

EDITORIAL

Cervical screening in pregnancy: an opportunity for nurses and midwives to drive equitable cervical cancer elimination

CORRECTION NOTICE - ERRATUM

In the original publication of this article, edits were introduced during the production process. This resulted in the publication of a version of the manuscript that did not represent the authors' writing or position.

The article has been updated to include the correct wording as written and intended by the authors.

The original article, marked with a Correction Notice has been archived and is available upon request from the journal.

The editors and publisher take full responsibility and apologise for this error and any confusion it might have caused.

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Language note: We use gendered language throughout this editorial, however, we acknowledge that people who don't identify as women also seek pregnancy care and are at risk of cervical cancer.

CERVICAL CANCER IN AUSTRALIA

Cervical cancer is a disease of inequity, predominantly caused by persistent infection with carcinogenic types of human papillomavirus (HPV) and is almost entirely preventable.¹ Despite long standing cervical screening and HPV vaccination programs in Australia, women continue to die from cervical cancer.¹ Screening remains the cornerstone of prevention in adult women, yet 70% of people diagnosed with cervical cancer are under- or never-screened ('under-screened').¹ When cervical cancer is diagnosed during pregnancy or early parenthood, the consequences are devastating for women and their babies, partners and communities.

In previous decades, cervical screening was a part of routine maternity care but fell out of practice, likely due to changing

models of care, increasing demands on practitioners, a shift in mindset about standard care and the movement away from routine pelvic exams.

In 2017, Australia's National Cervical Screening Program (NCSP) shifted from Papanicolaou (Pap) Smears, which examined cervical cells for abnormalities, to primary HPV screening, a more sensitive and effective test that requires less frequent screening.¹ Since July 2022, all eligible women have been able to choose between self-collection (using a small swab inserted into the vagina to collect their own sample) or clinician-collection (clinician inserts a speculum into the vagina to collect a cervical sample).¹ Self-collected vaginal samples are just as accurate for the detection of underlying precancer of the cervix as clinician-collected cervical samples because an infected cervix sheds HPV DNA into the vagina.²

Despite the introduction of self-collection, national cervical screening participation has stagnated, with one in four women overdue for screening.³ With rising cost-of-living pressures, a shortage of (bulk-billing) cervical screening providers, and increasing out-of-pocket fees, barriers to

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participation are growing.³ When screening is not accessible, systemic inequities deepen, widening disparities in health outcomes, particularly for communities already experiencing structural barriers to engaging with healthcare.

NATIONAL STRATEGY FOR THE ELIMINATION OF CERVICAL CANCER IN AUSTRALIA

In 2023, Australia launched its equity focused national strategy for the elimination of cervical cancer, which outlines strategic objectives across the three pillars of vaccination, screening, and treatment.

Australia's 2030 cervical cancer elimination targets include achieving 90 per cent HPV vaccination uptake for all eligible people, screening every five years for 70 per cent of eligible people, and delivery of optimal treatment for pre-cancer and cancer for 95 per cent of eligible people.¹ Overall, the targets seek to support positive, culturally safe, and inclusive experiences of prevention and care and would mean that by 2035, Australia could be the first country in the world to actively achieve elimination of cervical cancer.¹

HPV VACCINATION

Catch up HPV vaccination can be promoted before or after pregnancy for patients <26 years. A single catch-up dose is effective in this age group and is provided free for those who missed out at school under the national immunisation program.¹

SCREENING

Cervical screening is safe and effective at all stages of pregnancy and should not be delayed if due.⁴ The traditional model of screening involving a sample from the cervix created significant barriers to implementation in the antenatal setting. Regression of cytological changes in later pregnancy can lead to recommendations to complete screening postpartum.⁵ Additionally, the risk of cervical contact bleeding may not be acceptable to women or practitioners.⁴ Self-collection provides an acceptable alternative and offers meaningful choice for women.⁴

DIAGNOSTICS AND TREATMENT

If colposcopy (a closer examination of the cervix using a magnifying instrument) is required following an abnormal screening test, midwives should reassure patients that assessment is safe during pregnancy and should not be delayed until the postpartum period.⁵ The aim of colposcopy in pregnancy is to exclude invasive cancer and to reassure the patient that their pregnancy will not be affected by an abnormal cervical screening result.⁵ Where high-grade lesions are suspected, definitive treatment, except in cases of invasive cancer, can be safely deferred until after pregnancy.⁵

To reach equitable elimination, we need to draw on and strengthen the capacity of our existing resources.¹ One existing resource is maternity care in Australia.

MATERNITY CARE

Women in Australia are giving birth later in life, with the median age now 32 years.⁶ This demographic shift overlaps with cervical cancer epidemiology, where the peak incidence occurs between 35 and 49 years,³ when many women are pregnant or caring for young children.

In 2024, 292,318 babies were born in Australia, within a maternity system provided by midwives, nurses, obstetricians, general practitioners, or a combination of all four.⁶ Nurses and midwives are uniquely positioned within this system, with continuity and freedom of movement across community, hospital and home settings.

46% of all models of care now have a midwifery continuity component.⁶ As we move toward an expansion of midwifery-led models of care, midwives must be equipped to manage the full breadth of women's reproductive health issues, including cervical dysplasia. In parallel, we need to upskill our medical workforce within the tertiary system so they can champion cervical screening and support midwives and nurses to work at their full scope of their practice.

However, the perception that preventative care, such as cervical screening, does not belong in tertiary settings has shifted responsibility back to primary care. While general practitioners and practice nurses have a fundamental role in cervical screening provision, the growing pressures on primary care call for us to consider how screening and follow-up can be reintegrated into additional areas.

PREGNANCY AS AN EQUITY LEVER

For many under-screened women, antenatal care may be their only consistent engagement with the healthcare system, offering a predictable schedule of appointments, continuity and trusted relationships. Even a single lifetime screening can significantly reduce their risk of cervical cancer.³

Importantly, 95% of women will attend more than five antenatal visits, a level of engagement not often seen within the healthcare system.⁶ Pregnancy is also a time when external motivation is high; many women engage in preventive health not only for themselves but for the benefit of their baby and family. By embedding cervical screening into routine antenatal care, we can address gaps left by fragmented services and ensure prevention does not fall through the cracks.

The national strategy identifies five populations who are more likely to be under-screened. Efforts to improve access for these populations must be designed and delivered in consultation with the people they aim to benefit.

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For example, initiatives to increase cervical screening through pregnancy care must not be imposed on to First Nations women, but shaped through First Nations leadership, governance and community-driven decision making.

ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

Colonisation, institutional racism and a lack of culturally safe care has prevented First Nations women from feeling safe in maternity care. With the development of Birthing on Country models, which work to redress these issues, we are returning childbirth services to First Nations communities and First Nations Control.⁷ In 2023, First Nations mothers accounted for 5.6% of women who gave birth, with around 70% now accessing antenatal care.⁶

LGBTQ+ PEOPLE AND PEOPLE WHO ARE INTERSEX

People who identify as LGBTQ+ and people who are intersex frequently encounter cisheteronormative assumptions within reproductive health services, leading to inappropriate questions, stigma and a lack of recognition of their reproductive health needs. As a result of systemic barriers, they are less likely to be offered or participate in screening and may find examinations distressing.⁸

WOMEN WITH DISABILITY

Women with disability face multiple, compounding barriers to cervical screening, including inaccessible health services, limited provider training, and family, carer and provider misjudgements around sexual activity.⁹ Providers' tendency to prioritise disability-related concerns over preventative health can lead to cervical screening being missed. Pregnancy care can offer a safe context to discuss screening with these women and any hesitant carers or family members.

MIGRANT AND REFUGEE WOMEN - CULTURALLY AND LINGUISTICALLY DIVERSE

Women from migrant and refugee backgrounds now make up a third of women giving birth in Australia and are 50% less likely to have completed cervical screening compared to Australian-born women.^{6,10} These women may not have had previous access to HPV vaccination and screening, placing them at higher risk of developing cervical cancer.¹⁰ For many migrant and refugee women, pregnancy care will be their first interaction with the Australian healthcare system.

PEOPLE LIVING IN RURAL AND REMOTE AREAS

People living in rural and remote areas have less access to preventive health due to distance and inconsistent availability of healthcare providers. Upskilling nurses and midwives is strategic in these areas as there are more registered nurses and midwives per 100,000 people working

in remote and very remote areas, compared to medical professionals.¹¹

Pregnancy creates a unique and natural opportunity to address inequities by providing an inclusive, culturally safe, gender-affirming environment, irrespective of who you are or where you live. In this setting, people can be empowered to make informed decisions about their health, creating an optimal entry point for priority populations not only into cervical screening, but the entire pathway.

Nurses and midwives are well placed to facilitate this access during pregnancy due to their experience and ability to foster trusted relationships with their patients. They regularly provide services for women from diverse backgrounds, many of whom face substantial barriers to accessing traditional medical models of care.

OPPORTUNITIES AND CURRENT RESTRICTIONS: NURSES AND MIDWIVES' ROLE

Cervical screening is within the scope of practice of nurses and midwives, and while many have been providing this service for several years, some still don't see a role for themselves in this area. However, this is starting to change with the introduction of self-collection, which has expanded access for screening participants and opened doors for nurses and midwives to play a greater role in cervical screening. The autonomy inherent in self-collection provides increased flexibility in where and how the test is done and who can facilitate access. With appropriate training, clinical governance and support, nurses and midwives can deliver both screening options to the same quality as doctors, reducing patient wait times and improving patient satisfaction and outcomes.

The national strategy highlights the important role nurses and midwives play in achieving elimination, calling for clear pathways to enable them to "independently request and sign pathology request forms for a cervical screening test (and be eligible for Medicare reimbursement)".¹ Until July 2021, this was standard practice in Victoria, with one pathology service funded to process tests ordered by non-medical providers. Unfortunately, since this agreement lapsed, MBS funding for cervical screening is now restricted to providers with a Medicare Provider Number (MPN), such as doctors, nurse practitioners and endorsed midwives.

These restrictions create system-level barriers to expanding the autonomous screening role of nurses and midwives. In midwifery-led clinics, a MPN provider may not be readily available to co-sign pathology forms, limiting access and provision to cervical screening within maternity models of care.

Additionally, non-medical providers cannot independently access the National Cancer Screening Register (NCSR) to

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determine whether a patient is due for screening. Without direct NCSR access, ideally integrated into electronic medical record systems, we are making it harder for nurses and midwives to identify eligible women and provide timely care.

RECOMMENDATIONS FOR POLICY AND PRACTICE

We need to advocate for nurses and midwives to have greater visibility of, and involvement in delivering, the NCSP. This begins with including the national strategy in university curriculums and continues with the upskilling and strengthening of the current workforce nationally. If nurses and midwives find that flexible models aren't in place where they work, they should be supported to implement them.

Nurses and midwives delivering maternity care should feel confident in providing education, checking for symptoms of cervical cancer and offering the choice of self-collected or clinician-collected screening to eligible women. Training pathways to become a cervical screening provider are well established, and flexible delivery models such as nurse-led dysplasia clinics demonstrate the value of enabling providers to practice at their full scope.

Support requires investment in training, professional development, and opportunities for nurses and midwives to maintain and expand their clinical skills. Sustaining this change requires strong system, service and professional leadership to communicate the vision, and champion the role of non-medical providers.

Restrictions on who can order cervical screening tests, and who has direct access to patients' screening histories needs to be reviewed and updated to reflect the evolving nature of nurses and midwives' roles.

Taking the time now to set up flexible models of cervical screening provision during pregnancy will increase screening coverage and build the capacity of an already capable workforce.

ELIMINATING CERVICAL CANCER IS POSSIBLE

WE ALL HAVE A ROLE TO PLAY

Equitable elimination of cervical cancer is bigger than any one profession. Pregnancy is an opportune time to promote, educate, deliver and follow-up to ensure no more mothers or daughters are diagnosed with cervical cancer.

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