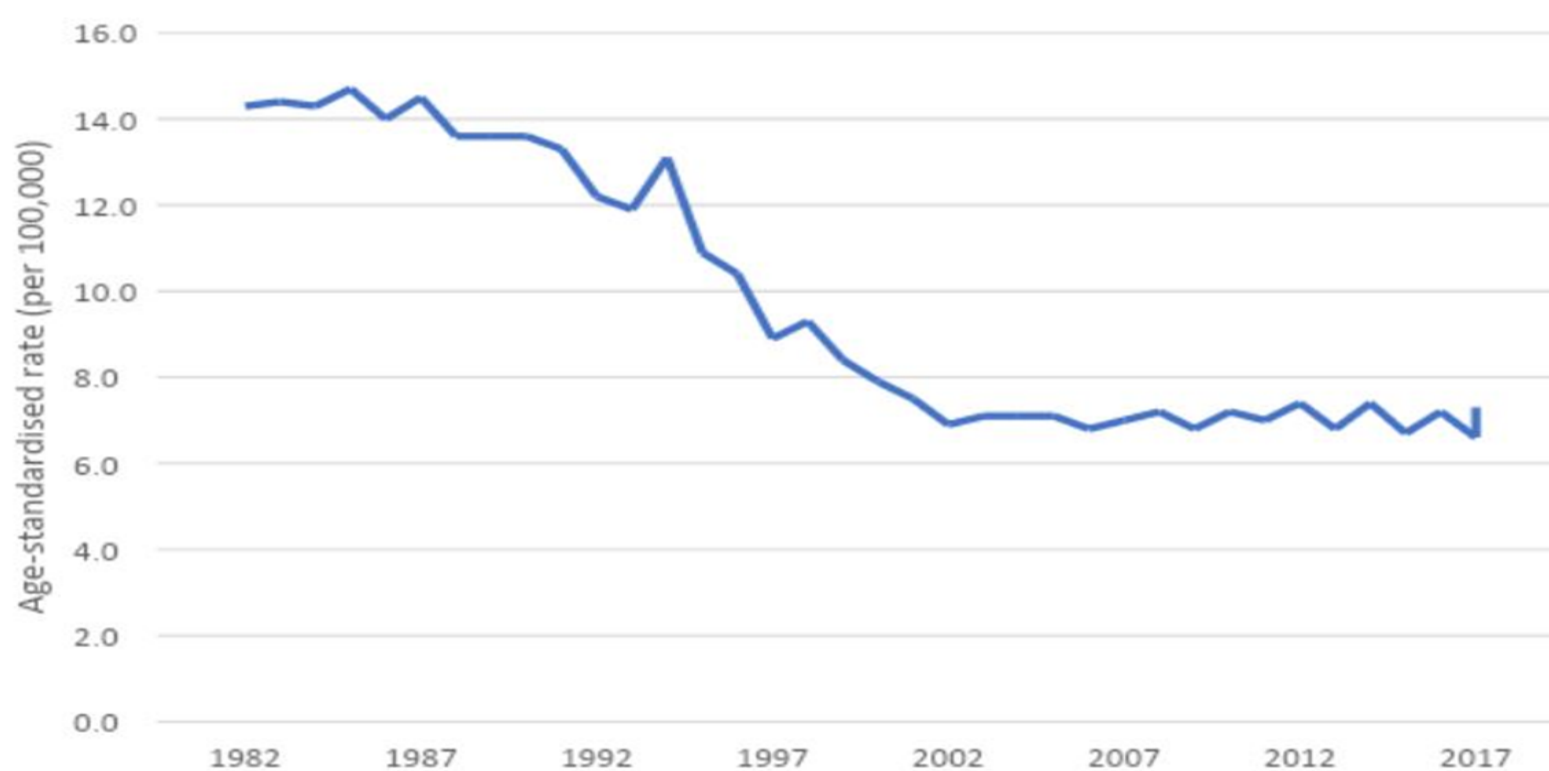


HISTORY OF CERVICAL SCREENING IN AUSTRALIA

- Opportunistic cervical screening since 1960s
- National Cervical Screening Program (NCSP) 1991
 - 2-yearly Pap Smear
- New National Cervical Screening Program
 - 1 December 2017
 - 5-yearly HPV
- HPV Vaccination in 2006
 - National vaccination program in 2007

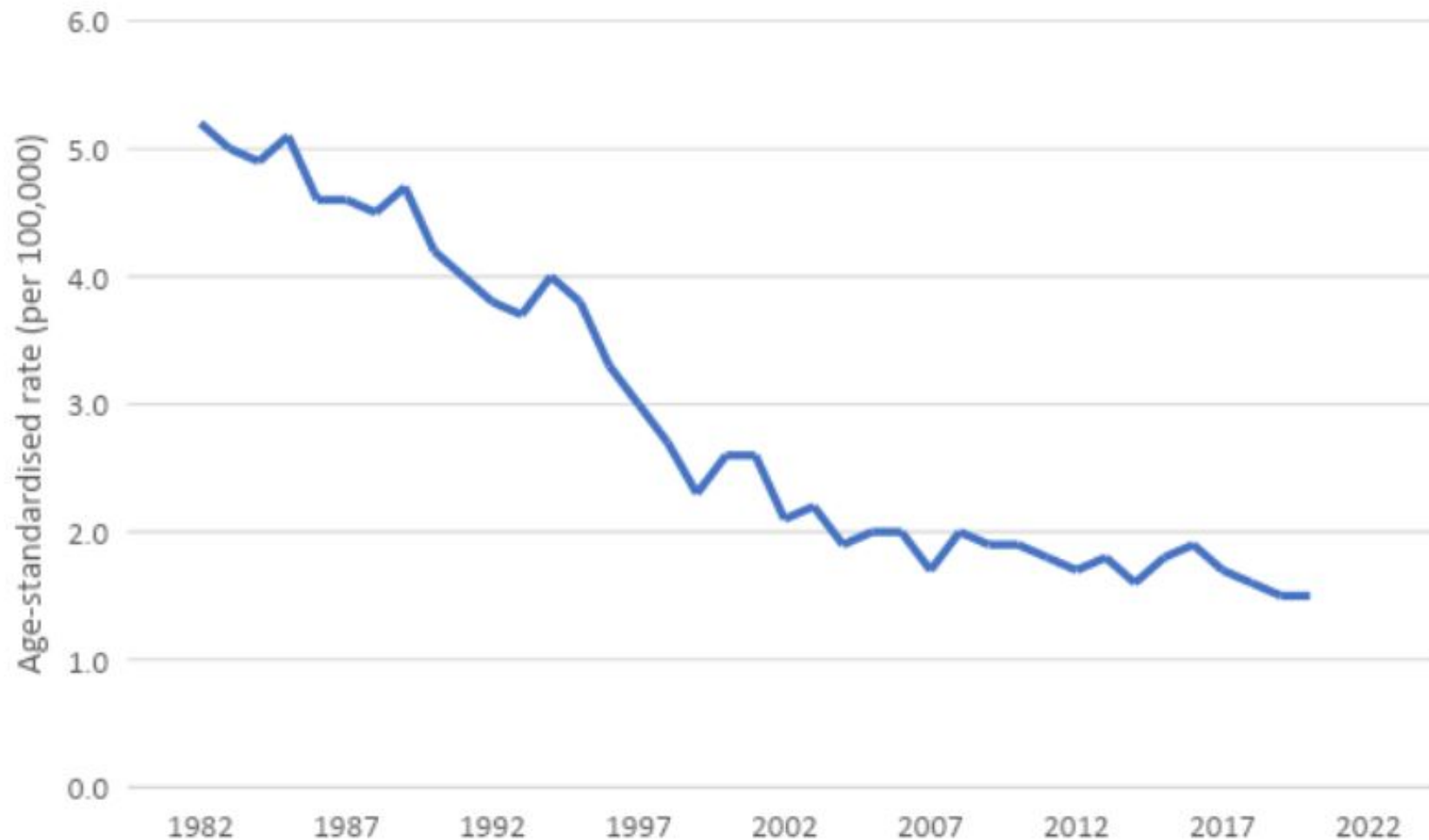


Incidence of cervical cancer 1982-2018



- 2018 – 7.3 cases per 100,000 female
- 2022 – 7.1 cases per 100,000 female

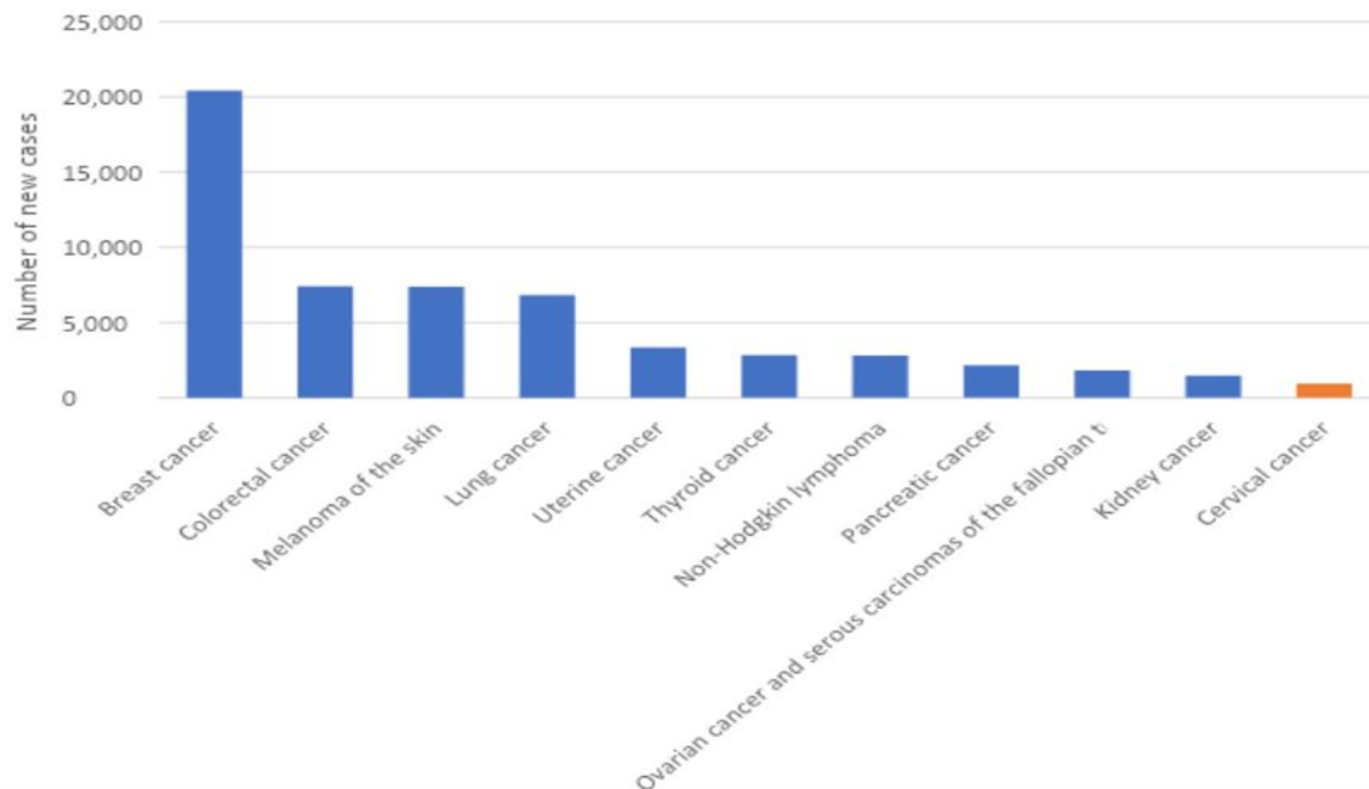
Mortality Rate for cervical cancer 1982-2020



CERVICAL CANCER

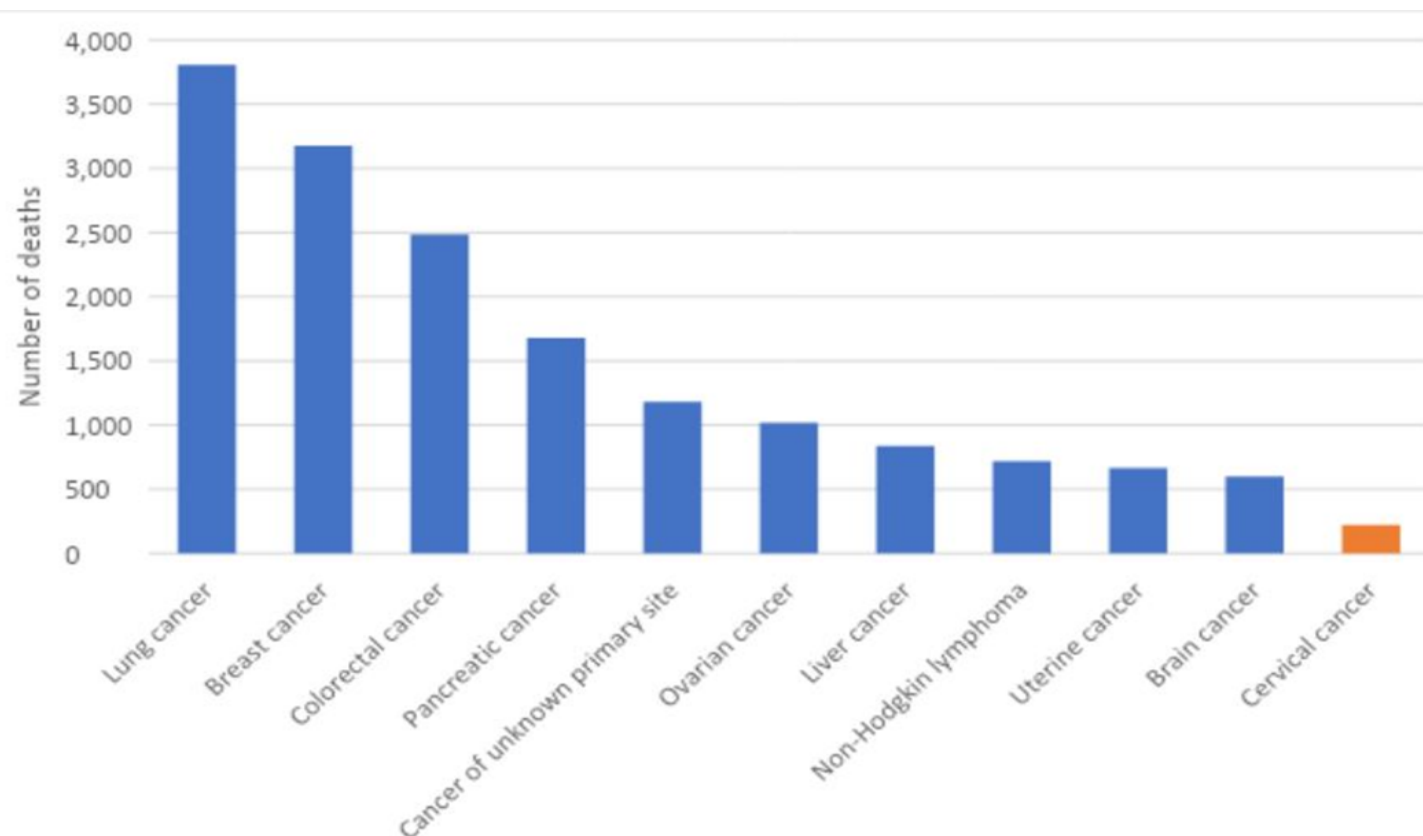
In 2022 (AIHW 2023)

- 942 women diagnosed with cervical cancer
- 1.3% of all new female cancer in 2022



Cancer Mortality in Australia

- 222 women died from cervical cancer
- 1% of all female deaths from cancer
- Survival rate of 74%



NATIONAL CERVICAL SCREENING PROGRAM 2017

- Oncogenic HPV testing
 - 25–69-year-old women
 - 5-yearly
 - Exit test — age 70–74-year-old
- National CST Registry



Australian Government

NATIONAL
CANCER
SCREENING
REGISTER

NCSP 5-year report (2018-2022)

- 4.7 million participants — **68%** of eligible population
- **10%** positive of any oncogenic HPV
 - 2% - HPV16 or HPV18
- in 2022
 - **14 in 1000** participants — high grade abnormality
 - **1 in 1000** participants – cervical cancer



UPDATE January 2021

Intermediate risk CST

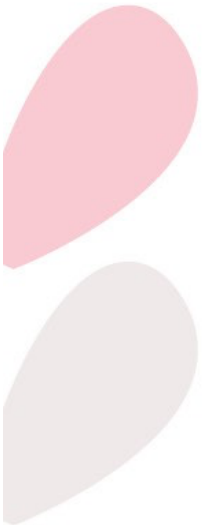
Women with a 12-month follow up HPV (not-16/18) result with LBC prediction negative, pLSIL or LSIL (**intermediate risk result**) should be recommended to undertake a further HPV follow up test in 12 months' time following their previous HPV test instead of referral to colposcopy.

Women who may be at higher risk of harbouring a high-grade abnormality should be referred to colposcopy :

- **Women two or more years overdue for screening at the time of the initial screen**
- **Women who identify as being of Aboriginal or Torres Strait Islander descent**
- **Women age 50 years or older**

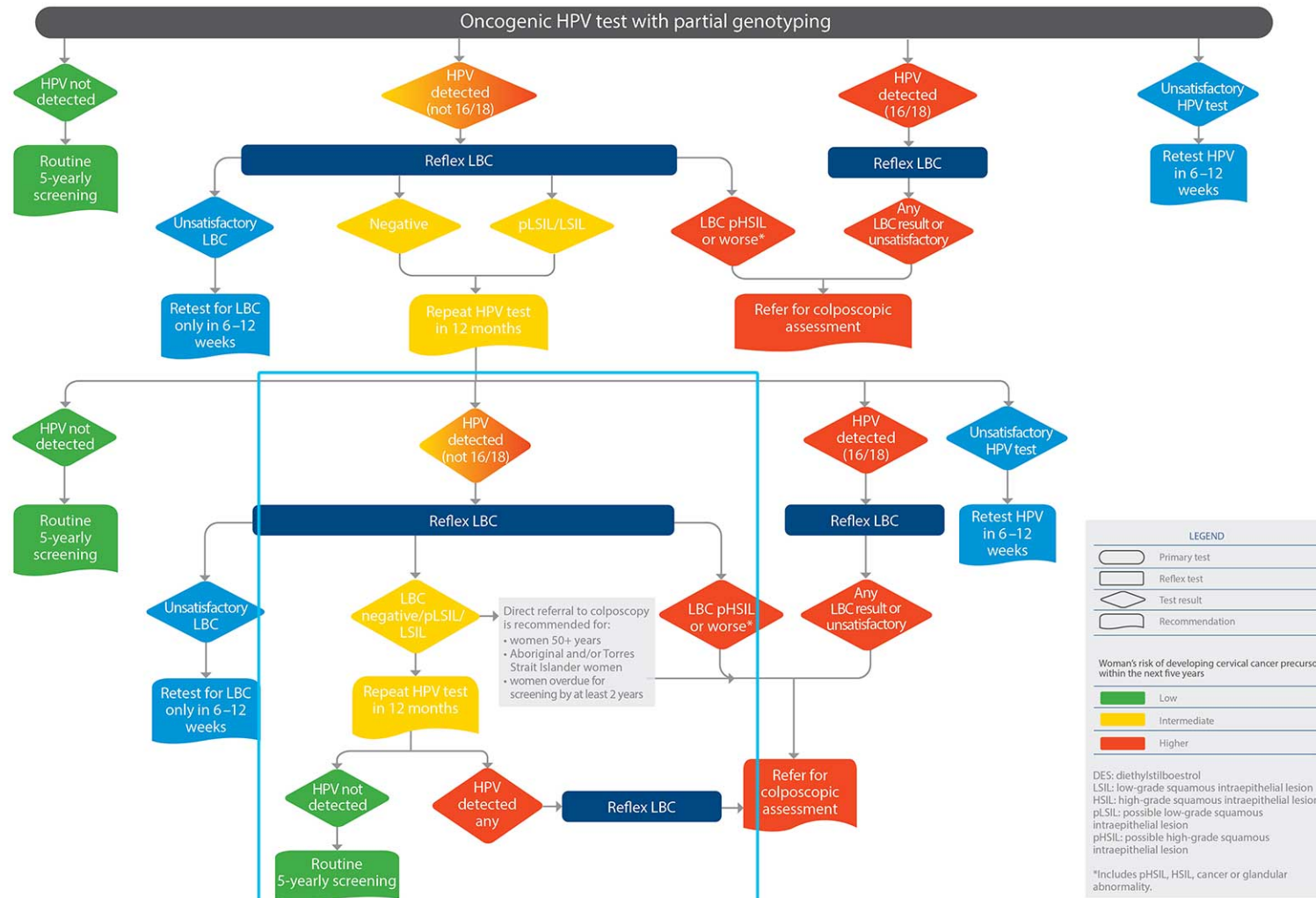
Exclusion

- Immune deficient women
- Women exposed to diethylstilboestrol (DES) *in utero*
- Women aged 70-74 (attending for an exit test)
- Women aged 75+



Intermediate risk CST

CERVICAL SCREENING PATHWAY



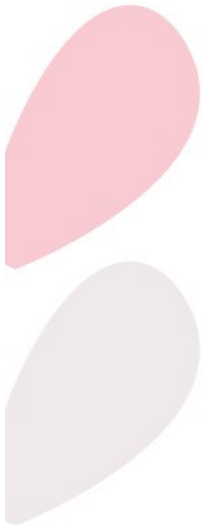
Suggested citation: Cancer Council Australia Cervical Cancer Screening Working Party. Clinical pathway: Cervical screening pathway. National Cervical Screening Program: Guidelines for the management of screen detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding. CCA 2016. Accessible from http://wiki.cancer.org.au/australia/Guidelines/Cervical_cancer/Screening. Updated Dec 2020.

**NATIONAL
CERVICAL SCREENING
PROGRAM**
A joint Australian, State and Territory Government Program



Intermediate risk CST

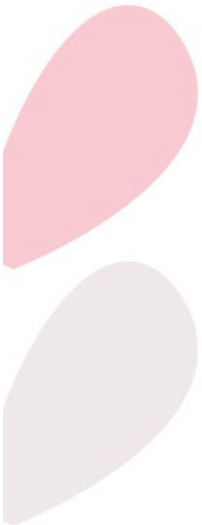
- Modelling based — literature review and result from the first 2 years of the new NCSP
 - Performing both 12-month and 24-month follow-up results in **<1% difference in cervical cancer incidence and mortality** and <1% difference in colposcopies, compared with 12-month follow-up only



UPDATE JULY 2022

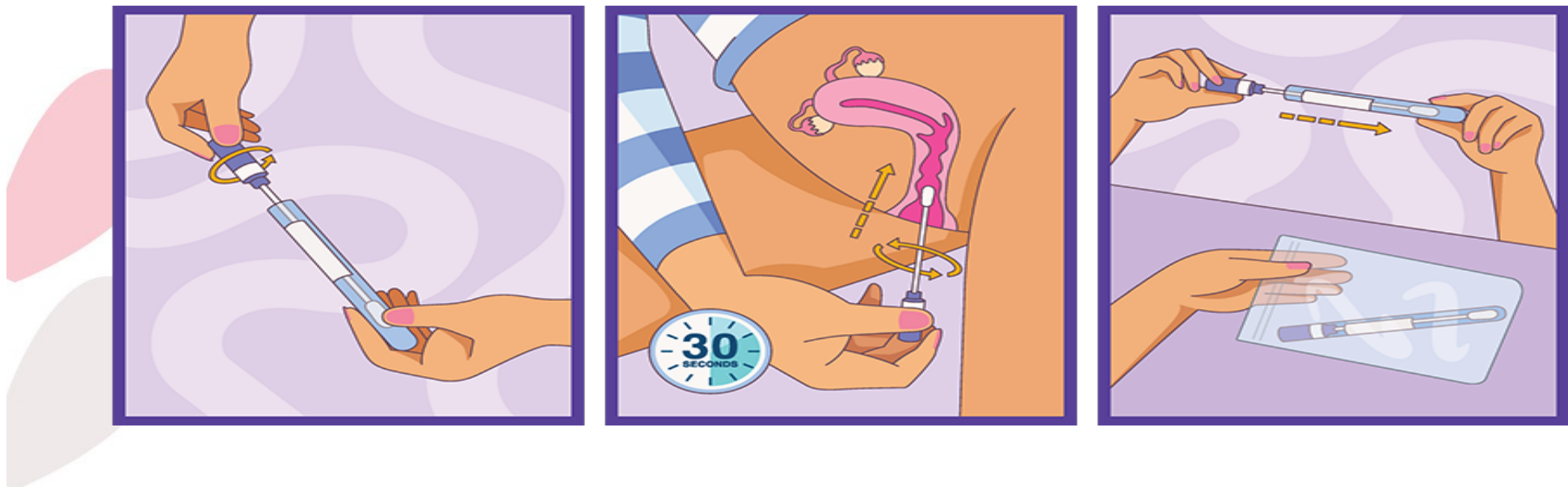
Self-Collected vaginal samples

- Medical Services Advisory Committee review
 - Majority of women with cervical cancer — never screened or under screened
 - Sensitivity and specificity of HPV test in self-collected samples — similar with clinician collected samples (PCR based assay)
 - High acceptability to women
 - Higher rate of adherence to follow up in HPV positive women
 - Offering self-collection is more effective than a reminder letter



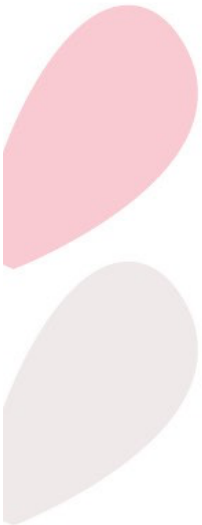
Self-collected vaginal samples

- Eligible for all women who needs HPV test – including pregnant women
- High sensitivity and high specificity
- **To increase participation to screening program**



Self-collected vaginal samples

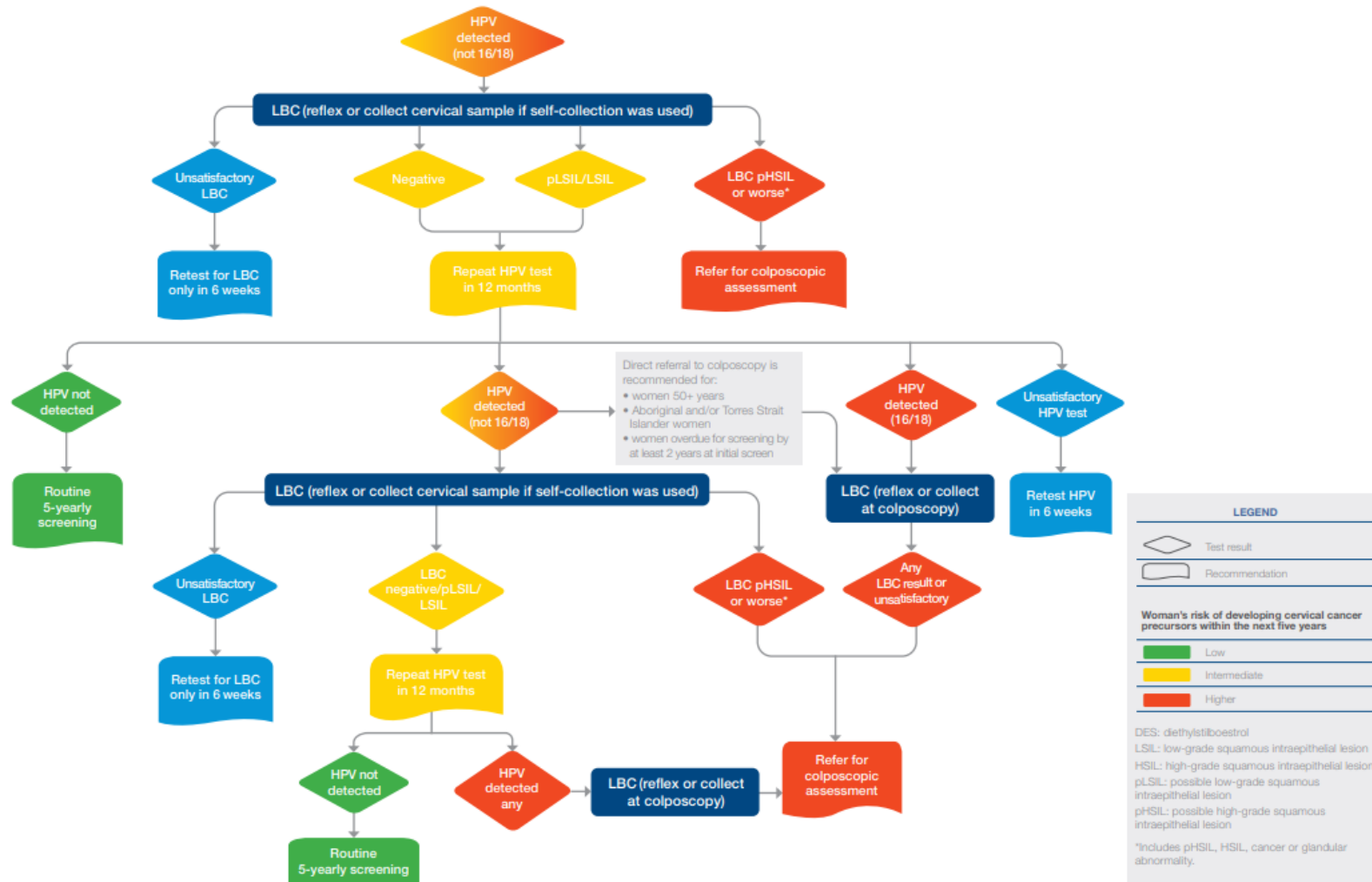
- Exclusion
 - Women who need a co-test
 - Recently treated HSIL
 - In utero exposure DES
 - Symptomatic women



Self-Collected vaginal samples

CERVICAL SCREENING PATHWAY (CLINICIAN COLLECTED OR SELF-COLLECTED)

Oncogenic HPV test with partial genotyping



WHO 2020

Elimination =
Less than 4 per 100,000
women-years



WHO

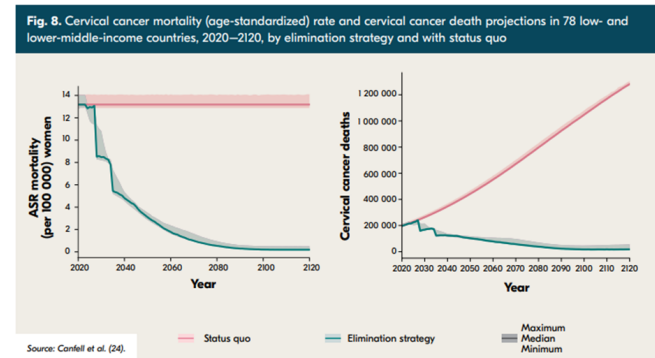
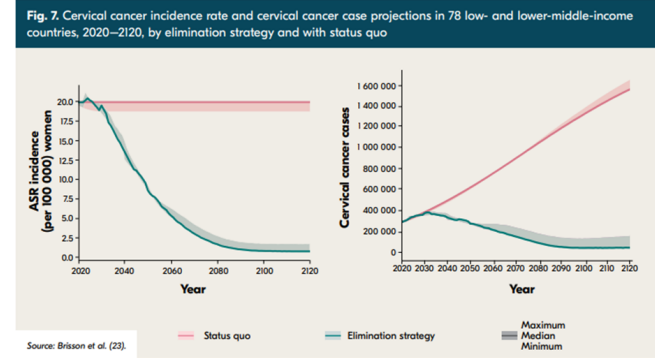
Meeting the following 90-70-90 targets by 2030 will put all countries on the path to elimination (24):

- **90%** of girls fully vaccinated⁷ with HPV vaccine by 15 years of age
- **70%** of women screened using a high-performance test⁸ by 35 years of age and again by 45 years of age (25)
- **90%** of women identified with cervical disease are treated:
 - **90%** of women with precancer treated
 - **90%** of women with invasive cancer managed.

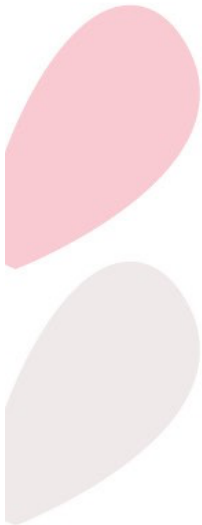
WHO 2020

Mathematical modelling

- median cervical cancer incidence rate will fall by **42% by 2045**, and by **97% by 2120**, averting more than **74 million** new cases of cervical cancer
- median cumulative number of cervical cancer deaths averted will be **300,000 by 2030**, over **14 million by 2070**, and over **62 million by 2120**



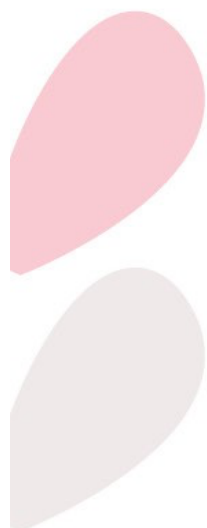
Strategic actions to achieve 90% coverage of HPV vaccination



	Secure sufficient and affordable HPV vaccines	A concerted effort will be needed between partners and the private sector to overcome vaccine supply constraints. Additionally, through appropriate market-shaping interventions, more affordable prices can be achieved while ensuring a healthy HPV vaccines market.
	Increase the quality and coverage of vaccination	Increasing the coverage of HPV vaccination will require efficient and sustainable multisectoral delivery platforms (such as school immunization programmes) and innovative community-based approaches to reach vulnerable populations (such as adolescent girls who are not in school). Monitoring systems or registers should track and improve coverage and quality.
	Improve communication and social mobilization	As HPV vaccination programmes are introduced and expanded, they will need nationwide, evidence-based communication and social mobilization efforts. Understanding the social, cultural, societal and other barriers that may affect the acceptance and uptake of the vaccine will be critical. Some communities will need extra engagement to overcome vaccine hesitancy and counter misinformation.
	Innovate to improve efficiency of vaccine delivery	National guidelines, policies and strategies should be updated as new evidence and innovations become available on better and more efficient approaches to HPV vaccination.

Strategic actions to achieve 70% coverage for screening and 90% treatment of precancerous lesions

	Understand barriers to accessing services and create an enabling environment	A robust understanding of the social, cultural, societal and structural barriers to the uptake of services is crucial. Such knowledge will inform the development of context-specific and culturally appropriate demand-creation strategies and the design of acceptable, accessible service delivery platforms. Local communities, especially women, must be engaged and empowered to lead the development of these critical programmes, serve as allies, counter misinformation or stigmatization, and support those needing more complex treatment. Increasing health literacy, knowledge of rights and awareness of cervical cancer prevention and control will help to mobilize, empower and engage communities and civil society, and women in their diversity.
	Integrate screening and treatment services into the primary care package	Services integrated into existing sexual and reproductive health services, HIV care and treatment clinics, antenatal care, well women clinics and school-based health outreach are points of entry for reaching women and girls. People-centred referral mechanisms should minimize inconvenience to patients and reduce opportunity costs.
	Promote a screen and treat approach	Countries will need to expand the number of facilities where a single-visit screen and treat approach could be implemented. Single-visit screen and treat approaches will not be feasible everywhere; however, they should be promoted and implemented as appropriate.
	Ensure an affordable supply of quality-assured, high-performance screening tests and treatment devices	Prompt registration and market shaping for cervical cancer diagnostics and treatment devices will lead to improved access and affordability. WHO will strengthen its prequalification capacity, as appropriate, to remain abreast of emerging technologies. Post-market surveillance for all medical devices, including in vitro diagnostics, will ensure that safety monitoring is in place as programmes scale up.
	Strengthen laboratory capacity and quality assurance programmes	Efficient, integrated networks of laboratory services will maximize the impact of limited human and financial resources. Strong quality assurance programmes are crucial to ensuring that services meet the requisite standards. Training and supervision must be an integral component of service delivery.



Strategic actions to achieve 90% treatment and care for cervical cancer cases

	Implement cervical cancer management guidelines	Developing and implementing national cervical cancer management guidelines, adapted to the national context, is central to ensuring high-quality care (41).
	Establish referral pathways and people-centred linkages throughout the continuum of care	Streamlining care pathways and referral networks linking all levels of care will ensure timely management of patients.
	Strengthen pathology services	Access to high-quality pathology services is crucial for management of invasive cancer. The development of regional pathology centres, making use of affordable telepathology platforms, is possible for countries with limited or no capacity to interpret samples. Where telepathology networks are already being used for complex cases, they could be used for routine ones (42).
	Expand surgical capacity	Cervical cancer can often be cured by surgery alone, if diagnosed and treated in its early stages. However, of the cancer patients who live in the world's poorest countries, less than 5% have access to safe, effective and timely cancer surgery (43). In high-income countries the predominant model of postgraduate surgical oncology education consists of multiyear specialty training within accredited programmes, supported by experienced board-certified oncological surgeons and a sophisticated, highly functional surgical infrastructure characterized by readily available anaesthetic services, intensive care units, ubiquitous blood banking and modern laboratory platforms. In most low- and middle-income countries the health care providers performing oncological procedures are generalists (general surgeons, gynaecologists, general practitioners and medical officers) without formal, certified subspecialty training, who provide cancer care out of necessity. Novel attempts to scale up surgical capacity in these environments using focused, competency-based training and North–South twinning partnerships have met with success and should be expanded (44, 45).
	Improve access to radiotherapy and chemotherapy	Most patients with cervical cancers in low- and middle-income countries present at stages that require radiation, so sustainable capacity for curative radiation therapy (external beam and brachytherapy) is critical.
	Strengthen and integrate palliative care services	Treatment plans should incorporate not only end-of-life care and pain relief for patients but also psychological support, family support and other services from the outset. Where possible, home-based models of palliative care should be integrated into primary health care.

Strategic actions to achieve 90% treatment and care for cervical cancer cases

Optimize health workforce competencies throughout the continuum of care	A strategy for long-term national health workforce education and training, recruitment and retention is the key to ensuring sustainable multidisciplinary team-based care. The WHO Global Strategy on Human Resources for Health: Workforce 2030 provides a blueprint for countries to address workforce challenges (46). In addition, a wide range of regional observatories on human resources in health systems provide valuable resources for planning and policy development. More options include twinning programmes, regional training hubs located in centres of excellence, telementoring (47), e-learning (48), mobile learning, and low-cost virtual reality surgical simulation (49). Remote training may be appropriate for areas such as surgery, radiology, pathology and patient consultation.
Reduce cancer stigmatization	Patient awareness, health literacy and education initiatives, especially through survivor groups, contribute to addressing stigmatization associated with cancer.
Provide comprehensive support designed to enhance quality of life and address physical, psychological, social and spiritual challenges faced by survivors	Such programmes are best developed locally, tailored to the sociocultural context of affected communities and engaging advocates of sexual and reproductive health and rights.

AUSTRALIA



Australian Centre
for the Prevention of
Cervical Cancer

NATIONAL STRATEGY FOR THE ELIMINATION OF CERVICAL CANCER IN AUSTRALIA

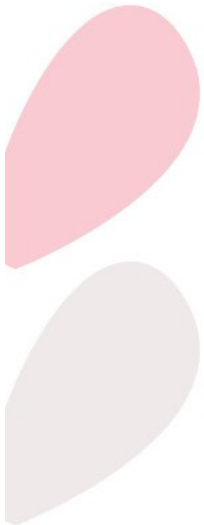
A pathway to achieve equitable elimination of
cervical cancer as a public health problem by 2035

November 2023



AUSTRALIA'S VISION

An Australia where preventable cervical cancer is a **disease of the past**, in which Australia's diverse communities have **equitable access** to information and to culturally safe and inclusive **vaccination, screening and treatment** services.



Eliminating cervical cancer in Australia by the year 2035 could make Australia the first country in the world to actively achieve elimination.

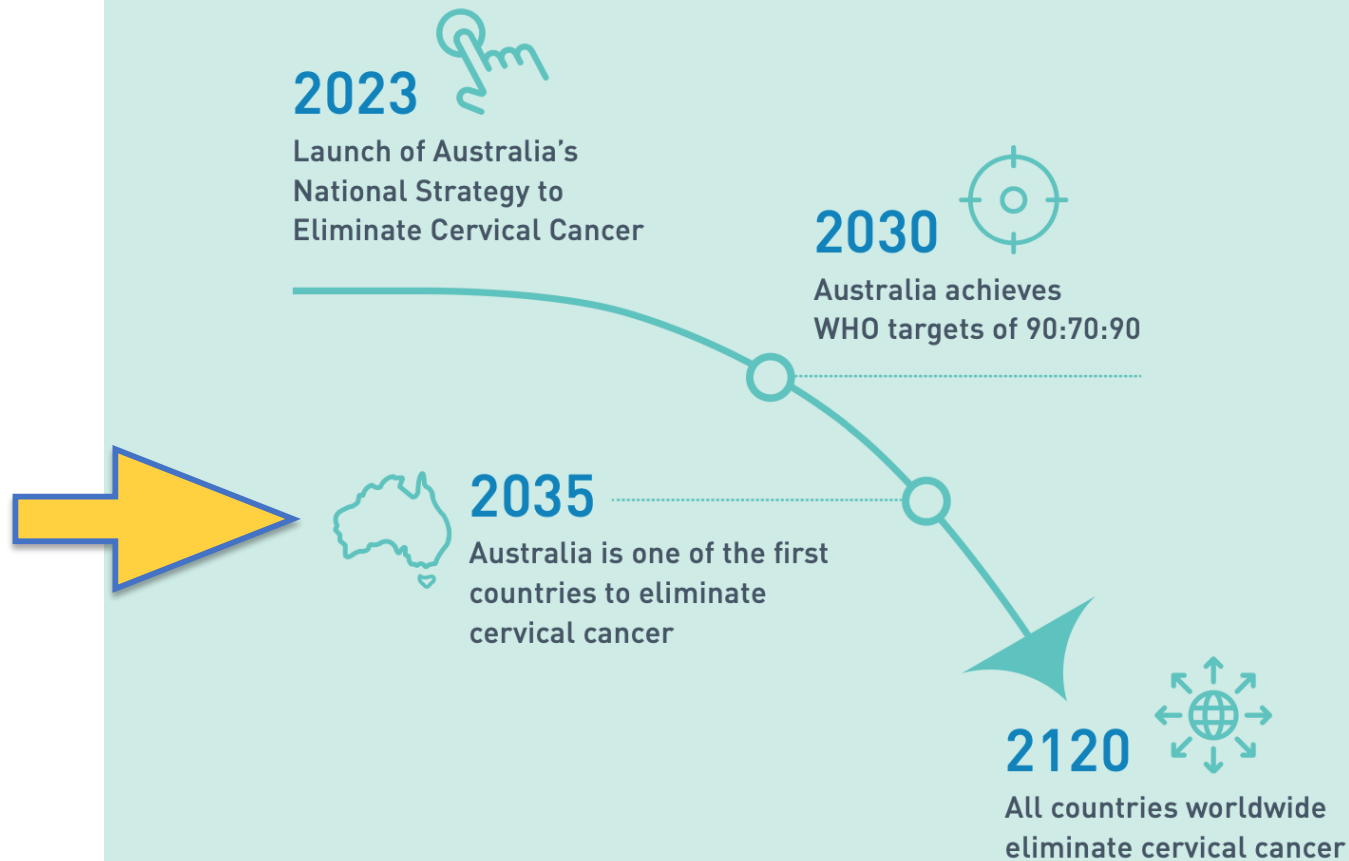


Figure 4. Australia and the global cervical cancer elimination journey.

AUSTRALIA'S ELIMINATION TARGETS



STRATEGIC PRIORITIES

TIMELY AVAILABILITY OF CANCER INCIDENCE AND MORTALITY DATA

- 1 Ensure that Australia has access to timely and accurate cervical cancer incidence and mortality data.

VACCINATION

- 2 Optimise the delivery of school-based HPV immunisation programs in all jurisdictions to maximise equity and achieve high coverage.
- 3 Optimise the reach and funding of complementary out-of-school HPV immunisation programs to achieve equity in delivery for all, including priority and medically high-risk populations (catch-up).
- 4 Develop a method to enable annual reporting of HPV vaccination coverage for priority and medically high-risk populations to monitor equity in immunisation.

SCREENING AND PRE-CANCER TREATMENT

- 5 Promote cervical screening regularly with the public and strategically with under-screened groups.
- 6 Increase access to screening, colposcopy and follow-up by expanding who can offer these services, and where and how they are offered, to improve reach and uptake.
- 7 Collect, use, and release data to enable and monitor equity of access to cervical screening and pre-cancer treatment services.

TREATMENT

- 8 Ensure communities and patients have equitable access to quality information about cervical cancer symptoms, and that each cancer patient has tailored information about their diagnosis, intended treatment and planned optimal care pathway.
- 9 Develop and implement a road map of coordinated care, with communities of practice, to optimise the delivery of safe, quality care to all patients.
- 10 Drive improvements in cervical cancer management through a data collection framework supporting systematic monitoring and enhancement of the quality of care, in alignment with the Australian Cancer Plan.

Incidence



Australia

6.5 new cases per 100,000 (2018)



WHO target

≤4 new cases per 100,000



Vaccination



Australia

80.5% of females aged 15 years in 2020 were fully HPV vaccinated¹



WHO target

90% of girls to be fully vaccinated with the HPV vaccine by 15 years of age



Screening



Australia

67% of women aged 45-49 years participated in cervical screening between 2018 to 2021²



WHO target

70% of women to be screened by 35 and again by 45 years of age using a high precision test i.e., an HPV PCR-based test



Treatment



Australia

85.8% of pre-cancers were treated within 6 months (2020).

No national data available on cancer treatment. Queensland data (2015-2019) show 95% were treated in metro, 96% in regional and 90% in rural/remote areas.



WHO target

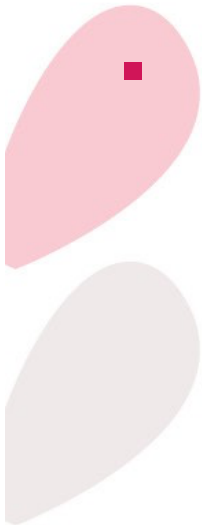
90% of women identified with cervical disease to receive treatment for pre-cancerous lesions or management of invasive cancer



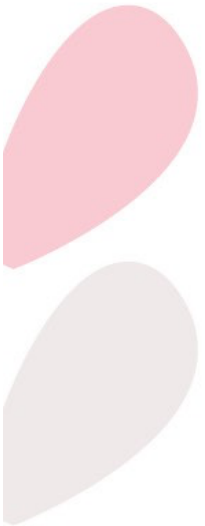
¹ Australian Immunisation Register (AIR) via the National Centre for Immunisation Research and Surveillance. Sex (Female) as recorded on AIR (Medicare derived).

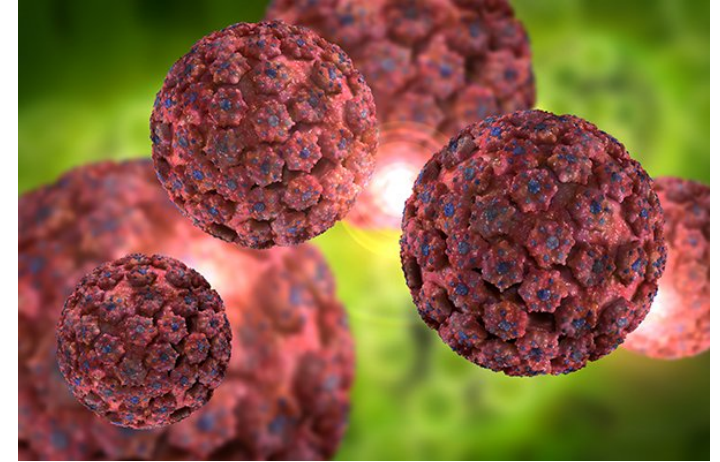
Actions for each strategic priority focusing on :

- Aboriginal and Torres Strait Islander people
- Culturally and linguistically diverse people
- People who are LGBTQ+ and people who are intersex
- People with disability
- People living in rural and remote areas



COMMON QUESTIONS FROM PATIENTS





How do I get HPV?

Should my partner be tested ?

How do I get rid of HPV ?

How long until I get rid of HPV ?

**My CST result is the same as last year,
why do I need another colposcopy ?**



THANK YOU

