



CANADIAN
PARTNERSHIP
AGAINST CANCER



Cervical Cancer Screening in Canada

ENVIRONMENTAL SCAN

Version 1.1

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2019 - 2020

Background

The Canadian Partnership Against Cancer collects information on national, provincial and territorial cervical screening guidelines, strategies and activities.

This environmental scan summarizes the data collected from provincial and territorial screening programs and is intended to provide information to inform provincial/territorial decision-making for policy and practice.

The information for this environmental scan was collected in June and July 2019. All provinces and territories responded to the environmental scan. Many provinces and territories provided updated data in early 2020. Due to the COVID-19 pandemic, some of the included data was not vetted by the provincial and territorial screening programs prior to publication.

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Canadian Partnership Against Cancer
145 King Street West, Suite 900
Toronto, ON M5H 1J8

For more information on this publication, please email:
screening@partnershipagainstcancer.ca

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Key Highlights – 2019-2020

- ◆ Organized cervical screening programs are available in most provinces. There are no organized programs in Yukon, Northwest Territories, Nunavut, Québec or Prince Edward Island. As of 2019, Yukon continues to plan an expansion of their ColonCheck screening program to include cervical screening.
- ◆ Provinces and territories recommend that cervical screening begin at age 21 or 25, continue until age 65 to 70 and occur every two to three years. Organized cervical screening programs in British Columbia, Alberta, Nova Scotia and Prince Edward Island have increased their screening start age to 25 to reflect Canadian Task Force on Preventive Health Care recommendations. Plans to increase the screening start age to 25 are being implemented in Ontario and Yukon and are under consideration in Newfoundland and Labrador.
- ◆ The Pap test is used as an entry level screening test for cervical cancer, utilizing liquid-based cytology or conventional cytology.
- ◆ Ontario and Prince Edward Island are actively planning the implementation of HPV testing for primary screening and it is under consideration in British Columbia and Québec.
- ◆ Several provinces and territories have begun to implement or pilot HPV testing for the purposes of triage or follow-up after treatment.
- ◆ HPV immunization is offered to children in all provinces and territories between grades 4 and 7.
- ◆ All provinces and territories have extended eligibility programs for immunization.
- ◆ Nine provinces and two territories have implemented strategies to increase participation in cervical screening among First Nations, Inuit and Métis populations.
- ◆ Seven provinces have implemented strategies to support cervical screening participation in underscreened populations.

Canadian Strategy for Cancer Control, 2019-2029

Since its launch in 2006, the Canadian Strategy for Cancer Control (the Strategy) has helped reduce the burden of cancer on Canadians—serving as a powerful tool for change and improvement. However, the cancer landscape has changed significantly since the Strategy was first developed, presenting new opportunities as well as new challenges. In 2019, the Canadian Partnership Against Cancer (the Partnership) released the refreshed [Canadian Strategy for Cancer Control](#) – a 10-year roadmap to improve equity in the cancer system and to deliver world-class cancer care to all Canadians, while focusing on a sustainable healthcare system for the future.

As the steward of the Strategy, the Partnership has led the modernization and renewal process. The Partnership engaged with Canadians across all provinces and territories, to learn about how cancer affects their lives and what they want from their national cancer strategy. While the Strategy's vision remains as relevant today as it was a decade ago, the priorities and actions have been modernized and refreshed to ensure they continue to guide our collective efforts in the years ahead.

The refreshed Strategy is a visionary and ambitious plan for the cancer and broader health system. Building on its already robust foundation, the refreshed Strategy provides a focused set of priorities and actions that will address the current and persistent challenges in delivering quality care.

Figure 1. Canadian Strategy for Cancer Control Priority 2



PRIORITY 2

Diagnose cancer faster, accurately and at an earlier stage



Action 2: Strengthen existing screening efforts and implement lung cancer screening programs across Canada

Figure 2. Canadian Strategy for Cancer Control Priority 4



PRIORITY 4

Eliminate barriers to people getting the care they need



Action 1: Provide better services and care adapted to the specific needs of underserved groups



Action 2: Ensure rural and remote communities have the resources required to better serve their people

The Strategy calls for moving toward elimination of cervical cancer through universal access to HPV vaccination programs for boys and girls. These efforts should be supplemented by secondary prevention strategies such as HPV testing for cervical cancer. In addition, the Strategy calls for the cancer community to continue focusing on the effectiveness of existing screening programs. This includes continuing measures to ensure the right people are getting screened at the right time using the recommended methods, and eliminating barriers to participation in screening, particularly in underscreened communities. Patients in rural and remote communities often need to travel to urban centres to access screening and follow-up services. While not all services and treatments can be located in all communities, the Strategy calls for the adoption of innovations and enablers that allow cancer care to be provided closer to home. For these communities, proven strategies such

as self-sampled HPV testing for cervical cancer should be pursued and expanded.^{1,2}

First Nations, Inuit and Métis continue to experience poorer cancer outcomes than other people in Canada, and face inequities and barriers in accessing care (especially culturally appropriate care).^{3,4,5,6,7} Some of the challenges are similar to the burden experienced by other underserved, remote, rural and isolated communities in Canada; however, there are historical and contemporary realities that amplify those challenges experienced by First Nations, Inuit and Métis. Priorities identified and the actions required are Peoples-specific and represent what the Partnership heard through engagement processes. These priorities and actions are an important element of the refreshed Strategy.

Figure 3. Canadian Strategy for Cancer Control First Nations, Inuit, and Métis Priorities

	FIRST NATIONS	INUIT	MÉTIS
<p>PRIORITY 6 Culturally appropriate care closer to home</p> 	<ol style="list-style-type: none"> 1 Recognize and reflect the First Nations holistic approach to health and wellness. 2 Recognize and eliminate the impacts of racism within the system. 3 Provide equitable access to basic health supports and cancer services. 4 Provide more services closer to home and improve the journey for those who must travel to access care. 5 Improve understanding of cancer and the cancer journey. 	<ol style="list-style-type: none"> 1 Provide equitable access to cancer services closer to home. 2 Improve travel policies. 3 Incorporate Inuit holistic approaches to health and wellness in cancer care. 4 Recognize and eliminate racism within the system. 5 Improve access to basic health supports. 6 Improve understanding of cancer and the cancer journey. 	<ol style="list-style-type: none"> 1 Provide equitable access to resources, programs and care across the cancer continuum. 2 Create a holistic system that is responsive to Métis culture. 3 Recognize and eliminate racism within the system. 4 Improve access to basic health supports. 5 Improve understanding of cancer and the cancer journey.
<p>PRIORITY 7 Peoples-specific, self-determined cancer care</p> 	<ol style="list-style-type: none"> 1 Design and deliver First Nations-determined programs and services. 2 Reduce jurisdictional barriers. 3 Improve communication, navigation and coordination across the system. 	<ol style="list-style-type: none"> 1 Design and deliver Inuit-driven programs and services. 2 Improve coordination and navigation of care. 	<ol style="list-style-type: none"> 1 Design and deliver Métis-determined programs and services. 2 Reduce jurisdictional barriers and improve communication, navigation, and coordination.
<p>PRIORITY 8 First Nations-, Inuit-, or Métis-governed research and data systems</p> 	<ol style="list-style-type: none"> 1 Collect First Nations-specific data and set First Nations-specific indicators and targets. 2 Invest in First Nations research capacity. 3 Implement First Nations governance of the collection and use of data and research. 	<ol style="list-style-type: none"> 1 Collect and report on Inuit-specific data. 2 Determine impact of environmental contamination on Inuit health, specifically cancer risk. 	<ol style="list-style-type: none"> 1 Collect Métis-specific data and develop Métis-determined indicators and outcomes. 2 Invest in Métis research capacity.

Executive Summary

Organized cervical screening programs are available in most provinces. These programs screen eligible women who are asymptomatic (no signs or symptoms of cervical cancer present) and at average risk for cervical cancer. There are no organized cervical screening programs in Yukon, Northwest Territories, Nunavut, Québec or Prince Edward Island, but opportunistic screening services may be available through primary care providers. In this scan, for these jurisdictions, information on opportunistic screening is provided where available. As of 2019, Yukon continues to plan an expansion of their ColonCheck screening program to include cervical screening ([Table 1](#)).

Provinces and territories recommend that cervical screening begin at age 21 or 25, continue until age 65 to 70 and occur every two to three years ([Table 2](#)). Organized cervical screening programs in British Columbia, Alberta, Nova Scotia and Prince Edward Island have increased their screening start age to 25 to reflect Canadian Task Force on Preventive Health Care recommendations. Once enough data are available, these provinces plan to evaluate the impact of this change. Furthermore, plans to increase the cervical screening start age to 25 are being implemented in Ontario and Yukon, and are under consideration in Newfoundland and Labrador ([Table 3](#)).

The Pap test is used as an entry level screening test for cervical cancer, utilizing liquid-based cytology or conventional cytology ([Table 5](#)). HPV testing is not currently used for primary screening within organized screening programs in Canada. However,

Ontario and Prince Edward Island are actively planning the implementation of HPV testing for primary screening and it is under consideration in British Columbia and Québec ([Table 6](#)). Several jurisdictions have begun to implement or pilot HPV testing for the purposes of triage or follow-up after treatment.

HPV immunization is offered to children in all provinces and territories, generally between grades 4 and 7. While these programs were initially available to girls only, all school-based immunization programs have now been expanded to include boys ([Table 13](#)). The provincial/territorial immunization uptake (for final dose) based on the most recent data ranges from 57-91% ([Tables 15](#) and [16](#)).

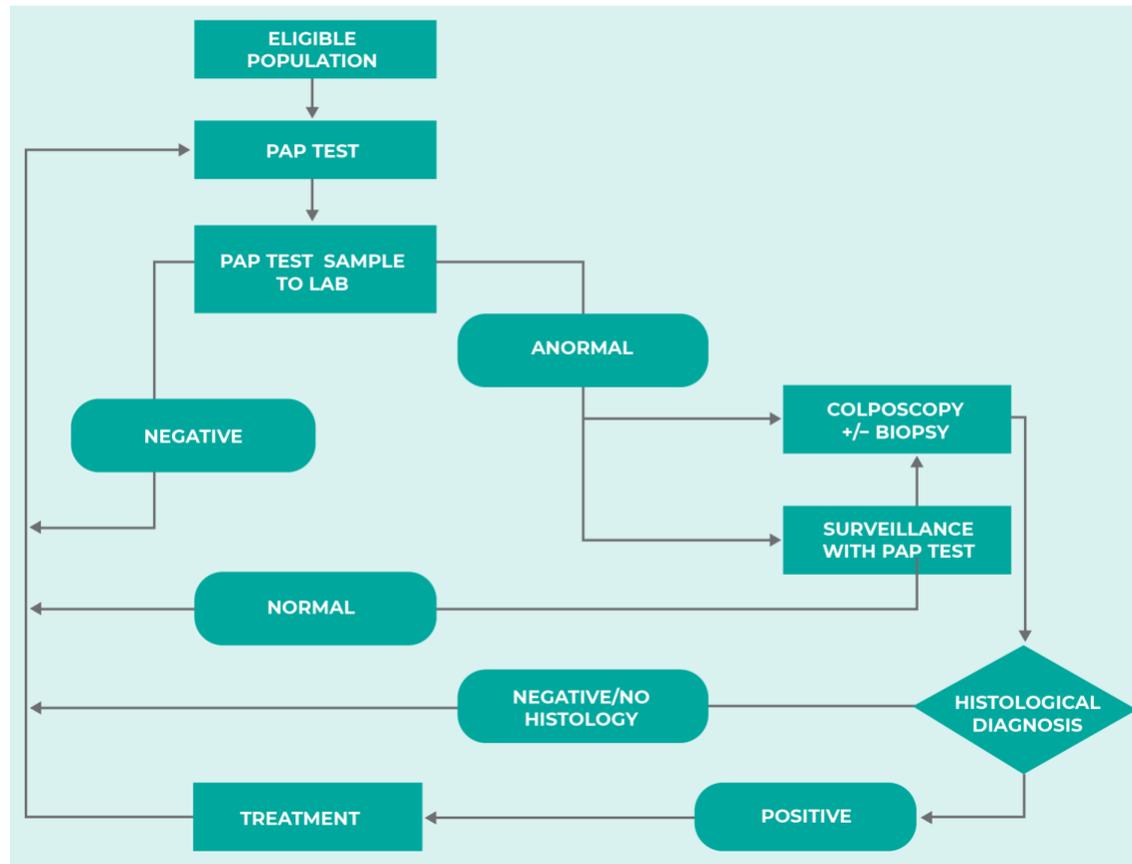
Canadian jurisdictions are engaging with First Nations, Inuit and Métis in decision making and informing approaches to culturally appropriate screening, and program resources specific to First Nations, Inuit, and Métis. Jurisdictions are also engaging with healthcare providers working directly with First Nations, Inuit, and Métis communities (see [Population Outreach - First Nations, Inuit and Métis](#) section).

Seven provinces have implemented strategies to help address cervical screening participation in underscreened populations. These strategies focus primarily on individuals in rural communities, new immigrants and low-income individuals, with some strategies related to LGBTQ2S+ populations (see [Population Outreach – Underscreened Populations](#) section).

1. Cervical Screening Programs and Guidelines

1.1 Cervical Screening Pathway

Figure 4. Cervical Screening Pathway^{8*}



Organized screening for cervical cancer in Canada involves four steps:

- Identification and invitation of the target population
- Provision of a screening test to the target population
- Follow-up of abnormalities detected by the screening test
- Recall after a normal screening outcome.

*Cancer screening pathways are a general representation of the organized screening process, and may not apply to all jurisdictions, especially those which do not have an organized screening program.

1.2 Canadian Task Force on Preventive Health Care Guidelines

Figure 5. Canadian Task Force on Preventive Health Care Cervical Cancer Screening Recommendations (2013)



This recommendation is for asymptomatic individuals who are or have been sexually active. The recommendation does not apply to individuals with symptoms of cervical cancer, previous abnormal screening results (until they have been cleared to resume normal screening), those who do not have a cervix (due to hysterectomy), or who are immunosuppressed.

Additional cervical screening recommendations by CTFPHC⁹ include:

- ◆ Routine screening for cervical cancer for individuals aged < 25 is not recommended
- ◆ Screening is not recommended for individuals aged 70 and over who have been adequately screened (i.e., 3 successive negative Pap tests in the last 10 years)
- ◆ For individuals aged 70 and over who have not been adequately screened, the CTFPHC recommends screening until 3 negative test results have been obtained

1.3 Cervical Screening Programs in Canada

Organized cervical screening programs are available in most provinces. These programs screen eligible individuals who are asymptomatic (no signs or symptoms of cervical cancer present) and at average risk for cervical cancer. There are no organized cervical screening programs in Yukon, Northwest Territories, Nunavut, Québec or Prince Edward Island, but opportunistic screening services may be available through

primary care providers. Health PEI established a Cervical Screening Service in 2015, which provides result letters for those that have a pap through outreach clinics. If a provider outside of these clinics takes a pap, the lab supports the clinicians by providing reminders on abnormal results that have not had a follow-up. Otherwise, no organized program exists in PEI.

Figure 6. Status of Cervical Screening Programs in Canada (July 2019)

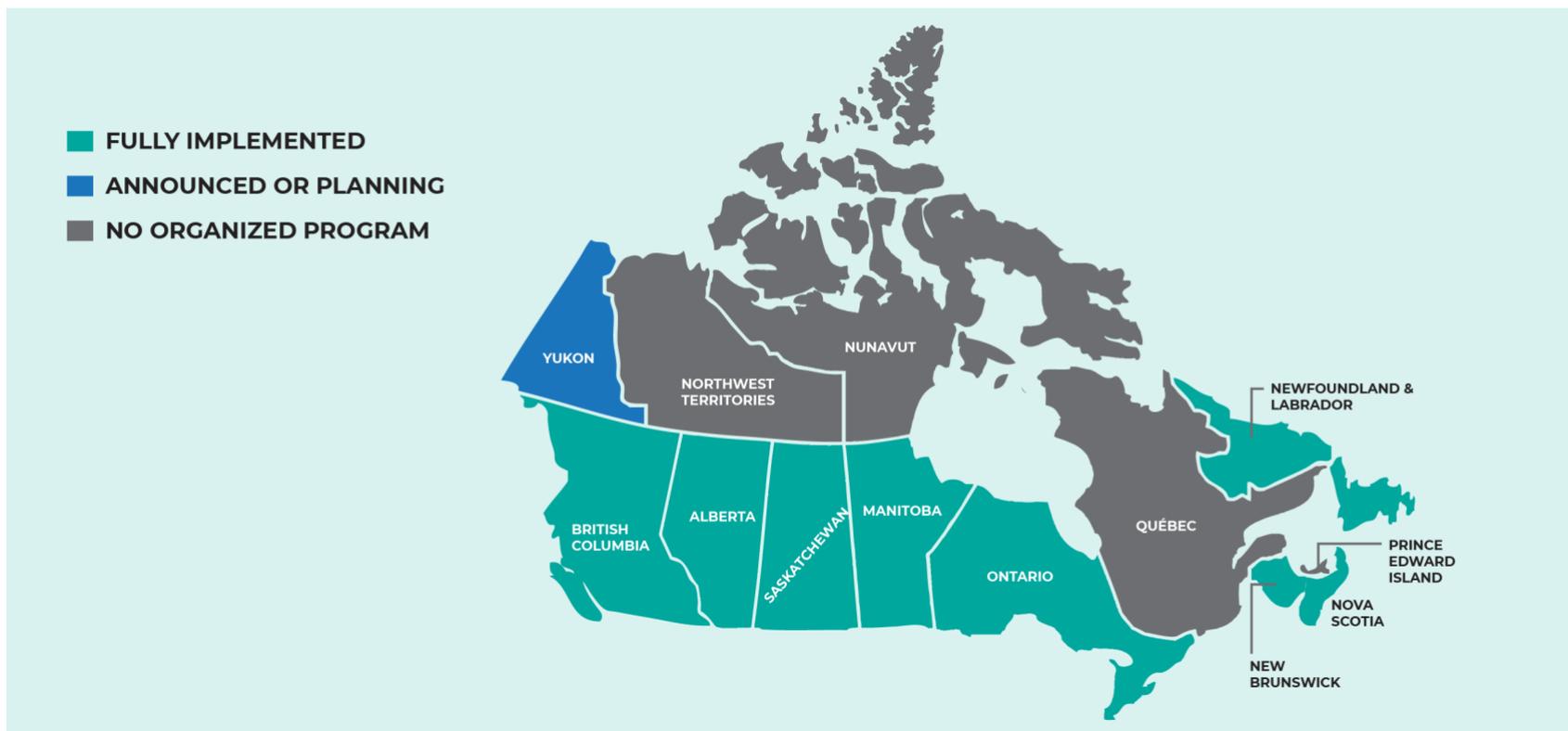


Table 1. Cervical Screening Programs in Canada

Jurisdiction	Program start date	Program name	Agency responsible for program administration
Yukon (YT)*	No organized screening program available (plans are underway to expand Yukon's ColonCheck screening program to include cervical screening)		Yukon Government Health and Social Services
Northwest Territories (NT)*	No organized screening program available		
Nunavut (NU)*	No organized screening program available		
British Columbia (BC)	1955	Cervix Screening Program	BC Cancer
Alberta (AB)	2000	Alberta Cervical Cancer Screening Program	Alberta Health Services
Saskatchewan (SK)	2003	Screening Program for Cervical Cancer	Saskatchewan Cancer Agency
Manitoba (MB)	2000	CervixCheck	CancerCare Manitoba
Ontario (ON)	2000	Ontario Cervical Screening Program	Ontario Health (Cancer Care Ontario)
Québec (QC)*	No organized screening program available		
New Brunswick (NB)	2014	New Brunswick Cervical Cancer Prevention and Screening Program	New Brunswick Cancer Network (NB Department of Health)
Nova Scotia (NS)	1991	Cervical Cancer Prevention Program	Nova Scotia Health Authority Cancer Care Program
Prince Edward Island (PE)*^	2001	Cervical Cancer Screening Service	Health PEI
Newfoundland and Labrador (NL)	2003	Cervical Screening Initiatives Program	Cancer Care Program, Eastern Health

* Information for YT, NT, NU, QC and PE in this publication refers to opportunistic cervical screening.

^ In 2001, had Pap clinic run by a general practitioner, which had outreach clinics. In 2015, Health PEI established a pap service, "Cervical Cancer Screening Service". The service provides result letters for those that have a pap through outreach clinics. If a provider outside of these clinics takes a pap, the lab supports the clinicians by providing reminders on abnormal results that have not had a follow-up. Otherwise, screening in PEI is primarily opportunistic.

1.4 Provincial and Territorial Screening Guidelines

Provinces and territories recommend that cervical screening begin at age 21 or 25, continue until age 65 to 70 and occur every two to three years.

Organized cervical screening programs in BC, AB, NS and PE have increased their cervical screening start age to 25 to

reflect the CTFPHC recommendation. Once enough data are available, these provinces plan to evaluate the impact of this change. YT and ON are planning to implement a start age of 25. This change is also under consideration in NL.

RECENT HIGHLIGHT

Since 2016, plans to increase the cervical screening start age to 25 years have changed in several jurisdictions.



Implemented

BC (2016), AB (2016), NS (2019), PE (2020)



In planning stages

YT, ON (as of 2019)



Under consideration

NL (as of 2019)

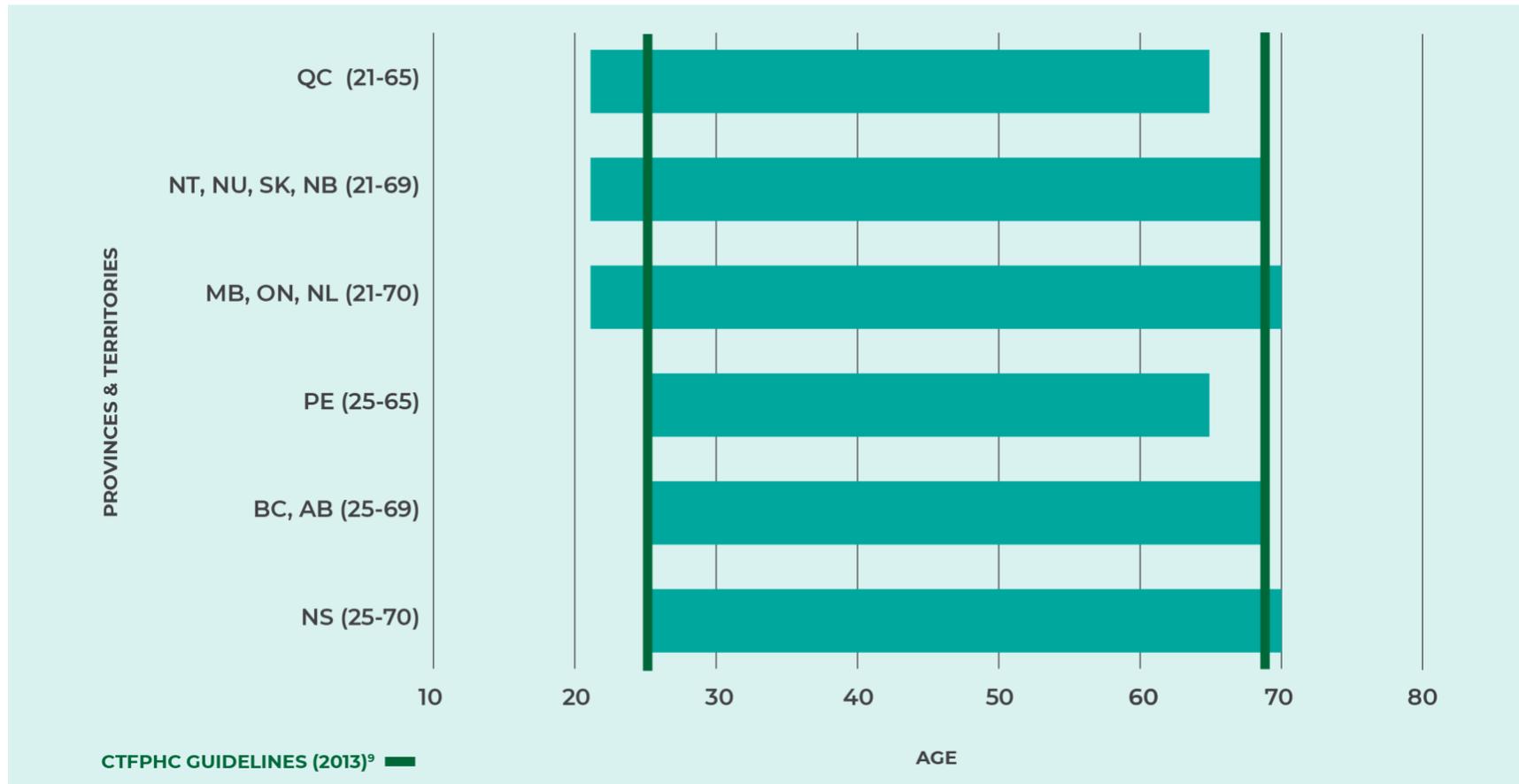
Table 2. Provincial and Territorial Screening Guidelines

Jurisdiction	Start age	Interval	Stop age
YT*	No organized screening program available		
NT*	21	Annual until 3 consecutive negative tests then every 2 years	69
NU*	21 if sexually active	3 years	69
BC	25	3 years	69
AB	25	3 years	69
SK	21 or 3 years post first sexual contact, whichever occurs later	2 years until 3 consecutive negative tests then every 3 years	69
MB	21	3 years	70 with adequate negative screening history in previous 10 years (i.e. 3 or more negative tests)
ON	21 if sexually active [^]	3 years	70 with adequate negative screening history in previous 10 years (i.e. 3 or more negative tests)
QC*	21	2-3 years	65 with 2 negative tests in previous 10 years
NB	21 or 3 years post first sexual contact, whichever occurs later	Annual until 3 consecutive negative tests then every 2-3 years	69 with adequate negative screening history in previous 10 years or 3 negative tests (for participants with little/no screening history)
NS	25	3 years	70
PE*	25	3 years	65 with adequate negative screening history in previous 10 years (i.e. 3 or more negative tests)
NL	21	Annual until 3 consecutive negative tests then every 3 years	70 with adequate negative screening history in previous 10 years (i.e. 3 or more negative tests)

* Information for YT, NT, NU, QC and PE in this publication refers to opportunistic cervical screening.

[^] While the Ontario Cervical Screening Program currently recommends screening starting at age 21, the program is supportive of healthcare providers who wish to initiate cytology-based screening at age 25 during the change to HPV testing.

Figure 7. Start and Stop Age for Cervical Screening in Canada*



* Information for YT, NT, NU, QC and PE in this publication refers to opportunistic cervical screening.

Table 3. Plans to Increase Cervical Screening Start Age to 25 Years

Jurisdiction	Plans to increase cervical screening start age to 25
YT ^{*^}	N/A
NT [*]	N/A
NU [*]	N/A
BC	Implemented change in 2016
AB	Implemented change in 2016
SK	No current plans
MB	No current plans
ON	Under consideration
QC [*]	N/A
NB	No current plans
NS	Implemented change in 2019
PE [*]	Implemented change in 2020
NL	Under consideration

* Information for YT, NT, NU, QC and PE in this publication refers to opportunistic cervical screening.

^ Yukon will be following BC's start age of 25 years

1.5 Screening Recruitment Strategies

Some cervical screening programs send invitations to never-screened women, providing information on screening and eligibility, and inviting women to participate in screening. Currently, five jurisdictions use initial letters of invitation as a recruitment method for their cervical screening programs. In NL, invitation letters are pending; however, a recall list is generated for primary care providers. No recruitment method is used in BC.

Table 4. Cervical Screening Recruitment Methods in Canada

Jurisdiction	Recruitment method
YT*^	No organized screening program available
NT*	No organized screening program available
NU*	Phone call from individual well-woman clinics
QC*	No organized screening program available
BC	N/A
AB	Initial letter of invitation
SK	Initial letter of invitation
MB	A letter of invitation is sent to eligible~ but never-screened women
ON	Initial letter of invitation and follow-up invitation to non-responders
NB	Initial letter of invitation
NS	N/A
PE*	N/A
NL	Invitation process pending

* Information for YT, NT, NU, QC and PE in this publication refers to opportunistic cervical screening.

^ YT plans to provide letters of invitation.

~ A woman is "eligible" to receive an invitation letter if she is a Manitoba resident who has been in the CervixCheck registry for a minimum of five years and has no Pap test or colposcopy records, no record of a total hysterectomy, and no record of invasive gynecological cancer.

2. Modalities for Cervical Screening

2.1 Cytology Detection Methods: The Pap Test

The Pap test is used as the primary screening test for cervical cancer. Five Canadian jurisdictions use liquid-based cytology in their cervical screening program. BC, SK and PE use conventional cytology QC and PE, NB, and NS use both liquid-based and conventional cytology for their cervical screening programs. Most provincial and territorial cervical screening programs base their terminology on the 2014 Bethesda Cervical Cytology Atlas for standardized cytology reporting.

Table 5. Cytology Detection Methods used in Canada

Jurisdiction	Cytology detection methods (and year began liquid-based cytology, if applicable)	Reporting system for standardized cervical cytology reporting
YT*^		No organized screening program available
NT*	Liquid-based cytology	2014 Bethesda Cervical Cytology Atlas
NU*		No organized screening program available
BC	Conventional cytology	2014 Bethesda Cervical Cytology Atlas
AB	Liquid-based cytology (2009)	2014 Bethesda Cervical Cytology Atlas
SK	Conventional cytology	2014 Bethesda Cervical Cytology Atlas
MB	Liquid-based cytology (2014)	2014 Bethesda Cervical Cytology Atlas
ON	Liquid-based cytology~	2014 Bethesda Cervical Cytology Atlas
QC*	Conventional cytology and liquid-based cytology	Standardized reports are currently under development and not yet available to clinicians
NB	Conventional cytology and liquid-based cytology	2001 and 2014 Bethesda Cervical Cytology Atlas
NS	Conventional cytology and liquid-based cytology**	2014 Bethesda Cervical Cytology Atlas
PE*	Conventional cytology	2014 Bethesda Cervical Cytology Atlas
NL	Liquid-based cytology (2008)	2014 Bethesda Cervical Cytology Atlas

* Information for YT, NT, NU, QC and PE in this publication refers to opportunistic cervical screening.

^ YT using conventional cytology; plan to move to liquid-based cytology using 2014 Bethesda Cervical Cytology Atlas

~ A small number of labs use conventional cytology

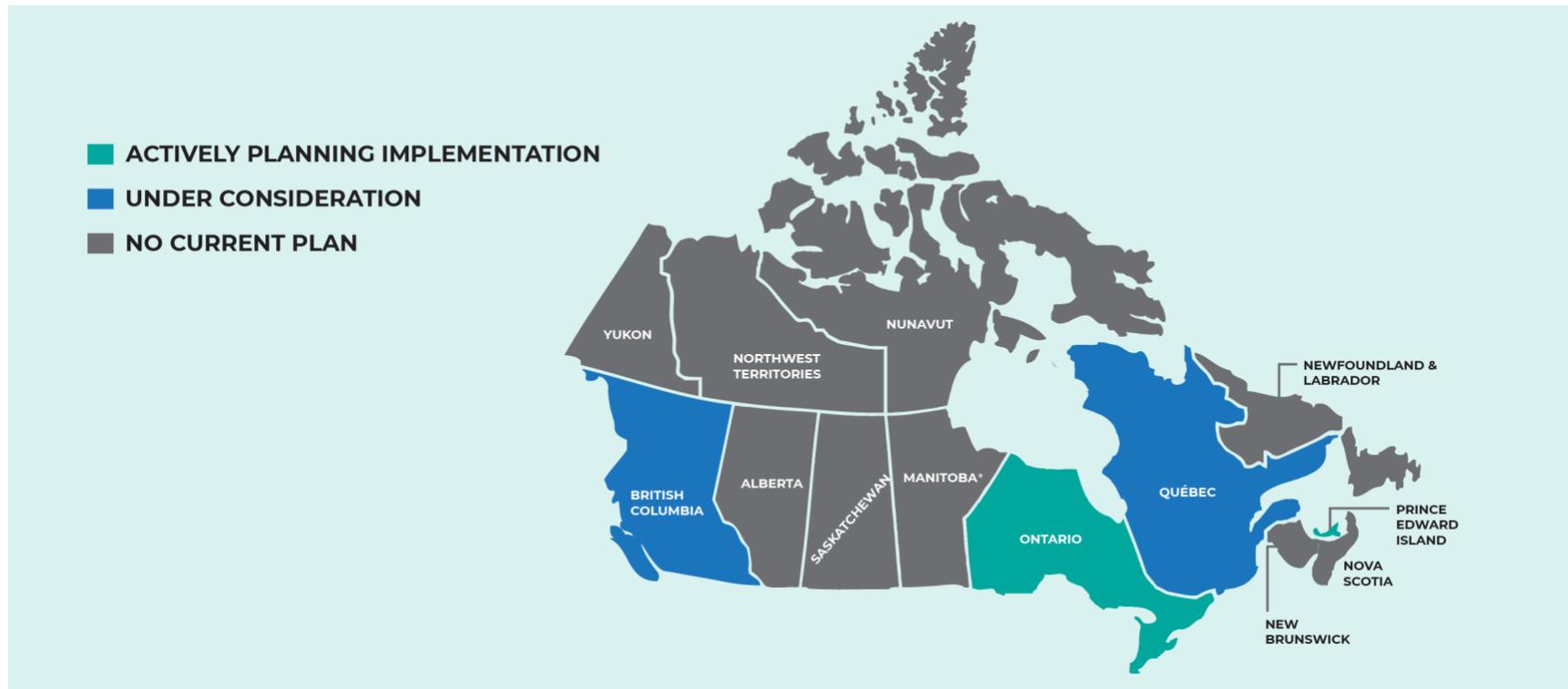
**One lab uses liquid-based cytology for Paps done on-site at the hospital

2.2 HPV Testing

HPV testing is not currently used for primary screening within organized screening programs in Canada. However, several provinces and territories are planning its use for primary screening or have begun to implement or pilot HPV testing for the purposes of triage after an abnormal Pap test or follow-up after treatment.

ON and PE are actively planning the implementation of HPV testing for primary screening and it is under consideration in BC and QC. There are no plans to implement HPV testing for primary screening in other provinces or territories at this time.

Figure 8. Current Status of Implementation of HPV Testing for Primary Screening in Canada (July 2019)



* Although there are no current plans to implement HPV testing for primary screening in Manitoba, the province continues to advocate for its use.

Table 6. HPV Testing in Canada

Jurisdiction	Capacity in which HPV testing is being used	Current status of implementation of HPV testing for primary screening
YT*	No organized screening program available	
NT*	Triage in women	No current plans
NU*	N/A	No current plans
BC	Post treatment	Under consideration
AB	Triage in women ≥30 with ASC-US or women ≥ 50 with LSIL	No current plans
SK	Pilot trial (for gynecologist to use only when requested, not a pilot for primary screening)	No current plans
MB	Personal requests Triage in women – implementation planning in progress	No current plans, continue to advocate for HPV testing for primary screening
ON	HPV testing is not currently funded; however, the program has best practice recommendations when its use is available (e.g. on a patient pay basis or in some hospital-based colposcopy units). Recommendations include HPV reflex testing if HPV status unknown at time of referral to colposcopy for women ≥ 30 with LSIL, ASC-US or normal cytology or if requested by clinician due to discordance.	Actively planning implementation in screening and colposcopy
QC*	Triage in women ≥ 30 with ASC-US	Reviewing the possibility of using HPV as a primary screening method
NB	Triage in women ≥ 30 with ASC-US or women ≥ 50 with LSIL	No current plans
NS	Colposcopy clinic	No current plans
PE*	Triage in women > 30 with ASC-US and no previous abnormal Pap HPV testing provided as a 12 month-follow-up test in treatment phase to confirm persistent or cleared HPV infection upon request by primary care provider, gynecologist	Actively considering logistics and have convened a working group
NL	Pilot trials/research Triage in women > 30 with ASC-US	No current plans

* Information for YT, NT, NU, QC and PE in this publication refers to opportunistic cervical screening.

Abbreviations: ASC-US: atypical squamous cells of undetermined significance; LSIL: low-grade squamous intraepithelial lesion

Table 7. Use of HPV Testing after an ABNORMAL Cervical Screening Test Result by Province/Territory

Jurisdiction	Pap with HPV Triage/Reflex Testing	Please describe when Pap with HPV Triage/Reflex Testing is used	HPV with Pap Triage	Please describe when HPV with Pap Triage is used	HPV with Genetic Triage	Please describe when HPV with Genetic Triage is used
YT*	To be determined		To be determined		To be determined	
NT*	✓	<ul style="list-style-type: none"> One year follow up for LSIL or ASC-US for 21-29 years ASC-US ≥30 years LSIL or ASC-US post-menopausal 	N/A		N/A	
NU*	N/A		N/A		N/A	
BC	N/A		N/A		N/A	
AB	✓	Pap with HPV reflex testing for women with ASC-US ≥30 and LSIL ≥ 50	N/A		N/A	
SK	N/A		N/A		N/A	
MB	N/A	In planning stages for 2020 implementation	N/A		N/A	
ON	✓	HPV testing is not currently funded; however, the program has best practice recommendations when available (e.g. on a patient pay basis or in some hospital-based colposcopy units). Recommendations include HPV reflex testing if HPV status unknown at time of referral to colposcopy for women ≥ 30 with LSIL, ASC-US or normal cytology or if requested by clinician due to discordance. If cytology shows HSIL, hrHPV positivity should be assumed and HPV testing is not required.	N/A	Under consideration as a part of planning for the implementation of HPV testing in screening	N/A	Under consideration as a part of planning for the implementation of HPV testing in screening

Jurisdiction	Pap with HPV Triage/Reflex Testing	Please describe when Pap with HPV Triage/Reflex Testing is used	HPV with Pap Triage	Please describe when HPV with Pap Triage is used	HPV with Genetic Triage	Please describe when HPV with Genetic Triage is used
QC*	N/A		N/A		✓ After an abnormal pap test screening, oncogenic HPV testing is used for women > 30 before following with colposcopy if HPV test is positive.	
NB	✓	Recommended for Women aged ≥30 with an ASC-US or ≥50 with LSIL	N/A		N/A	
NS	N/A		N/A		N/A	
PE*	✓	Triage in women ≥ 30 with ASC-US and no previous abnormal Pap. Further HPV testing on request by primary care provider for treatment/exit management, e.g. 12 months repeat testing to confirm persistent or cleared HPV infection			✓	Triage in women ≥ 30 with ASC-US and no previous abnormal Pap. Further HPV testing on request by primary care provider for treatment/exit management, e.g. 12 months repeat testing to confirm persistent or cleared HPV infection
NL	✓	Triage in women >30 with ASC-US	N/A		N/A	

* Information for YT, NT, NU, QC and PE in this publication refers to opportunistic cervical screening.

Abbreviations: ASC-US: atypical squamous cells of undetermined significance; LSIL: low-grade squamous intraepithelial lesion; HSIL: high-grade squamous intraepithelial lesion; hrHPV: high-risk HPV

3. Correspondence and Follow-Up Strategies for Cervical Screening

Recall letters and other forms of communication are used to notify individuals who have been screened by the program in the past to return for screening. Individuals who have a normal screening result are invited back at regular intervals, as per provincial/territorial screening guidelines, for subsequent screening. Individuals who have an abnormal screening result are invited for follow-up. A reminder is any correspondence from a cervical screening program to a participant or primary care provider (PCP) subsequent to previously sent communication.

3.1 Recall Following a Normal Pap Test

Seven provinces send recall letters at the program-identified interval following a normal Pap test. Five of these provinces send the letter to the participant only, and three send it to primary care providers only. NU and NL also use phone calls as a recall method. In addition, six jurisdictions send reminder letters if they did not initiate screening after receiving the recall letter

Table 8. Provincial and Territorial Recall Following a Normal Pap Test

Jurisdiction	Recall method	Recall sent to	Recall issued by	Reminder letter if screening is not initiated	Target age group for recall
YT**	No organized screening program available				
NT*	No organized screening program available				
NU*	Phone call	PCP	Individual well-woman clinics organized by nursing station nurses or clinic nurses organize the recalls based on results received on prior PAP	Yes	-
BC	Letter	PCP	Screening program	No	-
AB	Letter	Participants	Screening program	Yes – participants only	25-69
SK	Letter	Participant	Screening program	Yes	21-69
MB	Letter	Participant	Screening program	Yes – participants only	21-69
ON	Letter	Participant	Screening program; PCPs may use other strategies	Yes	21-69
QC*	No organized screening program available				
NB	Letter	Participant	Screening program	Yes	21-69
NS	N/A	N/A	N/A	N/A	N/A
PE*	No programmatic recall in place~				
NL	Letter Phone call	PCP	Screening program and individual PCP	No	21-69

* Information for YT, NT, NU, QC and PE in this publication refers to opportunistic cervical screening.

^ YT is planning to implement recall letter to participant. PCP will be notified that participant was recalled by program. Target age to be determined

~ Lab supports recall to pap with reminder letters to patients who are overdue for more than 5 years since last pap, with the first batch sent in 2018 to those overdue since 2009. Catch up in planning for 2020.

- No information was provided at the time the data were collected.

3.2 Follow-Up After an Abnormal Pap Test

Following an abnormal screening result, result letters are sent to participants and/or primary care providers. Five jurisdictions send follow-up notifications to both participants and primary care providers, whereas one jurisdiction follows up with participants only and four with primary care providers only.

Table 9. Provincial and Territorial Follow-Up After an Abnormal Pap Test

Jurisdiction	Follow-up method
YT*	<ul style="list-style-type: none"> • N/A
NT*	<ul style="list-style-type: none"> • N/A
NU*	<ul style="list-style-type: none"> • Letter to PCP
BC	<ul style="list-style-type: none"> • Letter with lab results to PCP (sent by lab); up to 2 reminder letters to PCP if follow-up has not occurred within 4 and 6 months of the lab's recommendation for colonoscopy (sent by program)
AB	<ul style="list-style-type: none"> • Results sent to PCP directly via fax and/or electronically. Participant's cancer screening status and recommended actions are updated and provided to PCP electronically (Netcare)
SK	<ul style="list-style-type: none"> • Letter to participant • Results to PCP from cytology lab
MB	<ul style="list-style-type: none"> • Letter to participant for all high-grade Pap test result • Letter to PCP and participant (if necessary) for all low-grade Pap test result where follow-up has not occurred
ON	<ul style="list-style-type: none"> • Letter to participant • Results are sent to PCP from cytology lab
QC*	<ul style="list-style-type: none"> • N/A
NB	<ul style="list-style-type: none"> • Initial letter sent to PCP for all high and low grade Pap results overdue for follow up; Reminder letters sent to Participant/cc to PCP if follow up has still not occurred.
NS	<ul style="list-style-type: none"> • Pap smear providers are notified when it appears that a patient with a significant abnormality has not been appropriately managed
PE*	<ul style="list-style-type: none"> • Letter to clients of the provincial cervical cancer screening service / pap clinics • Results to PCP from cytology lab^
NL	<ul style="list-style-type: none"> • Letter to PCP and then to participant

* Information for YT, NT, NU, QC and PE in this publication refers to opportunistic cervical screening.

^Lab supports abnormal follow-up monitoring. Notices are sent to doctors/ nurse practitioners over 12 months and then to patient if no follow-up is completed.

4. Colposcopy Services

Individuals with abnormal Pap test results requiring follow-up may be referred for colposcopy. Criteria for referring participants to colposcopy services vary across jurisdictions.

Table 10. Criteria for Referral to Colposcopy Services

Jurisdiction	ASC-US (1 st result)	LSIL (1 st result)	ASC-US and HPV+ result	Repeated ASC-US/LSIL after previous ASC-US/LSIL	Age ≥ 50 with LSIL and HPV+ result	AGC	HSIL+	Other
YT* ^A				No organized screening program available				
NT*		✓	✓	✓	✓	✓	✓	
NU*				No organized screening program available				
BC				✓		✓	✓	
AB			✓ (age ≥ 30)	✓	✓	✓	✓	
SK				✓		✓	✓	
MB				✓		✓	✓	<ul style="list-style-type: none"> Atypical endocervical cells, visual abnormality of the cervix, or all cytological abnormalities (including low grade lesions) of women who are immunosuppressed (HIV+ with CD4 count < 400 or transplantation with immunosuppressive therapy > 3 years) Exposure to diethylstilboestrol (DES) in utero
ON		✓	✓~	✓	✓	✓	✓	<ul style="list-style-type: none"> ASC-H, atypical endocervical cells, atypical endometrial cells
QC*		✓	✓ (age > 30)	✓		✓	✓	<ul style="list-style-type: none"> Postcoital bleeding or cervicitis
NB			✓ (age ≥ 30)	✓	✓	✓	✓	<ul style="list-style-type: none"> ASC-H
NS				✓		✓	✓	<ul style="list-style-type: none"> ASC-H
PE*			✓	✓		✓	✓	

Jurisdiction	ASC-US (1 st result)	LSIL (1 st result)	ASC-US and HPV+ result	Repeated ASC-US/LSIL after previous ASC-US/LSIL	Age ≥ 50 with LSIL and HPV+ result	AGC	HSIL+	Other
NL			✓ (age < 30 repeat ASC-US x3 at 6month interval; if the third Pap is abnormal, refer to colposcopy)	✓		✓	✓	

* Information for YT, NT, NU, QC and PE in this publication refers to opportunistic cervical screening.

^ YT will be following BCs criteria

~ HPV testing is not currently funded; however, the program has best practice recommendations when its use is available (e.g. on a patient-pay basis or in some hospital-based colposcopy units).

Abbreviations: ASC-US: atypical squamous cells of undetermined significance; LSIL: low-grade squamous intraepithelial lesion; AGC: atypical glandular cells; HSIL: high-grade squamous intraepithelial lesion.

Definitions: HSIL+: high grade squamous intraepithelial lesions or worse (HSIL+ includes HSIL, AIS and invasive carcinoma); ASC-H: atypical squamous cells, cannot exclude HSIL

Colposcopy services are most often provided in hospitals, colposcopy clinics and by individual practitioners. Six provinces and one territory currently use HPV testing in colposcopy care, and HPV testing is currently used as a test of cure for discharge purposes in several jurisdictions.

Table 11. Colposcopy Services in Canada

Jurisdiction	Location where colposcopy services are provided	How colposcopy services are provided
YT*	<ul style="list-style-type: none"> Hospital 	YT colposcopies are done in colposcopy clinic at Whitehorse General Hospital.
NT*	<ul style="list-style-type: none"> Hospital 	All colposcopies are performed by the OB-GYN service. The service is based out of Stanton Territorial Hospital in Yellowknife, but travels to other NT hospitals to provide the service.
NU*	<ul style="list-style-type: none"> Hospital Individual practitioner 	The hospital in Iqaluit has a colposcope and provides colposcopies for people in the eastern part of the territory. For people in the western and central part of the territory, colposcopy is done in Yellowknife, Edmonton or Winnipeg.
BC	<ul style="list-style-type: none"> Hospital Individual practitioner Colposcopy clinic 	Most colposcopy is done in a colposcopy clinic out of a hospital. A few colposcopists who have completed the BC Colposcopy Training Program provide colposcopy out of their office.
AB	<ul style="list-style-type: none"> Individual practitioner AHS colposcopy clinic 	Colposcopy clinics are key partners of the cervical screening program. Program has standardized colposcopy referral form, and procedure report form.
SK	<ul style="list-style-type: none"> Hospital Individual practitioner Colposcopy clinic 	Colposcopy services are provided by colposcopy clinics in the large cities and by individual colposcopists for the rest of the province
MB	<ul style="list-style-type: none"> Hospital Individual practitioner Colposcopy clinic 	One formal colposcopy clinic in Winnipeg. Other medical clinics and hospitals also offer colposcopy services by gynecologists. Referral to colposcopy are made by the referring clinician to colposcopy clinic. The program will follow up with the referring clinician if there is no colposcopy information in Cervix registry within pre-set time frames as per guidelines.
ON	<ul style="list-style-type: none"> Hospital Colposcopy clinic 	The majority of colposcopies occur in hospital-based clinics and are delivered by OB-GYNs. Clear referral criteria and evidence-based clinical guidance algorithms are provided.
QC*	<ul style="list-style-type: none"> Hospital Colposcopy clinic 	Colposcopy services are conducted in hospital settings. Referrals are done by the hospital and there are no formal programs.
NB	<ul style="list-style-type: none"> Hospital Colposcopy clinic 	Colposcopies are provided by each of the 8 regional hospitals across NB. Colposcopies are operationalized by the Regional Health Authorities.
NS	<ul style="list-style-type: none"> Hospital Colposcopy clinic 	Colposcopy is delivered primarily in hospital-based clinics. There are a few private office-based clinics that provide initial assessment with treatment performed in a hospital setting.
PE*	<ul style="list-style-type: none"> Individual practitioner 	Colposcopy services are provided by individual gynecologists primarily in an office setting.
NL	<ul style="list-style-type: none"> Hospital Individual practitioners Colposcopy clinics 	Colposcopy services are provided in 11 hospital-based sites within 4 Regional Health Authorities. There are also individual practitioner, private-based colposcopy services available. If treatment is required, it is performed in a hospital-based setting.

* Information for YT, NT, NU, QC and PE in this publication refers to opportunistic cervical screening.

Table 12. Use of HPV Testing in Colposcopy Care in Canada

Jurisdiction	Current use or plans to implement HPV testing in colposcopy care	Type of HPV test for colposcopy care	Use of HPV test as a test of cure for discharge purposes
YT*	Yes – available annually post treatment	Roche Cobas 4800	Yes – if HPV negative post treatment, will be discharged after appropriate follow-up.
NT*	Yes – limited use, only for women needing to travel long distances for colposcopy service	Not known	Yes – occasional use in restricted circumstances
NU*	No organized screening program available		
BC	Yes – available annually post treatment	Roche Cobas 4800	Yes – if HPV negative post treatment, will be discharged after appropriate follow-up.
AB	Yes – full provincial implementation underway	No decision yet	Yes - HPV test of cure using Hologic Aptima and Cobas 4800.
SK	Available for colposcopists on special request	Health Canada approved PCR method	Yes – based on colposcopist request
MB	No current plans	N/A	No
ON	Yes - in planning stages. HPV testing is not currently funded; however, the program has best practice recommendations when its use is available (e.g. on a patient pay basis or in some hospital-based colposcopy units)	No decision yet	No
QC*	Yes – used as a diagnosis tool	Roche Cobas 4800	Not frequently
NB	No current plans	N/A	Use is determined and operationalized by some providers and Regional Health Authorities
NS	Yes – used as test of cure and to help with triage of cases	Roche test	Yes – used at 6 months with Pap, not used by all colposcopists
PE*	No current plans	Roche Cobas 1800 ^	No
NL	No current plans	N/A	Available upon request

* Information for YT, NT, NU, QC and PE in this publication refers to opportunistic cervical screening.

^ HPV test is used for follow-up care in PEI, as opposed for colposcopy care or discharge purposes

5. HPV Immunization Programs

HPV immunization is offered to children in all provinces and territories, generally between grades 4 and 7. While these programs were initially available to school-aged girls only, immunization programs in all provinces and territories have been expanded to include school-aged boys.

As part of the National Immunization Strategy, the government of Canada has set a population goal of 90% vaccination coverage by 17 years of age for two or more doses of HPV vaccine by the year 2025.¹⁰

RECENT HIGHLIGHTS

As of 2017, all provinces and territories now have HPV immunization programs for both school-aged girls and boys.

Table 13. HPV Immunization Programs in Canada

Jurisdiction	Immunization Program for Girls		Immunization Program for Boys	
	Date of implementation	School grade when immunization is given	Date of implementation	School grade when immunization is given
YT	2009	Grade 6	2017	Grade 6
NT	2009	Grade 4-6	2017	Grade 4-6
NU	2013	Grade 6	2017	Grade 6
BC	2008	Grade 6	2017	Grade 6
AB	2008	Grade 6	2014	Grade 6
SK	2008	Grade 6	2017	Grade 6
MB	2008	Grade 6	2016	Grade 6
ON*	2007	Grade 7	2016	Grade 7
QC	2008	Grade 4	2016	Grade 4
NB	2008	Grade 7 [^]	2017	Grade 7
NS	2007	Grade 7	2015	Grade 7
PE	2007	Grade 6	2013	Grade 6
NL	2007	Grade 6	2017	Grade 6

* In the 2016-2017 school year, Ontario's program expanded to include boys in additions to girls and switched to delivering immunization in grade 7 instead of grade 8. Grade 8 females were also offered HPV vaccine in the 2016-2017 school year so that this cohort would not be missed in the transition from grade 8 to grade 7 delivery.

[^] In 2008/2009 school year both grade 7 & grade 8 girls received vaccine as one-year catch up program

Table 14. Vaccines Used in School-Based Immunization Programs by Province/Territory

Jurisdiction	Vaccine Used			Vaccine Name
	Bivalent	Quadrivalent	Nonavalent	
YT			✓	Gardasil®9
NT			✓	Gardasil®9
NU	-	-	-	-
BC			✓	Gardasil®9
AB			✓	Gardasil®9
SK			✓	Gardasil®9
MB			✓	Gardasil®9
ON			✓	Gardasil®9 (as of September 5, 2017)
QC	✓		✓	Gardasil®9 (Dose#1) and Cervarix (Dose#2)
NB			✓	Gardasil®9
NS			✓	Gardasil®9
PE			✓	Gardasil®9
NL			✓	Gardasil®9*

*Administered to males and females in two 0.5ml doses at 0 and 6 months.

- No information was provided at the time the data were collected.

5.1 HPV Immunization Program for Girls

All provinces and territories have a school-based HPV immunization program for girls. HPV vaccination is offered to girls on a 2 or 3 dose schedule. Immunization uptake data is available for different school years across jurisdictions. The provincial/territorial immunization uptake (for final dose) based on the most recent data ranges from 57.1-91.3%.

Table 15. Provincial and Territorial HPV Immunization Programs for Girls

Jurisdiction	School year of most recent available data	Total size of eligible cohort (girls only)	Immunization uptake (girls only)		
			1 st dose	2 nd dose	3 rd dose
YT	-	-	-	-	Two-dose schedule
NT	2015-2016	Not available	74.7%	64.4%	57.1%
NU	-	-	-	-	-
BC	2017-2018	NA	74.9%	66.9%	Two-dose schedule
AB	2017-2018	25,368	78.3%	-	68.2%
SK	2018-2019	5,593	76.5%	69.1%	Two-dose schedule
MB	2017	-	-	-	69.4%* Two-dose schedule
ON [^]	2017-2018	73,156	74.4%	62.4%	Two-dose schedule
QC	2017-2018	44,760	82.7%	77.0%	Two-dose schedule
NB	2017-2018	3,627	81.1%	74.8%	Two-dose schedule
NS	2015-2016	5,014	89.4%	80.8%	Two-dose schedule
PE	2017-2018	777	90.1%	86.4%	Two-dose schedule
NL	2017-2018	2,791	-	91.3%~	Two-dose schedule

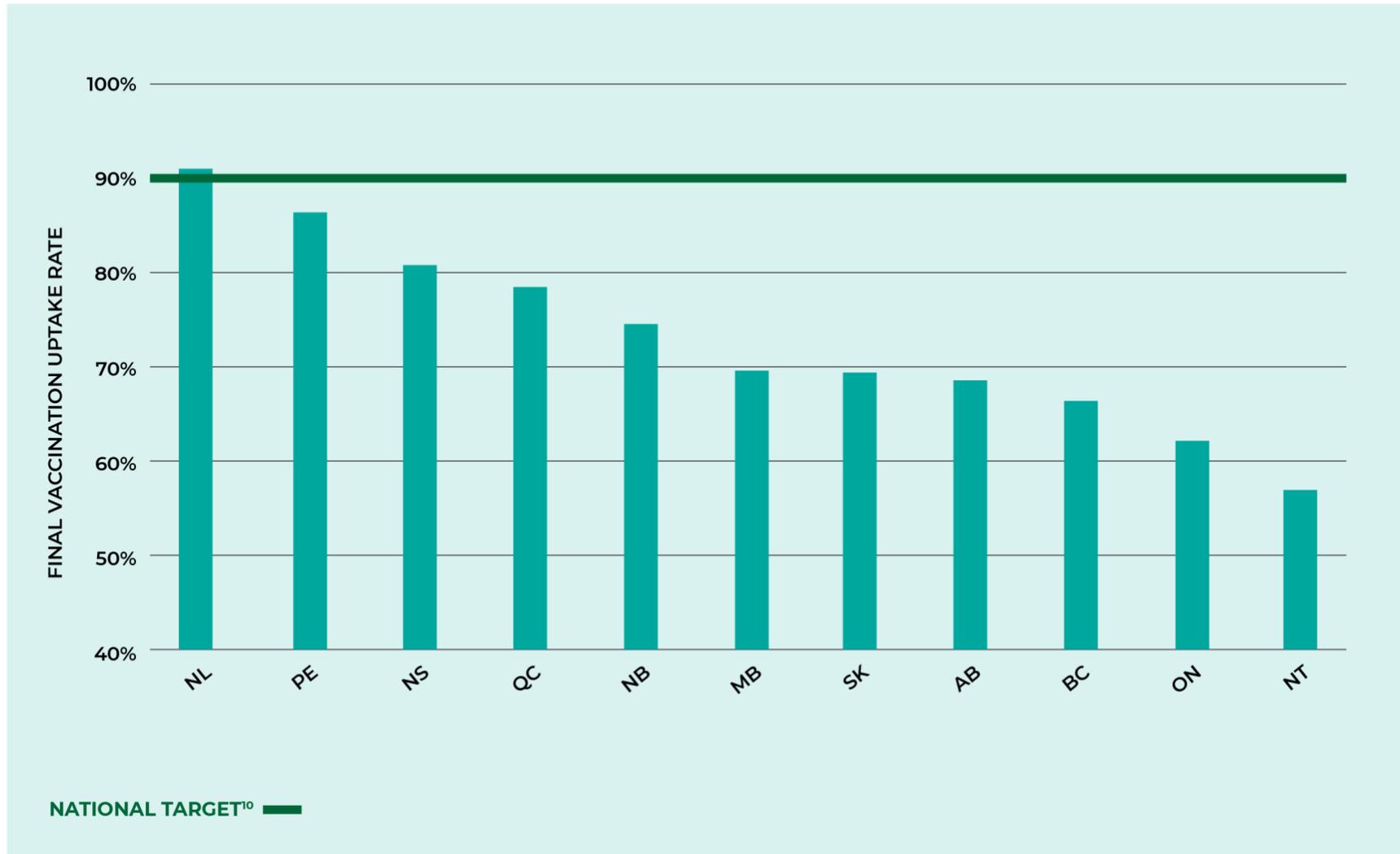
* Data represent immunization uptake based on being a continuous resident of MB. A continuous resident is defined as an individual with an uninterrupted registration with MHSAL from their date of birth to their birthday in the year of the report (i.e. 2017 immunization report). The data are NOT broken down by dose because “complete for age” is reported on. 3 doses are required to be complete for age at 17 (so rate presented at age 17 is for all 3 doses), while it’s only 2 doses to be complete for age at 13 (so the rate presented at age 13 is for 2 doses). This is due to the schedule change that was implemented September 2015, to be consistent with NACI.

[^] In the 2016-2017 school year, Ontario’s program expanded to include boys in additions to girls and switched to delivering immunization in grade 7 instead of grade 8. Grade 8 females were also offered HPV vaccine in the 2016-2017 school year so that this cohort would not be missed in the transition from grade 8 to grade 7 delivery. Age cohorts are used to approximate the grades at which students are eligible for school-based immunization programs (12-year-olds born in 2004 for grade 7, 13-year-olds born in 2003 for grade 8).

~Rate for boys and girls combined.

- No information was provided at the time the data were collected.

Figure 9. Final Dose Uptake Rates for HPV Vaccination for Girls in Canada



5.2 HPV Immunization Program for Boys

All provinces and territories have extended school-based HPV vaccination programs to include boys. The immunization uptake (for final dose) based on available data ranges from 57.5-91.3%.

Table 16. Provincial and Territorial HPV Immunization Programs for Boys

Jurisdiction	School year of most recent available data	Total size of eligible cohort (boys only)	Immunization uptake (boys only)		
			1 st dose	2 nd dose	3 rd dose
YT			Data not available		
NT			Data not available		
NU	-	-	-	-	-
BC	2017-2018	NA	73.7%	64.6%	Two-dose schedule
AB	2017-2018	26,356	78.5%	-	66.1%
SK			Data not available		
MB			Data not available		
ON	2017-2018	77,238	70.3%	57.5%	Two-dose schedule
QC	2017-2018	46,870	80%	74.0%	Two-dose schedule
NB	2017-2018	3,696	76.6%	70.2%	Two-dose schedule
NS	2015-2016	5,239	89.4%	81.0%	Two-dose schedule
PE	2017-2018	818	89.4%	85.6%	Two-dose schedule
NL	2017-2018	2,700	-	91.3%*	Two-dose schedule

* Rate for boys and girls combined.

- No information was provided at the time the data were collected.

Figure 10. Final Dose Uptake Rates for HPV Vaccination for Boys in Canada



Table 17. Cervical Screening Programs that Collect Data on HPV Immunization Status & Link Screening Results with Immunization Status

Jurisdiction	Can your program link cervical screening results (i.e. normal and abnormal results) with the immunization status of the screening participant?		If your program can link screening results with immunization status, can HPV immunization status be linked to a specific cytology result (e.g., HSIL)?	
	Yes	No	Yes	No
YT	Unsure		Unsure	
NT	✓		✓ Can link to LSIL, HSIL, AGC and ASC-H. Cervical screening data does not include CIN information.	
NU	-	-	-	-
BC	-	-	-	-
AB	✓ Exploring the options for possible linkage			✓ Possible
SK		✓		✓
MB	✓		✓	✓
ON		✓		
QC		✓		
NB	✓ As a formal Data request; Screening Program (CS-IIS) currently is not able to receive or store HPV immunization data		✓ As a formal data request; Screening Program (CS-IIS) currently is not able to receive or store HPV immunization data	
NS		As of August 2019, no. Working on implementing this linkage in fall 2019.		As of August 2019, no. Working on implementing this linkage in fall 2019.
PE		✓		
NL	✓		✓ Able to link data with linkages from the cytology register with data from the provincial government's immunization program	

- No information provided at the date of data collection

5.3 Extended Eligibility Programs for HPV Immunization

All provinces and territories have extended eligibility programs. This allows for those who did not receive or did not complete the HPV vaccine series at the provincially-specified grade or age to receive the publicly-funded vaccine if they meet certain eligibility criteria.

Table 18. Provincial and Territorial Extended Eligibility Programs for HPV Immunization

Jurisdiction	Extended eligibility component	Start date	End date	Target population	Location
YT	Yes	Girls 2011-12 Boys 2017-18	N/A	Provided free to: <ul style="list-style-type: none"> Females 15 years of age to 18 years of age at time of first dose. Females and Males HIV+ 9-45 years of age. Males high risk (9-26 years of age at time of 1st dose) 	<ul style="list-style-type: none"> Public health unit Nursing stations Schools
NT	Yes	-	-	<ul style="list-style-type: none"> Ages 9-26 for girls and boys 	<ul style="list-style-type: none"> Public health unit Nursing station
NU	Yes	2017	-	<ul style="list-style-type: none"> N/A 	<ul style="list-style-type: none"> Public health unit Medical clinics Nursing station
BC	Yes	Current criteria began June 2019	To present	<ul style="list-style-type: none"> Those who did not get the vaccine in grade 6 remain eligible for publicly funded HPV vaccine if they started their vaccine series before their 19th birthday. Applicable to all females, and for males born 2006 and later. 	<ul style="list-style-type: none"> School clinics (e.g., grade 9) Community-based clinics in public health STI clinics Family physician Pharmacist
AB	Yes – Grade 9 catch up program	Girls: 2008 Boys: 2014	-	<ul style="list-style-type: none"> Students who missed HPV as part of school-based program up to end of grade 12 Individuals 17 to 26 years of age biologically male at birth who have sex with individuals biologically male at birth HSCT recipients 9 to 17 years SOT candidates and recipients 9 to 26 years 	<ul style="list-style-type: none"> Public health office School
SK	Yes	2008	N/A	<ul style="list-style-type: none"> Females born since January 1, 1996 who are in grade 6 or who did not receive or complete a series when in grade 6 HIV infected males 9-17 years (3-dose series) 	<ul style="list-style-type: none"> School

Jurisdiction	Extended eligibility component	Start date	End date	Target population	Location
MB	Yes	-	No end date unless otherwise stated (by age cut-off, as per Health Canada approved indications for use)	<p>Females 9-45 years</p> <ul style="list-style-type: none"> • Immunocompetent HIV infected • Congenital immune deficiencies or acquired immune deficiencies • New diagnosis of high-grade cervical histopathology result • Victim of sexual assault <p>Males 9-26 years</p> <ul style="list-style-type: none"> • Immunocompetent HIV infected • Identify as gay or bisexual • Congenital immune deficiencies or acquired immune deficiencies • Victim of sexual assault <p>Other</p> <ul style="list-style-type: none"> • Males ≤ 18 years who are/have been incarcerated • Transgender males and transgender females 9-26 years of age • Individuals who currently/have previously been diagnosed with recurrent respiratory papillomatosis • Under the care of a hematologist or oncologist for malignant neoplasms or hypo-or asplenic and have been provided a CCMB directed immunization schedule 	<ul style="list-style-type: none"> • Public health unit • Physicians • Pharmacy • Nurse practitioners (limited amount) • School (in some regions)
ON	Yes	-	-	<ul style="list-style-type: none"> • Students eligible in Grade 7 may receive the vaccine series until the end of their Grade 12 year 	<ul style="list-style-type: none"> • Public health unit
QC	Yes	2008	N/A	<ul style="list-style-type: none"> • Immunization is free for girls under 18 years of age for the 1st dose and women and men who are immunosuppressed or HIV-infected up to 26 years of age. Since January 2016, it is also free for men who have sex with men. 	<ul style="list-style-type: none"> • Public health unit • Medical clinics • School

CERVICAL CANCER SCREENING IN CANADA – ENVIRONMENTAL SCAN 2019/2020

Jurisdiction	Extended eligibility component	Start date	End date	Target population	Location
NB	Yes	Grade 7 females or those born in 1995 Grade 7 males or those born in 2005 or later	Females until they reach the age of 27 years of age Males until they reach the age of 27 years of age	<ul style="list-style-type: none"> Criteria for eligibility is based on date of birth until they reach the age of 27 years 	<ul style="list-style-type: none"> School (Provided through the school immunization program by Public Health nurses but can also be given at Public Health office if required) Under certain circumstances can be given at physician's office at special request and approved by Public Health.
NS	Yes	Girls: 2007 Boys: 2015	-	<ul style="list-style-type: none"> Youth who have missed or refused HPV vaccine as part of the school-based program up to and including 18 years of age 	<ul style="list-style-type: none"> Public health unit
PE	Yes	2016	N/A	<ul style="list-style-type: none"> Males ages 18-26 with specified risk factors Females ages 18-45 with specified risk factors Immunocompetent males and females who have HIV Men who have sex with men 	<ul style="list-style-type: none"> Public health unit Nursing station Local Health PEI Public Health Nursing Office
NL	Yes - For females whose parents refused and who are now old enough to decide they want the vaccine	N/A	N/A	<ul style="list-style-type: none"> Females born 1994 or after 	<ul style="list-style-type: none"> Public health unit

- No information was provided at the time the data were collected.

Abbreviations: HSCT: haematopoietic stem cells transplant

6. Cervical Screening Pilots and Studies

Several jurisdictions conduct or participate in pilots or studies related to cervical screening. AB has undertaken a pilot to integrate cervical and colorectal cancer screening with mobile mammography services; a study to assess the impact of HPV vaccination on Pap test cytology results; and a retrospective review of the screening history of invasive cervical cancer cases. MB and NL both had studies of cervical screening self-sampling, and NL also assessed the effectiveness of HPV vaccination over time on precancerous cervical lesions.

Table 19. Cervical Screening Pilots and Studies in Alberta

Title	Enhanced Access to Cervical and Colorectal Cancer Screening (EACS) - Alberta	HPV vaccination impact on Pap test results - Alberta	Screening History of Invasive Cervical Cancer cases - Alberta
Purpose of the Study	The Enhanced Access to Cervical and Colorectal Cancer Screening (EACS) project was a 2-year pilot that aimed to integrate cervical and colorectal cancer screening with the Mobile mammography services. This study assessed the feasibility of integrated screening service delivery model and its impact on participation rates.	A school-based program with quadrivalent human papillomavirus (HPV) vaccination was implemented in Alberta in 2008. Assessed the impact of this program on Pap test cytology results using databases of province wide vaccination and cervical screening.	To examine the screening history of invasive cervical cancer (ICC) cases in Alberta, Canada to identify areas for improvement of the population-based cervical screening program.
Start and end date	Screen Test and Screen Test–EACS operated from Nov. 1, 2013, to Oct. 31, 2015, and from Sept. 18, 2013, to Oct. 8, 2015, respectively.	Conducted a nested case–control study involving a cohort of women in Alberta born between 1994 and 1997 who had at least 1 Pap test between 2012 and 2015.	Retrospective review of ICC cases diagnosed in 2 cities in Alberta between 2007 and 2012.
# of individuals recruited	A total of 8390 and 1312 women participated in Screen Test and Screen Test–EACS, respectively.	The total study population was 10,204.	There were 313 cases of ICC diagnosed in Calgary and Medicine Hat from January 1, 2007, to December 31, 2012. Of these, 280 (89.5%) occurred in women between 21 and 69 years old, who were eligible for cervical screening as per provincial guidelines at that time.
Study/ Pilot Inclusion Criteria	Inclusion criteria included rural and remote sites, with a focus on hard-to-reach women living in First Nations, Métis and Hutterite communities. Screen Test was the control and offered mammography only, while Screen Test–EACS was the intervention and offered mammography as well as cervical and colorectal cancer screening to eligible women.	The inclusion criteria for the study population included women born between 1994 and 1997, who had at least 1 Pap test between 2012 and 2015, and who had permanent residency in Alberta, as per the ACCSP eligibility criteria.	This study focused on the 2 Southern Alberta cities where the provincial cervical screening program was first implemented. Cases of ICC diagnosed in Calgary and Medicine Hat between January 1, 2007, and December 31, 2012, were extracted from the Alberta Cancer Registry Database.

Title	Enhanced Access to Cervical and Colorectal Cancer Screening (EACS) - Alberta	HPV vaccination impact on Pap test results - Alberta	Screening History of Invasive Cervical Cancer cases - Alberta
Results	<p>A total of 8390 and 1312 women participated in Screen Test and Screen Test–EACS, respectively. Screen Test–EACS significantly increased uptake of cervical (10.1% v. 27.5%) and colorectal (10.9% v. 22.5%) cancer screening, increasing the prevalence of women up to date with screening from 52.5% to 62.9% for cervical cancer screening and from 37.3% to 48.7% for colorectal cancer screening.</p>	<p>Adjusting for age, vaccinated women had a higher screening rate than unvaccinated women (13.0% v. 11.4%, $p < 0.001$). Among women who received full vaccination (≥ 3 doses), the adjusted OR for cervical abnormalities was 0.72 (95% confidence interval [CI] 0.63–0.82). For high-grade lesions, the adjusted OR was 0.50 (95% CI 0.30–0.85). With 2-dose HPV vaccination, the adjusted OR for cervical abnormalities was 1.08 (95% CI 0.84–1.38).</p>	<p>Of the 280 cases that occurred in women eligible for screening, 125 (44.6%) were adequately screened, 18 (6.4%) were under-screened, and 137 (49%) were unscreened. Among the adequately screened, 71 (56.8%) had normal Pap test results, but 48 (38%) had less than 3 previous Pap tests ($p = .003$). Cancer stages I to II were diagnosed in 48.8% and 44.1% of adequately screened and unscreened women and cancer stages III to IV in 30.6% and 66.1% in each group, respectively ($p = .0058$). Squamous cell carcinoma (SCC) was diagnosed in 189 women (67.5%). The proportion of SCCs was similar in adequately screened and unscreened women.</p>
Referral process	<p>Recall letters were sent to all clients who had participated in Screen Test in the past and who were due for breast cancer screening. For women in locations where Screen Test–EACS was scheduled, the letter also included a list of clinics that would be offering the additional screening. All Screen Test and Screen Test–EACS clients included in this study received a mammogram. Participation in cervical and colorectal screening was computed for both Screen Test and Screen Test–EACS clients at 2 points in time: 6 weeks before mammogram and 3 months after mammogram. The first point in time (6 w before the date of mammogram) was treated as the baseline. The net increase in the prevalence of women up to date with cervical and colorectal cancer screening was calculated as the proportion of women who were up to date 3 months after the mammogram minus the proportion of women who were up to date at baseline (6 w before mammogram).</p>	<p>To assign case–control status, we used the most severe cytology results (reported based on the Bethesda System) captured in the ACCSP database between Jan. 1, 2012, and Aug. 14, 2015. Women with negative cytology results were the controls, and women with low-grade (atypical squamous cells of undetermined significance [ASC-US] or low-grade squamous intraepithelial lesion [LSIL]) and high-grade (atypical squamous cells, cannot rule out a high-grade lesion [ASC-H]; or high-grade squamous intraepithelial lesion [HSIL]) cervical abnormalities were cases. We considered a woman “vaccinated” if there was a record of at least 1 dose of HPV vaccination before the Pap test used for the case–control assignment, “fully vaccinated” if she had 3 or more recorded doses of the HPV vaccination and “partially vaccinated” if fewer than 3 doses were recorded. “Unvaccinated” women were those with no record of vaccination before the Pap test. The first HPV vaccination in the study population took place in 2006, when the vaccine was approved in Canada.</p>	

Title	Enhanced Access to Cervical and Colorectal Cancer Screening (EACS) - Alberta	HPV vaccination impact on Pap test results - Alberta	Screening History of Invasive Cervical Cancer cases - Alberta
Recruitment methods	The Screen Test program visited 44 communities and held 74 clinics whereas the Screen Test-EACS pilot project visited 16 communities and held 24 clinics.	We conducted a nested case-control study involving a cohort of women in Alberta born between 1994 and 1997 who had at least 1 Pap test between 2012 and 2015. Women with negative cytology results were controls. Women with low-grade (atypical squamous cells of undetermined significance or low-grade squamous intraepithelial lesion) and high-grade (atypical squamous cells, cannot rule out a high-grade lesion; or high-grade squamous intraepithelial lesion) cervical abnormalities were cases. Exposure status was assigned according to records of HPV vaccination. Odds ratios (ORs) for abnormal cytology results by vaccination status were adjusted for neighborhood income, laboratory service, rural versus urban residency, and age.	Depending on the women's screening history, cases of ICC were classified into 3 groups according to the outcome indicators of screening history in cases of invasive cancer ⁹ : a) adequately screened are women who had a Pap test between 0.5 (6 months) and 3 years before the date of ICC diagnosis. b) Under-screened are women who had a Pap test between 3 to 5 years before date of ICC diagnosis. c) Unscreened are women who did not have records of a Pap test before the date of ICC diagnosis or had a Pap test greater than 5 years before the date of ICC diagnosis.
First Nations, Inuit and Métis Recruitment	Screen Test-EACS was offered between 2013 and 2015 in selected rural and remote sites, with a focus on hard-to reach women living in First Nations, Métis and Hutterite communities. Participation in cervical and colorectal cancer screening was analyzed for Screen Test and Screen Test-EACS participants 6 weeks before clients received their mammogram and then again 3 months after.		
Recruitment for Underscreened Populations	Although communities were not randomly assigned to receive the intervention, which lessens comparability among groups. However, we believe that the results of this evaluation are still relevant and may in fact underestimate the impact of the intervention because communities chosen for the Screen Test-EACS pilot were among the most disadvantaged in the province.		

Title	Enhanced Access to Cervical and Colorectal Cancer Screening (EACS) - Alberta	HPV vaccination impact on Pap test results - Alberta	Screening History of Invasive Cervical Cancer cases - Alberta
Reference (if the study has been published)	Enhancing access to cervical and colorectal cancer screening for women in rural and remote northern Alberta: a pilot study. Silvina, C. Mema, MD MSc, Huiming Yang, MD MSc, Sherry Elnitsky MA CE, Zhichang Jiang MMath, Marcus Vaska MLIS, Linan Xu MSc. CMAJO, October 3, 2017, Vol. 5 No. 4: E740-E745. 10.9778/cmajo.20170055	Kim, J., Bell, C., Sun, M., Kliewer, G., Xu, L., McInerney, Maria., Svenson, L., & Yang, H. (2016). Effect of human papillomavirus vaccination on cervical cancer screening in Alberta. Canadian Medical Association Journal. 188. 10.1503/cmaj.151528 .	Mema, S.C., Nation, J., Yang, H., Waghray, R., Sun, M.C., Xu, L., & Kliewer, G. (2017). Screening History in 313 Cases of Invasive Cancer: A Retrospective Review of Cervical Cancer Screening in Alberta, Canada. Journal of Lower Genital Tract Disease; 21 (1):17-20. 10.1097/LGT.0000000000000274

Table 20. Cervical Screening Pilots and Studies in Manitoba

Title	Cervical Screening Self-Sampling Study - Manitoba
Purpose of the Study	To assess whether screening participation could be improved in unscreened women by offering a mailed self-sampling kit for HPV testing instead of a Pap test.
Start and end date	~2016-18
# of individuals recruited	1050
Study/ Pilot Inclusion Criteria	Unscreened women who had been sent an invitation letter from CervixCheck in the past but who did not respond (by getting a Pap test).
Results	Screening participation was significantly higher in the intervention group than in the control group (n = 51, 9.6%, vs. n = 13, 2.5%; odds ratio: 4.7; 95% confidence interval: 2.56 to 8.77). Geographic area of residence (urban or rural) and age were not statistically significant.
Recruitment methods	Invitation letter
Recruitment for Underscreened Populations	Unscreened women from any population group
Reference	Jalili F, O’Conaill C, Templeton K, Lotocki R, Fischer G, Manning L, Cormier K, Decker K. Assessing the impact of mailing self-sampling kits for human papillomavirus testing to underscreened non-responder women in Manitoba. Current Oncology. 2019;26(3). http://dx.doi.org/10.3747/co.26.4575

Table 21. Cervical Screening Pilots and Studies in Newfoundland and Labrador

Title	Cervical Screening Self-Sampling Study – Newfoundland and Labrador	Pre-Cancerous Cervical Lesions in Newfoundland and Labrador
Purpose of the Study	The purpose of the study was to investigate whether a mailed self-sampling kit for HPV will affect cervical screening participation compared to invitation letters to have a Pap test, in non-responders in Cervical Screening.	Assess the effectiveness of HPV vaccination over time on precancerous cervical lesions in NL.
Start and end date	2016-2018	2014-2019 In partnership with the Public Health Agency of Canada and Cervical Screening Initiatives
# of individuals recruited	600 women allocated to Control Arm 5760 women allocated to Intervention Arm	
Study/ Pilot Inclusion Criteria	Females between 30 and 69 years Live in Eastern Health jurisdiction Have not had a Pap test in 36 months and no history of cytological abnormalities OR has not had a Pap test in 15+ months with a history of positive cytology [these women were identified as requiring follow up and were on a recall list sent to their Health Care Providers but have not returned for screening).	Females 20-24 years, who have screened for cervical cancer with Pap Testing
Results	Final results pending	Results pending end of the study in 2019
Referral process		Blinded specimens sent for further analysis
Recruitment methods	Arm 1: Control Invitation letter to book a Pap Test with HCP with Open Pap Clinic List and CSI Promotional Materials Arm 2: Intervention Arm Mailed HerSwab self-sampling kit Participant Recall invitation letter Questionnaire about acceptability of test CSI Promotional materials and Open Clinic List	Cytology technologists at EH cytology lab will be instructed to set aside all leftover LBC samples from females in age group 20 to 24 years, with a cytology diagnosis of LSIL-H, ASC-H, AGC, HSIL or worse, along with a random sample of LSIL. De-identified samples are then sent to the National Micro Biology Lab for testing and analysis
Reference	PI: Dr. Cathy Popadiuk, MD, FRCS Medical Director, Cervical Screening Initiatives	The Principal Investigator for PHAC is Dr. Alberto Severini; Principal Investigator for CSI is Dr. Cathy Popadiuk

7. Population Outreach

In general, screening participation rates are low among First Nations, Inuit and Métis.¹¹ This is also the case for low-income individuals, new immigrants, individuals living in rural communities, and other underscreened populations.¹² A variety of strategies have been implemented across Canada to help address screening participation in underscreened populations.

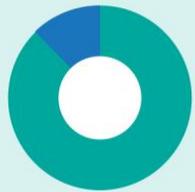
7.1 Framework for Interventions to Improve Cancer Screening

The Community Preventive Services Task Force (CPSTF), supported by the US Centers for Disease Control and Prevention (CDC), carried out an extensive review of factors related to screening for breast, cervical, colorectal and skin cancer.¹³ The review focused on interventions that increase community demand and access and increase provider delivery. The interventions identified aim to increase screening rates across the population but could also support efforts to improve screening equity. The framework outlines evidence-based intervention strategies to support decision making.

Table 22. CDC Framework for Interventions to Improve Cancer Screening¹³

Increase Community Demand	Increase Community Access	Increase Provider Delivery
<ul style="list-style-type: none"> • Group Education • One-on-one Education • Client Reminders • Client Incentives • Mass Media • Small Media 	<ul style="list-style-type: none"> • Interventions to Reduce Client Out-Of-Pocket Costs • Interventions to Reduce Structural Barriers <ul style="list-style-type: none"> ○ Reducing Administrative Barriers ○ Providing Appointment Scheduling Assistance ○ Using Alternative Screening Sites ○ Using Alternative Screening Hours ○ Providing Transportation ○ Providing Translation ○ Providing Childcare 	<ul style="list-style-type: none"> • Provider Reminders • Provider Incentives • Provider Assessment and Feedback

7.2 First Nations, Inuit and Métis



11/13

CANADIAN JURISDICTIONS ARE WORKING WITH FIRST NATIONS, INUIT AND MÉTIS TO INCREASE SCREENING PARTICIPATION

According to the limited data specific to First Nations, Inuit and Métis, participation rates for cervical screening are much lower among First Nations, Inuit and Métis than non-Indigenous people in Canada. The data also indicate considerable variation in screening participation among First Nations, Inuit and Métis across geographic location.¹¹

The cervical screening program in NT collects Indigenous and/or People-specific data (e.g. First Nations, Inuit, and/or Métis identifiers) through healthcare numbers. In ON, the Indigenous Cancer Control Unit (ICCU) is currently working with First Nations, Inuit and Métis communities, leadership and governance to explore access, use and reports relating to identifiers. The First Nations Health Authority and Métis Nation British Columbia are working with BC Cancer to establish data linkages that will result in People-specific screening data. Saskatchewan Cancer Agency is similarly working with First Nations and the Métis Nation-Saskatchewan to develop linkages that will result in People-specific screening data.

Currently, no other Canadian jurisdictions collect this type of data as part of their cervical screening programs.

Screening programs in nine provinces and two territories report work with First Nations, Inuit and Métis to increase cervical screening participation. This work includes engaging First Nations, Inuit and Métis in decision-making and informing approaches to culturally appropriate screening, development of First Nations, Inuit or Métis-specific resources, and engaging with healthcare providers working directly with First Nations, Inuit and Métis communities. Specifically, some programs engage with First Nations, Inuit and Métis in the development of cancer plans and through working groups. Dedicated mobile visits have also been implemented in several cervical screening programs, increasing access to screening for some First Nations, Inuit and Métis communities, along with other programs resources such as culturally appropriate material, presentations, pilots and social media campaigns.

In addition, some strategies were put in place to provide education to health care providers working directly with First Nations, Inuit and Métis communities, such as screening toolkits and cultural sensitivity training. NS is currently working with First Nations on a “Knowledge to Action”

project using the First Nations Client Linkage Registry to provide participating First Nations with aggregate data to support community health planning and evaluation. No strategies related to self-screening, childcare, or provider incentives were reported.

Figure 11. Strategies to Increase Screening Participation Among First Nations, Inuit and Métis (July 2019)

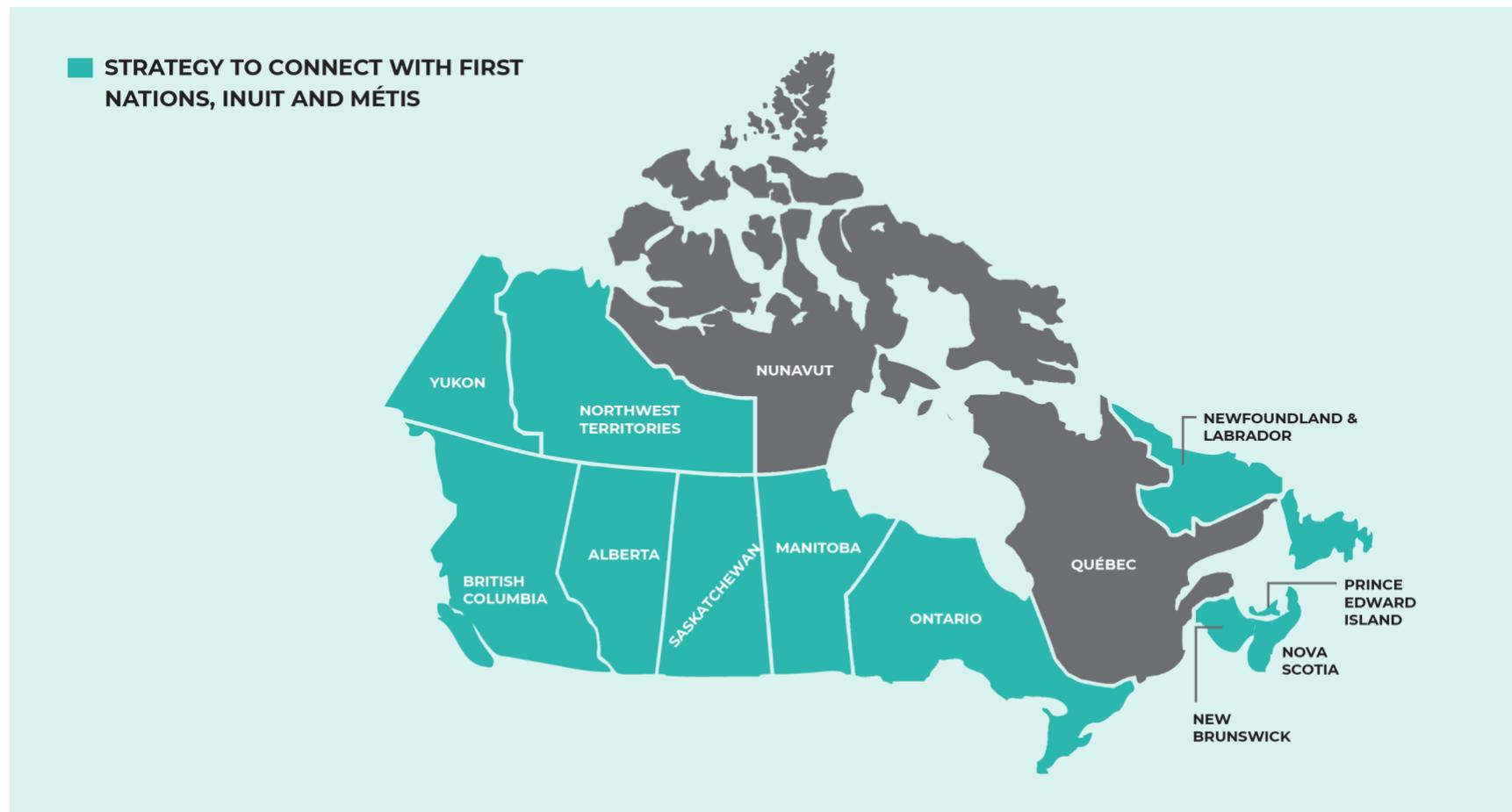


Table 23. Group Education Strategies to Increase Screening Participation Among First Nations, Inuit and Métis

Jurisdiction	Intended Audience			Description
	First Nations	Inuit	Métis	
AB	✓		✓	<ul style="list-style-type: none"> AHS works closely with Indigenous communities to improve cervical cancer prevention and screening among Indigenous populations.
MB	✓		✓	<ul style="list-style-type: none"> CervixCheck partners with Community Engagement Liaisons in each regional health authority in the province to provide resources for group education. CervixCheck provides Competency Training for all cervical screening providers in the province. This has also included working with 1 regional health authority to target training for First Nations. They have identified having trained professionals within First Nations, Inuit, Metis communities as their priority
NB	✓			<ul style="list-style-type: none"> Attend and present on Cancer Screening Programs, including Cervical Cancer awareness, at First Nation Wellness events or conferences, upon invitation. Currently working on a GIS mapping project to help identify areas of decreased participation and appropriate targeted awareness initiatives - including First Nation Communities.
ON	✓	✓	✓	<ul style="list-style-type: none"> Through Indigenous Cancer Care Unit (ICCU), Regional Indigenous Cancer Leads and regional teams, communities have been engaged through workshops and health fairs. Primary care providers are educated through Continuing Professional Development (CPD) accredited presentations.
PE	✓			<ul style="list-style-type: none"> Attending health fairs/community events with information and educating clinic staff
SK	✓		✓	<ul style="list-style-type: none"> Coordinate group education sessions at First Nations Health Fairs and Pow Wows
YT	✓			<ul style="list-style-type: none"> Plans to develop strategies

One-on-one education activities involve an individual (health care provider or layperson) explaining the benefits of screening and ways to overcome barriers to screening to clients individually either in person or by phone.

Table 24. One-on-One Education Strategies to Increase Screening Participation Among First Nations, Inuit and Métis

Jurisdiction	Intended Audience			Description
	First Nations	Inuit	Métis	
MB	✓		✓	<ul style="list-style-type: none"> CervixCheck partners with Community Engagement Liaisons in each regional health authority in the province to provide resources for one-to-one education. The Screening Program Health Educators also manage an email and respond to phone queries from the public. Attend events and speak one-on-one with individuals who have questions about cancer screening.
NT	✓	✓	✓	-
ON	✓	✓	✓	<ul style="list-style-type: none"> Partner with regional health authorities and community/organizational leadership to coordinate one-on-one education sessions. There are also more targeted sessions through the ICCU and regional teams with communities/organizations.

- No information was provided at the time the data were collected.

Client reminders (e.g., letters, phone calls) are used to remind clients that screening is due and provide follow-up information (e.g., benefits of screening, ways to address barriers, help to schedule appointments).

Table 25. Client Reminder Strategies to Increase Screening Participation Among First Nations, Inuit and Métis

Jurisdiction	Intended Audience			Description
	First Nations	Inuit	Métis	
ON	✓	✓	✓	<ul style="list-style-type: none"> Reminders are sent to all Ontarians through cancer screening correspondence letters for both invitations and recalls. The ICCU is currently engaged in a study to investigate current correspondence and identify methods to enhance patient reminders.
SK	✓		✓	<ul style="list-style-type: none"> Patient reminders indicating they are overdue for their Pap test

Table 26. Client Incentive Strategies to Increase Screening Participation Among First Nations, Inuit and Métis

Jurisdiction	Intended Audience			Description
	First Nations	Inuit	Métis	
SK	✓		✓	<ul style="list-style-type: none"> Provide small gifts and promotion materials at health fairs and Pap test clinics

Table 27. Mass Media Strategies to Increase Screening Participation Among First Nations, Inuit and Métis

Jurisdiction	Intended Audience			Description
	First Nations	Inuit	Métis	
AB	✓	✓	✓	<ul style="list-style-type: none"> Use websites to increase awareness about the importance of cervical cancer screening and prevention.
BC	✓	✓	✓	<ul style="list-style-type: none"> Use social media to increase awareness about the importance of cancer screening to eligible population.
MB	✓	✓	✓	<ul style="list-style-type: none"> Use social media, television, digital medias, and newsprint that is targeted to increase awareness about the importance of cancer screening to eligible Indigenous population.
NB	✓			<ul style="list-style-type: none"> Use social media to increase awareness about the importance of cancer screening to eligible population, including NB's Indigenous population.
NL	✓	✓	✓	<ul style="list-style-type: none"> Use social media to increase awareness about the importance of cancer screening to all eligible populations.
NT	✓	✓	✓	<ul style="list-style-type: none"> Use social media to increase awareness about the importance of cancer screening to eligible Indigenous population.
ON	✓	✓	✓	<ul style="list-style-type: none"> Use social media to increase awareness about the importance of cancer screening to eligible Indigenous population.
SK	✓		✓	<ul style="list-style-type: none"> Use social media to increase awareness about the importance of cancer screening to our eligible Indigenous population. Use of radio ads to remind and increase awareness of the importance of getting screened.

Small media include videos and printed materials such as letters, brochures, and newsletters. These materials can be used to inform and motivate people to be screened for cancer. They can provide information tailored to specific individuals or geared towards general audiences.

Table 28. Small Media Strategies to Increase Screening Participation Among First Nations, Inuit and Métis

Jurisdiction	Intended Audience			Description
	First Nations	Inuit	Métis	
AB	✓		✓	<ul style="list-style-type: none"> Indigenous cancer screening educational resources
BC	✓	✓	✓	<ul style="list-style-type: none"> Brochures, videos and handouts are all available.
MB	✓		✓	<ul style="list-style-type: none"> Have a basic resource translated in French, Oji-Cree, and Ojibway to help educate about the importance of cancer screening. Also have a colposcopy video translated into Cree and Ojibway.
ON	✓	✓	✓	<ul style="list-style-type: none"> Cancer Screening Fact Sheets, Toolkit, and awareness postcards were designed and tailored for each First Nation, Inuit and Métis population. Cancer 101 whiteboard video promotes cancer screening.
SK	✓		✓	<ul style="list-style-type: none"> Provide brochures and handouts with specific information about Pap test clinics in their local area.

Table 29. Strategies to Reduce Out-of-Pocket Costs for Screening Participation Among First Nations, Inuit and Métis

Jurisdiction	Intended Audience			Description
	First Nations	Inuit	Métis	
ON	✓	✓		<ul style="list-style-type: none"> The ICCU supports individuals (who are approved and eligible through the First Nation Inuit Health Branch) requiring medical transportation benefits under the Non-Insured Health Benefits (NIHB) program in the area of screening.

Structural barriers are obstacles (other than those related to economics/finances) that make it difficult to access screening, for example, distance to screening locations, hours of service, setting of screening, administrative procedures, etc. Interventions to reduce structural barriers may include providing mobile screening, reducing administrative burden, providing assistance with scheduling, providing translation, expanding hours of service, etc.

Table 30. Appointment Scheduling Strategies to Increase Screening Participation Among First Nations, Inuit and Métis

Jurisdiction	Intended Audience			Description
	First Nations	Inuit	Métis	
BC	✓	✓	✓	<ul style="list-style-type: none"> Clinic locator can be used to find providers who are willing to offer Pap tests. Hours and locations are available on line.
MB	✓	✓	✓	<ul style="list-style-type: none"> CervixCheck facilitates increased access to cervical screening services by partnering with clinics across the province and listing the partner location details on our website.
SK	✓		✓	<ul style="list-style-type: none"> Coordinate with nurse practitioners holding Pap test clinics in remote and rural locations.

Table 31. Alternative Site Strategies to Increase Screening Participation Among First Nations, Inuit and Métis

Jurisdiction	Intended Audience			Description
	First Nations	Inuit	Métis	
BC	✓	✓	✓	<ul style="list-style-type: none"> Clinic locator can be used to find providers who are willing to offer Pap tests. Hours and locations are available on line.
MB	✓	✓	✓	<ul style="list-style-type: none"> CervixCheck facilitates increased access to cervical screening services by partnering with clinics across the province and listing the partner location details on our website. This includes helping women identify clinics within their community or neighboring communities, depending on their preferences.
ON	✓	✓	✓	<ul style="list-style-type: none"> Ontario has a mobile screening coach that offers cancer screening services (including cervical screening) in the North West region.

Table 32. Alternative Hours Strategies to Increase Screening Participation Among First Nations, Inuit and Métis

Jurisdiction	Intended Audience			Description
	First Nations	Inuit	Métis	
BC	✓	✓	✓	<ul style="list-style-type: none"> Clinic locator can be used to find providers who are willing to offer Pap tests. Hours and locations are available on line.
MB	✓	✓	✓	<ul style="list-style-type: none"> CervixCheck partners with clinics all over the province. Each site provides parameters around appointments vs. walk-ins and times/days of the week.

Table 33. Transportation Strategies to Increase Screening Participation Among First Nations, Inuit and Métis

Jurisdiction	Intended Audience			Description
	First Nations	Inuit	Métis	
MB	✓		✓	<ul style="list-style-type: none"> CervixCheck partners with the Regional Mobile Primary Healthcare Units to provide cervical screening access to rural and Indigenous populations across the province.
NT	✓			<ul style="list-style-type: none"> Mobile Health Unit travels the northern part of the province providing information to First Nation groups about the importance of getting cervical, colorectal and breast screening.
ON	✓	✓	✓	<ul style="list-style-type: none"> Ontario has a mobile screening coach that offers cancer screening services (including cervical screening) in the North West region.
SK	✓		✓	<ul style="list-style-type: none"> Mobile Health Unit travels the northern part of the province providing information to First Nation groups about the importance of getting cervical, colorectal and breast screening.

Table 34. Translation Strategies to Increase Screening Participation Among First Nations, Inuit and Métis

Jurisdiction	Intended Audience			Description
	First Nations	Inuit	Métis	
MB	✓	✓	✓	<ul style="list-style-type: none"> We have resources translated into French, Oji-Cree, and Ojibway.
NL	✓	✓		<ul style="list-style-type: none"> Work within RHA to provide services where possible
ON	✓	✓	✓	<ul style="list-style-type: none"> Informational resources are available in several Indigenous languages.

Provider reminder and recall systems remind providers that it is time for a client to be screened for cancer or that the client is overdue for a test (e.g., in electronic medical records, via email, etc.)

Table 35. Provider Reminder Strategies to Increase Screening Participation Among First Nations, Inuit and Métis

Jurisdiction	Intended Audience			Description
	First Nations	Inuit	Métis	
BC	✓	✓	✓	-
MB	✓	✓	✓	CervixCheck will send a healthcare provider a reminder when the appropriate follow-up management is not in registry.
ON	✓			The Screening Activity Report (SAR) is an online report, which provides screening data to help family doctors improve their cancer screening rates and appropriate follow-up. The report allows family doctors to quickly find specific cancer screening information for each patient, including those who are overdue or have never been screened. In June 2018, the screening activity report (SAR) was expanded to Sioux Lookout Zone which consists of several First Nations communities, provides non-patient enrollment model physicians and nurses access to their community data. This SAR was developed specifically for the Sioux Lookout municipality and the 27 First Nation communities that reside in the Sioux Lookout Zone.
SK	✓		✓	Provider reminders to complete follow up tests within the approved clinical guidelines

- No information was provided at the time the data were collected.

Provider assessment and feedback interventions evaluate provider performance and give providers information about their performance in offering screening services.

Table 36. Provider Assessment and Feedback Strategies to Increase Screening Participation Among First Nations, Inuit and Métis

Jurisdiction	Intended Audience			Description
	First Nations	Inuit	Métis	
AB	✓	✓	✓	<ul style="list-style-type: none"> Provide Pap Test Manual and training for nurses and healthcare providers to improve access to cervical cancer screening services in Indigenous communities.
BC	✓	✓	✓	<ul style="list-style-type: none"> Provide Pap Test Competency Training for healthcare providers to provide increased access to Pap test services. Provider quality reports with outcome measures to health care providers who provide Pap tests.
MB	✓	✓	✓	<ul style="list-style-type: none"> CervixCheck distributes provider feedback reports reflecting individual clinician performance relative to their provincial peers and the national target for each quality indicator.
NL	✓	✓	✓	<ul style="list-style-type: none"> Online learning module available to staff on cultural sensitivity. All staff are encouraged to complete the course.
NT	✓	✓	✓	<ul style="list-style-type: none"> Provide Pap Test Competency Training for healthcare providers working in Indigenous communities to provide increased access to Pap test services
ON	✓	✓	✓	<ul style="list-style-type: none"> Provide training for healthcare providers working in Indigenous communities to promote and support Pap tests (Regional Indigenous Cancer Leads and teams provide education and training) (First Nations specific) The Screening Activity Report (SAR) is an online report, which provides screening data to help family doctors improve their cancer screening rates and appropriate follow-up. The report allows family doctors to quickly find specific cancer screening information for each patient, including those who are overdue or have never been screened. In June 2018, the SAR was expanded to Sioux Lookout Zone which consists of several First Nations communities, providing non-patient enrollment model physicians and nurses access to their community data. This SAR was developed specifically for the Sioux Lookout municipality and the 27 First Nation communities that reside in the Sioux Lookout Zone.

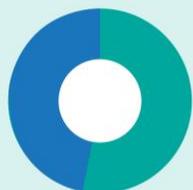
Table 37. Policies and Guidelines to Increase Screening Participation Among First Nations, Inuit and Métis

Jurisdiction	Intended Audience			Description
	First Nations	Inuit	Métis	
AB	✓	✓	✓	<ul style="list-style-type: none"> Provide Pap Test Guidelines and training to support nurses working in Indigenous communities to improve access to cervical cancer screening services.
NT	✓	✓	✓	<ul style="list-style-type: none"> Developed and signed formalized agreements (Relationship Protocols, Memorandums of Understanding) with PTOs, Independent First Nations, Inuit Service Providers, and the Métis Nation of Ontario which outline our approach to working together Cancer Strategy development included First Nations, Inuit and Metis input.
ON	✓	✓	✓	<ul style="list-style-type: none"> Through the relationships developed and fostered by the Indigenous Cancer Care Unit, regional teams have been able to continue working with communities as guided through the Indigenous Cancer Strategy. The ICCU also works across the programs to inform guidelines and engage in studies to address community requests (i.e. assessing age eligibility for screening).

Table 38. Other Strategies to Increase Screening Participation Among First Nations, Inuit and Métis

Jurisdiction	Intended Audience			Description
	First Nations	Inuit	Métis	
NS	✓			<ul style="list-style-type: none"> Currently working with First Nations on “Knowledge to Action” project using the First Nations Client Linkage Registry. Project purpose is to provide participating First Nations with aggregate data to support community health planning and evaluation.

7.3 Underscreened Populations



7/13

CANADIAN JURISDICTIONS IMPLEMENTING STRATEGIES TO SUPPORT PARTICIPATION IN UNDERSCREENED POPULATIONS

Screening participation rates are low among low-income individuals, new immigrants and those living in rural and remote communities when compared to the general Canadian population.¹²

Seven provinces have implemented strategies to help address participation in underscreened populations. These strategies focus primarily on individuals in rural communities, new immigrants and low-income individuals.

Some of the strategies identified reach underscreened populations through social media campaigns, presentations, and program material, which focus on increasing awareness and education on cervical screening. Other strategies are geared towards healthcare providers, who in turn work directly with underscreened populations.

No underscreened population strategies related to client incentives, reducing out-of-pocket expenses, or childcare were reported.

Table 39. Underscreened Population Examples

Population Groups			
<ul style="list-style-type: none"> • Low-Income • Socially Deprived • Materially Deprived • New Immigrants • Long Term Immigrants 	<ul style="list-style-type: none"> • Specific Cultural Groups • Refugees • Economic Immigrants • Visible Minorities • Non-English Speakers 	<ul style="list-style-type: none"> • Those living in an urban setting • Those living in a rural setting • Those living in a remote setting • LGBTQ2S+ 	<ul style="list-style-type: none"> • Those with co-morbidities • Those with mental illness • Those with physical disabilities

Figure 12. Underscreened Population Outreach Strategies in Canada (July 2019)



Table 40. Group Education Strategies to Increase Screening Participation Among Underscreened Populations in Canada

Jurisdiction	Intended Audience	Description
MB	<ul style="list-style-type: none"> • Newcomers • Individuals with low literacy 	<ul style="list-style-type: none"> • Cancer screening education module created with and for educators with students with low literacy. • Curriculum designed for educators to use with adults with low literacy. The curriculum is on our website.
NB	<p>1) Will be based on Study Results which we expect will include: Those living in Rural Settings; Those living in Urban settings; Non-English communities; Low-income; Specific cultural groups</p> <p>2) All</p>	<p>1) Currently working on a GIS mapping project to help identify areas of decreased participation and appropriate targeted awareness activities based on the needs of the identified under screened population.</p> <p>2) Attend and present on Cancer Screening Programs, including Cervical Cancer awareness, at Wellness events or conferences, upon invitation.</p>
NL	<ul style="list-style-type: none"> • New immigrants • Non-English Speakers • Low-income individuals • Socially Deprived 	<ul style="list-style-type: none"> • Regional Coordinators provide education on cervical screening at local community resource centres, family resource centres, planned parenthood and the Association for New Canadians to provide education and awareness sessions on cervical screening.
SK	<ul style="list-style-type: none"> • New immigrants • Non-English Speakers • Visible Minorities • Low-income individuals • Socially Deprived • Materially deprived • Specific cultural groups 	<ul style="list-style-type: none"> • Coordinators provide education on cervical screening at local community health centers. Education sessions include PowerPoint slides which have several pictures to help new immigrants understand the content. Learning module for low literacy (including adult English as an Additional Language) are offered to increase awareness of cancer screening.

One-on-one education activities involve an individual (health care provider or layperson) explaining the benefits of screening and ways to overcome barriers to screening to clients individually either in person or by phone.

Table 41. One-on-One Education Strategies to Increase Screening Participation Among Underscreened Populations in Canada

Jurisdiction	Intended Audience	Description
MB	<ul style="list-style-type: none"> All 	<ul style="list-style-type: none"> Receive phone calls, emails, and approaches at public events from the public asking questions about cervical screening.
NB	<ul style="list-style-type: none"> All 	<ul style="list-style-type: none"> Toll Free Cancer Screening line available for people to call with questions or for information on how to participate in Cervical Screening.

Client reminders (e.g., letters, phone calls) are used to remind clients that screening is due and provide follow-up information (e.g., benefits of screening, ways to address barriers, help to schedule appointments).

Table 42. Client Reminder Strategies to Increase Screening Participation Among Underscreened Populations in Canada

Jurisdiction	Intended Audience	Description
MB	<ul style="list-style-type: none"> All underscreened 	<ul style="list-style-type: none"> Recall letters are sent to all individuals who are overdue for cervical screening.
NB	<ul style="list-style-type: none"> Those living in Rural Settings Non-English communities Low-income (possibly) 	<ul style="list-style-type: none"> Program sends Invitation, Recall and Reminder letters directly to participants and PCPs via mail.
NL	<ul style="list-style-type: none"> Low-income individuals Those living in an urban setting Those living in a rural setting Those living in a remote setting 	<ul style="list-style-type: none"> Reminder letters are sent to providers to encourage them to contact their patients who are overdue for cervical screening.
ON	<ul style="list-style-type: none"> Non-specific 	<ul style="list-style-type: none"> Reminders are sent to all Ontarians through Ontario Health (Cancer Care Ontario)'s cancer screening correspondence program for both invitations and recall letters.

Table 43. Mass Media Strategies to Increase Screening Participation Among Underscreened Populations in Canada

Jurisdiction	Intended Audience	Description
NL	<ul style="list-style-type: none"> • Those living in an urban setting • Those living in a rural setting • Those living in a remote setting 	<ul style="list-style-type: none"> • Social media and radio ads are used to promote and encourage screening for cervical cancer
ON	<ul style="list-style-type: none"> • Visible minorities • Specific cultural groups 	<ul style="list-style-type: none"> • Ontario holds a Cervical Cancer Awareness Week (CCAW) campaign each October. The campaign includes the development and dissemination of promotional materials to provincial regions. These materials include images which are representative of diverse groups.
SK	<ul style="list-style-type: none"> • Those living in a rural setting • Those living in a remote setting • Low-income individuals 	<ul style="list-style-type: none"> • Radio ads to inform residents of the importance of cervical screening

Small media include videos and printed materials such as letters, brochures, and newsletters. These materials can be used to inform and motivate people to be screened for cancer. They can provide information tailored to specific individuals or geared towards general audiences.

Table 44. Small Media Strategies to Increase Screening Participation Among Underscreened Populations in Canada

Jurisdiction	Intended Audience	Description
MB	<ul style="list-style-type: none"> • All 	<ul style="list-style-type: none"> • Brochures, booklets, posters, tear offs, and videos translated into a variety of languages.
NB	<ul style="list-style-type: none"> • NB Non-English Speakers • Low Literacy 	-
NL	<ul style="list-style-type: none"> • Those living in an urban setting • Those living in a rural setting • Those living in a remote setting 	<ul style="list-style-type: none"> • Brochures and materials are available for all in the target population

- No information was provided at the time the data were collected.

Table 45. Self-Screening Strategies to Increase Screening Participation Among Underscreened Populations in Canada

Jurisdiction	Intended Audience	Description
MB	<ul style="list-style-type: none"> Unscreened women 	<ul style="list-style-type: none"> 2017 March – Self-sampling HPV study was piloted.
NL	<ul style="list-style-type: none"> Those living in an urban setting Those living in a rural setting 	<ul style="list-style-type: none"> Program was involved in a self-sample study in 2016-2017

Structural barriers are obstacles (other than those related to economics/finances) that make it difficult to access screening, for example, distance to screening locations, hours of service, setting of screening, administrative procedures, etc. Interventions to reduce structural barriers may include providing mobile screening, reducing administrative burden, providing assistance with scheduling, providing translation, expanding hours of service, etc.

Table 46. Appointment Scheduling Strategies to Increase Screening Participation Among Underscreened Populations in Canada

Jurisdiction	Intended Audience	Description
BC	<ul style="list-style-type: none"> All 	<ul style="list-style-type: none"> Clinic locator can be used to find providers who are willing to offer Pap tests. Hours and locations area available on line.
MB	<ul style="list-style-type: none"> All 	<ul style="list-style-type: none"> CervixCheck facilitates increased access to cervical screening services by partnering with clinics across the province and listing the partner location details on our website. This includes helping women identify clinics within their community or neighboring communities, depending on their preferences.

Table 47. Alternative Site Strategies to Increase Screening Participation Among Underscreened Populations in Canada

Jurisdiction	Intended Audience	Description
BC	<ul style="list-style-type: none"> Individuals with mobility issues 	<ul style="list-style-type: none"> Clinic locator can be used to find providers who are willing to offer Pap tests. Hours and locations area available on line.
MB	<ul style="list-style-type: none"> Individuals with mobility issues 	<ul style="list-style-type: none"> Each partner Pap test clinic reports on 4 items of accessibility: access to a Hoyer lift, access to an attendant onsite to assist with transfer to exam table, height-adjustable exam table, and a wheelchair accessible site.

Jurisdiction	Intended Audience	Description
NB	<ul style="list-style-type: none"> New Immigrants/ Newcomers to NB Those without a PCP Rural Setting Urban setting 	<ul style="list-style-type: none"> Participate and encourage clinics to increase access to Cervical Screening by offering additional Pap test clinics as part of the Federation of Medical Women of Canada’s Pap Awareness/Cervical Cancer Awareness Campaign (October 21-25, 2019) Working with Regional Health Authorities to establish nurse run Pap Test Clinics to increase access to screening.
ON	<ul style="list-style-type: none"> Low-income individuals Those living in a rural setting Those living in a remote setting 	<ul style="list-style-type: none"> Ontario has a mobile screening coach that offers cancer screening services (including cervical screening) in the North West region.

Table 48. Alternative Hours Strategies to Increase Screening Participation Among Underscreened Populations in Canada

Jurisdiction	Intended Audience	Description
BC	<ul style="list-style-type: none"> All 	<ul style="list-style-type: none"> Clinic locator can be used to find providers who are willing to offer Pap tests. Hours and locations area available on line.
MB	<ul style="list-style-type: none"> All 	<ul style="list-style-type: none"> CervixCheck partners with clinics all over the province. Each site provides parameters around appointments vs. walk-ins and times/days of the week.

Table 49. Transportation Strategies to Increase Screening Participation Among Underscreened Populations in Canada

Jurisdiction	Intended Audience	Description
ON	<ul style="list-style-type: none"> Low-income individuals Those living in a rural setting Those living in a remote setting 	<ul style="list-style-type: none"> Ontario has a mobile screening coach that offers cancer screening services (including cervical screening) in the North West region.
SK	<ul style="list-style-type: none"> Specific cultural groups 	<ul style="list-style-type: none"> Mobile Health Unit travels the northern part of the province providing information to under screened groups about the importance of getting cervical, colorectal and breast screening.

Table 50. Translation Strategies to Increase Screening Participation Among Underscreened Populations in Canada

Jurisdiction	Intended Audience	Description
BC	<ul style="list-style-type: none"> Specific Cultural Groups 	<ul style="list-style-type: none"> Brochures, videos and handouts are available in a variety of languages.

MB	<ul style="list-style-type: none"> • Newcomers • Individuals with low literacy 	<ul style="list-style-type: none"> • Access to the Language Access Interpreter services for those in Winnipeg to assist with informed consent to participate in cervical screening. • Have a basic set of information translated into 28 languages.
NB	<ul style="list-style-type: none"> • Non-English Speakers 	<ul style="list-style-type: none"> • All program correspondence and communications are available in French.
SK	<ul style="list-style-type: none"> • Specific Cultural Groups • New Immigrants • Non-English Speakers • Visible Minorities 	<ul style="list-style-type: none"> • Interpreters attend group education sessions to assist with translation.

Provider reminder and recall systems remind providers that it is time for a client to be screened for cancer or that the client is overdue for a test (e.g., in electronic medical records, via email, etc.)

Table 51. Provider Reminder Strategies to Increase Screening Participation Among Underscreened Populations in Canada

Jurisdiction	Intended Audience	Description
BC	<ul style="list-style-type: none"> • All 	<ul style="list-style-type: none"> • Reminders are sent to all providers.
MB	<ul style="list-style-type: none"> • Underscreened women 	<ul style="list-style-type: none"> • CervixCheck sends out fax letter reminders to clinicians whose patients have not received the appropriate follow-up after an abnormal result.
NB	<ul style="list-style-type: none"> • All types of underscreened Individuals with a PCP 	<ul style="list-style-type: none"> • Program sends Reminder letters to PCPs to notify of participants lost to follow up.
ON	<ul style="list-style-type: none"> • Non-specific 	<ul style="list-style-type: none"> • The Screening Activity Report (SAR) is an online report, which provides screening data to help family doctors improve their cancer screening rates and appropriate follow-up. The report allows family doctors to quickly find specific cancer screening information for each patient, including those who are overdue or have never been screened.
SK	<ul style="list-style-type: none"> • All 	<ul style="list-style-type: none"> • Provider reminders to complete follow up tests within the approved clinical guidelines

Table 52. Provider Incentive Strategies to Increase Screening Participation Among Underscreened Populations in Canada

Jurisdiction	Intended Audience	Description
ON	<ul style="list-style-type: none"> • New immigrants • Non-English speakers • Those with co-morbidities • Those with mental illness 	<ul style="list-style-type: none"> • To support family doctors in ensuring that their patients participate in eligible screening programs, the Ministry of Health and Long-Term Care has implemented Cumulative Preventive Care Bonuses. Through this program, eligible family doctors who practice as part of a Patient Enrolment Model, meaning, patients are formally rostered to a family doctor, may receive bonuses for maintaining specified levels of preventive care to their enrolled patients. Depending on the specific practice of the physician, the Cumulative Preventive Care Bonuses may support screening in targeted populations.

Provider assessment and feedback interventions evaluate provider performance and give providers information about their performance in offering screening services.

Table 53. Provider Assessment and Feedback Strategies to Increase Screening Participation Among Underscreened Populations in Canada

Jurisdiction	Intended Audience	Description
BC	<ul style="list-style-type: none"> • All 	<ul style="list-style-type: none"> • Provide Pap Test Competency Training for healthcare providers to provide increased access to Pap test services. • Provider quality reports with outcome measures to health care providers who provide Pap tests.
MB	<ul style="list-style-type: none"> • All Manitoba Cervical Cancer Screening Providers 	<ul style="list-style-type: none"> • CervixCheck distributes provider feedback reports reflecting individual clinician performance relative to their provincial peers and the national target for each quality indicator. • Provide Pap test competency training for healthcare providers • Distributes Colposcopist report cards to provide feedback on performance relative to their provincial peers and the national targets when available • Distributes lab report cards to provide feedback on performance relative to the province
ON	<ul style="list-style-type: none"> • All 	<ul style="list-style-type: none"> • The Screening Activity Report (SAR) is an online report, which provides screening data to help family doctors improve their cancer screening rates and appropriate follow-up. The report allows family doctors to quickly find specific cancer screening information for each patient, including those who are overdue or have never been screened.
NS	<ul style="list-style-type: none"> • All 	<ul style="list-style-type: none"> • Provide support when requested and where resources allow. (Ex. Small media items for physician education, etc.)

Table 54. Policies and Guidelines to Increase Screening Participation Among Underscreened Populations in Canada

Jurisdiction	Intended Audience	Description
BC	<ul style="list-style-type: none"> • LGBTQ2S+ • Visible minorities • Specific cultural groups 	<ul style="list-style-type: none"> • The cervical screening guidelines include screening guidelines for transgender individuals. • All materials are being reviewed for inclusive language/images.
MB	<ul style="list-style-type: none"> • LGBTQ2S+ 	<ul style="list-style-type: none"> • The cervical screening guidelines include specific guidelines for transgender individuals. In addition, the program offers educational resources that target LGBTQ2S+ individuals. Consultation with the LGBTQ2S+ community helped to ensure that these resources along with the screening program’s website use inclusive language
ON	<ul style="list-style-type: none"> • LGBTQ2S+ 	<ul style="list-style-type: none"> • Ontario has developed a breast cancer screening and cervical screening policy for trans and non-binary people, which is not yet publicly available. The policy recommendations include cervical screening guidance on eligibility, interval and modality for trans and non-binary people at average and increased risk. The policy provides screening follow-up and recall recommendations, and lab requisition considerations with cross-sex hormone use. The policy encourages providers to take steps to provide a trans-friendly clinical environment and screening experience. Currently, the Ontario Cervical Screening Guidelines Summary recommends that “transgender men who have retained their cervix should be screened according to the guidelines.”
NL	<ul style="list-style-type: none"> • LGBTQ2S+ 	<ul style="list-style-type: none"> • Transgender inclusion criteria are built into screening program guidelines.
NB	<ul style="list-style-type: none"> • LGBTQ2S+ 	<ul style="list-style-type: none"> • Recommendations for screening for transgender individuals are included in website FAQs

7.4 LGBTQ2S+ Communities

In BC and MB, the cervical screening guidelines include specific guidelines for transgender individuals. In addition, the MB program offers educational resources specific to LGBTQ2S+ individuals. Consultation with the LGBTQ2S+ community helped to ensure that these resources, along with the screening program’s website, use inclusive language.

The Ontario Cervical Screening Program has a trans persons policy; however, this policy is not yet publicly available. The program recommends that transgender men who have retained their cervix should be screened according to the program guidelines.

NB has recommendations for screening for transgender individuals included in their website’s FAQs, and NL has inclusion criteria built into their screening program guidelines.

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CONTACT US

145 King Street West, Suite 900
Toronto, Ontario, Canada M5H 1J8

Telephone: 416-915-9222
Toll free: 1-877-360-1665

Email: info@partnershipagainstcancer.ca
www.partnershipagainstcancer.ca