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HPV Global Action
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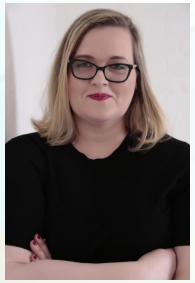
Consortium for Infectious Disease Control
Presents

www.CIDCgroup.org

Advancing Cervical Cancer Prevention:
Global Evidence, Self-sampling Insights & Implications for Canada



Presenter: Matejka Rebolj, PhD

- Senior Epidemiologist
  Wolfson Institute of Population Health,
  Queen Mary University of London
  London, UK

Presenter: Teresa Norris

- Founder and President
  HPV Global Action
- President
  Quebec Cancer Coalition

Moderator: Carmen Wyton

- Principal,
  Ripple Enterprises
- Founder and President,
  Women's Health Coalition of Canada

This educational program is made possible through the support of **Hologic Canada ULC**

April 15, 2026

Moderator

Carmen Wyton

- Principal,
Ripple Enterprises

- Founder and President,
Women's Health Coalition of Canada

Webinar Objectives

1- Clarify the role of HPV self-sampling in modern cervical screening

2- Review the evidence supporting the accuracy of self-collected HPV testing

3- Explain recommended approaches for deploying self-sampling to improve uptake, equity, and clinical outcomes

4- Discuss ACCESS survey insights on women's preferences and how these findings, and recent partner experiences, inform self-sampling implementation in Canada

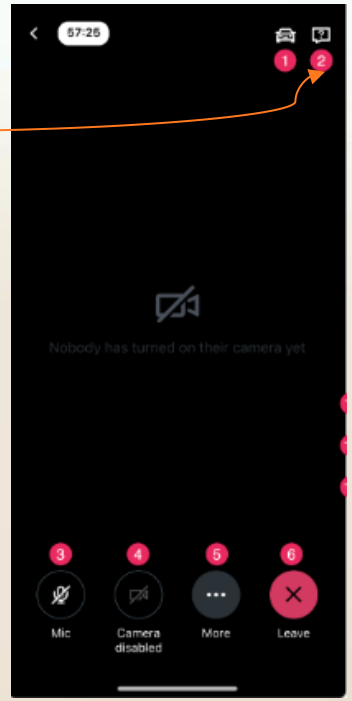
Administrative Information

- **Sound:** All participants have joined in "listen-only mode" and will hear the audio for today's webinar via computer speakers
- **Question & Answer Period:** ask a question at any time

  Questions will be answered at the end of the presentation

On a **computer**, submit your text question using the Questions Pane after clicking the icon (#3)

NOTE: On a **mobile device**, tap on the "?" (#2) to submit a question on the Questions Pane



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Note: A recording of the presentation will be made available at www.CIDCgroup.org and hpvglobalaction.org

www.CIDCgroup.org

Evaluation

Complete the Evaluation Survey at:

https://forms.gle/KbmnTU9WhH7fyCHWA

Completion of survey is requested to receive a certificate of participation

– all registered participants will receive an email with this link

Slides and Video Recording

The webinar **Slides and Recording** will be archived at:

hpvglobalaction.org and www.CIDCgroup.org

Presenter

Matejka Rebolj, PhD

Senior Epidemiologist
Wolfson Institute of Population Health,
Queen Mary University of London
London, UK

Queen Mary
University of London

Lessons learnt in self-sampling

Matejka Rebolj

Wolfson Institute of Population Health, Queen Mary University of London, UK

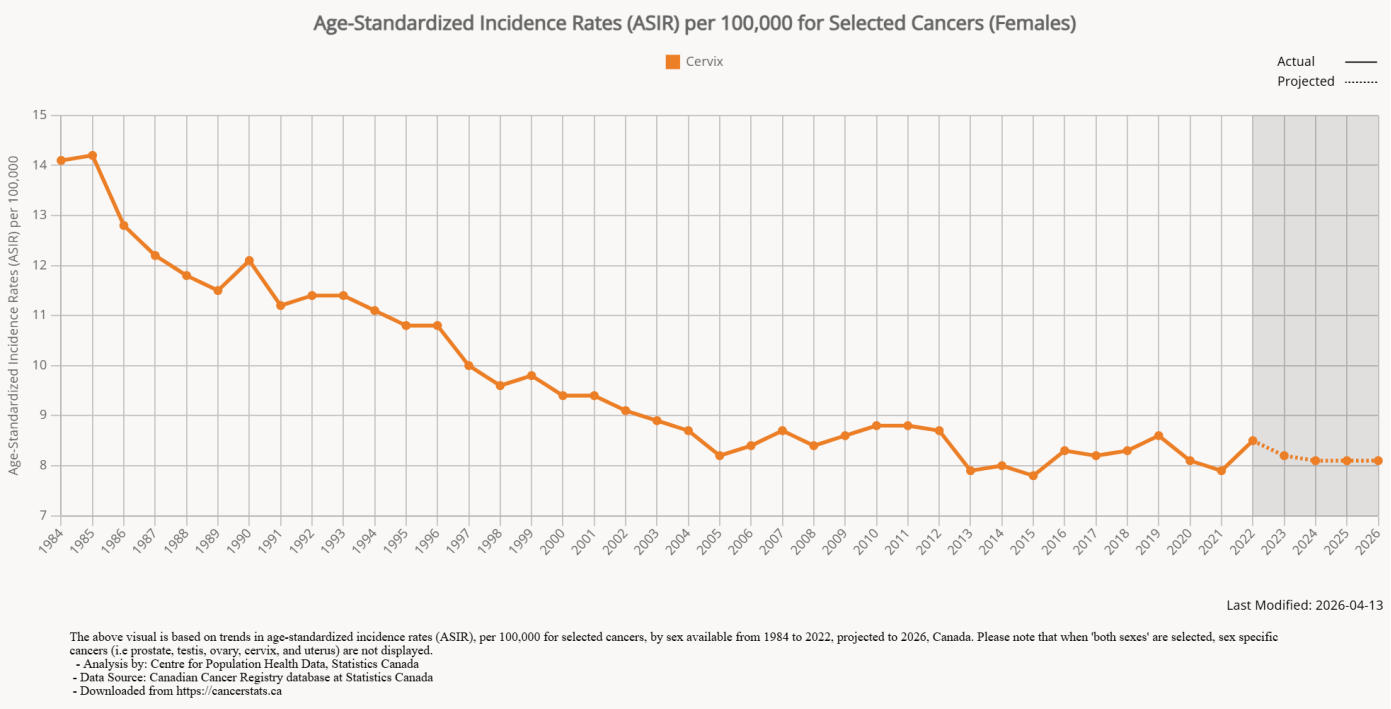
Advancing Cervical Cancer Prevention:

Global Evidence, Self-Sampling Insights, and Implications for Canada

15 April 2026 (online)

“women” = women and other people with a cervix

Cervical cancer in Canada: plateau after a decline



Considerable decline in the incidence until ~2005

Thereafter: unstable rates, increase in some years, overall plateau (no improvement)

Goal: “elimination” = incidence <4/100,000

Vaccination + screening

Canadian Cancer Statistics Dashboard: https://cancerstats.ca/Incidence/Sex

Cervical screening saves lives

Cervical cytology

Very effective at short intervals

Prevents cervical cancer by removing CIN2+ in women with abnormal cytology

Estimates for England (55-60 million people):

- ~700 cervical cancer **deaths** every year
- Without cervical screening: ~2500 (+1800)
- If everyone were screened: ~200-300 more could be prevented

Cancer Research UK: https://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/cervical-cancer/mortality

Landy et al. Br J Cancer 2016; Rebolj et al. BJOG 2022; Rebolj et al. Cancer Cytopathol 2022

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HPV testing

Detects more abnormalities:

-Increases detection of CIN2+ by 60%

-Increases detection of CIN3+ by 50%

-Increases detection of cervical cancer by 40%

It detects these abnormalities earlier:

-Through earlier recognition of cytological abnormalities (“informed reading”)

-Through repeated testing of the remaining HPV-positive women with normal cytology

Cancer Research UK: https://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/cervical-cancer/mortality

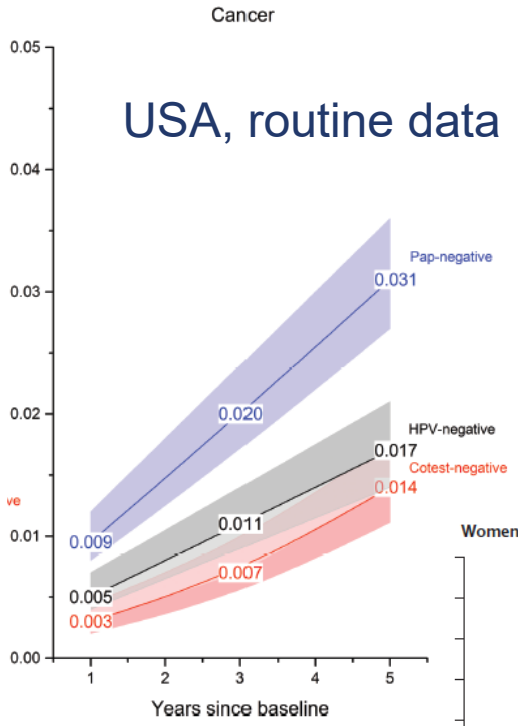
Landy et al. Br J Cancer 2016; Rebolj et al. BJOG 2022; Rebolj et al. Cancer Cytopathol 2022

Extra CIN2+ detection prevents cervical cancer

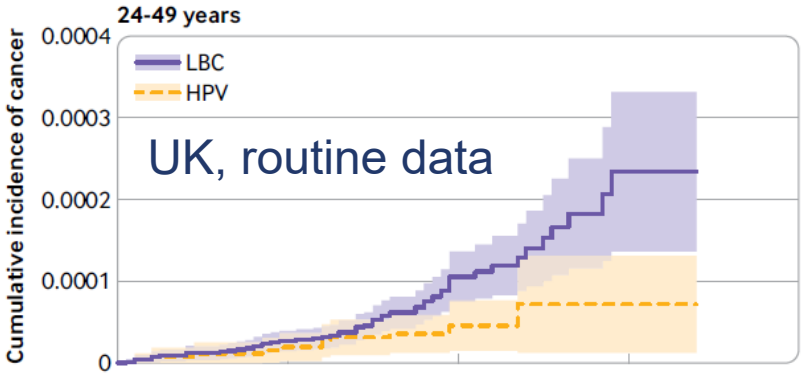
A positive HPV test identifies more CIN2+

This leaves fewer undetected CIN2+ in HPV-negative women to progress to cancer

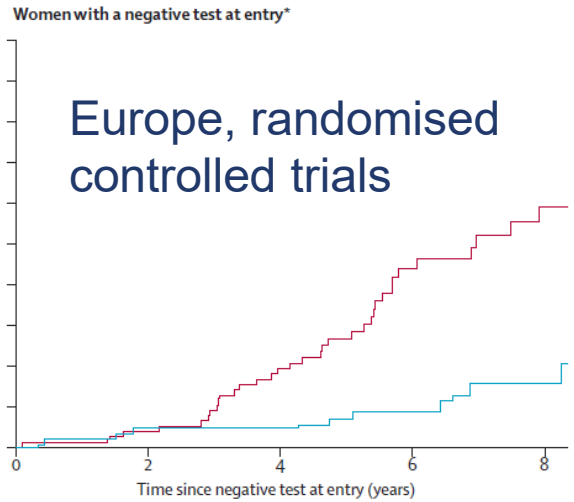
50-70% reduction in cervical cancer risk after a negative screening test



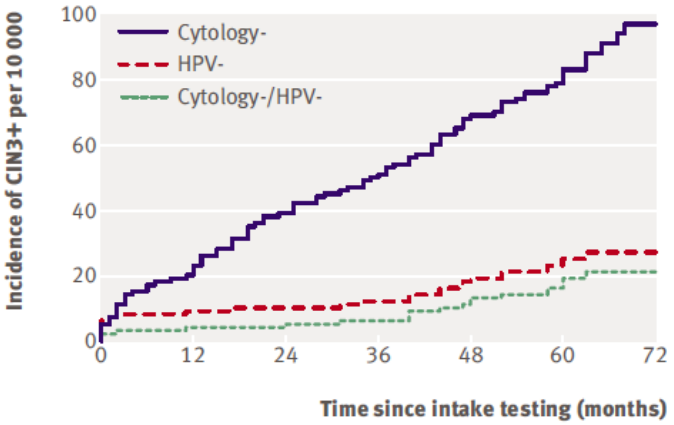
USA, routine data



UK, routine data



Europe, randomised controlled trials



Europe, cohort studies

Dillner et al. BMJ 2008; Ronco et al. Lancet 2014; Gage et al. JNCI 2014; Rebolj et al. BMJ 2022

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HPV testing

Helps laboratories identify abnormal cells, increases the detection of CIN2+

Prevents cancer in cytology-negative women

Maintains safety with longer intervals

Requires fewer lifetime screens

Enables effective cervical screening with **self-sampling**

Cancer Research UK: https://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/cervical-cancer/mortality

Landy et al. Br J Cancer 2016; Castanon et al. J Med Screen 2017

Gaps in cervical screening coverage

1 out of 3 eligible women are not up-to-date with cervical screening

Up from 1 in 4 in 2017

Same trend across the entire age range

Cervical cancer elimination plan:

WHO target: 70%

Canada target: 90%

Table 2
Had a Pap smear test within the past 3 years, females aged 25-69, Canada excluding the territories, 2024

	2017			2024		
		95% confidence interval			95% confidence interval	
	Had a recent Pap smear test (past 3 years)	Lower limit	Upper limit	Had a recent Pap smear test (past 3 years)	Lower limit	Upper limit
	percentage					
Canada Total (excluding territories)	74.0	73.1	75.0	68.7*	67.5	69.9
Age group						
25 to 34 years	79.2	77.1	81.3	69.6*	66.7	72.5
35 to 49 years	79.4	77.8	81.1	74.7*	72.8	76.6
50 to 69 years	67.3	65.8	68.7	63.4*	61.8	65.1
Province						
Newfoundland and Labrador	78.5	74.5	82.5	67.7*	62.1	73.3
Prince Edward Island	69.4	63.8	75.0	60.4	51.5	69.4
Nova Scotia	75.7	72.0	79.5	61.8*	57.7	65.9
New Brunswick	76.0	71.7	80.3	64.5*	59.4	69.6
Quebec	67.6	65.6	69.7	63.4*	61.1	65.8
Ontario	75.3	73.5	77.1	71.0*	68.7	73.3
Manitoba	81.7	78.3	85.2	72.6*	68.1	77.1
Saskatchewan	78.8	75.2	82.4	74.5	70.4	78.6
Alberta	80.2	78.1	82.3	74.9*	72.1	77.6
British Columbia	72.2	69.5	74.8	65.5*	62.6	68.4
Area type[1]						
Urban (Population Centre)	74.7	73.5	75.8	69.0*	67.6	70.3
Rural area	71.2	69.3	73.1	67.6*	65.4	69.7

* significantly different from previous reference period ($p < 0.05$)
1. Population centres are those continuously built-up areas having a population concentration of 1,000 or more, and a population density of 400 or more per square kilometre based on Census population counts. Rural areas are areas with a population concentration of less than 1,000.
Source: Canadian Community Health Survey 2024.

Statistics Canada: https://www150.statcan.gc.ca/n1/pub/82-625-x/2025001/article/00002-eng.htm

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Vulnerable groups → lower coverage

Vulnerable groups: higher background risk → greatest potential for prevention

→ Value of HPV self-sampling

Table 4
Had a recent colorectal test, Pap smear test or mammogram, by population group, Canada, excluding the territories, 2024

	Had a recent fecal test (past 2 years) or a sigmoidoscopy (past 10 years), age 50-74	95% confidence interval		Had a recent Pap smear test (past 3 years), age 25-69	95% confidence interval		Had a recent mammogram (past 3 years), age 50-74	95% confidence interval	
		Lower limit	Upper limit		Lower limit	Upper limit		Lower limit	Upper limit
	percentage								
Canada Total (excluding territories)	49.1	45.9	52.3	68.7	67.5	69.9	78.5	77.4	79.7
Racilized population									
Racialized population	49.2	46.0	52.4	62.7*	59.6	65.8	77.3	73.5	81.1
South Asian	47.5	39.8	55.1	54.6*	47.3	61.9	69.4	58.0	80.8
Chinese	52.4	45.4	59.3	62.5*	56.4	68.6	75.5	67.6	83.4
Black	46.9	38.2	55.7	66.6	59.3	74.0	79.7	70.7	88.7
Filipino	56.2	47.2	65.3	66.8	58.3	75.3	82.8	74.0	91.5
Latin American	41.6	30.3	52.9	77.2	69.7	84.7	82.4[E]	72.1[E]	92.7E[E]
Arab	36.7*	25.1	48.3	49.2*	37.8	60.6	F	F	F
Southeast Asian	53.7[E]	37.4[E]	70.1[E]	59.7	47.3	72.1	F	F	F
West Asian	45.8[E]	30.3[E]	61.3	66.0[E]	50.3[E]	81.7[E]	90.6E*	81.6[E]	99.7E[E]
Korean	56.1[E]	39.0[E]	73.3[E]	69.9[E]	54.6[E]	85.2[E]	F	F	F
Japanese	61.3[E]	45.0[E]	77.5[E]	82.4[E]	69.7[E]	95.1[E]	F	F	F
Visible minority not indicated elsewhere/multiple visible minorities	F	F	F	80.0[E]	69.6[E]	90.3[E]	F	F	F
Non-racialized population (Reference category)	49.2	48.1	50.3	71.3	70.1	72.5	79.0	77.7	80.2
Immigration status									
Immigrants[1]	48.7	46.2	51.2	65.0*	62.3	67.6	78.3	75.5	81.2
Immigrated less than 10 years ago	53.6	42.4	64.8	66.7	61.9	71.5	64.2[E]	47.2[E]	81.1E[E]
Immigrated 10 years ago or more	48.6	46.0	51.1	64.8*	61.5	68.0	79.1	76.1	82.1
Non-permanent residents	F	F	F	46.1*	35.5	56.6	F	F	F
Canadian-born (Reference category)	49.3	48.2	50.3	71.1	69.9	72.4	78.7	77.4	79.9
Indigenous identity									
Indigenous people[2]	49.9	45.9	53.8	70.5	66.6	74.3	73.0*	68.6	77.5
First Nations people living off reserve	46.8	40.1	53.4	69.7	63.8	75.7	70.8*	63.6	78.1
Métis	52.1	47.1	57.1	70.6	65.3	75.8	76.5	71.0	82.0
Inuit	F	F	F	F	F	F	F	F	F
Non-Indigenous (Reference category)	49.1	48.0	50.2	68.7	67.5	70.0	78.6	77.4	79.8
Disability[3]									
Identifies as a person with a disability	48.5	45.7	51.2	57.9*	54.5	61.3	71.1*	67.8	74.4
Does not identify as a person with a disability (Reference category)	49.1	48.0	50.3	69.8	68.5	71.1	79.5	78.3	80.8

Statistics Canada. Health Fact Sheets: Colorectal, cervical and breast cancer screening tests, 2024 (Release date: August 6, 2025). URL: https://www150.statcan.gc.ca/n1/pub/82-625-x/2025001/article/00002-eng.htm

Self-collection increases cervical screening participation

Easy use

Avoids speculum use

Less embarrassment →

More convenience

Easier access in remote areas

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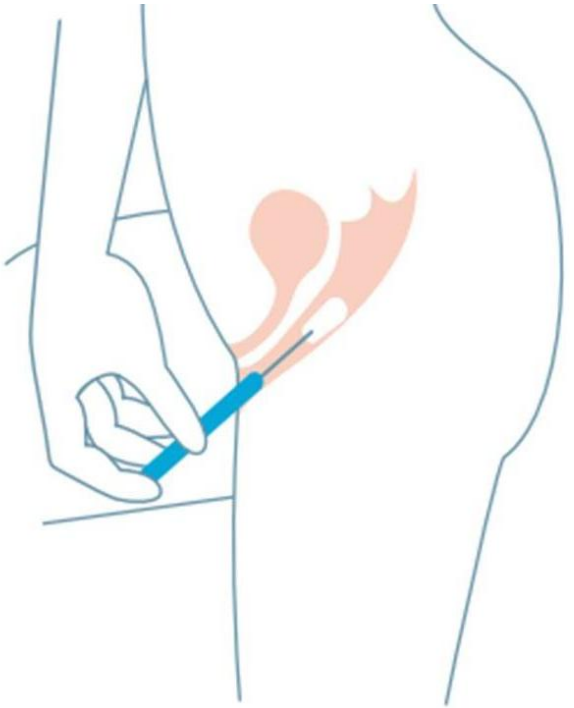
Widens access to cervical screening

More acceptable by groups less likely to engage with cervical screening

→ Used by 1 in 5 under-screened

→ Coverage: 70% → 76%



FLOQSwab (Copan)

Evalyn Brush (Rovers Medical)

Aptima Multitest Swab (Hologic)

https://screening.iarc.fr/atlasHPVdetail.php?Index=033&e=
https://phescreening.blog.gov.uk/2021/04/28/cervical-screening-self-sampling-study/
Costa et al. Br J Cancer 2023

Real-world example targeted at the under-screened: Capital Region in Denmark

Pilot implementation (2014-2015)

Target population: at least 1 year overdue

Screened ("opt in" offer, women order a SS kit):

20% with SS, 10% with CC (30% in total)
- 46% if intermittently screened
- 23% if long-term unscreened

Routine implementation (2017 and later)

Same target population

Screened ("opt in" offer):

17% with SS, 14% with CC (31% total)
- 43% if missed 1 round,
- 33% if missed >1 round
- 18% if never screened

"Opt out" offer (a SS kit is sent to all those eligible): 25% with SS, 10% with CC (35% total)

Lam et al. Int J Cancer 2017
Ejegod et al. Prev Med 2022
Pedersen et al. Int J Cancer 2025

Widespread adoption of self-sampling as a choice for all

The most typical offer of SS at present

<u>Hypothesis</u>

If everyone is offered self-sampling, then:

-Those under-screened might feel compelled to participate, without a targeted invitation

-Those well-screened might substitute clinician collection with self-collection, and:

- Use a less burdensome test
- Experience less decrease in the quality of life due to cervical screening attendance
- Free up the time of primary care providers

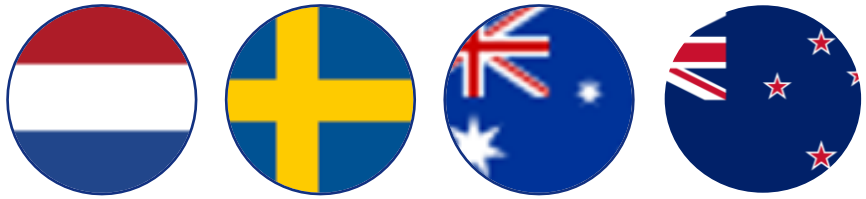
In other words:

-Under-screened: increase the coverage

-Well-screened: transform their cervical screening

No data from clinical trials or pilots

Data from routine implementation:



Transforming cervical screening: what makes it effective?

Cervical screening is a process, not merely a test

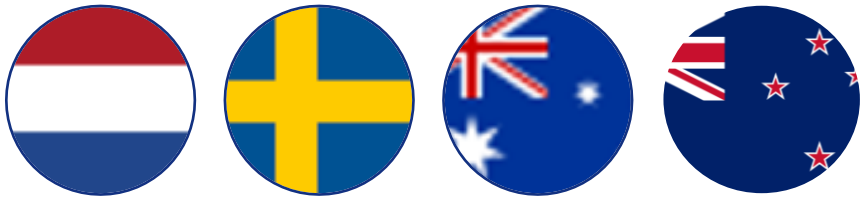
Cervical screening invitations: identification and invitation of everyone who is eligible; no cost

High coverage, including in vulnerable groups

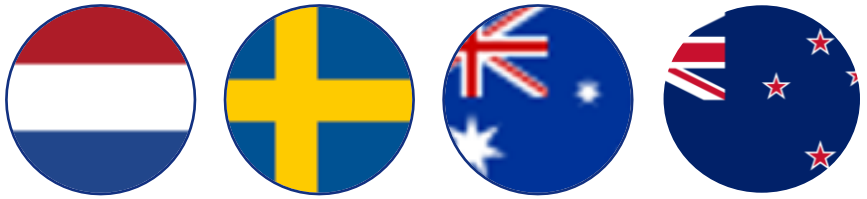
High test sensitivity for the detection of CIN2+

Those with positive HPV tests adhere with clinically recommended follow-up

How is a universal offer of self-sampling transforming cervical screening?



Cervical screening invitations



	Self-sampling implemented since	Population-based invitations since	Free tests since
Sweden	~2021 (by region)	Historic	2010's
Netherlands	2017 ("opt in") 2023 ("opt out")	Historic	Historic
Australia	2022 (universal)	2017	Historic
New Zealand	2023	2023	2023 for vulnerable groups only

Change in population-based cervical screening coverage after implementation of HPV self-sampling

Sharp increases in SS test use

Main change: cervical screening behaviour among the well-screened

Modest improvements in population-based coverage

	Self-sampling implementation	Coverage before self-sampling (year)	Recent coverage (year)	% SS among screening samples
Sweden	~2021	83% (2020)	83% (2024)	58%
Netherlands	2017 (“opt in”) 2023 (“opt out”)	78% (2016) 69% (2022)	73% (2024)	63%
Australia	2022	81% (2023)	78% (2025)	46%
New Zealand	2023	67% (2022)	75% (2025)	>80%

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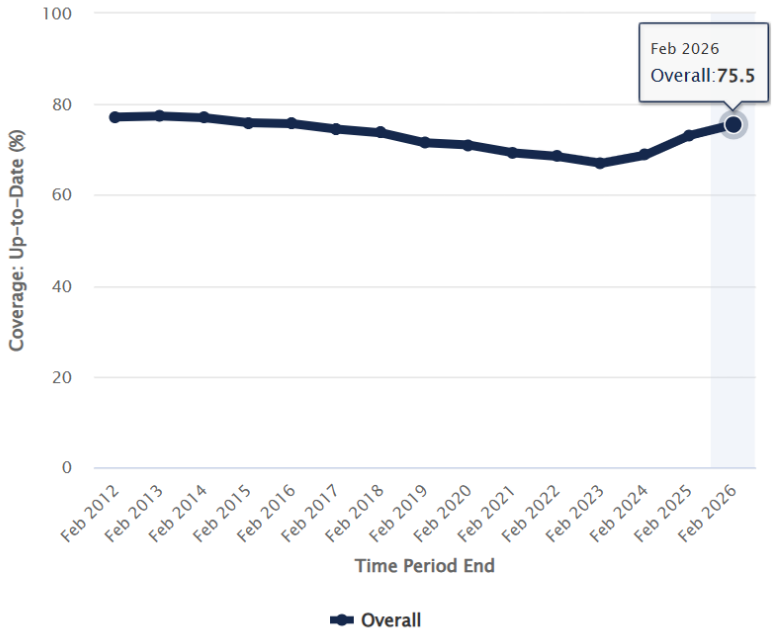
Swedish National Cervical Screening Registry: https://www.nkcx.se/index_e.htm; Andersson et al. J Med Screen 2025; RIVM: https://www.rivm.nl/sites/default/files/2026-01/monitor-bevolkingsonderzoek-baarmoederhalskanker-2024.pdf; Australian Institute of Health and Welfare: https://www.aihw.gov.au/getmedia/efb6bfa6-30de-4f42-b021-034bd2502d45/National-Cervical-Screening-Program-monitoring-report-2025.pdf?v=20251117103426&inline=true; Australian National Cancer Register: https://www.health.gov.au/sites/default/files/2025-10/update-on-cervical-screening-self-collection-uptake.pdf; Health New Zealand: https://tewhatuora.shinyapps.io/nsu-ncsp-coverage/

Persistent socioeconomic disparities (example: New Zealand)

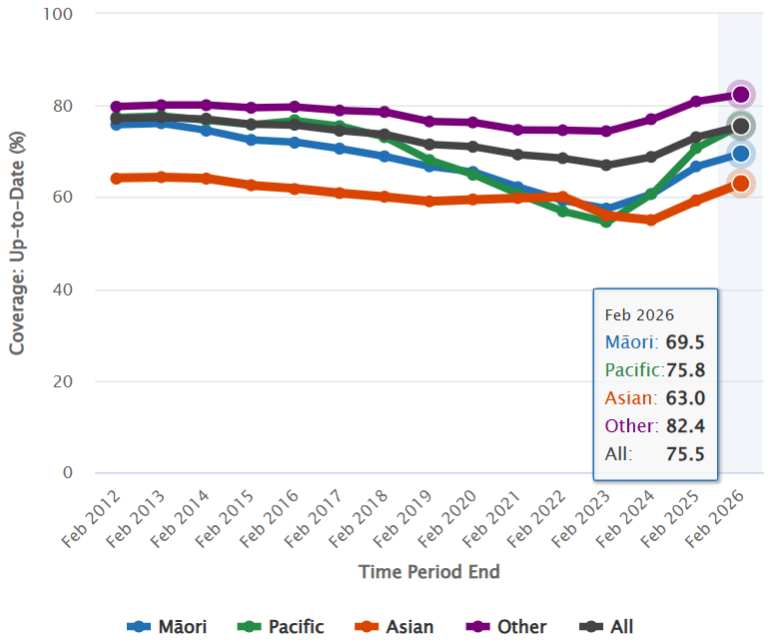
Coverage: Up-to-Date

New Zealand, Ages 25 to 69 years, 15 years to Feb 2026



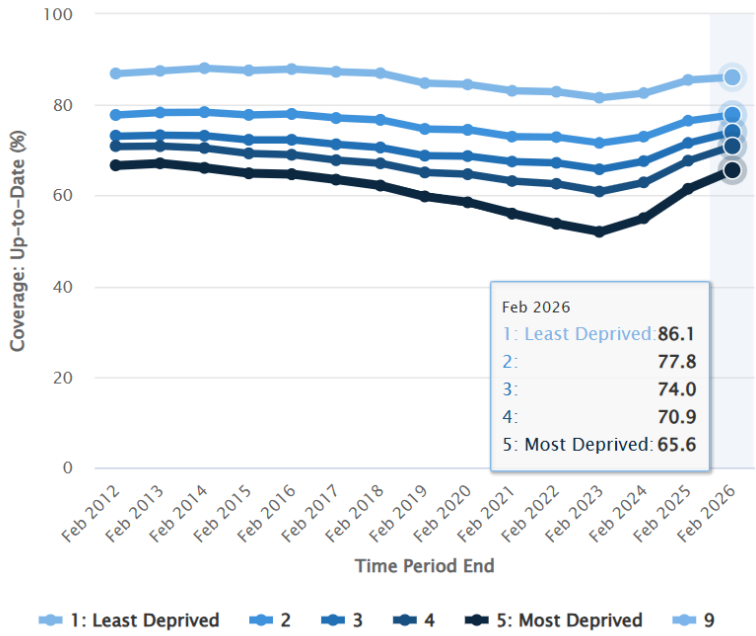
Coverage: Up-to-Date, by Ethnicity

New Zealand, Ages 25 to 69 years, 15 years to Feb 2026



Coverage: Up-to-Date, by Deprivation

New Zealand, Ages 25 to 69 years, 15 years to Feb 2026



Health New Zealand: https://tewhatuora.shinyapps.io/nsu-ncsp-coverage/

Self-sampling is not a silver bullet for increasing cervical screening coverage

Self-sampling addresses some, but not all barriers

<u>Canadian data:</u>

-Access

-Lack of awareness, no recommendation from the healthcare provider: half of under-screened women

-Disengagement after prior engagement: cervical screening reattendance only ~60%

Data like these emphasise continued importance of

-Raising awareness, starting at a young age

-Providing information and educating

-Understanding the needs of vulnerable subgroups – co-produce acceptable strategies

-Improving cervical screening experience – e.g., with reasonable adjustments

-Improving access, capacity within the healthcare system

-Improving professional guidance for providers

Alongside widening access through self-sampling

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Ontario Health: https://www.cancercareontario.ca/sites/ccocancercare/files/assets/OCSPRfullReport.pdf;
Statistics Canada: https://www150.statcan.gc.ca/n1/pub/82-625-x/2025001/article/00002-eng.htm;
Rigney et al. (advanced draft)

Controversies around test sensitivity

HPV assays: calibrated for CC, repurposed for SS

Evidence from referral population studies: SS=CC
→ “nothing needs changing”

But:

-SS have different characteristics than CC samples (e.g., cellularity)

-Referral population studies only include CIN2+ with abnormal cytology (easiest to detect)

-Missing reassurance for using SS with long intervals after HPV-negative results

CC=clinician collection. SS=self-sampling.

Arbyn et al. BMJ 2018; Inturrisi et al. Lancet Reg Health Eur2021; Stanczuk et al. Int J Cancer 2022; Aitken et al. CEBP 2023; Brentnall et al. J Clin Epidemiol 2024; Perkins et al. CA Cancer J Clin 2026

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Scarce evidence for test sensitivity in primary cervical screening of well-screened populations, using validated HPV assays

-Best available evidence: ~10% loss in sensitivity for CIN2+ compared with CC

American Cancer Society: do not extend the cervical screening interval for women screened with SS

CC=clinician collection. SS=self-sampling.

Arbyn et al. BMJ 2018; Inturrisi et al. Lancet Reg Health Eur2021; Stanczuk et al. Int J Cancer 2022; Aitken et al. CEBP 2023; Brentnall et al. J Clin Epidemiol 2024; Perkins et al. CA Cancer J Clin 2026

Communicating differences in test sensitivity

Impact of a reduction in test sensitivity:

Important for informed decision-making

a. Well-screened women (switching from CC to SS): a slightly less effective test

b. Under-screened women (alternative: no cervical screening): 90% relative test sensitivity is still great

Communication needs to be:

-Context-appropriate, acceptable to multiple cohorts

-Consistent

-Input from experts, the public

Considered a challenge

Communicating differences in test sensitivity

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Considered a challenge

ACCESS Group survey (Canada, N=1000, 2025)

Information provided, as presented in the survey	Patient opinion of information provided	Canada
		N (%)
	Total	1000 (100%)
Statement #1: "Self-collection from the vagina may be less reliable than clinician-collection from the cervix, which means it may miss cervical disease and cancer."	Clear and easy to understand	887 (89%)
	New	577 (58%)
	Helpful to decision making	805 (81%)
	Made me feel more educated	747 (75%)
	Most important message of the 5	350 (35%)
Statement #2: "If a woman who has often been screened by a clinician switches to HPV self-collection, there is a higher chance of missed disease (signs of pre-cancer) and cancer that could otherwise be detected with clinician-collection."	Clear and easy to understand	870 (87%)
	New	611 (61%)
	Helpful to decision making	792 (79%)
	Made me feel more educated	767 (77%)
	Most important message of the 5	134 (13%)

O'Connor et al. (advanced draft)

Cervical screening saves lives only if abnormal results are followed up

National clinical management recommendations

Agree triage test:

-Clinician-collected HPV test + cytology?

-Clinician-collected cytology only?

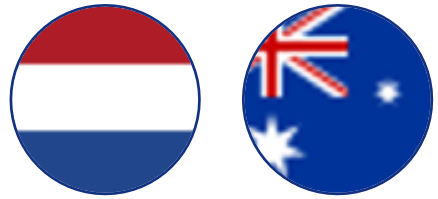
-Other biomarkers on the SS sample?

Agree criteria for referral to colposcopy:

-How many early recalls (repeat tests)?

Who is responsible? Who pays?

Cervical screening saves lives only if abnormal results are followed up



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Patient adherence

Triage:

~80% of HPV-positive women have a CC test ASAP

An additional ~10% have a CC test with a delay

Early recall:

~85% (vs ~95% after CS)

Colposcopy:

Direct: ~95% (vs ~95% after CC)

After early recall: ~90% (vs ~95% after CC)

Queen Mary University of London

Olthof et al. Int J Cancer 2024; RIVM: https://www.rivm.nl/sites/default/files/2026-01/monitor-bevolkingsonderzoek-baarmoederhalskanker-2024.pdf; Australian Institute of Health and Welfare: https://www.aihw.gov.au/getmedia/efb6bfa6-30de-4f42-b021-034bd2502d45/National-Cervical-Screening-Program-monitoring-report-2025.pdf?v=20251117103426&inline=true

Summary: how should self-sampling be deployed?

Increasing coverage

1. Population-based organisation: invitations, evidence-based national guidelines, national consistency, sufficient capacity
2. Invest in awareness, education, dialogue with vulnerable groups
3. Identify and target non-responders
4. Plan the communication strategy with experts and the public (public-facing, professional guidance)
5. Self-sampling is not a replacement for well-functioning and accessible clinician-led cervical screening

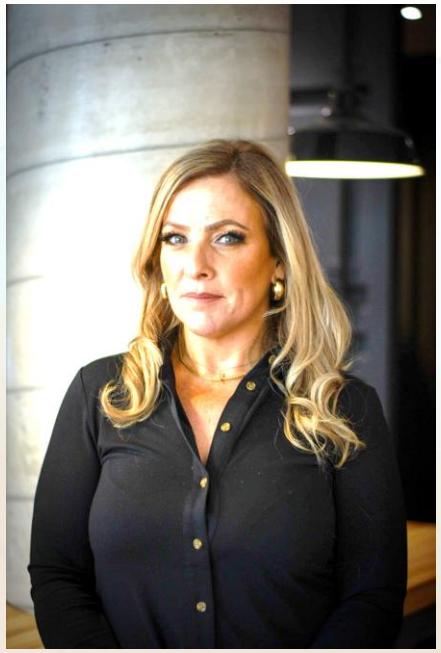
Ensuring effectiveness beyond the coverage

1. Switch from cytology to HPV testing
2. Agree clinical management guidelines and ensure adherence, identify those responsible
3. Ensure a safety net until there is evidence that HPV testing on self-collected samples is as sensitive as on clinician-collected samples (e.g., shorter intervals for HPV-negative women)
4. Monitor process indicators and outcomes, and finetune

Thank you

m.rebolj@qmul.ac.uk

Presenter



Teresa Norris

- Founder and President
  HPV Global Action
- President
  Quebec Cancer Coalition

Advancing Cervical Cancer Prevention: Recent partner experiences, informing self-sampling implementation in Canada

Presented by Teresa Norris
Sexual Health Specialist
Founder and President, HPV Global Action
President, Coalition Priorité Cancer au Québec

Thank you to all of our partners and collaborators for making this initiative possible

HPV tests NOT AVAILABLE EVERYWHERE...yet

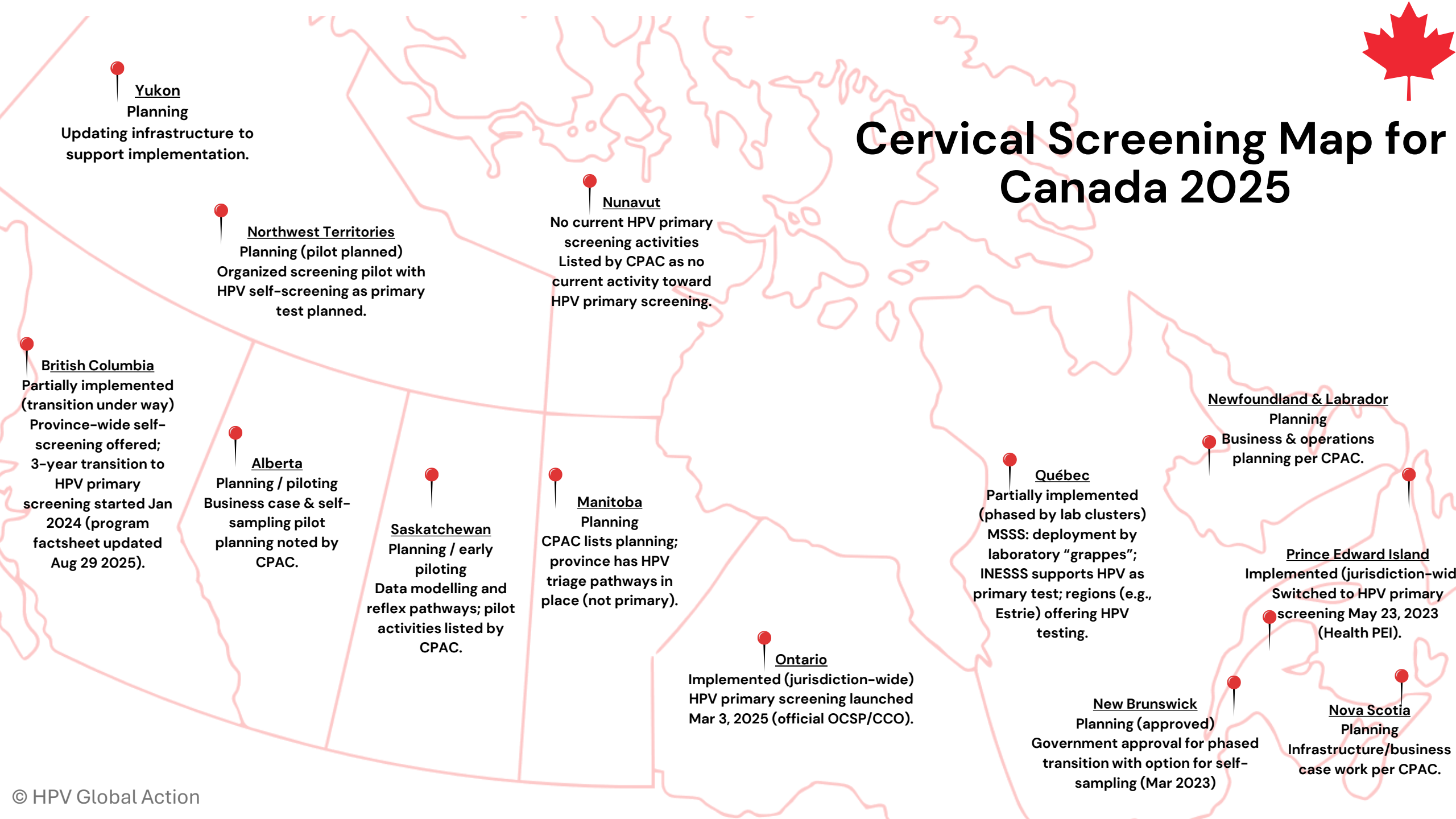
- Many clinics and regions across Canada still do cervical screening using Pap tests or have not fully rolled out HPV testing

- HPV testing may not be proactively offered to patients that are coming to a clinic for cervical screening. **Patients need to ask for it**!

- People may still be required to pay for their HPV test.
  Many insurance companies will reimburse this.

- People should check with their individual insurance plan to confirm coverage.

Cervical Screening Map for Canada 2025



Yukon
Planning
Updating infrastructure to support implementation.

Northwest Territories
Planning (pilot planned)
Organized screening pilot with HPV self-screening as primary test planned.

Nunavut
No current HPV primary screening activities
Listed by CPAC as no current activity toward HPV primary screening.

British Columbia
Partially implemented (transition under way)
Province-wide self-screening offered; 3-year transition to HPV primary screening started Jan 2024 (program factsheet updated Aug 29 2025).

Alberta
Planning / piloting
Business case & self-sampling pilot planning noted by CPAC.

Saskatchewan
Planning / early piloting
Data modelling and reflex pathways; pilot activities listed by CPAC.

Manitoba
Planning
CPAC lists planning; province has HPV triage pathways in place (not primary).

Ontario
Implemented (jurisdiction-wide)
HPV primary screening launched Mar 3, 2025 (official OCSP/CCO).

Québec
Partially implemented (phased by lab clusters)
MSSS: deployment by laboratory "grappes"; INESSS supports HPV as primary test; regions (e.g., Estrie) offering HPV testing.

Newfoundland & Labrador
Planning
Business & operations planning per CPAC.

Prince Edward Island
Implemented (jurisdiction-wid
Switched to HPV primary screening May 23, 2023 (Health PEI).

New Brunswick
Planning (approved)
Government approval for phased transition with option for self-sampling (Mar 2023)

Nova Scotia
Planning
Infrastructure/business case work per CPAC.

Pop-Up Clinic Campaign:
Why this Initiative?

- Cervical cancer is preventable with regular cervical screening

- Many individuals face barriers to access

- Cervical Cancer Awareness Month = opportunity to act and launch dedicated days to this

Pop-Up Clinic Campaign:
An Idea & Our Role

- Our organization reached out to clinics across Canada to present the opportunity to participate in the initiative

- We provided the concept, educational materials, promotional assets (posters, messaging),and supplies from Hologic

Pop-Up Clinic Campaign:
How it worked

- The clinics selected a date and time based on what worked for them

- They advertised locally & hosted the free cervical screening day

- HPV Global Action helped with promoting local cervical screening days

Pop-Up Clinic Campaign:
Impact & Lessons Learned

From One-Day Events to Ongoing Programs

- Clinics expanded beyond initial events
- Now offering **regular cervical screening days**

Examples of sites that have extended the pop- up clinics:

- Hull, Ontario: 2x month free screening days
- Akwesasne, Quebec: last three days of every month they are doing pop up clinics for cervical screening
- Alberta clinic: offering free screening every 2 weeks
- Montreal region, QC: Offered 5 free screening days

Pop-Up Clinic Campaign:
Lessons Learned

- **It's easy to initiate, ACTION is the key step**
- **Clinics will run with a good idea**
- **Small initiatives can create lasting change**

Cervical Screening: Pop-Up Clinics

PARTNER QUOTES :

"We have the tools to eliminate cervical cancer. Expanding access to HPV-based cervical screening, ensuring strong support through every step of care, and empowering women with knowledge to act on screening opportunities bring us closer to a future free of cervical cancer."

Amelie McFadyen, CEO, HPV Global Action

"We have an opportunity to end cervical cancer by focusing on HPV screening and follow up. We need to raise awareness and work with diverse health care professionals to reach women where they are."

Carmen Wyton, CEO, Women's Health Coalition

"Many women are not receiving the care they deserve, and as a leading innovator in women's health, we are on a mission to change that. We are grateful to work with our partners and clinics across Canada to bring these pop-ups to women and people with a cervix, in an effort to increase access to necessary screenings that can help prevent cervical cancer."

Sheron Brosseau, Marketing Manager, Hologic Inc

"Improving access to cervical screening across Canada is key to ensuring everyone has a fair chance at early detection and preventing cervical cancer."

Cidalia Sluce, National Manager, Society of Gynecologic Oncology of Canada

Thank You For Listening!

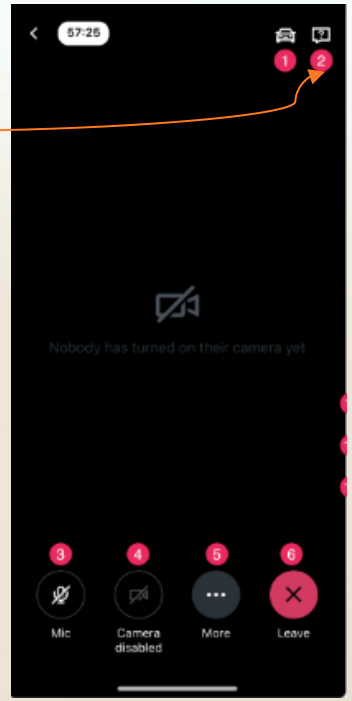
Teresa Norris
tnorris@hvpglobalaction.org

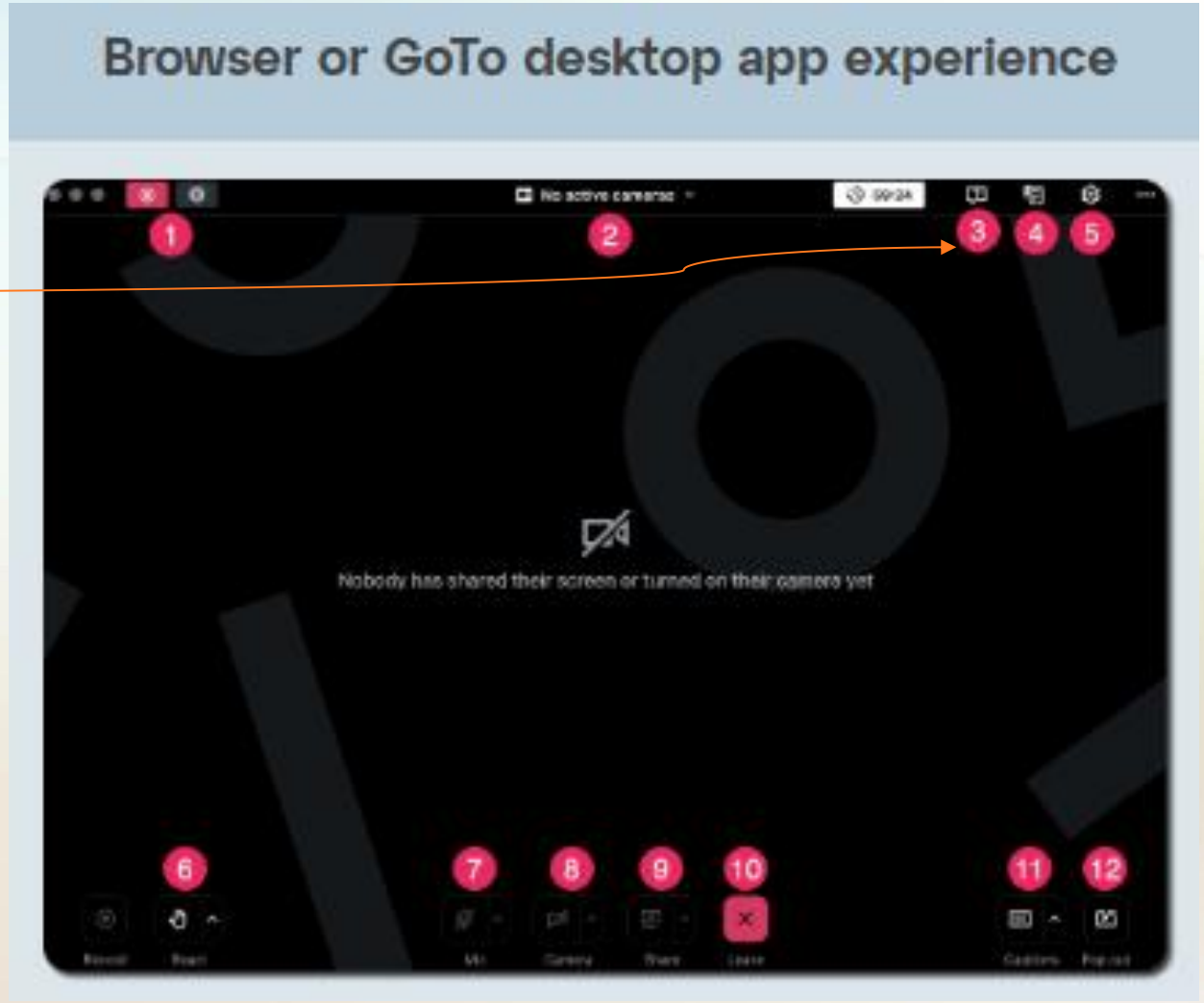
hpv global action

Question & Answer Period

On a **computer**, submit your text question using the Questions pane after clicking the icon (#3)

NOTE: On a **mobile device**, tap on the "?" (#2) to open the questions pane





Advancing Cervical Cancer Prevention:
Global Evidence, Self-sampling Insights & Implications for Canada

Evaluation: https://forms.gle/KbmnTU9WhH7fyCHWA

Slide Set, Video recording, HPV documents at:
hpvglobalaction.org & www.CIDCgroup.org

Thank you for participating!

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The opinions expressed in this webinar are those of the presenter and do not necessarily reflect the views of CIDC, HPV Global Action or their partners