

**NARRATIVE REVIEW** OPEN ACCESS

# Cervical Cancer Elimination in Australia and the Asia Pacific: Progress and Barriers

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## ABSTRACT

Australia has been at the forefront of innovation and implementation of cervical cancer control and is predicted to eliminate cervical cancer by 2035, the first country to achieve elimination using active measures. This is a result of Australia being an early adopter of universal human papillomavirus (HPV) vaccination and early transition to a primary HPV-based cervical screening program. However, to ensure timely and equitable elimination, disparities in coverage among underserved populations must be addressed, and recent declines in vaccination and screening uptake must be reversed. Improved routine data linkages are required to ensure gaps in participation in subpopulations can be identified. Primary health providers have an important role in checking vaccination and screening status and offering vaccination catch-up or screening as appropriate. A universal option of self-collection of an HPV sample for all screen-eligible people has increased acceptability overall, but further innovative and flexible models of service delivery are required to ensure equitable access for all. Australia has also played an important role in cervical cancer control globally and was a co-sponsor of the 2020 World Health Assembly resolution to accelerate the global elimination of cervical cancer as a public health problem. In the Indo-Pacific region, regional frameworks have been developed to advance strategic actions to progress implementation of the global strategy. The Elimination Partnership in the Indo-Pacific for Cervical Cancer (EPICC), a major initiative supported by the Australian Government and the Minderoo Foundation, provides tailored support to countries, considering local needs and priorities.

**JEL Classification:** Neoplasms, Infectious diseases

## 1 | Introduction

Australia has been at the forefront of innovation and implementation of cervical cancer control and was a co-sponsor of the 2020 World Health Assembly resolution to accelerate the global elimination of cervical cancer as a public health problem. As one of the first countries to introduce national vaccination against human papillomavirus (HPV) and to transition from a cytology-based to HPV-based cervical screening program, Australia is on track to be the first country to eliminate

cervical cancer via active deployment of prevention and control interventions [1, 2]. Australia has also been instrumental in supporting countries in the Indo-Pacific region to develop and amplify cervical cancer elimination efforts. In this narrative review, we discuss Australia's progress towards achieving elimination, and doing so equitably, within the predicted 2035 timeframe, and provide an overview of Australia's role in supporting elimination in the region. This review summarises relevant peer-reviewed articles, sourced through literature searches informed by the authors' expertise and knowledge,

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and also draws on national and international government reports and data.

Throughout this article, we have used the inclusive term ‘people’ to refer to all those with a cervix when discussing policy or recommendations. However, the terms ‘females/women/girls’ and ‘males’ are used as appropriate when needed to accurately reflect the wording of policy or guidelines published by the World Health Organization (WHO) and other country governments, and as required to reflect formal classification of data by sex, where this is relevant to the cited source.

## 2 | The Global Strategy to Accelerate Cervical Cancer Elimination

In 2018, the WHO issued a call-to-action to eliminate cervical cancer as a public health problem, and in 2020, released a global strategy to accelerate the elimination of cervical cancer [3]. Based on modelled analysis of the impact of combined, scaled-up interventions [4, 5], the WHO strategy called for the following targets to be met by 2030, to set every country on the path to elimination of cervical cancer: 90% of girls to receive HPV vaccination by age 15 years, 70% of women to be screened with a high-performance HPV test by age 35 and again by age 45 years, and 90% of women with pre-cancer or invasive cervical cancer able to access treatment. The elimination threshold is defined as 4 cases per 100,000 women per annum (age-standardised using the WHO World 2015 female population) [6]. The modelled analysis supporting the strategy demonstrated the synergistic effects of the various interventions: increasing access to pre-cancer/cancer treatment leads to the most rapid impact on lives saved (within a decade), cervical screening with pre-cancer treatment and associated early detection saves lives in the interim period (30–50 years) and prophylactic HPV vaccination of young adolescents will save lives over the longer term by protecting younger cohorts against HPV exposure and eventually lowering the risk of developing cervical cancer in adults [4, 5].

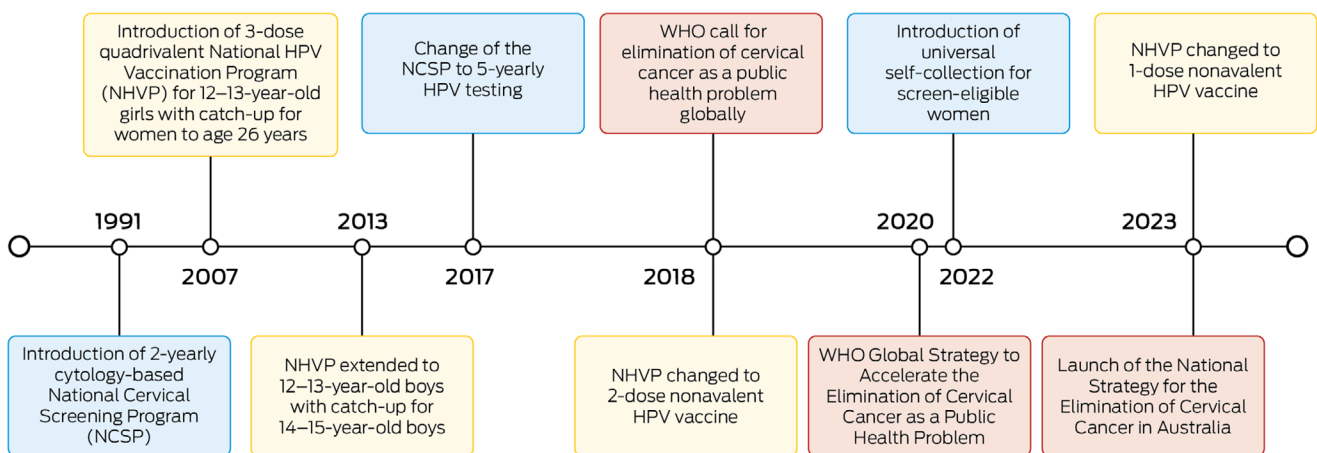
## 3 | Australia: A Case Study for Elimination

Australia is an exemplar for high-income countries internationally, in terms of demonstrating the potential of combined

and scaled-up interventions across the cervical cancer control spectrum. The timeline for the implementation of various developments in vaccination and screening is shown in Figure 1. Opportunistic cytology (Pap test) screening occurred in Australia from the mid-1960s, and in 1991, Australia introduced an organised National Cervical Screening Program (NCSP), with cytology screening recommended every 2 years for women aged between 20 and 69 years. In the decade following the NCSP introduction, cervical cancer incidence and mortality halved in most age groups, but incidence then plateaued from the early 2000s [7, 8]. The reduction in incidence was predominantly seen in squamous cell carcinomas, with little impact on adenocarcinomas, and there was no reduction observed in cervical cancer incidence in 20- to 24-year-olds [8, 9].

In 2007, Australia became the first country to introduce national publicly funded HPV vaccination, with school-based delivery for adolescent females and an initial catch-up to age 26. The program was extended to include adolescent males in 2013. At the inception of the program, a 3-dose quadrivalent vaccine regimen was recommended, transitioning to a 2-dose recommendation for nonavalent vaccine in 2018 and then to single-dose vaccination in 2023. A number of surveillance studies have demonstrated the substantial impact of vaccination on various health outcomes; for example, the reported prevalence of vaccine-preventable HPV types in 2015 was 92% lower among those aged 18–24 years (vaccinated age ~12–17 years) and 90% lower in those aged 25–35 years (vaccinated age ~16–26 years) compared with pre-vaccination rates [10]. After the introduction of HPV vaccination, there was also a substantial reduction in the rates of high-grade cervical lesions, initially in the 20- to 24-year age group and later in the 25- to 29-year age group [11].

In December 2017, the NCSP transitioned from cytology screening every 2 years to screening with primary HPV testing every 5 years. Compared with cytology screening, primary HPV screening has been shown to be more effective in preventing the highest grade of pre-cancer (cervical intraepithelial neoplasia grade 3 [CIN3]) and invasive cervical cancer [12–15]. At the time of the transition, an option was included for HPV vaginal sample self-collection for people aged 30–74 years who were 2 or more years overdue for screening. Since July 2022, and based on emergent evidence of comparable accuracy to clinician-collected samples



**FIGURE 1** | Timeline of important cervical cancer control measures in Australia. HPV, human papillomavirus; WHO, World Health Organization.

[16], it is recommended that all eligible cervical screening participants be offered the option of self-collection [17]. The NCSR is supported by the National Cancer Screening Register (NCSR), which replaced state-based registries in the HPV-based program. The NCSR sends invitations to eligible people, based on Medicare (the national health scheme) enrolment data, using a call-recall system. Healthcare providers, including general practitioners (GPs), nurses and specialists, can access the NCSR to obtain the person's cervical screening history.

Modelled analysis of the combined impact of vaccination and screening suggested that Australia could reduce rates of cervical cancer to below the 4 cases per 100,000 women per annum elimination threshold by 2028–2035 at a population level [1, 2]. However, inequities in coverage of prevention measures may result in delays in elimination in some subpopulation groups. To support national elimination of cervical cancer by 2035, and across all subpopulation groups, a *National Strategy for the Elimination of Cervical Cancer in Australia* was developed in collaboration with a wide range of community stakeholders and released in 2023 [18]. The strategy outlines four 2030 targets that align with but also build on the WHO targets, 10 strategic priorities needed to ensure equitable elimination of cervical cancer and 35 supporting actions to achieve the priorities (Figure 2) [18]. Five priority groups were identified: people who identify as Aboriginal and/or Torres Strait Islander, people of culturally and linguistically diverse backgrounds, residents of rural and remote areas, gender and sexually diverse people and people with disability.

Annual reports that track Australia's progress towards elimination have been published since 2021 by the National Health and Medical Research Centre of Research Excellence in

Cervical Cancer Control (C4), supported by the Commonwealth Department of Health, Disability and Ageing [19]. However, reporting against indicators has been limited for some priority groups by a lack of availability of routinely collected data stratified to priority subpopulations. This has resulted in limited or no reporting of coverage in people of culturally and linguistically diverse backgrounds, gender and sexually diverse people and people with disability and gaps in reporting coverage in people who identify as Aboriginal and/or Torres Strait Islander.

## 4 | Australia: Current Snapshot of Progress Towards Elimination

### 4.1 | Cervical Cancer Incidence and Mortality

In the latest available national incidence and mortality data, 5-year cervical cancer incidence was 6.4 per 100,000 women nationally (2017–2021) (age-standardised using the WHO World 2015 female population), but incidence rates in Aboriginal and Torres Strait Islander women were nearly twice that of non-Indigenous women, and incidence increased with increasing area-level socio-economic disadvantage and tended to increase with increasing remoteness [19]. It is estimated that, with current vaccination and screening rates, elimination in Aboriginal and Torres Strait Islander people will occur a full decade later than the 2035 target date set in the national elimination strategy. However, modelling has identified that a concerted screening catch-up campaign, with sustained ongoing efforts, could accelerate elimination in Indigenous women and align timing to near the national target date [20]. There has been a steady decline in cervical cancer incidence in younger age groups, suggestive of a preventive effect of HPV vaccination [19]. In women aged

WHO 2030 targets	Australia 2030 targets	Strategic priorities to achieve elimination
<4 cases of new cervical cancer per 100,000 women		1. Ensure that Australia has access to timely and accurate cervical cancer incidence and mortality data
90% of girls fully vaccinated with the HPV vaccine by age 15 years	90% of all eligible people vaccinated against HPV	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
70% of women screened with an HPV test by age 35 years and again by age 45 years	70% of eligible people screened every 5 years	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 equity and uptake 7. Collect, use and release data to enable and monitor equity of access to cervical screening and pre-cancer treatment services
90% of women receive treatment for pre-cancerous lesions or management of invasive cancer	95% of eligible people receive optimal treatment for pre-cancer and cancer	8. Ensure communities and patients have equitable access to quality information about cervical cancer symptoms and that each patient has tailored information about their diagnosis, intended treatment plans and optimal care pathways 9. Develop and implement a road map of coordinated care, with communities of practice, to optimise the delivery of safe, high quality care to all 10. Deliver a national cervical cancer management model through a data collection framework supporting systematic monitoring and enhancement of the high quality of care, in alignment with the Australian Cancer Plan

**FIGURE 2** | World Health Organization (WHO) and Australian 2030 elimination targets and strategic priorities to achieve cervical cancer elimination by 2035 in Australia. Adapted with permission from the National Strategy for the Elimination of Cervical Cancer in Australia [18]. HPV, human papillomavirus; WHO, World Health Organization.

25–29 years, rates dropped from 9.3 cases per 100,000 in 2013, to 3.4 cases per 100,000 in 2021. No new cases of cervical cancer were diagnosed in women younger than 25 years in 2021, but exact rates in this age group must be interpreted with caution as numbers are small. Higher cervical cancer mortality rates (2019–2023) were observed among women who are Aboriginal or Torres Strait Islander, resided in areas of higher socio-economic disadvantage and resided in outer regional areas (rates for women residing in remote and very remote area were not published due to small numbers) [19]. Routine data are not currently available for culturally and linguistically diverse people but the most recent national analysis (2005–2014) found that cervical incidence rates were significantly higher in women who had migrated from Polynesia, New Zealand and the Philippines [21].

#### 4.2 | HPV Vaccination

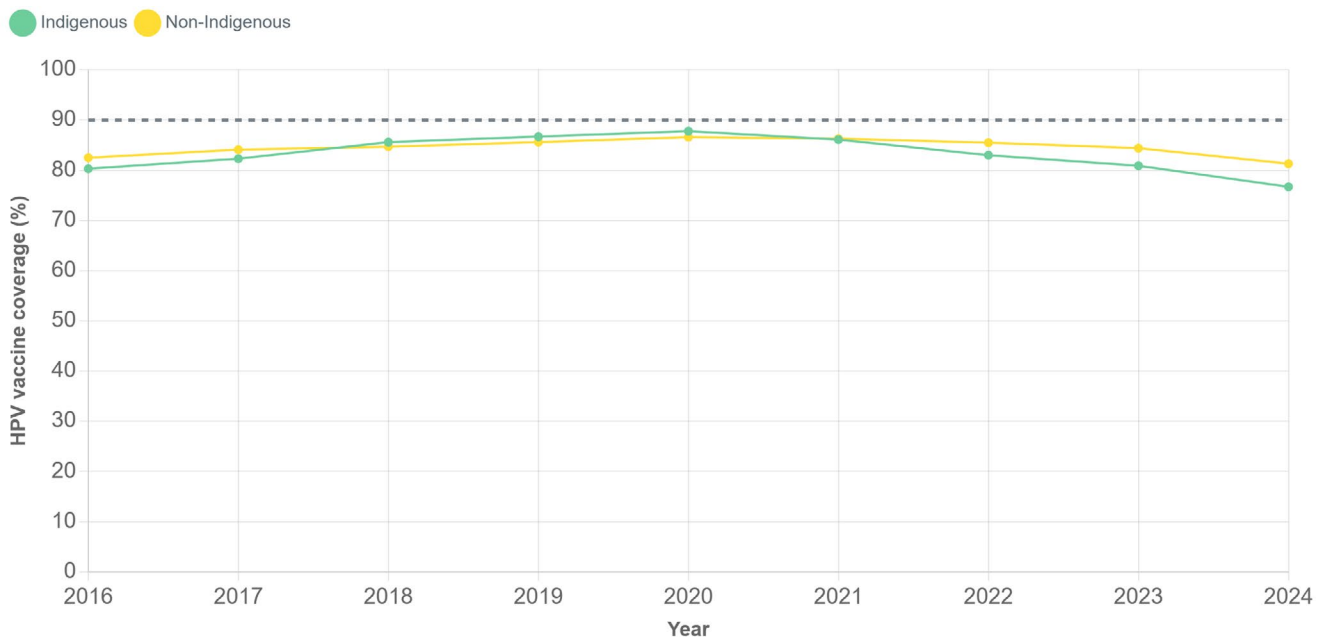
While relatively high HPV vaccination coverage has been achieved since the inception of the program, and coverage had been increasing over time, since the coronavirus disease 2019 (COVID-19) pandemic there have been year-on-year falls in vaccination coverage and increasing inequity in coverage (Figure 3) [19]. Peak coverage rates (86.6%) were reached in the female cohort who turned 15 years in 2020, with coverage dropping to 85.3% and 81.1% in the 2022 and 2024 cohorts, respectively [22]. In the 2020 cohort, coverage was higher in Aboriginal and Torres Strait Islander females than in non-Indigenous females, but there has since been a greater decline in coverage of Indigenous females [19]. There were also greater drops in coverage in females overall living in remote and very remote areas and in those living in areas of highest socio-economic disadvantage. While vaccine hesitancy/fatigue may be contributing to falls in vaccine coverage, practical issues are probably equally or more important; the change to the one-dose HPV vaccination regimen has resulted in

a single opportunity in the school year to be vaccinated meaning children not at school that day will miss out (with school absentee rates remaining higher than pre-pandemic rates) [22, 23]. The use of electronic consent, which has been progressively introduced across some states, will disadvantage those with no internet access. Catch-up vaccination is available through schools in some state/territory programs and in community-based settings including GPs, paediatricians, other community-based health workers and pharmacies, up to, and including, the age of 25. GPs and other community-based health workers can play a vital role in checking vaccination status by accessing the Australian Immunisation Register and offering catch-up vaccination to those who missed out on routine vaccination [24].

#### 4.3 | Cervical Screening

There has been limited time for people in Australia to have had two HPV tests by age 45, but nationally, by the end of 2024, 85.0% of women aged between 35 and 39 years had been screened at least once with an HPV test and the 70% WHO target for the first HPV screen is being met in all states and territories and across all area-level socio-economic status (SES) and remoteness groups [19]. However, data are not yet complete for this target to be assessed among Aboriginal and Torres Strait Islander people.

In the 2023 national elimination strategy, the screening target was set at 70% of eligible participants to be screened every 5 years (versus the WHO target of 70% of women to be screened [twice] by 35 and again by 45 years). At the end of 2024, 74.2% of those eligible for screening were up-to-date, but the 70% threshold was not reached in those aged 25–29 years (50.0%), 30–34 years (68.0%) and 70–74 years (68.8%), and in those residing in the lowest SES quintile (67.9%), and was only



Target shown in grey dashed line.

**FIGURE 3** | Human papillomavirus (HPV) vaccine coverage over time by age 15 years by Indigenous status in females (2016–2024). Reproduced with permission of Smith et al. [19]. HPV, human papillomavirus.

just achieved in women residing very remotely (70.5%) [19]. Furthermore, the proportion of all eligible women screened had dropped slightly to 74.2% from 76.5% in 2022 [19], consistent with a longer-term decline in screening coverage seen in Australia since 2000 [25, 26], which has also been observed in other high-income countries [27]. There are no HPV-based screening coverage data available for culturally and linguistically diverse subgroups, but studies of overseas-born women living in NSW found lower participation in the cytology-based program, in particular among Pacific Islander, Southern/Central Asian and New Zealand women [28, 29]. Gender and sexually diverse people have experienced misinformation regarding their need for cervical cancer prevention measures and face additional barriers including discomfort related to clinician-collected cervical sampling, contributing to lower screening rates than the general population [30].

At the time of the introduction of HPV testing, the option of self-collection was available to women aged 30–74 years who were 2 or more years overdue for cervical screening, but uptake of self-collection was less than 1% from 2018 to 2019 [31]. The expansion of self-collection eligibility in July 2022, complemented by outreach programs and publicity campaigns from September 2024, including extensive GP education and targeting of priority groups [32–34] has seen a progressive increase in the proportion of screening tests that are self-collected. In the second quarter (April–June) of 2022, immediately before the change to allow universal access, 1.2% of all HPV screening tests were self-collected, increasing to 46% by the second quarter of 2025, with the increase in the proportion of self-collected samples seen across all age groups, states and territories, SES areas and remoteness areas [35, 36]. Substantial increases were seen in the underscreened and never screened groups, with 60% and 54% of tests, respectively, being self-collected in these groups in the second quarter of 2025. The overall impact on population coverage has not yet been quantified, because screening volumes have oscillated since the transition to 5-yearly HPV testing in December 2017, and some self-collection will reflect people switching from a clinician-collected to a self-collected test for their routine screening examination [36].

#### 4.4 | Follow-Up and Treatment of Cervical Pre-Cancer

For individuals with screen-detected abnormalities classified as higher risk in 2022, 46.5%, 61.6% and 69.4% of women had a record of colposcopy attendance by 3, 6 and 12 months, respectively [37]; age-adjusted attendance rates by 3 months were lower in Aboriginal and Torres Strait Islander participants (50.8%) than non-Indigenous participants (60.8%) [38]. Attendance was lowest at all time points in those living in remote and very remote areas [19]. While no targets have been set as part of the elimination strategy, colposcopy assessment is necessary to determine which women require treatment. Introduction of targets for colposcopy, as occurs in comparable countries such as New Zealand and the United Kingdom, could be considered to ensure timely diagnosis of high-grade disease [39, 40].

Among women with high-grade cervical disease detected in 2023, 54.6%, 82.7% and 86.5% were treated within 8 weeks, 6 months and 12 months, respectively, falling short of both the

WHO and Australian national elimination strategy targets of 90% and 95%, respectively. There were also small drops over time observed from 2020 to 2021, from 2021 to 2022, and again from 2022 to 2023 in the proportions treated. The proportion of women with high-grade disease treated in 2023 varied by state/territory, with the lowest rates (by 6 and 12 months) observed in individuals residing in the Northern Territory, Victoria and NSW [19]. Possible reasons for lack of treatment at 6 or 12 months are loss to follow-up, treatment refusal and women opting for surveillance of cervical intraepithelial neoplasia grade 2 (CIN2). Competition for surgical resources after the COVID-19 pandemic may partly explain falling treatment rates in 2021 and 2022.

## 5 | Progress Towards Elimination in the Indo-Pacific Region

For countries in the Indo-Pacific region, health system capacity for elimination and socio-political contexts vary. Recognising this, the WHO Western Pacific Regional Office (WPRO) and the South-East Asia Regional Office (SEARO) developed the *Strategic Framework for the Comprehensive Prevention and Control of Cervical Cancer in the Western Pacific Region 2023–2030* [41] and the *Regional Implementation Framework for Elimination of Cervical Cancer as a Public Health Problem: 2021–2030* [42], respectively. These frameworks advance strategic actions to progress implementation of the global strategy in the Indo-Pacific region, while allowing each country to tailor their programs according to local priorities.

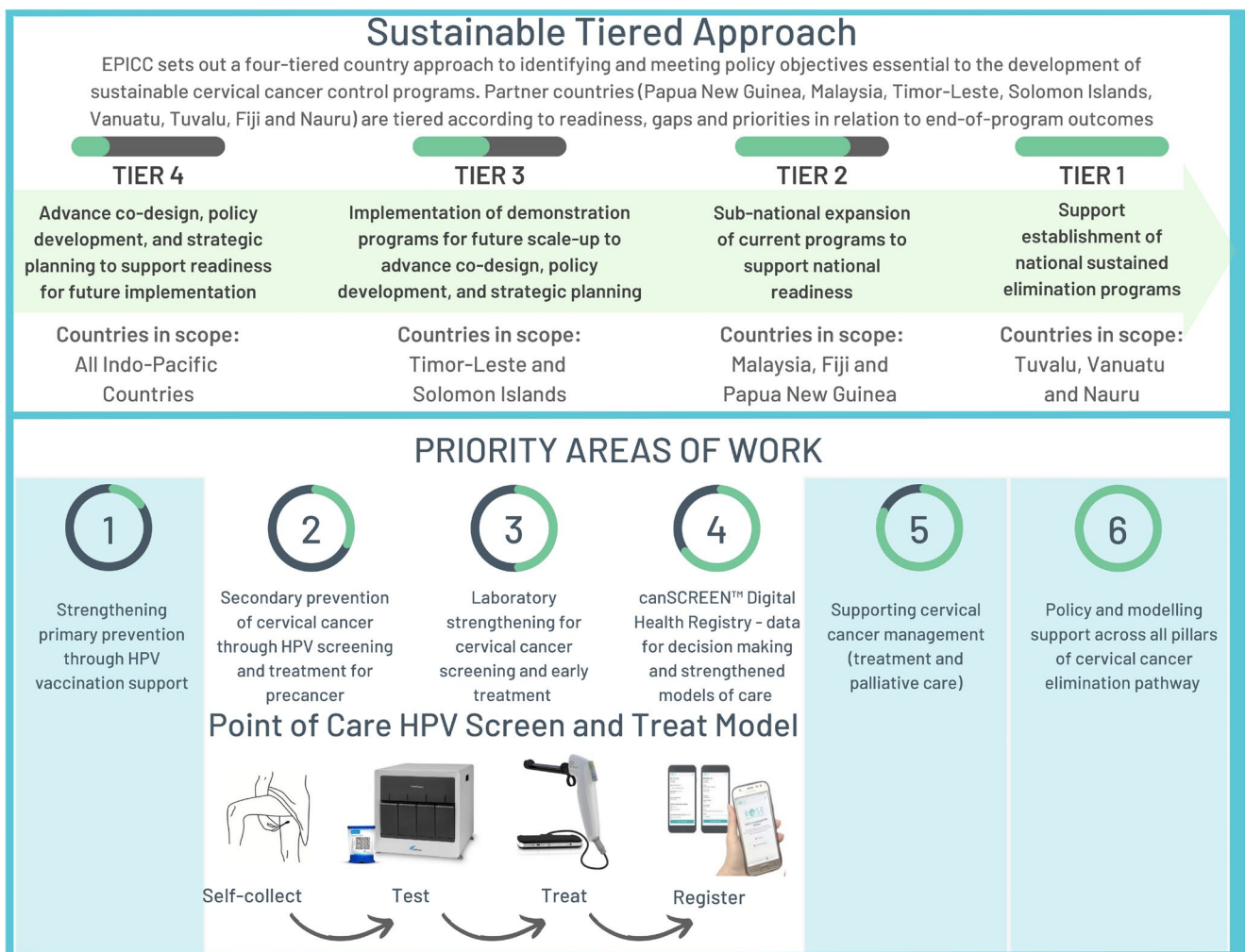
Many Indo-Pacific countries experience very high cervical cancer incidence and mortality rates. In 2022, around 196,000 women in the Southeast Asia region and about 185,000 women in the Western Pacific region were newly diagnosed with cervical cancer, with an estimated 70,000 women dying from the disease [43, 44]. For example, Indonesia has annual age-standardised cervical cancer incidence and mortality rates of 23.4 cases and 13.9 deaths per 100,000 women, among the highest in Southeast Asia [45]. In the Western Pacific, Vanuatu reports an incidence rate of 17.1 cases per 100,000 women and a mortality rate of 14.9 deaths per 100,000 women [46]. These figures represent incidence rates 3–4 times and mortality rates 10 times higher than in Australia [19]. These disparities across countries are largely attributable to historically limited access to HPV vaccination and effective cervical screening and treatment services.

Coordinated efforts are essential to overcome the burden of disease inequities in the region. Australia has played a key role in supporting neighbouring countries to progress towards cervical cancer elimination. The Elimination Partnership in the Indo-Pacific for Cervical Cancer (EPICC) program, funded by the Australian Government and the Minderoo Foundation, brings together in-country leaders and Australian and international partners to support multiple countries in advancing cervical cancer elimination [47, 48]. The total investment in EPICC and its foundational programs exceeds \$42 million AUD, with additional philanthropic initiatives in the region complementing EPICC's efforts and helping to catalyse progress [49–52]. EPICC is an end-to-end, sustainable regional program supporting the cervical cancer control continuum,

structured around six priority areas of work (Figure 4), which encompass activities across the three elimination pillars (prophylactic HPV vaccination, screening and triage, treatment and management). A tiered implementation framework provides support based on country priorities and requests: Tier 1 countries are supported towards meeting the 90-70-90 WHO targets nationally, Tier 2 countries are expanding programs sub-nationally (scaling evidence-based cervical cancer models of care in selected subnational areas), Tier 3 countries are implementing initial demonstration programs (initiatives designed to pilot and tailor models of care before national or sub-national rollout), and Tier 4 countries are progressing policy development and planning activities (Figure 4). One example of a Tier 1 country is Vanuatu, which has demonstrated commitment to cervical cancer elimination through the rollout of screening and vaccination services and is the first Pacific Island country to have a national elimination strategy. HPV vaccine delivery has commenced in all provinces, via schools and community-based settings, coupled with implementation of a nation-wide point-of-care HPV screening and pre-cancer treatment program. Vanuatu's continued expansion of services and current emphasis on working towards sustainability, establishes the country as a regional leader and model for the Indo-Pacific region.

A Tier 2 country example is Malaysia, which has faced challenges common to many countries, including low levels of awareness, fear of screening and limited access to services. However, building on its introduction of HPV vaccination in 2010, Malaysia has made substantial progress by transitioning to primary HPV screening via the introduction of Program ROSE, with the Ministry of Health phasing in the program from 2019 and setting a target to increase screening coverage from 40% to 70% by 2023 [53]. A modelled analysis has demonstrated that if Malaysia maintains high HPV vaccination coverage (90%) and implements national 5-yearly HPV screening by 2030, with 70% of women getting screened by 2040, cervical cancer could be eliminated by 2055–2059 [54]. Program ROSE involves centralised laboratory-based HPV screening, with self-collection, and as for all EPICC-supported countries, harnesses a digital screening registry whereby women are notified of their results and linked to follow-up care as required. The program has operated in over 200 community locations across 12 of the 13 Malaysian states, contributing to equity and national coverage [55].

Timor-Leste, with leadership from the Ministry of Health (an example of an EPICC Tier 3 country), is implementing a demonstration project to inform future national scaling of activities



**FIGURE 4** | Overview of the sustainable tiered approach and priority areas of work for the Elimination Partnership in the Indo-Pacific for Cervical Cancer (EPICC) Program. Used with permission from the Australian Centre for the Prevention of Cervical Cancer. HPV, human papillomavirus.

with the launch of an HPV screen-and-treat clinic in Dili, offering self-collection and same day treatment with thermal ablation for eligible women. This marks a significant step in providing access to an organised and integrated screening service [56]. In parallel, Timor-Leste has demonstrated strong early momentum in HPV vaccination, achieving about 90% coverage within the first 3 weeks of program initiation [57].

A final example is Indonesia (an EPICC Tier 4 example), which is showing strong national commitment to providing affordable and comprehensive care as part of its efforts towards cervical cancer elimination. This commitment has been made clear through the development of its *National Cervical Cancer Elimination Plan for Indonesia 2023–2030*, which promotes a whole-of-society approach and outlines health system reforms to support these efforts [58]. This commitment was reaffirmed at the second WHO Global Cervical Cancer Elimination Forum in June 2025, where the Minister of Health of Indonesia highlighted the country's vision to expand across cervical cancer services [59]. The focus is on development of sustainable plans and financing mechanisms that align health, energy and data systems to create long-term pathways that can sustain cervical cancer elimination efforts; recently a major technical assistance facility was launched, supported by EPICC and the Women's Health and Economic Empowerment Network (WHEN) [60].

## 6 | Conclusion

It has been over 5 years since the launch of the WHO global strategy to accelerate the elimination of cervical cancer as a public health problem, and therefore, there are just 5 years remaining to achieve the 2030 targets for vaccination, screening and treatment. In Australia, there are 9 years left to 2035, to realise the national goal to achieve elimination and to do so equitably. Some critical enablers of success will include the vital role of primary health providers in checking vaccination and screening status and offering vaccination catch-up or screening as appropriate. Improved routine data linkage is important to identify gaps and disparities in various subpopulations. Overcoming such gaps will require innovative and flexible models of service delivery (e.g., capitalising on emerging opportunities for an expanded scope of self-collection services including via telehealth, using point-of-care approaches in remote Indigenous communities [61] and co-designing more accessible screening information for underserved people such as those with disability). In the broader Indo-Pacific region, ongoing efforts must continue to support countries to build on progress to implement sustainable programs and to establish robust monitoring systems to track progress towards elimination.

### Author Contributions

**Susan Yuill:** writing – original draft, writing – reviewing and editing. **Carol Naidu:** writing – original draft, writing – reviewing and editing. **Megan Smith:** writing – reviewing and editing. **Deborah Bateson:** writing – reviewing and editing. **Marion Saville:** writing – reviewing and editing. **Boniface Damutalau:** writing – reviewing and editing. **Karen Canfell:** conceptualisation, supervision, writing – reviewing and editing.

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### Disclosure

Commissioned; externally peer reviewed.

### Conflicts of Interest

Karen Canfell declares she is co-principal investigator of an investigator-initiated trial of human papillomavirus screening in Australia ('Compass'), which is conducted by the Australian Centre for the Prevention of Cervical Cancer (ACPCC), a government-funded health promotion charity. The ACPCC has previously received equipment and a funding contribution for the Compass trial from the Australian Government, Roche Molecular Systems USA and Micobix. She is also co-principal investigator on a major implementation program 'Elimination Partnership for Cervical Cancer in the Indo-Pacific', which receives support from the Australian Government, the Minderoo Foundation and equipment donations from Cepheid Inc. Marion Saville is an investigator on the Compass trial and EPICC. ACPCC has received funding from Copan for independent assessment of Copan products. ACPCC has also received equipment or supplies from Abbott, AusDiagnostics, BD, Cepheid, Copan, Hologic, Microbiologics, MicroBix, Teal Health, V-Veil, Qiagen, Rovers, Roche and Seegene for research purposes. Deborah Bateson is a co-principal investigator on an implementation program 'Elimination of Cervical Cancer in the Western Pacific', which has received support from the Minderoo Foundation and equipment donations from Cepheid Inc. Deborah Bateson is deputy lead of an Australian Government program 'Elimination Partnership in the Indo-Pacific for Cervical Cancer'.

### Data Availability Statement

The authors have nothing to report.

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