

BUILDING RESILIENT SYSTEMS TOWARDS CERVICAL CANCER ELIMINATION

A 3-Part Webinar Series

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IGCS  INTERNATIONAL
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Webinar 1 Key Take Home Messages

View the recording here: <https://youtu.be/r9OF-tqse7c> -

Faculty - Elimination Landscape



Mauricio Maza

Regional Advisor for Cancer
Prevention and Control, Pan
American Health Organization
(PAHO)



Karen Canfell

Professor of Public Health NHMRC
Leadership Fellow, School of Public
Health University of Sydney, Australia



Michelle Halligan

Director, Prevention, Performance
Measurement + Evaluation,
Canadian Partnership Against
Cancer



Tamika Felder

Tamika Felder, Chief Visionary
Cervivor Inc.
Co-Chair, Elimination Work Group,
American Cancer Society, National
Roundtable on Cervical Cancer

Faculty - Treatment



Kathleen Schmeler, MD

University of Texas
MD Anderson



Lucy Gilbert, MD

McGill University Health Centre



Ashanda Saint Jean, MD

New York Medical College



Jennifer Young Pierce, MD

University of South Alabama
Mitchell Cancer Institute



Tiffany Zigras, MD

University of Toronto, Trillium Health
Partners, Cancer Care Ontario

Welcome & Introduction

Julie Torode - Institute of Cancer Policy, King's College London, Mary Eiken - Chief Executive Officer, IGCS

- Highlighted the IGCS 5-year project with the bold vision that by 2030, every high-burden country will have a national cervical cancer elimination strategy that is actively being implemented. The ACCESS initiative — Accelerating Cervical Cancer Elimination Strategies Symposia – kicked off in Cape Town and will follow the IGCS conference each year, with 2026 in Montreal, Canada.
- <https://igcs.org/introducing-igcs-access-series/>
- The new global map of national cervical cancer elimination strategies and resources for implementers identified in a global mapping are available for view, use and adding new tools over time – participants are encouraged to view: www.iccp-portal.org
- Welcomed co-chair for the North America ACCESS Webinar series and Symposium – Heather Brandt, Director of the HPV Cancer Prevention Program at St. Jude Children's Research Hospital.

Part One: Snapshot of Progress Towards the Elimination of Cervical Cancer in North America

Moderator: Julie Torode

Regional Progress & Trends — The PAHO Perspective

Maurizio Maza - Advisor for Cancer Prevention and Control, Pan American Health Organization

- Highlighted the high priority of this work for all Member States of the Americas. <https://iris.paho.org/items/2f3b7597-10a8-4fb9-a919-b11ff79bd93a> and the capacity building offer: **add**
- Shared PAHO's Regional Dashboard - a fabulous tool that tracks progress across the three pillars of the global strategy, enabling comparison and identification of countries that are doing well for potential exchange and cross-learning. <https://www.paho.org/en/end-cervical-cancer/cervical-cancer-elimination-dashboard>
- HPV vaccination trends:
The region is achieving over 70% coverage. There is a trend toward adoption of single dose regimens and vaccination of girls and boys. While significant challenges persist post-pandemic recovery; historical challenges with vaccine hesitancy; some late adopters. All countries are moving forward and showing that vaccination rates can recover to high coverage levels. Trailblazer Peru has reached over 90% coverage and is expected to sustain it. Over 30 countries procure HPV vaccine needs via the PAHO revolving fund: <https://www.paho.org/en/revolving-fund>
- Cervical screening and treatment trends:
Most countries currently have cytology-based programs, with a transition underway toward high performance HPV tests. Treatment, this remains the most complex pillar. Very few countries effectively track what happens to women with abnormal screening results or disease. There is a significant gap in radiation services in the Caribbean that must be addressed. The PAHO strategic fund is starting to work with Member States for the procurement of screening commodities <https://www.paho.org/en/paho-strategic-fund>

Drivers of Impact Towards Elimination, Karen Canfell - Professor of Public Health, University of Sydney

Key points emphasized about the 90-70-90 targets:

- The importance of acting on all three pillars simultaneously, with a life-course, end-to-end approach and it is critically important to have data systems capturing all these linkages across the care continuum.
- The 70% target is a minimum for twice-lifetime screening with a high-performance test. The only high-performance test at this moment is HPV primary screening. Many high-income countries have adapted national elimination plans, conceiving the 70% target at up to five-yearly screening.
- The last 90% is actually many 90s, encompassing multiple treatment targets: pre-invasive treatment, colposcopy, surgery for early-stage disease, chemotherapy, radiotherapy, and palliative care.
- The economic case is significant. The return on investment of the global strategy has been calculated at \$3.20 for every dollar invested in low- and middle-income countries through 2050 — rising to \$26 for every dollar if broader societal benefits are included.
- Reaching the elimination threshold (4 per 100,000 women per annum or less) does not mean the work is done, it will always require active programmatic intervention to maintain sustain rates equitably.

- Australia is on track to be the first country in the world to eliminate cervical cancer (2028 and 2035) through incremental realization of progress, there is no magic wand. Annual surveillance monitors many indicators and sub-indicators across the three pillars, including in priority population subgroups.
- Current five-yearly HPV screening coverage is over 74%. A major development is introduction of universal self-collection. Half of all screening participants are choosing to self-collect, with even higher uptake in previously underserved priority populations.
- Modelling by the CISNET collaboration projects that the U.S. demonstrates elimination in the US could be expedited by at least a decade by leveraging screening and treatment as accelerators.

Canada's National Plan, Michelle Halligan - Director of Prevention, Canadian Partnership Against Cancer

- The Canadian strategy was co-developed with communities and a wide breadth of health experts. Our plan is ambitious with 90-90-90 targets across the three pillars. This plan is centered on closing equity gaps with focused work ahead with Indigenous populations and other equity-denied groups.
- We are a nation where universal health care is delivered by 13 different provinces and territories. We've had robust cervical screening programs and school-based, gender-neutral HPV immunization programs for decades, and we have quite robust cancer registries and increasingly interoperable health data.
- Cervical cancer incidence has fallen in Canada, thanks mostly to organized screening programs and the more recent introduction of the HPV vaccine. We're now at an incidence of 8.7 per 100,000 women. However, approximately 1,600 people are diagnosed each year and more than 400 die — a tragedy given that this disease is preventable.
- Canada is in a very good position to achieve elimination in my lifetime and modelling indicates this could be by 2040.

The Patient and Survivor Perspective - Tamika Felder | Chief Visionary, Cervivor

- I was diagnosed with cervical cancer 25 years ago. I speak on behalf of the patient advocate community.
- Our clear message: every cervix matters, and no one can be left behind. Partnering with PWLE is critical.
- We do that through our programs and our empowered survivor stories, also for those no longer here.
- In my role as co-chair of the ACS National Elimination Work Group, I'm pleased to share that we presented a national elimination framework at our recent meeting and look forward to sharing soon.

Part Two: Deep Dive on Pillar 3 — Treatment Moderator: Heather Brandt - Director, HPV Cancer Prevention Program, St. Jude Children's Research Hospital

Overview of Cervical Cancer Treatment

Dr. Kathleen Schmeler, University of Texas MD Anderson Cancer Center

- The more women we screen, the more pre-invasive and invasive cancers we will find. We need a clear plan for all, that is including navigation strategies and processes for referral and treatment.
- Treatment modalities include surgery, radiation, chemotherapy, immunotherapy, and palliative care.
- Treatment for pre-invasive disease (CIN 2/3): and invasive cancer using the FIGO system (stages 1–4), are described. When curative treatment is unavailable or cancer recurs: Palliative care to alleviate symptoms and support quality and dignity of life.
- The WHO and others have established benchmarks for timeliness. In North America, these are often met in higher-resource areas, but not consistently in underserved communities.
- To make this work, we need: Multidisciplinary teams: GYN oncologists, radiation oncologists, pathologists, radiologists, pharmacists, nurses, social workers, palliative care, and navigators clinical and from the community)
- Also, political commitment and funding, capacity building, data and monitoring systems, and advocacy
- Cancer control plans at every level

Treatment — The Canadian Perspective, Dr. Lucy Gilbert | McGill University Health Centre

- For early-stage disease: Surgery is the key. the landmark Canadian-led SHAPE trial, demonstrated that in selected patients a simple hysterectomy with sentinel lymph node dissection achieves the same oncological outcome as a radical hysterectomy, with significantly less sexual dysfunction and urinary symptoms. This is important because these patients are often very young.

- Locally advanced disease: Unfortunately, most patients in Canada present with advanced disease. The standard of care is concurrent chemoradiation. In Canada, all cervical cancers are treated in tertiary and quaternary care centers, with uniform guidelines and standardized care.
- A critical advance: 40% of patients historically returned with recurrent disease and died within five years. Canada participated in a trial examining the addition of pembrolizumab (immunotherapy) to chemoradiation showed a 33% reduction in the risk of death. Pembrolizumab is available, though this comes at significant cost, underscoring why boosting vaccination and screening are so important.

Treatment — The U.S. Perspective, Dr. Ashanda St. Jean - New York Medical College

- The United States sees 13,000 new cervical cancer diagnoses and over 4,000 deaths each year.
- Nearly all are caused by persistent high-risk HPV infection - types 16 and 18 in 70% of cases. HPV vaccination reduces cervical precancerous lesions by 80% among vaccinated young women. The vaccine also protects against HPV-related cancers of the anus, vulva, vagina, penis, and oropharynx.
- Significant disparities exist in detection, screening, and prevention among Black, Hispanic, rural, and underserved populations. The stark reality of healthcare deserts needs to be confronted.
- The FDA has approved HPV self-collection, including a first at-home test. This has the potential to increase screening participation, improve reach to underserved communities, reduce structural barriers (transportation, childcare, and geography), and make screening more acceptable than pelvic exams.
- Remaining challenges in the U.S.: Approximately 1 in 4 are not up to date on screening. Under-screening remains the strongest risk factor for cervical cancer diagnosis; Healthcare and racial disparities among Black and Hispanic women and rural populations persist; A significant proportion of Americans are underinsured or uninsured.

Wipeout Cervical Cancer Alabama Dr. Jennifer Young Pierce | University of Alabama

- The Alabama patient population is over 30% African American, over 40% rural, with patients driving 50 minutes to three hours to see me, and the next major medical center over 200 miles away.
- Wipeout Cervical Cancer Alabama was the vision of two women coming together in early 2021. To date, we have conducted 12 regional trainings across the state. Statewide summits continued in 2025 and 2026, with over 150 attendees and we are hitting the 90:90:90 targets.
- At the time, of the inaugural Summit in 2022 Alabama ranked third nationally in both cervical cancer incidence and mortality, with vaccination rates below the national average. Prior to the program, 23 Alabama counties had no OBGYN provider of any kind, and 35 counties had no colposcopy services. Now all 67 counties can be reached by colposcopy services, led by a team of nurse practitioners. This has driven colposcopies from approximately 200–250 at large referral centers to nearly 1,200 at local health departments, with follow-up rates increasing from 30% at large centers to over 75% at local health departments.
- Over 45 organizational partners have joined Wipeout Cervical Cancer Alabama in its first three years. The message: build coalitions, find your partners, and get motivated. Elimination is possible.

HPV Results Management — Ontario’s Approach, Dr. Tiffany Zegers | University of Toronto

- Each Canadian province operates independently. HPV testing implementation is proceeding PEI (May 2023), British Columbia (January 2024), Ontario (March 2025), Alberta, Quebec, and the Northwest Territories (partial implementations) and remaining provinces planning but not yet live.
- Ontario has surpassed 1 million participants tested with HPV tests since the March 2025 launch. Self-collection is being evaluated before a full-scale rollout. Not all HPV-positive results trigger colposcopy referral. Colposcopy pathways, treatment preferences and post-treatment surveillance were shared.
- In Ontario, screening participation has been relatively fixed at 60%. Even with universal healthcare and no-cost testing, getting participation rates above 60% has proven difficult. Self-sampling presents a significant opportunity.

Register for Webinar 2 here:

https://us06web.zoom.us/webinar/register/WN_XFJKoD-8QWWvu8-29PZRGQ#/registration