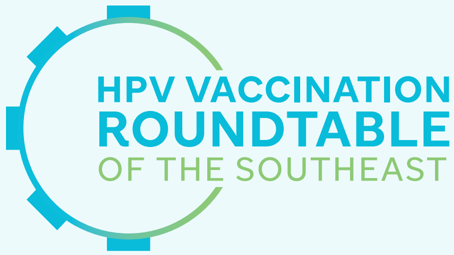
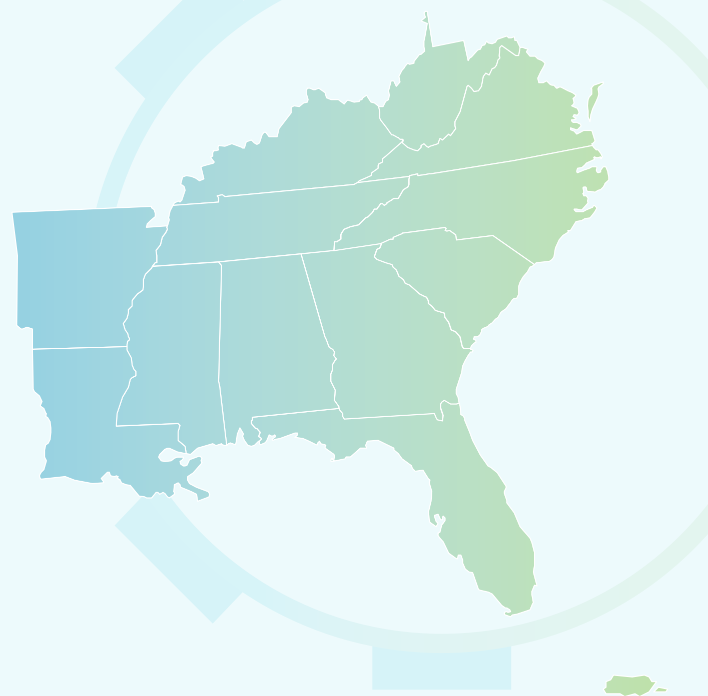




Southeast United States Call to Action

Elimination of HPV Cancers Starting with Cervical Cancer as a Public Health Concern

TABLE OF CONTENTS

EXECUTIVE SUMMARY OF THE SOUTHEAST UNITED STATES CALL TO ACTION: ELIMINATION OF HPV CANCERS STARTING WITH CERVICAL CANCER AS A PUBLIC HEALTH CONCERN — 3

INTRODUCTION — 5

HPV CANCER PREVENTION — 6

DEFINING ELIMINATION PLANNING — 6

CERVICAL CANCER ELIMINATION FIRST — 7

EXISTING AND EMERGING EFFORTS TO ELIMINATE HPV CANCERS STARTING WITH CERVICAL CANCER AS A PUBLIC HEALTH CONCERN IN THE SOUTHEAST — 8

- Global Efforts — 8
- National Efforts — 8
- State-Level Efforts — 9

ELIMINATING HPV CANCERS STARTING WITH CERVICAL CANCER AS A PUBLIC HEALTH CONCERN IN THE SOUTHEAST — 12

SOUTHEAST ROUNDTABLE SUPPORT TO ELIMINATE HPV CANCERS STARTING WITH CERVICAL CANCER AS A PUBLIC HEALTH CONCERN IN THE SOUTHEAST — 15

- Goal 1: Increase the percentage of adolescents aged 13–17 years and starting at age 9 where data are available, across the Southeast completing the HPV vaccination series to 80% by 2030. — 17
- Goal 2: Increase the percentage of people with a cervix across the Southeast who are UTD an cervical cancer screening based on the current U.S. Preventive Services Task Force (USPSTF) guidelines to 80% by 2030. — 21
- Goal 3: Increase the percentage of people with a cervix across the Southeast who receive appropriate follow-up care and treatment (if needed) for abnormal cervical cancer screening results to 80% by 2030. — 26

SPECIAL CONSIDERATIONS — 29

NEXT STEPS — 30

ACKNOWLEDGMENTS — 32

REFERENCES — 34

EXECUTIVE SUMMARY OF THE SOUTHEAST UNITED STATES CALL TO ACTION: ELIMINATION OF HPV CANCERS STARTING WITH CERVICAL CANCER AS A PUBLIC HEALTH CONCERN

The HPV Vaccination Roundtable of the Southeast has prioritized the elimination of HPV cancers starting with cervical cancer as a public health concern. This team was tasked with developing and disseminating an elimination plan for the Southeast region. An elimination plan is a way to garner support and catalyze action to improve HPV cancer prevention and treatment efforts, with the goal of eliminating HPV cancers starting with cervical cancer. The plan presented here describes the interests of the Southeast Roundtable and its coordinated efforts to eliminate HPV cancers starting with cervical cancer as a public health concern in the Southeast, and recommended priorities and actionable steps to achieve this goal.

ELIMINATING HPV CANCERS STARTING WITH CERVICAL CANCER AS A PUBLIC HEALTH CONCERN IN THE SOUTHEAST

The contents of this regional call to action were informed by the results of the Elimination Policy in the Southeast Needs Assessment conducted by the Southeast Roundtable in Fall 2024. The assessment, which aimed to better understand the context of elimination efforts across the Southeast, consisted of an online survey, virtual interviews with subject matter experts, and a data synthesis to inform strategic planning for regional HPV cancer elimination.

This regional call to action for the elimination of HPV cancers starting with cervical cancer as a public health concern is representative of subject matter experts, those with relevant professional and lived experiences, and partners across the Southeast and serves as the first multi-state and jurisdiction collective and collaborative elimination effort.

Partnered together, we can influence efforts towards the development and implementation of state or jurisdiction level elimination plans across the Southeast. We acknowledge that capacity and resources may vary by state or jurisdiction, and not every state or jurisdiction will have immediate support for the development of elimination plans. However, opportunities exist to develop state- or jurisdiction-level elimination goals or statements. There are also opportunities to include elimination strategies in state- or jurisdiction-level cancer control plans.

The Southeast Roundtable encourages state-level alignment with Southeast Roundtable elimination priorities, but state- or jurisdiction-level elimination plans should be informed by local data, context, and available resources. Individual states within the Southeast are encouraged to engage with a diverse group of key partners and collaborators to inform elimination efforts. State- or jurisdiction-level elimination plans are intended to be developed and implemented in coordination with each state's Comprehensive Cancer Control Program and should not aim to replicate or replace existing cancer control efforts.

SOUTHEAST ROUNDTABLE SUPPORT TO ELIMINATE HPV CANCERS STARTING WITH CERVICAL CANCER AS A PUBLIC HEALTH CONCERN IN THE SOUTHEAST

The Southeast Roundtable identified three primary elimination goals to inform the development and implementation of state-level plans. The Southeast Roundtable intends to advise, promote, and/or support these recommended priorities and strategies but not their direct implementation:

SOUTHEAST ROUNDTABLE PRIMARY ELIMINATION GOALS

1. Increase the percentage of adolescents aged 13-17 years, and starting at age 9 where data are available, across the Southeast completing the **HPV vaccination** series to 80% by 2030.

2. Increase the percentage of people with a cervix across the Southeast who are UTD on **cervical cancer screening** based on the current U.S. Preventive Services Task Force (USPSTF) guidelines to 80% by 2030.

3. Increase the percentage of people with a cervix across the Southeast who receive appropriate **follow-up, diagnosis, and treatment** (if needed) for abnormal cervical cancer screening results to 80% by 2030.

In support of the three primary elimination goals and associated strategies to advance elimination efforts across the Southeast, the Southeast Roundtable commits to the following elimination support strategies:

ELIMINATION SUPPORT STRATEGIES

1. Provide support for elimination planning efforts to states and jurisdictions in the Southeast region.
2. Develop and disseminate elimination resources to states and jurisdictions in the Southeast region
3. Provide technical assistance to states and jurisdictions in the Southeast region

Download the full Call to Action and request access to the elimination Toolkit at stjude.org/southeast-elimination.

Learn more about Southeast Roundtable at stjude.org/southeast-roundtable.

INTRODUCTION

The HPV Vaccination Roundtable of the Southeast has prioritized the elimination of human papillomavirus (HPV) cancers starting with cervical cancer as a public health concern. To address this priority, the Southeast Roundtable convened an implementation team consisting of representatives from across the region. This team was tasked with developing and disseminating an elimination plan for the Southeast region. An elimination plan is a way to garner support and catalyze action to improve HPV cancer prevention and treatment efforts, with the goal of eliminating HPV cancers starting with cervical cancer. The plan presented here describes the interests of the Southeast Roundtable and its coordinated efforts to eliminate HPV cancers starting with cervical cancer as a public health concern in the Southeast, and recommended priorities and actionable steps to achieve this goal.

HPV CANCER PREVENTION

HPV is a common virus linked to six types of cancer in men and women. Four out of five people will be infected with HPV during their lifetime. Every year, HPV cancers are diagnosed in more than 37,000 people in the United States. Although there is no cure for HPV itself, HPV vaccination protects against more than 90% of HPV cancers. HPV vaccination is safe, effective, and provides long-lasting protection against HPV cancers. The U.S. Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) recommends routine HPV vaccination at 11 or 12 years of age and starting at age 9. The American Cancer Society (ACS) and the American Academy of Pediatrics (AAP) recommend HPV vaccination for all adolescents between the ages of 9 and 12 years. The CDC ACIP also recommends vaccination for everyone through the age of 26 years if they were not adequately vaccinated previously. Some adults aged 27 through 45 years may decide to receive the HPV vaccine, based on discussion and shared decision-making with their clinician, if they were not vaccinated when they were younger.

HPV VACCINATION PROTECTS **AGAINST MORE THAN 90% OF HPV CANCERS**

Implementing evidence-based strategies to improve HPV vaccination coverage remains the most cost-effective approach to preventing HPV cancers. However, HPV vaccination alone does not completely reduce the burden of these cancers; it must be reinforced by adherence to screening guidelines and timely follow-up, diagnosis, and treatment. In particular, population-based screening for cervical cancer is recommended, and risk-based screening for anal cancer is recommended for certain subpopulations. Supporting improvements in continuity of care for HPV cancers, across prevention, screening, and treatment, can greatly influence elimination efforts.

DEFINING ELIMINATION PLANNING

Elimination planning refers to the strategic coordination of unified efforts to reduce the burden of HPV cancers. Although eliminating HPV cancers can appear as an immense task, formalizing an elimination plan with shared goals and objectives makes elimination realistic and achievable.

The Southeast Roundtable acknowledges the limitations related to the elimination of HPV cancers. To clarify this further, the purpose of this plan is to provide a guide to eliminating HPV cancers. We emphasize the purpose of elimination and our collective commitment to significantly reducing the burden of HPV-related diseases, specifically cervical cancer, and their impact on communities. This effort should be clearly differentiated from eradication, i.e., achieving the complete absence of disease, which is not the purpose of this plan.

Importantly, elimination planning may not always take the form of a state- or jurisdiction-level plan; it can also take the form of a shared commitment to elimination efforts, such as a consensus statement, an elimination goal in a state- or jurisdiction-level cancer plan, or similar.

CERVICAL CANCER ELIMINATION FIRST

We are optimistic about the potential to eliminate all types of cancer caused by HPV. Currently, cervical cancer presents the greatest opportunity for elimination due to routine recommendations for HPV vaccination, cervical cancer screening, and cervical cancer treatment.

Cervical cancer is the HPV cancer diagnosed most commonly among people with a cervix (predominantly identifying as women), with 91% of such cancers being attributable to HPV.[1] In the United States, the national incidence rate of cervical cancer is 7.0 cases per 100,000 women,[2] slightly exceeding the World Health Organization (WHO) definition of elimination (4.0 cases per 100,000 women). The incidence varies greatly by geography and among certain population groups;[3] however, in combination, HPV vaccination, cervical cancer screening, and cervical cancer treatment will result in HPV elimination. Pre-cancerous changes to cervical cells caused by HPV can typically be detected and treated through routine cervical cancer screening, thus preventing new cases of cancer. Early detection, surveillance, and clinical intervention make cervical cancer highly treatable. With an early-stage diagnosis, the 5-year relative survival rate for cervical cancer is 91%.[4]

IN THE US, **THE NATIONAL INCIDENCE RATE OF CERVICAL CANCER IS 7 CASES** PER 100,000 WOMEN[2]

EXISTING AND EMERGING EFFORTS TO ELIMINATE HPV CANCERS STARTING WITH CERVICAL CANCER AS A PUBLIC HEALTH CONCERN IN THE SOUTHEAST

This call to action models existing elimination efforts, including strategies developed by Australia, Canada, and Alabama, the ACS Elimination Statement on HPV Cancers, and others, but it has been adapted to the context of the Southeast United States. The following section includes examples of ongoing and emerging elimination efforts globally, nationally, and at the state level.

Global Efforts

Cervical cancer elimination strategies have been announced and are being implemented globally since the WHO introduced the Global Strategy to Accelerate the Elimination of Cervical Cancer as a Public Health Problem in November 2020.[3] This comprehensive strategy aims to achieve an incidence rate of fewer than four cases per 100,000 women through HPV vaccination, cervical cancer screening, and timely follow-up, diagnosis, and treatment of cervical precancer and cancer. The Southeast elimination plan aligns with the WHO strategy.

The WHO elimination strategy focuses solely on women and girls and includes 90-70-90 targets for HPV vaccination, cervical cancer screening, and cervical cancer treatment.

WHO Targets

1. 90% of girls to be fully vaccinated with the HPV vaccine by 15 years of age
2. 70% of women to be screened for cervical cancer by age 35 and again by 45 years of age, using a high-precision test, i.e., an HPV polymerase chain reaction (PCR) test
3. 90% of women identified with cervical disease receive treatment for pre-cancerous lesions or management of invasive cancer

National Efforts

In the United States, and more specifically in the Southeastern United States, the approach to cervical cancer elimination differs from the WHO global strategy, as HPV vaccination is routinely recommended for both male and female individuals aged 9–26 years. Additionally, HPV vaccination may be recommended for some individuals aged 27–45 years who were not previously vaccinated.

At this time, there is no national elimination strategy for the United States. However, in conjunction with the WHO global elimination strategy, the ACS, the ACS National HPV Vaccination Roundtable, and the ACS National Roundtable on Cervical Cancer have convened an advisory group and are leading national cervical cancer elimination efforts in the United States.[5]

State-Level Efforts

As of September 2025, Alabama was the only state in the Southeast United States to have developed, announced, and implemented a statewide cervical cancer elimination plan, which is known as OPERATION WIPE OUT.[6] OPERATION WIPE OUT has gained national attention and has galvanized action to develop similar elimination plans in other states and regions.

> **"If I can see the end of two diseases in my lifetime, I mean my mom would be so happy."**
>
> **Isabel Scarinci, Ph.D.,**
> *vice chair for Global and Rural Health in the Department of Obstetrics and Gynecology, University of Alabama at Birmingham, and polio survivor*

OPERATION WIPE OUT focuses on the three pillars of elimination proposed by the WHO: increased HPV vaccination, increased screening with HPV or Pap testing, and increased appropriate follow-up and treatment. In addition, the effort focuses on ensuring that entire communities know that eliminating cervical cancer is possible and that everyone can play a role in this. Increasing awareness and streamlining the public message is a priority. Although HPV can cause multiple cancers, cervical cancer is the only cancer that can be eliminated through HPV vaccination, regular screening, and treatment. As a result, approaches in the Alabama state plan focus on cervical cancer.

OPERATION WIPE OUT developed an action plan to eliminate cervical cancer as a public health problem through engaging a community of health care providers and public health leaders, with an emphasis on rural providers, at a 1.5-day summit. Barriers to each of the three pillars of elimination, and corresponding solutions, were discussed in breakout sessions and then prioritized as a group. The summit ended with a vote to name the effort OPERATION WIPE OUT and to develop an action plan that included evidence-based solutions identified at the summit. An action plan was then written, and a draft was sent for comment to all partners and attendees. Once approved, the State Health Officer held a press conference to release the action plan, and multiple partners were asked to provide a five-minute perspective on the importance of the action plan.

Community engagement of partners at every level, including school systems, Rotarians, health systems, academic institutions, and not-for-profit organizations was integral to developing and implementing Alabama's efforts to eliminate cervical cancer as a public health problem. From the outset, measures were taken to ensure that the program was independent and not a part of a specific organization or institution. Furthermore, evaluation of partner efforts at the community and state level was a priority. Although it is challenging to monitor efforts and measure outcomes, it is imperative that implementation efforts are coordinated with an evaluation plan.

As other Southeastern states and the nation take steps to increase HPV vaccination and inform the public of the importance of vaccination in protecting them from HPV cancers, efforts/plans will ultimately vary as a consequence of individual state partners, priorities, barriers, and community input regarding solutions. Opportunities to identify appropriate branding, naming, and implementation of marketing efforts are an important part of developing state action plans. Any and all of those variations will serve only to increase HPV vaccination and advance the mission to eliminate cervical cancer.

All OPERATION WIPE OUT materials, ideas, and resources are available for public use, and use of the term OPERATION WIPE OUT is neither required nor expected. The effort asks only that if the name or logo of OPERATION WIPE OUT is used, it only refers to the elimination of cervical cancer and that leaders are made aware of adaptations to ensure consistency. All materials can be edited or used with alternative branding and messaging.

As a public, unfunded effort, all resources are available for use, with the request that the effort's credibility and clarity are maintained. As OPERATION WIPE OUT strives to make progress in Alabama, lessons learned are freely provided. For more information about how to join OPERATION WIPE OUT or on Alabama's efforts to implement an action plan to eliminate cervical cancer, please contact the effort at operationwipeout.org. The implementation of OPERATION WIPE OUT and the lessons learned offer a unique opportunity to inform the development and implementation of a regional plan to eliminate HPV cancers starting with cervical cancer as a public health concern. For additional guidance on adapting OPERATION WIPE OUT resources, in alignment with the Southeast United States call to action, please request access to the Southeast United States Elimination Toolkit.

Although there is currently just one state-level elimination plan in the Southeast, more recent elimination efforts have emerged through planning efforts in Kentucky, Louisiana, and Mississippi. Other states, such as Florida and North Carolina, have incorporated alternative elimination strategies. Florida included an elimination goal in its 2020–2045 state cancer plan, and partners in North Carolina included an elimination statement in an HPV Call to Action Letter that was distributed to providers in March 2025.

Goal 4

Eliminate cervical cancer as a public health problem in Florida by increasing vaccination against human papillomavirus (HPV) and increasing cervical cancer screening.

Florida Cancer Plan 2020–2025

By working together and prioritizing HPV vaccination, we can create a better future for our youth and reduce the burden of cancer in North Carolina. Our goal is to work toward the elimination of HPV-associated cancers, beginning with cervical cancer.

North Carolina Immunization Task Force and Advisory Committee on Cancer Coordination and Control 2025

The Southeast Roundtable is closely monitoring these efforts to determine alignment with this regional call to action and to provide support as resources are available.

ELIMINATING HPV CANCERS STARTING WITH CERVICAL CANCER AS A PUBLIC HEALTH CONCERN IN THE SOUTHEAST

The contents of this regional call to action were informed by the results of the Elimination Policy in the Southeast Needs Assessment conducted by the Southeast Roundtable in Fall 2024. The assessment, which aimed to provide a better understanding of the context of elimination efforts across the Southeast, consisted of an online survey, virtual interviews with subject matter experts, and a virtual listening session.

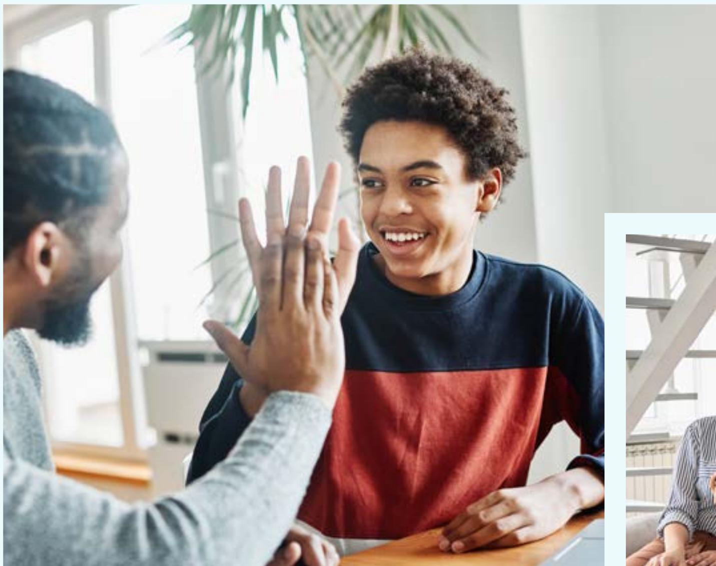
This regional call to action for the elimination of HPV cancers as a public health concern starting with cervical cancer is representative of experts and partners across the Southeast and serves as the first multi-state and multi-jurisdiction collective and collaborative elimination effort.

Eliminating HPV Cancers

The Southeastern United States has historically been characterized by low HPV vaccination coverage and high rates of HPV cancer when compared with other regions of the country and with the United States overall. As of 2024, national rates of HPV vaccination initiation and being up to date (UTD) among adolescents aged 13–17 years were 78% and 63%, respectively.[7] Comparatively, the rate of HPV vaccination initiation for the Southeast region was 78% and that for UTD was 62%.[7] The number of cervical cancer cases per state or jurisdiction varies greatly with respect to geographical distribution (e.g., Virginia has an incidence rate of 6.3 per 100,000, whereas Mississippi and Puerto Rico have incidence rates of 8.4 per 100,000 and 10.5 per 100,000, respectively), as well as among certain population groups.[2]

Across the Southeast, inclusive strategies are necessary to eliminate HPV cancers starting with cervical cancer as a public health concern through improvements in HPV vaccination coverage, cervical cancer screening uptake, and timely follow-up, diagnosis, and treatment of cervical precancers and cancers. Recommended elimination priorities and strategies should be tailored to address racial, ethnic, and geographic disparities that may influence elimination efforts among populations that often carry the heaviest disease burden and risk.

AS OF 2024, **NATIONAL RATES OF HPV VACCINATION** INITIATION AND BEING UTD AMONG ADOLESCENTS AGED 13-17 YEARS WERE **78% AND 63%,** RESPECTIVELY.[7]



Partnered together, we can influence efforts to develop and implement state- or jurisdiction-level elimination plans across the Southeast. We acknowledge that capacity and resources may vary by state or jurisdiction and that not every state or jurisdiction will have immediate support for developing elimination plans. However, opportunities exist to develop state- or jurisdiction-level elimination goals or statements. There are also opportunities to reflect elimination strategies in state- or jurisdiction-level cancer control plans.

The Southeast Roundtable encourages state-level alignment with Southeast Roundtable elimination priorities, but state- or jurisdiction-level elimination plans should be informed by local data, context, and available resources. Individual states within the Southeast are encouraged to engage with a diverse group of key partners and collaborators to inform elimination efforts. State- or jurisdiction-level elimination plans are intended to be developed and implemented in coordination with each state's Comprehensive Cancer Control Program and should not aim to replicate or replace existing cancer control efforts.

> "It wasn't until after my diagnosis that I learned HPV is the leading cause of cervical cancer—and that this is a cancer that is almost entirely preventable with a vaccine. That realization hit me hard. I kept thinking, ***Why didn't I know this sooner?***"
>
> **Lindsay Gullatte-Lee**
> *Cervical cancer survivor, North Carolina*

SOUTHEAST ROUNDTABLE SUPPORT TO ELIMINATE HPV CANCERS STARTING WITH CERVICAL CANCER AS A PUBLIC HEALTH CONCERN IN THE SOUTHEAST

The Southeast Roundtable has identified three primary elimination goals and implementation of state-level plans. The Southeast Roundtable intends to advise, promote, and/or support these recommended priorities and strategies but not their direct implementation:

SOUTHEAST ROUNDTABLE PRIMARY ELIMINATION GOALS

1. Increase the percentage of adolescents aged 13-17 years, and starting at age 9 where data are available, across the Southeast completing the **HPV vaccination** series to 80% by 2030.

2. Increase the percentage of people with a cervix across the Southeast who are UTD on **cervical cancer screening** based on the current U.S. Preventive Services Task Force (USPSTF) guidelines to 80% by 2030.

3. Increase the percentage of people with a cervix across the Southeast who receive appropriate **follow-up, diagnosis, and treatment** (if needed) for abnormal cervical cancer screening results to 80% by 2030.

In support of the three primary elimination goals and associated strategies to advance elimination efforts across the Southeast, the Southeast Roundtable commits to the following elimination support strategies:

ELIMINATION SUPPORT STRATEGIES

1. Provide support for elimination planning efforts to states and jurisdictions in the Southeast region.
2. Develop and disseminate elimination resources to states and jurisdictions in the Southeast region
3. Provide technical assistance to states and jurisdictions in the Southeast region

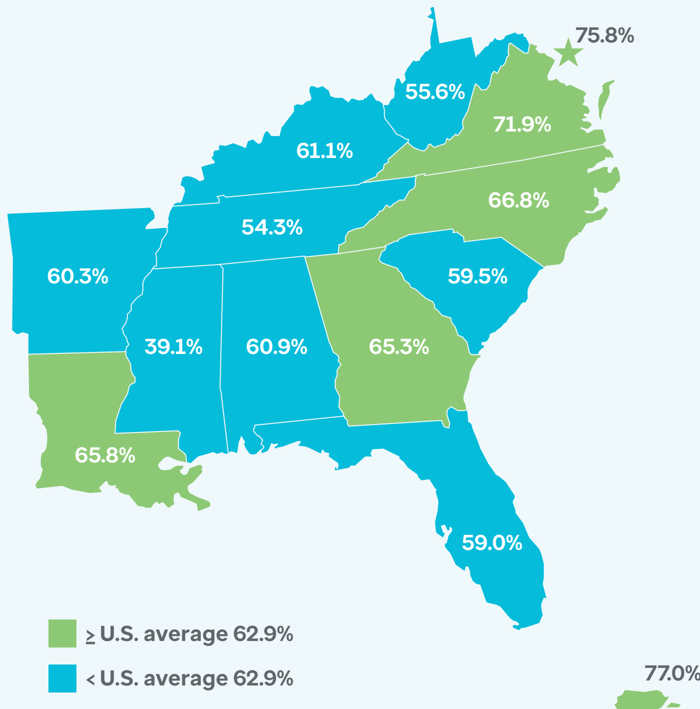
Table 1. Southeast Roundtable support to eliminate HPV cancers, 2025

Elimination Planning	Elimination Resources	Technical Assistance
1. Disseminate regional HPV cancer elimination plan to inform state-level elimination plans 2. Identify state-level partners to champion statewide elimination planning 3. Identify HPV cancer survivors to champion statewide elimination planning 4. Support state-level partners in statewide elimination planning 5. Support state-level partners in implementing statewide elimination plans	1. Update and publish the fact sheet on HPV cancer elimination in the Southeast 2. Develop and disseminate the HPV cancer elimination plan in the Southeast toolkit 3. Develop and disseminate elimination planning and implementation templates 4. Monitor progress toward HPV cancer elimination across the Southeast 5. Monitor and disseminate HPV vaccination data across the Southeast 6. Monitor the incidence and mortality of HPV cancer across the Southeast	1. Compile contact information for key elimination experts and partners across the Southeast and make connections as appropriate 2. Organize and host quarterly virtual collaborative learning opportunities for individual states across the Southeast to share information 3. Organize and host in-person collaborative learning opportunities (as resources allow) for individual states across the Southeast to share information 4. Consult with experts to inform and refine state-level implementation plans 5. Support evaluation of elimination efforts across the Southeast

GOAL 1: INCREASE THE PERCENTAGE OF ADOLESCENTS AGED 13–17 YEARS AND STARTING AT AGE 9 WHERE DATA ARE AVAILABLE, ACROSS THE SOUTHEAST COMPLETING THE HPV VACCINATION SERIES TO 80% BY 2030

The Southeastern United States region has historically been characterized by low HPV vaccination coverage and high rates of HPV cancer incidence when compared with other regions of the country and the United States overall. In 2024, the rates of HPV vaccination initiation and completion for the Southeast region were 78% and 62%, respectively.[7] When compared to the national rates, the Southeast region has eight of 14 states and jurisdictions that are below national rates for both initiation and completion of HPV vaccination (Table 2). Arkansas, Georgia, Kentucky, Mississippi, and West Virginia have been identified as having the lowest HPV vaccination coverage in the region, making them high-priority states for HPV vaccination efforts through elimination planning (Figure 1).

Figure 1: HPV Vaccination Coverage Up-to-Date, Southeast Region, National Immunization Survey-Teen, 2024



HPV vaccination is recommended as a routine vaccination at age 11 or 12 years and starting at age 9. The CDC ACIP also recommends vaccination for everyone through 26 years of age if they were not vaccinated previously. Some adults aged 27 through 45 years may decide to receive the HPV vaccine, based on discussion with their clinician, if they were not adequately vaccinated when they were younger.

Published research has shown high levels of overall and HPV-specific vaccination hesitancy, a lower frequency of health care provider recommendations for HPV vaccination, a high prevalence of myths and misconceptions undermining confidence in HPV vaccination, and barriers to accessing HPV vaccination.

According to the HPV Vaccination: Improving Health Systems to Boost HPV Vaccination evidence summary published by the ACS National HPV Vaccination Roundtable, clinical interventions to improve HPV vaccination coverage include, but are not limited to, reminder and recall system interventions, provider prompts, educational interventions, assessment and feedback interventions, multi-level interventions, standing orders, and immunization information systems (IIS).[8]

Some countries have moved to a one-dose HPV vaccination schedule. However, the Food and Drug Administration (FDA) has not yet approved such a change, and the U.S. ACIP has not yet made such a recommendation. Additional evidence is needed to support adopting a one-dose schedule in the United States. The Southeast Roundtable will continue to monitor anticipated changes to the recommendations.

> "It is so important for me to get my son his HPV vaccination because I want him to be protected from cancer. I want other parents to know that the HPV vaccination can be given starting at age 9 for both girls AND boys!"
>
> **Crystal Rommen**
> *Parent, Louisiana*

Table 2. HPV vaccination rates among adolescents aged 13–17 years in southeastern states, 2024

	Initiation % (95% CI)	Up to date % (95% CI)
United States	78.2 (77.2–79.2)	62.9 (61.6–64.1)
Alabama	77.7 (72.8–82.0)	60.9 (55.1–66.4)
Arkansas	80.7 (75.7–84.9)	60.3 (53.8–66.5)
District of Columbia	89.3 (84.4–92.8)*	75.8 (68.3–82.1)*
Florida	84.2 (78.6–88.5)*	59.0 (51.1–66.4)
Georgia	74.5 (66.5–81.1)	65.3 (56.9–72.8)
Kentucky	75.0 (68.1–80.8)	61.1 (53.8–68.0)
Louisiana	74.5 (68.3–79.9)	65.8 (59.1–71.9)
Mississippi	58.6 (51.0–65.8)*	39.1 (31.8–46.9)*
North Carolina	80.0 (74.5–84.6)	66.8 (60.8–72.3)
South Carolina	74.6 (69.5–79.1)	59.5 (54.0–64.9)
Tennessee	73.0 (66.7–78.4)	54.3 (47.3–61.1)*
Virginia	86.9 (82.4–90.4)*	71.9 (66.1–77.1)*
West Virginia	72.4 (67.1–77.1)*	55.6 (49.9–61.1)*
Puerto Rico	91.8 (86.2–95.3)*	77.0 (66.0–85.1)*

Source: Pingali C, Yankey D, Elam-Evans LD, et al. Vaccination Coverage Among Adolescents Aged 13–17 Years — National Immunization Survey-Teen, United States, 2024. MMWR Morb Mortal Wkly Rep 2025;74:466–472. DOI: http://dx.doi.org/10.15585/mmwr.mm7430a1.

Note: Vaccination rates highlighted in green are below the national average, vaccination rates highlighted in blue are in states or jurisdictions with school entry requirements for HPV vaccination.

* Vaccination coverage values are significantly different from the national average, using 95% confidence interval.

HPV vaccination targets vary across elimination plans, as noted in Table 3. The Southeast Roundtable HPV vaccination goal (Table 4), i.e., to increase the percentage of adolescents aged 13–17 years, and starting at age 9 where data are available, across the Southeast completing the HPV vaccination series to 80% by 2030, draws from multiple sources but was based on the most recent HPV vaccination recommendations, coverage, and evidence-based practices.

Table 3. Established HPV vaccination targets across elimination plans

WHO Target	90% of girls to be fully vaccinated with the HPV vaccine by 15 years of age
Healthy People 2030 Target	Increase the proportion of adolescents who get recommended doses of the HPV vaccine to 80%.
American Society for Colposcopy and Cervical Pathology (ASCCP) Target	90% of girls fully vaccinated with the HPV vaccine by the age of 15
OPERATION WIPE OUT 2033 Target	Increase HPV vaccination dose completion among Alabama children between the ages of 9 and 12 (priority group) and among Alabama children between the ages of 13 and 17 (catch-up group) to 80%.

Table 4. Southeast Roundtable elimination goal 1: HPV Vaccination

Southeast Roundtable Elimination Goal 1	Increase the percentage of adolescents aged 13–17 years and starting at age 9 where data are available, across the Southeast completing the HPV vaccination series to 80% by 2030.
Strategic objectives	Promote HPV vaccination to the general public through the dissemination of a regional communication campaign (It's Our Way Down South).
	Facilitate opportunities for health care providers and professionals to learn more about strategies to recommend HPV vaccination and address vaccine hesitancy.
	Promote the implementation of evidence-based quality improvement strategies, such as reminder and recall system interventions, provider prompts, assessment and feedback interventions, multi-level interventions, and standing orders.
	Encourage participation of health care providers and professionals in the state-level Immunization Information System (IIS) for standardized and more complete HPV vaccination data reporting.
	Encourage participation of health care providers and professionals in the Vaccines for Children (VFC) program to enhance accessibility.
	Monitor HPV vaccination data by geographic unit (state, sub-state, county, etc.) and demographics.
	Monitor anticipated changes to HPV vaccination recommendations.

GOAL 2: INCREASE THE PERCENTAGE OF PEOPLE WITH A CERVIX ACROSS THE SOUTHEAST WHO ARE UTD ON CERVICAL CANCER SCREENING BASED ON THE CURRENT U.S. PREVENTIVE SERVICES TASK FORCE (USPSTF) GUIDELINES TO 80% BY 2030

Routine screening guidelines are not currently in place for all HPV cancers. However, pre-cancerous changes to cells of the cervix caused by HPV can typically be detected through routine screening. Cervical cancer screening recommendations vary according to the recommending body (Table 5), but the USPSTF recommends provider-performed cervical cancer screening for women aged 21 to 65 years with either a Pap test every 3 years or, for women aged 30 to 65 years, an HPV/Pap co-test or an HPV test alone every 5 years. These recommendations are being reviewed and updated as of spring 2025.

Table 5. Cervical Cancer Screening Recommendations in the United States, 2021

Age Range	ACOG and USPSTF	ACS
<21 years	Screening not recommended	Screening not recommended
21–29 years	Cytology alone every 3 years	Start screening at age 25; primary HPV test* every 5 years (preferred) or cytology and HPV co-testing every 5 years (acceptable) or cytology alone every 3 years (acceptable)
30–64 years	Primary HPV test* every 5 years or cytology and HPV co-testing every 5 years or cytology alone every 3 years	Primary HPV test* every 5 years (preferred) or cytology and HPV co-testing every 5 years (acceptable) or cytology alone every 3 years (acceptable)
65 years or older	Stop screening if there are adequate prior negative screening results, defined as 3 consecutive negative cytology results or 2 consecutive co-testing results within the previous 10 years and the most recent test was within the past 5 years**	Stop screening if adequate prior negative screening results, defined as 3 consecutive negative cytology results or 2 consecutive co-testing results within the previous 10 years and the most recent test was within the past 5 years**
65 years or older	No further screening necessary**	No further screening necessary**

Source: National Association of Nurse Practitioners in Women's Health. (2021). Position statement: Cervical cancer screening. Women's Healthcare—a Clinical Resource for Nurse Practitioners https://www.npwomenshealthcare.com/position-statement-cervical-cancer-screening-2/

ACOG, American College of Obstetricians and Gynecologists; ACS, American Cancer Society; HPV, human papillomavirus; USPSTF, U.S. Preventive Service Task Force

*Only tests approved for primary cervical cancer screening should be used

**Continued surveillance is recommended for at least 2 or histologic high-grade squamous intraepithelial lesions (HSILs); cervical intraepithelial neoplasia (CIN) 2, CIN 3, or adenocarcinoma in situ or high-grade cytology or persistent atypical squamous cells cannot exclude HSIL, even if the patient is older than 65 years.

Another option for screening is self-collection for HPV testing, as recently approved by the FDA. As of February 2025, new guidelines on self-collection were published. These updated guidelines are expected to be incorporated into the upcoming release of the USPSTF guidelines. The American Society for Colposcopy and Cervical Pathology (ASCCP) recommends HPV testing of either provider-collected or self-collected samples every 3 years.

In May 2025, the FDA approved the first at-home self-collection tool for cervical cancer screening, although this is currently available only in California. Additional approvals may result from the availability of this tool, and the Southeast Roundtable is closely monitoring these changes.

"Self-collection helps expand access to potentially life-saving screening to patients who would prefer not to have a speculum exam. For people who don't have a lot of time in their busy schedules, have comfort concerns, trauma or mobility issues, or whose primary care physicians don't conduct pelvic exams, self-collection may be a good option to help avoid the need for an additional appointment with another specialist."

Rebecca Perkins, MD

Obstetrician and gynecologist and investigator, Mother-Infant Research Institute, Tufts Medical Center

Table 6. Cervical cancer screening, percentage of up-to-date screened with HPV/pap co-test or HPV test, age 21-65

	Up-to-date Screened with HPV/Pap Co-test or HPV Test, Age 21-65, % (95% CI)
United States	78.0 (77.3-78.6)
Alabama	79.8 (76.8-82.4)
Arkansas	77.6 (74.0-80.9)
District of Columbia	80.7 (77.5-83.6)
Florida	77.5 (73.9-80.7)
Georgia	76.8 (73.5-79.9)
Kentucky	81.6 (78.6-84.3)
Louisiana	78.9 (75.4-81.9)
Mississippi	82.3 (79.9-84.5)
North Carolina	82.5 (80.1-84.7)
South Carolina	78.8 (75.2-82.0)
Tennessee	78.2 (74.8-81.3)
Virginia	80.2 (77.9-82.4)
West Virginia	79.4 (76.7-81.8)
Puerto Rico	80.1 (77.7-82.3)

Source: Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance System Prevalence & Trends Data: Age-Adjusted Prevalence for "Pap test in past 3 years (women aged 21–65)", 2020. Accessed via BRFSS Prevalence & Trends Data Portal, June 2024.

Cervical cancer screening targets vary across elimination plans, as noted in Table 7. The Southeast Roundtable cervical cancer screening goal (Table 8), i.e., increase the percentage of people with a cervix across the Southeast who are UTD on cervical cancer screening based on the current USPSTF guidelines to 80% by 2030, draws from multiple sources but was based on the most recent cervical cancer screening recommendations, available data, and evidence-based practices.

Table 7. Established cervical cancer screening targets

WHO Target	70% of women to be screened (twice) by 35 years of age and again by 45 years of age, using a high-precision test. i.e., an HPV PCR-based test
Healthy People 2030	Increase the proportion of females who are screened for cervical cancer to 79.2%.
American Society for Colposcopy and Cervical Pathology (ASCCP)	70% of women to be screened using a high-performance test by the age of 35 years and again by the age of 45 years
OPERATION WIPE OUT 2033	Increase the percentage of Alabama women between 21 and 65 years of age who are adherent to cervical cancer guidelines, with no disparities regarding race/ethnicity, educational attainment, or yearly household income, to 90%.

Table 8. Southeast Roundtable elimination goal 2: Cervical cancer screening

Southeast Roundtable Elimination Goal 2	Increase the percentage of people with a cervix across the Southeast who are UTD on cervical cancer screening based on the current U.S. Preventive Services Task Force (USPSTF) guidelines to 80% by 2030.
Strategic objectives	Promote routine HPV/Pap testing based on recommended screening guidelines.
	Train health care providers and professionals in quality improvement (QI) strategies to improve the clinical practices of recommending and providing HPV/Pap testing to eligible people with a cervix and providing needed information to patients to ensure follow-up and treatment following an abnormal test.
	Promote increased access to cervical cancer screening follow-up and treatment through mobile colposcopy.
	Promote increased access to cervical cancer screening follow-up and treatment through the certification of nurse practitioners as colposcopy providers.
	Monitor cervical cancer screening and incidence data by geographic unit (state, sub-state, county, etc.) and demographics.

GOAL 3: INCREASE THE PERCENTAGE OF PEOPLE WITH A CERVIX ACROSS THE SOUTHEAST WHO RECEIVE APPROPRIATE FOLLOW-UP CARE AND TREATMENT (IF NEEDED) FOR ABNORMAL CERVICAL CANCER SCREENING RESULTS TO 80% BY 2030

In 2022, the national rate of new cases of all HPV cancers was 12.2 per 100,000 people.[2] For cervical cancer specifically, the national rate was 7.1 cases per 100,000 women, which is higher than the WHO definition of elimination, and there was great variation by geography and among certain population groups.[2]

Along with vaccination against HPV, cervical cancers can be prevented through timely screening and appropriate follow-up and treatment of abnormal cervical cell changes. In particular, early detection, surveillance, and clinical intervention make cervical cancer highly treatable. With an early localized-stage diagnosis, the 5-year relative survival rate for cervical cancer is 91%,[4] but survival is not without long-term adverse effects.

.

"Stay consistent with your checkups. if they say, ***hey, you are high risk. I recommend you come in more often***, do that. The earlier the better for sure."

Brittany Rose
Cervical cancer survivor, Arkansas

Table 9. Rate of new HPV cancers by state and jurisdiction and cancer type in southeastern states, 2022

	All HPV Cancers	Anal	Cervical	Oropharyngeal	Penile	Vaginal *	Vulvar
United States	12.2	2.1	7.0	5.3	0.8	0.3	1.5
Alabama	13.0	1.7	8.0	5.2	0.6	0.6	2.5
Arkansas	15.0	2.2	9.1	6.6	1.1	––	1.5
District of Columbia	11.3	4.2	5.8	3.3	––	––	––
Florida	14.4	2.4	8.3	6.4	0.8	0.4	1.6
Georgia	13.2	2.3	7.7	5.9	0.7	0.2	1.2
Kentucky	16.9	2.9	8.1	7.6	1.0	––	2.0
Louisiana	14.3	2.3	9.5	6.3	1.0	0.6	1.5
Mississippi	13.6	2.2	8.4	5.7	1.0	––	1.3
North Carolina	13.5	2.1	7.0	5.9	1.0	0.4	2.3
South Carolina	13.3	2.4	6.8	5.9	––	––	2.0
Tennessee	13.1	1.1	6.2	5.9	1.1	––	1.7
Virginia	11.1	2.0	6.3	4.5	0.5	0.3	1.8
West Virginia	16.9	2.5	10.3	6.7	1.5	––	2.8
Puerto Rico	11.1	1.6	10.5	2.4	1.7	––	0.9

*Vaginal cancer with cervical involvement is classified as cervical cancer, which may make vaginal cancer rates appear lower.

Source: U.S. Cancer Statistics Working Group. U.S. Cancer Statistics Data Visualizations Tool. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute; https://www.cdc.gov/cancer/dataviz, released in June 2025.

Cervical cancer screening targets and follow-up, diagnosis, and treatment targets vary across elimination plans, as noted in Table 10. The Southeast Roundtable cervical cancer follow-up, diagnosis and treatment goal (Table 11), i.e., increase the percentage of people with a cervix across the Southeast who receive follow-up, diagnosis, and treatment (if needed) for abnormal cervical cancer screening results to 80% by 2030, draw from multiple sources but are based on the most recent follow-up, diagnosis, and treatment recommendations, available data, and evidence-based practices.

Table 10. Established cervical cancer follow-up, diagnosis, and treatment targets

WHO Target	90% of women identified with cervical disease to receive treatment for pre-cancerous lesions or management of invasive cancer
Healthy People 2030	Not available
American Society for Colposcopy and Cervical Pathology (ASCCP)	90% of women with cervical precancer are treated and 90% of women with invasive cancer managed.
OPERATION WIPE OUT 2033	Increase adherence to follow-up and treatment for abnormal cervical cancer screening results among Alabama women to 90%.

Table 11. Southeast Roundtable elimination goal 3: Cervical cancer follow-up, diagnosis, and treatment

Southeast Roundtable Elimination Goal 3	Increase the percentage of people with a cervix across the Southeast who receive appropriate follow-up, diagnosis, and treatment (if needed) for abnormal cervical cancer screening results to 80% by 2030.
Strategic objectives	Increase awareness that cervical cancer can be prevented and is curable if diagnosed and treated early.
	Promote provider knowledge of the American Society for Colposcopy and Cervical Pathology (ASCCP) app to help navigate the ASCCP Risk-Based Management Consensus Guidelines and determine appropriate follow-up based on test results and family history for people with a cervix with abnormal cervical cancer screening tests.
	Monitor cervical cancer data by geographic unit (state, sub-state, county, etc.) and demographics, as available.

SPECIAL CONSIDERATIONS

Although cervical cancer is preventable and treatable, certain subgroups remain heavily burdened by poor disease outcomes. In particular, individuals who are underinsured or uninsured, lower-resourced, and/or live in rural areas tend to have lower uptake of preventive measures and have worse health outcomes.

Recent research has shown that people with a cervix in low-income US counties have increasing rates of cervical cancer, particularly advanced distant-stage disease, whereas rates in high-income counties remain stable or are declining.[9] Furthermore, the incidence of cervical cancer and the associated mortality are, respectively, 25% and 42% higher in rural US counties than in urban US counties.[10] These findings vary by race and ethnicity. Studies of rurality also show that, since 2000, the gap between rural and urban HPV cancer incidences has widened significantly, particularly for anal and cervical cancers in the female population and for oropharyngeal cancers in both sexes.[10]

These pronounced differences in disease burden and outcomes are highly reflective of the need to consider adapting our implementation efforts to ensure that we are focused on eliminating HPV cancers, beginning with cervical cancer, across all groups. Our planning efforts should include key people representing those populations in low-resourced settings and rural areas. We should also work with key representatives of safety-net health systems, including federally qualified health centers (FQHCs) and rural health associations, to ensure that their input is considered and included as we plan implementation strategies to reach elimination.

The Southeast Roundtable is committed to providing states and other jurisdictions across the Southeast region with resources to facilitate these discussions and consider how states may work together with safety-net health systems and rural communities to ensure that all are involved in elimination planning.

NEXT STEPS

The Southeast Roundtable emphasizes that implementing state-level elimination plans that are in alignment with Southeast Roundtable priorities will require close partnerships with the National Breast and Cervical Cancer Early Detection Program (NBCCEDP), the National Comprehensive Cancer Control Program (NCCCP), state health officers, public health immunization divisions, immunization task forces, Rotary Clubs, state and national chapters of the ACS, academic universities and cancer centers, members of the American Academy of Family Practitioners (AAFP), the AAP, the ACOG, federally qualified health center associations, rural health associations, school-related associations, and others. These partners should be identified and invited to participate in early efforts to eliminate cervical cancer as a public health concern. These partnerships should be sustained, revisited, and expanded often.

To support states in operationalizing these efforts, the toolkit will incorporate a framework adapted from the Integrative Systems Praxis for Implementation Research (INSPIRE) model,[11] which outlines a phased approach for integrating research methods, implementation science frameworks, and practical implementation strategies This framework provides a structured guide for action across four phases: **Understand the System**, **Find Leverage**, **Act Strategically**, and **Learn and Adapt**. It includes strategies such as stakeholder engagement, readiness assessments, infrastructure modification, dynamic training, and continuous evaluation—all grounded in established implementation science models such as the consolidated framework for implementation research (CFIR) and the reach, effectiveness, adoption, implementation, and maintenance (RE-AIM) evaluation framework.[11] By using this framework, state-level elimination planning will be equipped to build tailored implementation plans that reflect both evidence-based practices and the unique contexts of their communities.

Eliminating HPV Cancers

Continuous engagement of partners is important to achieving elimination and can be supported by providing regular opportunities for states and state-level partners to collaborate, consult, and share efforts to eliminate cervical cancer as a public health concern. This call to action has been released publicly with open access. The purpose of this document is to provide a starting point for the planning, implementation, and evaluation of HPV cancer elimination efforts across the Southeast. An accompanying toolkit is available including templates and resources to guide the development of plans to eliminate HPV cancers starting with cervical cancer as a public health concern in the Southeast. The Southeast Roundtable is committed to monitoring the elimination landscape, providing ongoing technical assistance, and facilitating opportunities for collaborative learning and information sharing across the Southeast region. Together, we can eliminate HPV cancers starting with cervical cancer. For more information about this call to action, and to request access to the toolkit, please visit stjude.org/southeast-elimination. To learn more about the Southeast Roundtable, visit stjude.org/southeast-roundtable.

ACKNOWLEDGMENTS

This work was supported by the American Lebanese and Syrian Associated Charities (ALSAC) of St. Jude Children's Research Hospital.

We thank the HPV Vaccination Roundtable of the Southeast Executive Committee:

- Robert Bednarczyk, Emory University Rollins School of Public Health
- Gabrielle Darville-Sanders, American Cancer Society National HPV Vaccination Roundtable
- Jessica Davis, American Cancer Society
- Pam Hull, University of Kentucky Markey Cancer Center
- Jennifer Young Pierce, University of South Alabama Mitchell Cancer Institute

We thank the HPV Vaccination Roundtable of the Southeast Steering Committee:

- Mariana Arevalo, Moffitt Cancer Center Office of Community Outreach, Engagement, and Equity
- Crystal Back, Kentucky Department of Public Health
- Amanda Baig, American Cancer Society
- Lindsay Barr, West Virginia Immunization Network, Center for Rural Health Development
- Robert Bednarczyk, Emory University Rollins School of Public Health
- Heather Brandt, St. Jude Children's Research Hospital
- Julia Brown, St. Jude Children's Research Hospital
- Silvia Camata, O' Neal Comprehensive Cancer Center at University of Alabama—Birmingham
- Vivian Colón-López, University of Puerto Rico
- Casey Daniel, University of South Alabama Mitchell Cancer Institute
- Amy Ellis, American Cancer Society
- Jane Grey, American Cancer Society National HPV Vaccination Roundtable, State Coalitions Task Force
- Kim Hale, American Cancer Society
- Nikki Hayes, Centers for Disease Control and Prevention
- Cara McCarthy, Louisiana Cancer Prevention & Control Programs
- Madeline McNee, St. Jude Children's Research Hospital
- Andrea Mendes, Virginia Department of Health
- Heather Mercer, Immunize Arkansas
- Hannah Nein, American Cancer Society
- Jill Pait, American Cancer Society

- Beth Poore, South Carolina Department of Health
- Yara Sanchez, University of Puerto Rico
- Dorothy Sinard, Immunize Tennessee
- Sherrie Wallington, The George Washington School of Nursing, Milken Institute School of Public Health, GW Cancer Center
- Samantha Wells, St. Jude Children's Research Hospital

We also thank the Southeast Roundtable Elimination Implementation Team:

- Leanne Alexander, Merck
- Carlton Allen, Cancer Prevention and Research Institute of Texas
- Trisha Amboree, Medical University of South Carolina Hollings Cancer Center
- Robert Bednarczyk, Emory University Rollins School of Public Health
- Lori Blanton, American Cancer Society
- Sherri Booker, Tennessee Department of Health
- Heather Brandt, St. Jude Children's Research Hospital
- Tami Brooks, Mississippi Department of Health
- Julia Brown, St. Jude Children's Research Hospital
- Penelope Burns, Student, Vanderbilt University
- Silvia Camata, O' Neal Comprehensive Cancer Center at University of Alabama—Birmingham
- Maria Campos Araujo, Tennessee Breast and Cervical Screening Program
- Monalisa Chandra, MD Anderson Cancer Center
- Vivian Colon Lopez, University of Puerto Rico
- Casey Daniel, University of South Alabama
- Angela Davis, American Cancer Society
- Heather Dollinger, North Carolina Department of Health and Human Services
- Amy Ellis, American Cancer Society
- Syeda Fatima Batool, North Carolina Department of Health and Human Services
- Vickie Fowler, North Carolina Advisory Committee on Cancer Coordination and Control
- Jordan Hatchett, Norton Cancer Institute
- Pam Hull, University of Kentucky Markey Cancer Center
- Portia Knowlton, St. Jude Children's Research Hospital
- Cara McCarthy, Louisiana Cancer Prevention and Control Programs
- Madeline McNee, St. Jude Children's Research Hospital
- Eryka Murray, Emory University Winship Cancer Institute
- Hannah Nein, American Cancer Society

- Tara Pendygraft, Kentucky Department for Public Health
- Christina Turpin, American Cancer Society National HPV Vaccination Roundtable
- Yara Sanchez, University of Puerto Rico
- Jessy Sanders, Kentucky Rural Health Association - Immunize Kentucky Coalition
- Marina Santa Cruz Terrazas, University of Tennessee Health Sciences Center
- Shelly Shang, Centers for Disease Control and Prevention
- Melanie Slan, Medical University of South Carolina Hollings Cancer Center
- Ryan Suk, Emory University
- Jennifer Watkins, Cornerstone Healthcare Group
- Samantha Wells, St. Jude Children's Research Hospital
- Yolanda Woods, Shelby County Health Department
- Nancy Wright, Alabama Department of Public Health
- Jennifer Young Pierce, University of South Alabama Mitchell Cancer Institute

Additionally, we would like to thank the needs assessment survey respondents and in-depth interview participants who shared their time and wisdom with us.

REFERENCES

1. Centers for Disease Control and Prevention. Cancers linked with HPV each year. Centers for Disease Control and Prevention. https://www.cdc.gov/cancer/hpv/cases.html. Accessed June 2025. 2.U.S. Cancer Statistics Working Group. United States Cancer Statistics Data Visualizations Tool. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute. https://www.cdc.gov/cancer/dataviz. Published June 2025.
3. World Health Organization. Cervical Cancer Elimination Initiative. https://www.who.int/initiatives/cervical-cancer-elimination-initiative. Published 2024. Accessed July 2025.
4. National Cancer Institute. Cervical Cancer Prognosis and Survival Rates. https://www.cancer.gov/types/cervical/survival. Published 2023. Accessed July 2025.
5. American Cancer Society. American Cancer Society Roundtables. https://www.cancer.org/about-us/our-partners/nonprofit-partners/american-cancer-society-roundtables.html. Published 2024. Accessed July 2025.
6. OPERATION WIPE OUT. Strategic Action Plan for Cervical Cancer Elimination as a Public Health Problem in the State of Alabama--2023-2033. https://operationwipeout.org/about/alabamas-cervical-cancer-elimination-plan. Accessed July 2025.
7. Pingali C, Yankey D, Elam-Evans LD, et al. Vaccination Coverage Among Adolescents Aged 13–17 Years — National Immunization Survey-Teen, United States, 2024. MMWR Morb Mortal Wkly Rep 2025;74:466–472. DOI: http://dx.doi.org/10.15585/mmwr.mm7430a1.
8. ACS National HPV Vaccination Roundtable. HPV vaccination: Improving health systems to boost HPV vaccination. https://hpvroundtable.org/wp-content/uploads/2024/11/HPV-Vaccination-Improving-Health-Systems-to-Boost-HPV-Vaccination.pdf. Published 2024. Accessed July 2025.
9. Amboree TL, Damgacioglu H, Sonawane K, Adsul P, Montealegre JR, Deshmukh AA. Recent trends in cervical cancer incidence, stage at diagnosis, and mortality according to county-level income in the United States, 2000-2019. Int J Cancer. 2024;154(9):1549-1555. doi:10.1002/ijc.34860
10. Semprini J, Zahnd W, Brandt HM. What cancers explain the growing rural-urban gap in human papillomavirus-associated cancer incidence? J Rural Health. 2025;41(1):e12915. doi:10.1111/jrh.12915
11. Patti E. Gravitt, Anne F. Rositch, Magdalena Jurczuk, Graciela Meza, Lita Carillo, Jose Jeronimo, Prajakta Adsul, Laura Nervi, Margaret Kosek, J. Kathleen Tracy, Valerie A. Paz-Soldan; for the Proyecto PreCancer Study Group, Integrative Systems Praxis for Implementation Research (INSPIRE): An Implementation Methodology to Facilitate the Global Elimination of Cervical Cancer. Cancer Epidemiol Biomarkers Prev 1 September 2020; 29 (9): 1710–1719. https://doi.org/10.1158/1055-9965.EPI-20-0501