RECOMMENDATIONS ON CERVICAL CANCER SCREENING IN SPAIN

The perspective of experts from different autonomous communities

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Preparation and review of the report

Advancing Cervical CancEr ScreeningS (ACCESS) International Consensus Group

National Expert Group

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Secretariat

The ACCESS Group Secretariat coordinated the process of developing the exploratory analysis on cervical cancer screening in Spain, providing administrative and methodological support at all its stages. We participated in drafting the report and the questionnaire addressed to experts, managed the collection and analysis of the responses obtained, and organized consensus meetings that made it possible to identify barriers and priorities for improvement. In addition, we conducted interviews with selected stakeholders, such as healthcare professionals, regional program managers and patient representatives, in order to incorporate a plural and contrasted perspective that would strengthen the validity and applicability of the conclusions of the report.

Table of Contents

Introduction

Cervical cancer continues to be a relevant public health problem, despite the scientific and technological advances that allow its prevention and early detection. Spain, in line with the global objectives of the World Health Organization (WHO) for the elimination of this disease, has in recent years undertaken a transition towards an organized population-based screening model, with universal coverage and homogeneous quality criteria. This change represents a decisive step towards equity, effectiveness and sustainability of early detection programs throughout the country.

This exploratory analysis, promoted by the Advancing Cervical CancEr ScreeningS (ACCESS) International Consensus Group, aims to identify good practices, detect implementation gaps and issue actionable recommendations in a group of Spanish autonomous communities, which guide health authorities and public policy decision-makers in the consolidation of their screening programs. Based on the six recommendations of the White Paper Turning the Tide of the ACCESS Group, the analysis seeks to contribute practical evidence to national efforts to achieve the elimination of cervical cancer.

The analysis adopts an exploratory approach, based on a structured questionnaire addressed to a National Expert Group, which included representatives from Catalonia, Extremadura, Galicia, Madrid and the Basque Country. In addition, collaboration was obtained from the Valencian Community, whose experts provided partial information. The questionnaire was complemented with the review of official documents, technical guidelines and national and international consensus. The methodological coordination was supervised by an International Steering Group composed of three members of the ACCESS Group, responsible for validating the technical criteria and the traffic light classification model (green, amber and red) used to assess the levels of implementation of the recommendations of the White Paper Turning the Tide.

The results presented in this report offer a first comparative approximation of the status of some of the regional screening programs in Spain, identifying both the progress achieved and the challenges still present. Based on this, the ACCESS Group may continue expanding the analysis in future phases, consolidating a comprehensive vision that reflects the territorial diversity and the opportunities for improvement of the Spanish healthcare system.

1. Context: cervical cancer and relevance of screening

Cervical cancer is one of the most preventable types of cancer and, at the same time, a still avoidable cause of disease and death in Spain[1]. Although population-based registries show a slight annual decrease in incidence since 2010, the age-adjusted rate (6.1 cases/100,000 women)[1] continues to be above the elimination threshold set by the World Health Organization (WHO) (4/100,000)[1].

Each year, it is estimated that around 2,326 new cases are diagnosed and approximately 802 deaths occur in Spain[1]. Beyond these figures, the pyramid of cervical pathology caused by the human papillomavirus (HPV) represents a real healthcare burden: it is estimated that 1.5 million Spanish women[1] are living at any given time with infection by high-risk genotypes and that nearly 600,000 present some cytological abnormality[1]; of these, around 6,368 develop HSIL/CIN 3 lesions annually, which are direct precursors of cancer[1]. These figures demonstrate the significant clinical and economic burden that this disease represents for the National Health System (SNS) and underline the urgency of effective and equitable prevention.

The 2025 Guideline of the Spanish Association of Cervical Pathology and Colposcopy (AEPCC) reports that 64.16% of sexually active women aged ≥ 18 have been screened at least once in the last five years[1]. Likewise, the 2020 European Health Survey indicates that 80% of women aged 25–65 would have undergone cytology during this period[1]. However, regional gaps and heterogeneity in the transition of models persist: while two of the seventeen autonomous communities in Spain initiated the transition from opportunistic population-based screening in 2018 (Castilla-La Mancha and the Basque Country), two others did so in 2020 (Castilla y León and Galicia) and five between 2022 and 2023 (Asturias, Extremadura, La Rioja, Madrid and Navarra); the rest have begun in 2024. In the case of Ceuta and Melilla, as of July 2024, specific dates for moving from an opportunistic model to an organized population-based one had yet to be defined[1].

In this way, most autonomous communities and autonomous cities are in the process of implementation or in the rollout phase of population-based screening programs. However, participation rates and mechanisms for inviting women (letter, postal mail, SMS or electronic appointment) continue to vary by community, which underlines the need for robust monitoring systems to ensure equity and maximize the impact of the program[1].

1.1. Creation of the ACCESS Group and its White Paper Turning the Tide

In 2023, in response to the stagnation and even decline in participation in screening programs in several high-income countries, the Advancing Cervical CancEr ScreeningS (ACCESS) International Consensus Group was established. It is a multidisciplinary group of eleven experts from the European Union, the United Kingdom, the United States and Canada, including two members from Spain: Dr. Xavier Bosch, clinical oncologist and epidemiologist, co-founder of the HPV Information Centre (ICO and IARC), director of HPV World (HPW), and Dr. Rosario Granados, Head of the Pathology Department at Getafe University Hospital (Madrid Health Service), former president of the European Federation of Cytology Societies and of the Spanish Society of Cytology. Its mission is to promote international collaboration, share best practices and propose solutions to increase participation in screening, especially among under-screened women[2].

As a first milestone, the group developed the White Paper *Turning the Tide: Recommendations to Increase Cervical Cancer Screening Among Under-Screened Women*[2]. This document synthesizes the available evidence and formulates six key recommendations addressed to governments and health authorities in high-income countries with organized screening programs[2]:

1. Develop national plans for the elimination of cervical cancer, with clearly defined elimination targets and ambitious participation goals in screening programs.
2. Implement culturally appropriate education, information and awareness initiatives, especially aimed at populations with low participation in screening.
3. Improve accessibility to cervical cancer screening for under-screened populations (e.g.: optimization of invitation systems, flexible screening options, self-sampling reserved for individuals with low participation).
4. Support healthcare professionals to increase participation in cervical cancer screening, through training, education, empathy and financial incentives.
5. Promote and support the creation of national advocacy groups for cervical cancer patients and national coalitions for the prevention of this disease.

6. Ensure that health insurance adequately covers screening for all screening options and access for individuals without health insurance.

For high-income countries, the White Paper emphasizes that these actions should go beyond the minimum WHO targets and align with broader women's health strategies. In Spain, the ACCESS Group has promoted an initial exploratory analysis to understand to what extent public policies, both national and in some autonomous communities, comply with these recommendations. The process included virtual meetings with representatives of the participating autonomous communities, a detailed questionnaire, as well as expert contributions during the drafting phase of this report. This exploratory analysis reflects the analysis of data, using the White Paper as a comparative framework and starting point to identify best practices, gaps and prioritize specific interventions.

1.2. Objectives and scope of the exploratory analysis: implementation of screening in a group of autonomous communities

The comparative report on participation in cervical cancer screening in Spain aims to:

1. Identify good practices in Spain, recognizing the progress already achieved and highlighting examples that may serve as a reference for other regions or settings.
2. Diagnose gaps in public policies that hinder the implementation of the six recommendations of the ACCESS Group White Paper in Spain, providing practical and actionable evidence to guide decision-makers.
3. Issue high-level recommendations, supported by a traffic light rating model (RAG: red/amber/green) that reflects current levels of implementation and helps prioritize key areas for improvement.

2. Public policies around screening

2.1. Structure of responsibilities: national and regional scope

The cervical cancer screening program in Spain is structured around a multi-level governance model. The Ministry of Health establishes the basic legal framework through Royal Decree 1030/2006[3] — which defines the common service portfolio of the National Health System (SNS) — and, in particular, through Order SCB/480/2019[4], which incorporated population-based cervical cancer screening and granted five years to the autonomous communities to implement it with individual invitation to the entire target population[1].

In this regard, the Ministry of Health exercises both a regulatory and standardization function (technical guidelines, indicators, quality requirements) and a coordinating function through the collegiate bodies of the Interterritorial Council, the Public Health Commission and the Screening Committee. As a result of this joint work, at the end of 2024 the Consensus Document for the development and implementation of the population-based cervical cancer screening program was approved, which standardizes the use of primary HPV testing from the age of 30 and sets national coverage targets close to 100%[1]. In addition, the Network of Cancer Screening Programs, in collaboration with the AEPCC, has developed a specific classification to evaluate cervical cancers within the context of population-based programs. This system allows assessment of both the effectiveness of screening and areas for improvement to optimize results.

Its unified application facilitates monitoring and comparison of results between autonomous communities, contributing to continuous improvement of the program[1].

The autonomous communities are responsible for planning and operational execution. Each creates its own technical screening office, develops the population registry, selects invitation channels, contracts reference laboratories and finances the infrastructure[1]. Decentralization encourages territorial innovation, although it also generates significant variations.

2.2. Screening coverage: rates and recent evolution

Until 2019, participation of Spanish women in screening was achieved almost exclusively through opportunistic consultations; there was no state system guaranteeing systematic invitation to all target women. Order SCB/480/2019 changed this approach by encouraging autonomous communities to transform the program into an organized, population-based one. It granted them five years to implement it and another five to bring coverage — understood as "invitation to participate" — close to 100% of the population aged 25 to 65[5].

The Consensus Document on the modification of the screening program (Public Health Commission, 2023–24) confirms this timeline and specifies it[5]: the effective start of the reorganized program must take place in all autonomous communities within three years of the publication of the new ministerial order that will update the service portfolio.

On the other hand, some autonomous communities establish regional targets, as is the case for the six that participated in this exploratory analysis:

o Catalonia: The current plan (Protocol 11/2023) aims to progressively implement an organized population-based program, with HPV testing as the primary test (ages 30–65) and cytology (ages 25–29), to guarantee full coverage and territorial equity. The transition is planned before 2029[6].

o Valencian Community: The objective is to screen 1.7 million women by 2029, achieving full coverage of the target population aged 25 to 65[7].

o Extremadura: The objective is to guarantee access to the program in 100% of basic health areas (a total of 297,527 women aged 25 to 65) and to progressively increase participation of the target population until 2029[8].

o Galicia: The population-based cervical cancer screening program has been progressively extended in the region, reaching full coverage since December 2023. The program includes systematic invitations to women aged 35 to 65[9].

o Madrid: The CERVICAM program, which began in April 2023 in the catchment area of Hospital Ramón y Cajal and the associated primary care centers, aims to send screening invitations to more than 2.1 million women aged 25 to 65[10], with HPV detection from age 30 as standard practice since its extension to the entire region in November 2025, and with completion expected within three years.

o Basque Country: Since the launch of the cervical cancer early detection program in 2018, Osakidetza has managed to extend invitation coverage to the entire target population (25–65). First, in 2022, 100%

invitation coverage was achieved for women aged 25 to 34; subsequently, by December 2024, full invitation coverage was achieved[11].

Although the national framework defines the target population as women aged 25 to 65, differences are observed in the lower age limit — ranging between 25 and 35 years — depending on regional projects, local epidemiological evidence and interpretation of the validity of the technologies used. These adaptations reflect the flexibility of autonomous communities to optimize resources and tailor programs to the healthcare reality of each territory.

However, the national consensus establishes a common reference framework regarding recommended tests and intervals, with the aim of harmonizing coverage and comparability of results between autonomous communities.

The same document redefines the table of tests and intervals that will underpin this coverage: cytology every three years for women aged 25–29 (only for women without vaccination protection) and high-sensitivity HPV testing every five years for women aged 30 to 65, with specific triage if HPV is positive. With this change, coverage will no longer be measured by the number of cytologies performed, but by the proportion of women invited and screened within the recommended intervals[5].

For its part, the Consensus Document on the information system of the population-based cancer screening program of the National Health System (2025) establishes that autonomous communities must record and annually report program data in a common system, following homogeneous criteria for disaggregation and quality. Based on this information, an annual results report will be produced to assess compliance with agreed objectives and standards for each screening phase[12].

In the case of cervical cancer, the system will include basic and complementary indicators — such as invitation and examination coverage, participation rates, detection and interval cancer — differentiated by type of test (cytology or HPV, clinician-collected or self-sampling), age group and autonomous community. This framework will, for the first time, allow comparable data at national level and enable continuous evaluation of equity and effectiveness of the screening program[12].

It is expected that the first comparable rates may be published after the initial round of invitations (2026–2027). Until then, historical figures (for example, the 92% acceptance of self-sampling according to surveys) will be replaced by factual records that allow monitoring of territorial equity and identification of areas where acceptance of HPV testing falls below the 70% target set by WHO[5].

Therefore, Spain has moved from assessing coverage through opportunistic and self-reported data to establishing a goal of universal invitation by 2029[5], supported by a clear timeline and the obligation to report common indicators. This progress is also supported by Orders of the Ministry of Health SND/606/2024[13] and SND/454/2025[14], which consolidate population-based screening programs and improve coordination, monitoring and equity mechanisms between autonomous communities.

Final figures will now depend on the capacity of each community to complete its first round of invitations and accurately record who participates and with what outcome.

3. Methodology (traffic light/RAG model)

3.1. Selection of members of the National Expert Group

It was decided to establish a National Expert Group with the aim of ensuring territorial balance. To this end, members of the Screening Programs of Andalusia, Castilla-La Mancha, Catalonia, Valencian Community, Extremadura, Galicia, Madrid and the Basque Country were invited to participate in this exploratory analysis. Finally, the National Expert Group was composed of representatives from Catalonia, Extremadura, Galicia, Madrid and the Basque Country. The latter participated mainly by providing data from the autonomous community. Additionally, experts from the Valencian Community collaborated by providing partial information through a shortened questionnaire.

This broad perspective was complemented by the profile of the participating experts, professionals with extensive experience in the management or design of cervical cancer screening programs. The invitation was based on criteria such as their current position, their involvement in the development or implementation of public policies in the field of screening, and their ability to provide an operational perspective from different levels of the healthcare system.

In addition to regional representatives, technical profiles from key institutions were invited, such as the Unit of Population Screening Programs of the Ministry of Health, which ultimately was unable to participate in the information collection through the questionnaire.

On the other hand, an International Steering Group was formed with members of the ACCESS Group, who were responsible for approving the questionnaire criteria and the traffic light model. The International Steering Group consisted of:

o Dr. Rosario Granados, Head of the Pathology Department at Getafe University Hospital (Madrid Health Service), who has been president of the European Federation of Cytology Societies (EFCS) and of the Spanish Society of Cytology;

o Professor Philippe Descamps, Co-chair of the ACCESS Consensus Group, Professor and head of the Department of Obstetrics and Gynecology at Angers University Hospital, former vice president of the International Federation of Gynecology and Obstetrics (FIGO);

o Dr. Mairead O’Connor, Researcher at the Irish National Screening Service;

These experts represent the international dimension of the ACCESS Group, whose role is to ensure alignment of the project with its priorities and objectives, as well as to approve the methodology, enabling its potential extrapolation to other countries.

Finally, the National Expert Group was structured into different levels of participation. First, a Coordination, responsible for supervising the methodological development of the project and ensuring the coherence of the analysis with the objectives of the study, in which Dr. Xavier Bosch and Dr. Rosario Granados, members of the ACCESS Group, participated. Second, a group of collaborating experts, responsible for providing technical and contextual information on the implementation of screening programs in the participating autonomous communities, as well as contributing comments and observations during the report review process. Lastly, Other Participants contributed by providing specific data on their respective regional programs.

3.2. Design and deployment of the questionnaire

The main instrument for data collection was a questionnaire specifically designed to gather the perspective of the National Expert Group on cervical cancer screening programs (Annex 8.1). The questionnaire included 30 questions organized around the recommendations of the ACCESS Group White Paper to improve participation in screening: development of elimination plans, accessibility, education and awareness, support for healthcare professionals and patient groups.

The questionnaire was distributed electronically to members of the National Expert Group, and data collection took place during the month of June 2025. Additionally, partial contributions were obtained from experts of the Valencian Community, who completed only part of the questionnaire to provide contextual information about their respective programs.

In addition, four complementary methodological stages were defined to guide the development of the study:

Phase	**Activity**	**Key results**
Directed document review	Inventory of national and regional policies, coverage data and indicators extracted from the AEPCC-2025 Guideline and the ACCESS Group White Paper “Turning the Tide”	Current situation for each recommendation: existence of regulation, available indicators and information gaps
Assignment of “traffic light model” (RAG) ratings	Application of criteria agreed in advance with the International Steering Group of the ACCESS Group: green (full implementation), amber (partial/heterogeneous) and red (not implemented/no evidence)	RAG tables and maps by recommendation and by autonomous community
Consensus and validation meetings	Discussion of preliminary results with the National Expert Group; final adjustments of colours and key messages	Validated report

This sequential approach combines secondary evidence (documentation and official data) with primary evidence (representative expert opinion), allowing for a robust and actionable snapshot of the degree of adoption of the ACCESS Group recommendations in a group of autonomous communities in Spain.

3.3. Definition of analysis criteria (green/amber/red)

To facilitate comparability between autonomous communities and provide a visually accessible reading of the degree of implementation of the recommendations, a classification based on three levels of compliance was adopted, represented by a traffic light color code:

- Green: the recommendation is fully and consistently implemented.
- Amber: the recommendation is partially implemented, in pilot phase or with significant limitations.
- Red: the recommendation is not implemented or there is no evidence of relevant actions.

The specific criteria for assigning each color were defined prior to the analysis and were applied homogeneously to the thematic blocks, taking into account both quantitative and qualitative information provided by the participating experts.

3.4. Processing of responses

A total of six complete questionnaires and one with partial contributions were received. After a preliminary review, responses were validated and minor inconsistencies in format were resolved.

Based on the responses, the criteria defined in section 3.2 were applied to classify the degree of implementation of each recommendation of the ACCESS Group. The results were grouped into different thematic dimensions in order to facilitate comparative interpretation across regions.

The analysis also considered qualitative observations collected in the questionnaire, identifying common patterns, best practices and critical areas.

However, several limitations of the study must be considered, which affect the scope and representativeness of the findings and should be taken into account when interpreting the results:

- Incomplete territorial coverage. Although experts from six autonomous communities (Catalonia, Valencian Community, Extremadura, Galicia, Madrid, Basque Country) participated, other contacted regions (Andalusia and Castilla-La Mancha) were unable to participate, which limits the ability to reflect the reality of the whole of Spain.

- Absence of the Ministry of Health. The lack of direct information from the Ministry of Health constitutes an important limitation, given that it is the body responsible for defining the national framework.

- Variable level of detail in responses. Not all contributions provided the same depth or precision, generating imbalances in the information available for each dimension.

- Limitations in information systems. Additional comments from experts highlight the lack of maturity and interoperability of current tools, which hinders the consolidation of homogeneous and comparable data.

- Regional heterogeneity. The diversity of responses to similar questions reveals fragmentation of the healthcare system in relation to screening, with differences in strategies, tools and priorities between autonomous communities.

4. Results of the comparative evaluation

4.1. Analysis by thematic blocks

Block 1: Participation rate in cervical cancer screening

Most of the National Expert Group who responded to this section indicated that official data on participation in screening are published. However, when examining the analysis in greater depth, significant variations are observed in terms of territorial coverage, screening, periodicity and accessibility of such data.

Regarding the territorial level of publication, participants indicated that data are published only at the regional level. In addition, in an open-ended question, experts were asked to identify which autonomous communities publish these data. Despite the dispersion of responses, full coverage of all regions was achieved, suggesting a general perception of availability, although not always uniform or corroborated with official data.

Qualitative comments reflect that in some communities — such as Catalonia — data are available but require a specific request to access them. Others, such as Madrid or the Basque Country, acknowledge recent progress in the implementation of screening, but highlight that many regions are still in a pilot phase regarding data recording, which limits the reliability of current participation data and their outcomes.

The need to also consider opportunistic screening in order to obtain a real estimate of screening coverage is emphasized.

Block 2: Development of National Elimination Plans

Most participating experts stated that a National Plan for the Elimination of Cervical Cancer does exist[4]. However, not all derived regional plans fully include the key elements indicated in the recommendation.

- Specific participation targets in screening: The majority indicated that the Plan does include them.

- Equity measures within participation targets: all communities responded affirmatively.

- Evaluation of the degree of implementation by the Ministry of Health: Qualitative responses reflect a fragmented perception regarding the existence of systematic mechanisms.

o Tools such as the indicators working group or the Screening Committee[15] are mentioned, as well as a Consensus Document of the Ministry of Health[5] with shared indicators.

o However, experts do not perceive homogeneous oversight.

Block 3: Education, information and awareness initiatives

The responses collected reflect a fragmented situation regarding the existence of operational registries and adapted information programs for cervical cancer screening. Most existing tools are developed exclusively at the regional level and their scope varies significantly between autonomous communities.

Regarding operational registries for monitoring participation, most experts stated that these exist at the regional level, without national implementation. The autonomous communities mentioned as examples were the Basque Country, Extremadura, Valencian Community, Madrid and Catalonia. However, some experts expressed uncertainty about the real scope of these registries outside their own region.

With respect to registries that allow identification of groups with low participation, their existence was confirmed in some autonomous communities. The Basque Country, Catalonia, Extremadura and Galicia were cited as references, although it is acknowledged that the development of these tools is still ongoing and their capacity to identify inequalities varies.

The Valencian Community, for its part, indicated that the operational registry, in addition to collecting data on invitation, participation and results, also includes information on the quality of the screening process.

Regarding specific educational programs targeting under-screened women, experts indicated that these are present in fewer than half of the regions. However, initiatives were mentioned in Catalonia and the Basque Country, but without evidence of coordinated or systematic strategies.

Additional comments highlight current limitations of these tools, both in coverage and maturity. The Basque Country notes that “as most of Spain is in the implementation phase, it is difficult to take into account populations with low participation or greater vulnerability”. Extremadura reports that follow-up is carried out “only at regional level”. In Madrid, participation data were recorded in the pilot study until November 2025, when the extension to population-based screening in the autonomous community began. Participation data are collected in this context. In addition, in the hospital tumor registry (RTMAD), the number of precancerous and cancerous cervical lesions (CIN2+) is recorded.

Block 4: Accessibility to cervical cancer screening

Expert responses show partial and uneven development of measures aimed at improving access to screening, both in terms of proactive invitation and availability of schedules, diversity of settings and provision of self-sampling. Most of the actions described are limited to pilot experiences or specific regions.

- Regarding optimization of the invitation system, experts indicated that these improvements are applied only in some regions.

- In Galicia, screening invitations are generated systematically every month through a centralized computerized system. The region also has a specific operational registry — the CRIIS system — which allows automated management and analysis of key program indicators, including invitation, participation, results and clinical referrals.

- Regarding self-sampling, participants indicated that while in some autonomous communities it is being implemented for under-screened women and in others it is available to all women, in some regions it has not yet been incorporated into the screening program.

- Likewise, most experts indicated that information on the advantages and disadvantages of self-sampling and clinician-collected samples is provided only in some regions.

- The availability of screening outside normal consultation hours was one of the lowest-rated items, as according to experts it is only offered in some communities.

- Finally, regarding the provision of screening in alternative settings, participants indicated that this only occurs in some regions, and one indicated that such an option does not exist.

Galicia offers a flexible access model, combining self-sampling and clinician-collected sampling. Invited women can choose between performing self-sampling or requesting an appointment with their midwife, with specific schedules enabled for the program.

From Madrid, the limited availability of information and data to identify vulnerable populations is highlighted. It is also noted that, in general, there is no collaboration in alternative settings outside health centers, although it is unknown whether some regions are progressing in this regard. For its part, the Basque Country reports that it will offer self-sampling to non-participating women from 2026.

Block 5: Support for healthcare professionals

Responses show that training and support for healthcare professionals to provide information and advice on cervical cancer screening are available only partially and unevenly across regions.

For example, Catalonia, Galicia, Madrid and the Basque Country mentioned that they provide training and support to healthcare professionals. However, no formal mechanisms of structured support for healthcare professionals across the entire national territory were identified.

Regarding financial incentives aimed at healthcare professionals to encourage participation in screening, experts indicated that these do not exist in any region. The Basque Country, for its part, expressed a critical stance regarding the use of financial incentives in the public sector.

Block 6: Support for cervical cancer advocacy and prevention coalitions

Responses reveal that institutional support for patient groups and associations linked to cervical cancer prevention is insufficient in the autonomous communities. Experts indicated that no support is provided at national level, only in some regions.

Block 7: Strengths and gaps of cervical cancer screening programs

Participating experts agreed in identifying both relevant progress and persistent limitations in cervical cancer screening programs. Responses reveal significant territorial heterogeneity, with important differences in the level of development, coverage, organization and institutional support of regional programs.

Strengths:

Among the positive elements, efforts to consolidate a population-based approach across the country stand out, with agreed quality criteria and progress in the design of information systems. Madrid and Galicia, for example, have developed highly structured processes with components such as personalized invitation, inter-institutional coordination, digitalization and the key role of midwives and gynecology professionals as reference healthcare personnel. The Basque Country also reports significant progress, especially in evaluation strategies.

At national level, universal healthcare coverage is positively valued as the basis for implementing equitable programs, although some experts point out that only some autonomous communities have fully implemented programs.

Gaps:

Regarding limitations, participants highlighted as main weaknesses the lack of coordination in implementation between autonomous communities, low participation in screening in many regions, challenges in reaching under-screened populations through self-sampling and ensuring adequate follow-up, and the absence of specific strategies for vulnerable populations. Inequalities in the interoperability of registries also persist, as well as the challenge of achieving a fully population-based and universal approach.

Different approaches between autonomous communities in the implementation of self-sampling were also identified. While Catalonia offers it non-selectively within its population-based screening program, Galicia offers participating women the option to choose between clinician-collected sampling by a midwife or self-sampling; the Basque Country plans to introduce self-sampling in 2026 targeted at under-screened women. Other autonomous communities participating in this exploratory analysis, such as Madrid and Extremadura, do not plan to incorporate it in the short or medium term. Available evidence on the impact of these different strategies remains inconclusive, making continuous monitoring and evaluation essential.

Organizational problems were also mentioned, such as overload of gynecology services during implementation, difficulties in follow-up, and deficiencies in information systems for monitoring cases and evaluating results.

4.2. Level of implementation according to ACCESS Group recommendations (traffic light model)

Based on the analysis of the seven thematic blocks of the questionnaire, the degree of implementation of the ACCESS Group recommendations was assessed using the traffic light model (green, amber, red) as a comparative tool. This exercise makes it possible to identify the gap between current practices in the group of autonomous communities analyzed and the standards proposed by the ACCESS Group to move towards the elimination of cervical cancer.

ACCESS Group recommendation	Thematic block	Traffic light classification	Justification
1. National elimination plan with ambitious targets aligned with women's health	1. Participation rate in screening 2. National elimination plans	AMBER	Spain formally has a national cervical cancer elimination plan, and most experts confirmed that it includes

	🟨	screening participation targets. However, there is no evidence that all regional plans incorporate equity measures, and doubts remain regarding the existence of robust monitoring mechanisms. Furthermore, no explicit elimination targets with defined timelines are identified, nor a clear alignment with broader women’s health strategies.

ACCESS Group recommendation	Thematic block	Traffic light classification	Justification
2. Education and information initiatives culturally relevant for under-screened women	3. Education, information and awareness	RED	Although some autonomous communities have initiated specific educational programs, their coverage is limited, dispersed and lacks a structured approach. There is also no evidence of cultural campaigns, collaborations with influencers or strategies targeting vulnerable women from an equity perspective.

ACCESS Group recommendation	Thematic block		Traffic light classification	Justification
3. Improvement of accessibility to screening (self-sampling for under-screened women, optimized invitation, schedules, settings)	4. Accessibility to screening	Self-sampling targeted at women with low participation	AMBER	Implementation varies between regions, partly due to remaining uncertainties in the evidence base and differences in regional contexts. In communities where self-sampling has already been introduced, more data are needed to assess its impact.
		Screening invitation system	AMBER	Some autonomous communities have initiated improvements such as reminders and proactive invitations.
		Screening in alternative settings to health centers	AMBER	Available in some autonomous communities, but not uniformly.

Systematic provision of comparative information on self-sampling and clinician sampling	**RED**	In communities where self-sampling is offered, there is no evidence that adequate information is provided to women about its advantages and disadvantages compared to clinician-based screening.
Availability of screening outside normal consultation hours	**RED**	This option is not available in the autonomous communities analyzed.

ACCESS Group recommendation	Thematic block		Traffic light classification	Justification
4. Support for healthcare professionals (training and incentives)	5. Support for healthcare professionals	Training for healthcare professionals	AMBER	Some autonomous communities offer occasional training, but there are no national-level recommendations and training is considered insufficient in terms of coverage and systematization.
		Financial incentives	RED	Experts confirmed the complete absence of incentive policies for healthcare professionals.

ACCESS Group recommendation	Thematic block	Traffic light classification	Justification
5. Support for patient associations and prevention coalitions	6. Support for patient groups and coalitions	AMBER	Institutional support for patient associations and prevention coalitions is practically non-existent. Responses show that neither at national level nor in most regions is the creation of these spaces promoted or funded.

ACCESS Group recommendation	Thematic block	Traffic light classification	Justification
6. Coverage of screening by the healthcare system or insurance		GREEN	Since the National Health System in Spain guarantees universal coverage, there are no financial barriers related to insurance for accessing screening.

While block 7 of the questionnaire, related to strengths and gaps of cervical cancer screening programs, cannot be evaluated using a traffic light classification, as it collects qualitative impressions about the programs as a whole, it is essential for contextualizing the results analyzed in previous blocks. Expert responses highlight significant progress but also identify structural challenges that may limit the implementation of population-based screening in Spain.

5. Discussion of results

5.1. Progress and recent achievements

The exploratory analysis carried out within the framework of the ACCESS Group recommendations suggests that Spain, as a whole, is moving towards an organized population-based cervical cancer screening model. This process, driven by regulation, marks a structural shift: moving from an approach based on opportunistic consultation to a proactive system of invitation and follow-up, with universal coverage as the goal.

In terms of health policy, this change also implies a transformation in the logic of regional programs. Success is no longer measured by the number of tests performed, but by the capacity to invite and screen the entire target population within the established timeframes.

Highlighted progress includes:

- Existence of prior consensus and institutional frameworks. The Screening Committee, shared indicators and the Consensus Document of the Public Health Commission reflect a clear willingness in Spain’s interterritorial policy to move towards a common framework aligned with WHO objectives, although there is still a long way to go before effective implementation across all autonomous communities

- Increasing involvement of healthcare professionals. Midwives, primary care professionals and specialists are assuming a central role in program implementation and follow-up.

- Advanced regional experiences. Communities such as Madrid, Galicia and the Basque Country have deployed structured programs that include invitation systems, digital components, professional coordination and accessibility strategies, which could serve as a reference for other regions.

- Technological availability and management tools. Digitalization, dashboards and computerized registries allow improved monitoring of screening programs and optimization of invitation, follow-up and evaluation processes, which are being developed in the autonomous communities consulted.

- Universal healthcare coverage. It constitutes the basis upon which equitable programs can be built that offer coverage to the entire population.

5.2. Challenges and limitations

Despite the progress identified, the analysis also reveals inequalities in the implementation of screening which, together with the review of literature and international guidelines, has made it possible to identify significant challenges:

- Territorial fragmentation that hinders coordination between regions. Despite the existence of a National Elimination Plan, Spain’s interterritorial health policy means that most actions depend on regional decisions and, in some cases, do not follow a sufficiently operational common framework.

For effective coordination, it would be necessary to:

1. avoid heterogeneity in organizational models and in the timing of implementation across autonomous communities;

2. have agile and standardized governance mechanisms that clearly define responsibilities and resources between the Ministry of Health and the autonomous communities;
3. achieve full interoperability between regional information systems and health registries;
4. ensure full and effective technical coordination when introducing new technologies and in the continuous training of involved personnel.

• Partial and uneven implementation of population-based screening. In many autonomous communities, the model remains in a pilot phase, without full coverage or regularity in invitations. This generates significant inequalities in access to cervical cancer prevention, as well as a lack of data. Likewise, it is difficult to evaluate the development of these pilots and their results in terms of women's preferences, technical challenges, available devices and associated costs, among other factors.

• Lack of consolidated data. Although some autonomous communities have begun to develop specific information systems, there is still no operational national database that allows systematic evaluation of key indicators such as invitation, uptake, follow-up and screening outcomes. This limitation hinders monitoring of territorial equity and evidence-based decision-making.

Similarly, standardization of processes, interoperability of information systems and the availability of homogeneous indicators that ensure comparability of results between autonomous communities are essential.

• Low participation in screening and limited adaptation to under-screened groups. Coverage levels vary widely between autonomous communities and, in general, strategies sufficiently adapted to women with lower probability of participation have not been deployed. Communication, education and accessibility initiatives are not systematically designed or targeted at these population groups.

• Heterogeneous implementation of self-sampling. Self-sampling has the potential to increase participation in screening, especially when targeted at under-screened women. However, its implementation remains heterogeneous across Spain's autonomous communities. For example, Catalonia and Galicia have incorporated it into their general population-based programs, while the Basque Country plans to introduce it in 2026 targeted at women with low participation. Other communities, such as Madrid and Extremadura, do not yet plan its implementation. In Madrid specifically, population-based screening relies on midwives and its inclusion will be reviewed once full rollout is completed.

As indicated in the AEPCC Guideline, it is essential that the selected self-sampling device, as well as the HPV detection process through self-sampling, be validated[16]. Likewise, "it is important to consider the acceptability of the test and how it is managed in the population, and to carry out quality controls of the process to ensure proper implementation of this strategy"[17].

• Limited use of accessibility strategies. The questionnaire reveals low availability of flexible hours, alternative settings to health centers or digital invitation systems. These measures, recommended internationally, are key to facilitating participation and improving the screening experience.

• Absence of incentives for healthcare professionals. The autonomous communities analyzed do not have incentives to promote the participation of healthcare personnel in screening. This lack of recognition may limit their active involvement in screening programs.

- Limited institutional support for patient groups. Organizations advocating for cervical cancer prevention do not receive sufficient support or visibility at national or regional level. However, their participation may be key to building trust and mobilizing women with low adherence to screening.

- Lack of a culture of systematic evaluation and interterritorial learning. There are no institutionalized mechanisms for review between autonomous communities, nor regular spaces for exchanging best practices. This slows down the identification of common solutions and limits continuous improvement of the screening program.

5.3. Facilitating factors

Despite these limitations, important facilitating factors have also been identified, which could serve as a basis to accelerate the implementation of cervical cancer screening programs:

- Institutional commitment: the national timeline towards 2029 and ministerial orders[13],[14] establishing a three-year period for modifying regional cervical cancer screening programs provide stability and a clear direction to the process. Furthermore, these orders, together with the efforts of the Ministry of Health, aim to improve coordination, monitoring and equity mechanisms between autonomous communities.

- Motivated and trained professionals: midwives have consolidated their role as key agents in increasing participation and supporting women. In addition, primary care and hospital gynecology professionals play an essential role in follow-up and program organization. Scientific societies can also support the creation of fast-track clinical pathways for confirmation and treatment.

- Innovative pilot experiences: already underway in some autonomous communities, they provide practical learning and reference models that can be scaled or adapted in other territories.

- Emerging interterritorial consensus: although still incipient, they lay the foundations for building a common framework of indicators, quality standards and equity criteria applicable at national level.

- Clear international recommendations (WHO, ACCESS Group): they provide a validated roadmap adaptable to the Spanish context, guiding both the design and evaluation of screening.

6. Recommendations

Based on the findings of the exploratory analysis, the following lines of action are proposed:

6.1. At national level

- Strengthen the strategic role of the Ministry of Health, by following an ambitious and coordinated roadmap for the implementation of screening at national level. This strategy should include defined timelines, targets exceeding the minimum set by the World Health Organization and an approach focused on territorial equity.

- Continue supporting the common evaluation architecture to consolidate the system of homogeneous indicators (invitation, uptake, follow-up, outcomes), with data disaggregated by age group, autonomous community and vulnerability factors.

- Standardize and consolidate operational registries, ensuring their interoperability, national coverage and capacity to assess territorial inequalities. As established in the 2023 Consensus Document of the Ministry of Health[18], registries of population censuses and health cards, cancer registries, primary care information systems and screening program information systems must be interoperable with vaccination information systems, among others, so that registries become a key tool for informed, data-driven decision-making.

- Promote national information and awareness campaigns, culturally adapted and especially targeted at women with low participation in screening. Communication strategies should combine traditional, digital and community-based media and be coordinated with regional health services.

- Promote partnerships with key social actors, including patient groups, community organizations and women's health organizations. Following the ACCESS Group recommendations, health policies should be aimed at establishing funding mechanisms, technical support and educational campaigns to promote screening and identify cultural or social barriers.

- Incorporate economic evaluation as part of the national system of indicators, promoting cost-effectiveness studies comparing different screening strategies (cytology, HPV and self-sampling) to guide public investment decisions based on their health and budgetary impact.

- Establish stable interterritorial learning spaces to facilitate systematic exchange of experiences, best practices and lessons learned between autonomous communities.

- Strengthen multi-level coordination, articulating efforts between the Ministry of Health, regional health services and social actors to reduce inequalities in implementation and ensure national coverage.

- Mobilize European and national resources, prioritizing their allocation to autonomous communities facing greater technical and institutional challenges, in order to accelerate implementation of the population-based model and promote innovative measures.

6.2. At regional level

- Adapt regional plans to the national framework, ensuring alignment with coverage objectives, quality standards and equity priorities. Regions with greater operational and budgetary difficulties should receive technical support from the Ministry of Health.

- Deploy effective accessibility strategies, especially in autonomous communities with lower coverage, prioritizing:

  - Optimized invitation systems (SMS, postal mail and digital channels).
  - Extension of screening hours.
  - Provision of screening in alternative settings outside health centers.

- Consider the gradual implementation of self-sampling as a valid tool to increase participation in screening, ensuring that its application is subject to evaluation. The AEPCC Guideline[1] supports self-sampling as a valid option for sample collection in cervical cancer screening. It also emphasizes the importance of evaluating the acceptability of this test in the population, as well as establishing quality control mechanisms at all stages of the process, in order to ensure proper implementation of this strategy.

In this regard, regions that implement self-sampling must ensure adequate mechanisms for quality control and traceability. As indicated by national and European guidelines, implementation must be progressive and evaluated, ensuring validation of devices, analysis of coverage and outcomes, traceability of samples and the existence of clear clinical follow-up protocols.

Before implementation, in addition to available evidence, aspects such as how invitations will be carried out, distribution and return points for sampling kits, and sample stability at room temperature must be considered, among other essential elements to ensure the validity and reliability of the process.

- Incorporate economic evaluation into the design and monitoring of screening programs. Cost-effectiveness analysis — including selection of the primary test, screening intervals and follow-up strategies — should be part of technical and planning criteria at both national and regional level. This approach would allow optimization of resources, evidence-based decision-making and strengthening of long-term program sustainability.

- Ensure continuous training and support for healthcare personnel, especially midwives and primary care professionals, including tools to improve communication with women with low adherence. It is recommended to explore non-financial incentives such as accreditation, institutional recognition or inclusion in performance evaluation systems.

- Strengthen technical coordination between regional health services and scientific societies in order to harmonize quality criteria, training and professional accreditation in cervical cancer screening and follow-up.

In summary, advancing towards more equitable and effective screening requires sustained political commitment at both national and regional levels. Only through coordinated, evidence-based action that takes into account under-screened populations will it be possible to guarantee the right to cervical cancer prevention throughout the entire territory.

7. Conclusions

The exploratory analysis carried out on cervical cancer screening in Spain, based on the responses of the National Expert Group and on the recommendations of the Advancing Cervical CancEr ScreeningS (ACCESS) International Consensus Group –ACCESS Group–, highlights a scenario in transformation: Spain has initiated a relevant transition towards an organized and population-based model, although important structural and territorial challenges still persist.

The new regulatory framework and recent technical consensus reflect a clear willingness to move towards universal coverage, systematic follow-up and equity in access to screening. Likewise, there is increasing involvement of key healthcare professionals and an uneven but promising development of pilot experiences in several autonomous communities.

However, the findings also reveal fragmentation in implementation, disparities in coverage and limited adaptation of strategies to women with lower participation in screening. The absence of homogeneous data at national level, the lack of stable mechanisms for interterritorial coordination and the need to consolidate collaboration between public administrations and scientific societies limit the ability to evaluate, learn and improve collectively.

There are, nevertheless, solid facilitating factors on which to build: technological availability, professional capacity, advanced experiences in some autonomous communities and a clear international framework that provides strategic guidance. Leveraging these opportunities requires institutional leadership, sustained investment and a culture of evidence-based evaluation.

Ultimately, the success of the screening program will depend on the capacity of the healthcare system to guarantee its equitable deployment throughout Spain. Coordinated political action, both at national and regional level, will be key to transforming this aspiration into an effective reality for all women. Likewise, continued collaboration with the Ministry of Health will be essential to define and consolidate best practices in screening programs.

This analysis constitutes a first approximation of the situation of screening in a group of autonomous communities and lays the groundwork for continuing to expand the study and document the progress and efforts of other regions in the future.

8. Annexes

8.1. Full questionnaire

Participation questionnaire on Cervical Cancer Screening

This questionnaire aims to assess the implementation of the cervical cancer screening program in Spain and identify areas for improvement to increase participation in screening and reduce the burden of this disease.

* Indicates required question

Please indicate the Autonomous Community to which you belong *

Participation rate in cervical cancer screening

1. Are official data on participation in screening regularly published? *

Yes, official data are published regularly
Yes, official data are published, but irregularly or partially
No, official data are not published
I do not know

2. Are the published data at national level, regional level or both? *

Only at national level
Only at regional level

Both, national and regional
I do not know

3. Do you know which autonomous communities publish these data? If so, please select the regions from the following list (Select all that apply)

Check all that apply.

Andalusia
Aragon
Principality of Asturias
Balearic Islands
Canary Islands
Cantabria
Castilla y León
Castilla-La Mancha
Catalonia
Valencian Community
Extremadura
Galicia
La Rioja
Community of Madrid
Region of Murcia
Chartered Community of Navarre
Basque Country
Ceuta
Melilla

4. Please share any additional information you may have on the availability, accessibility or reliability of official data related to participation in screening.

(Maximum 150 words)

Development of National Elimination Plans

5. Is there a national plan for the elimination of cervical cancer? If the answer is "no", please go to question #8. *

Yes
No

6. Does the published elimination plan include specific participation targets for screening?

Yes
No

7. Do the participation targets include equity measures (for example, participation targets for identifiable social groups)?

Yes
No

8. What tools or strategies do the national authorities of the Ministry of Health have or are planning to evaluate the degree of compliance of the 17 autonomous communities regarding the implementation of screening programs and population participation in them?

(Maximum 150 words)

Education, information and awareness initiatives

9. Are there operational registries to monitor patient attendance to cervical cancer screening? *

Yes, there is a national registry
Yes, but registries are implemented at regional level
No, no registry has been implemented in Spain

10. If regional registries exist, please select the autonomous communities where they are implemented

Check all that apply.
Andalusia
Aragon
Principality of Asturias
Balearic Islands
Canary Islands
Cantabria
Castilla y León
Castilla-La Mancha
Catalonia
Valencian Community
Extremadura
Galicia
La Rioja
Community of Madrid
Region of Murcia
Chartered Community of Navarre
Basque Country
Ceuta
Melilla

11. Are there registries that allow identification of groups with insufficient screening? *

Yes, there is a national registry that allows identification
Yes, there are registries implemented at regional level that allow this
No, there are no registries that allow this in Spain

12. If regional registries exist, please select the autonomous communities where they are implemented (Select all that apply).

Check all that apply.

- Andalusia
- Aragon
- Principality of Asturias
- Balearic Islands
- Canary Islands
- Cantabria
- Castilla y León
- Castilla-La Mancha
- Catalonia
- Valencian Community
- Extremadura
- Galicia
- La Rioja
- Community of Madrid
- Region of Murcia
- Chartered Community of Navarre
- Basque Country
- Ceuta
- Melilla

13. Are there programs that provide education and information on cervical cancer screening tailored to groups with low participation? *

- Yes, implemented at national level
- Yes, implemented in more than half of the regions
- Yes, but only implemented in fewer than half of the regions
- No, it is not implemented in Spain

14. If so, please select the autonomous communities where these programs are implemented (Select all that apply).

Check all that apply.

- Andalusia
- Aragon
- Principality of Asturias
- Balearic Islands
- Canary Islands
- Cantabria
- Castilla y León
- Castilla-La Mancha
- Catalonia
- Valencian Community
- Extremadura

Galicia
La Rioja
Community of Madrid
Region of Murcia
Chartered Community of Navarre
Basque Country
Ceuta
Melilla

15. Please provide any additional comments on the existence of registries or the availability of information tailored to populations with low participation in screening

(Maximum 150 words)

Accessibility to cervical cancer screening

16. Is the invitation system for cervical cancer screening optimized to facilitate access (for example, through electronic booking, electronic reminders, etc.)? *

Yes, optimized at national level
Yes, optimized in more than half of the regions
Yes, but only optimized in some regions
No, it is not optimized in Spain

17. Is self-sampling offered to groups with insufficient screening? *

Yes, offered at national level
Yes, offered in more than half of the regions
Yes, but only offered in some regions
No, it is not offered in Spain

18. If known, please indicate the autonomous communities where self-sampling is offered to under-screened groups (Select all that apply).

Check all that apply.
Andalusia
Aragon
Principality of Asturias
Balearic Islands
Canary Islands
Cantabria
Castilla y León
Castilla-La Mancha
Catalonia
Valencian Community
Extremadura
Galicia

La Rioja
Community of Madrid
Region of Murcia
Chartered Community of Navarre
Basque Country
Ceuta
Melilla

19. Is self-sampling offered to all women? *

Yes, offered to all women at national level
Yes, offered to all women in more than half of the regions
Yes, but only offered in some regions
No, it is not offered to all women in Spain

20. Where self-sampling is offered, is information provided to women about the advantages and disadvantages of clinician-collected samples and self-sampling? *

Yes, information is provided at national level
Yes, information is provided in more than half of the regions
Yes, but only in some regions
No, it is not provided in Spain

21. Is screening routinely available outside normal consultation hours? *

Yes, available at national level
Yes, available in more than half of the regions
Yes, but only in some regions
No, it is not available in Spain

22. Is screening routinely available in a variety of settings (for example, sexual health clinics, mobile screening units)? *

Yes, available at national level
Yes, available in more than half of the regions
Yes, but only in some regions
No, it is not available in Spain

23. Please provide any additional comments on barriers, facilitating factors or general issues related to accessibility to cervical cancer screening.

(Maximum 150 words)

Support for healthcare professionals

24. Is training and support routinely provided to healthcare professionals to provide information and advice on participation in screening? *

Yes, provided at national level
Yes, in more than half of the regions
Yes, but only in some regions
No, it is not provided in Spain

25. If applicable, select the autonomous communities where training and support are provided to healthcare professionals (Select all that apply).

Check all that apply.
Andalusia
Aragon
Principality of Asturias
Balearic Islands
Canary Islands
Cantabria
Castilla y León
Castilla-La Mancha
Catalonia
Valencian Community
Extremadura
Galicia
La Rioja
Community of Madrid
Region of Murcia
Chartered Community of Navarre
Basque Country
Ceuta
Melilla

26. Are adequate financial incentives available for healthcare professionals in order to encourage greater participation in screening? *

Yes, at national level
Yes, in more than half of the regions
Yes, but only in some regions
No, they are not available in Spain

27. Please indicate any additional comments on support or incentives aimed at healthcare professionals to promote or increase participation in cervical cancer screening.

(Maximum 150 words)

Support for cervical cancer prevention advocacy and coalitions

28. Is support provided to cervical cancer prevention coalitions and patient associations to help facilitate participation in screening?

Yes, at national level
Yes, in more than half of the regions
Yes, but only in some regions
No, it is not provided in Spain

Strengths and gaps of the cervical cancer screening program

29. Please describe the key strengths of the cervical cancer screening program(s) in Spain, indicating whether these strengths are present at national level or are specific to certain autonomous communities *

(Maximum 150 words)

30. Please describe the main gaps in cervical cancer screening programs in Spain, indicating whether these gaps occur at national level or are specific to certain regions *

(Maximum 150 words)

Thank you for your participation. Your responses will contribute to the development of policy recommendations to improve cervical cancer screening in Spain.

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