**National Cervical Screening Programme: Changing the Primary Laboratory Test**

**CONSULTATION SUBMISSIONS**

**1 - 87**

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| **1** | Submitter name | Dr Jill McIlraith |
| Submitter organisation | Aurora Health Centre |

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| Name: | Dr Jill McIlraith |
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| In addition to the modelling work done to date, are there any other options that you believe the NCSP should investigate further? | We support the preferred pathway but would like to see more done to make self-swabbing an option across the board for patients who feel shy about having a vaginal examination. However, increased self-swabbing does mean those patients miss out on having a vaginal examination which may pick up other things. (Several years ago, our medium-sized health centre did a survey as to reasons why women overdue for a smear did not take up the offer of a free smear The single most commonly cited reason on our written questionnaire was a sense of shyness/embarrassment at having a vaginal examination.) |
| What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway? | nil we can think of |
| On the proposal to routinely screen women every five years: | 5 yearly seems reasonable as long as higher risk patients can have "interval" HPV testing for eg those with multiple partners, sexual assault victims, immunosuppressed patients. |
| On the potential change in age range for cervical screening from the current 20–69 years to 25–69 years: | 25-69 is acceptable as a screening range; in some situations a diagnostic HPV test (as opposed to a screening one) may need to be done in those under 25 eg a patient who had childhood sexual abuse. |
| Referrals to colposcopy: | not in a situation to comment |
| Screening equity: |  |
| Self-sampling: | We would like it to be more widely available just as self-administered STI swabs are now the norm in asymptomatic individuals (in both general practice and most sexual health clinics). It is likely to increase screening in other reluctant patients. It does take a few minutes to explain how to do the swab correctly, but will have a high patient acceptance rate if the uptake of self-administered STI swabs is a guideline. I don't think it matters if is done at home or in the clinic - what matters is giving clear instructions how to do it and, as part of the consent process, be told that she may need a vaginal exam to do get cells for cytology in a small number of cases. Biggest issue with self-sampling is clear, simple instructions on how to do it and to make it clear that the swab has to go into the vagina by usually 2-5 cm, that they cannot hurt themselves or loose the swab. We have had had cases where young women have been told to "put the swab down there and wave it around" and the patient has taken this to mean that it doesn't even have to touch the skin- so clear patient pamphlet will be key. |
| Invitation and recall to screening: | Opt-on is best. Inviting women via general practice is a good place to start but not all are enrolled and some move around ie shearing gangs in Central Otago so provision for these needs to be included. Will need media advertising and via key NGO's, Maori health providers etc. Some special clinics may need to be held to target highest risk eg the ones we have done on Saturday morning at Dunedin Hospital for high needs patients - free, food provided and transport if needed. |
| Cervical screening workforce: | Clear colourful pamphlets that we can give to all women patients -- and to their partners; for doctors and nurses, laminated flow charts that we can put on the wall work really well. What doesn't work is reams of documents or detailed booklets - they tend to be binned. Also an email hot line to ask questions for smear takers would be useful. |
| Do you have any other feedback? | I think the change is good, make sure to include men in the advertisements, and also need to be working towards immunising boys for HPV as well along the lines of Aussie where is has been very successful. Boys are the vectors and the new HPV vaccines (ie two instead of 3 and more subtypes included) should be aimed not just as girls. |

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| In addition to the modelling work done to date, are there any other options that you believe the NCSP should investigate further? |  |
| What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway? | Support proposal changes but continue screening from 20 years of age not 25. |
| On the proposal to routinely screen women every five years: | Support Proposal |
| On the potential change in age range for cervical screening from the current 20–69 years to 25–69 years: | We should not make the mistakes the UK have made. The reality is that our population are sexually active early and our vaccination rates are low. We have young women developing micro invasive and early invasive cancers in the 20-25 year age group and if we catch them early we allow the option of fertility saving surgical options. |
| Referrals to colposcopy: | There is no reason a temporary increase in the numbers of women requiring colposcopy cannot be absorbed by the DHB's contracting some of their service to reputable private practice. I would be quite happy to see women who are HrHPV pos without cytology as it can easily be done at the time of colposcopy (and one knows it has been sampled correctly) and forms an integral part of the colposcopy assessment. |
| Screening equity: | There are many successful strategies already underway. Most women will be screened if they are accompanies by a culturally appropriate support person. Also if the screening is being offered by a sensitive female practitioner. |
| Self-sampling: | Good question. If we just offer self-sampling to women too frightened to have a speculum examination for various reasons how likely are they to agree to colposcopy after a positive result? The success of self-sampling would all depend on the knowledge of self-anatomy and the women we are trying to reach in this manner may have the least knowledge and potentially not take the sample correctly. Perhaps we should continue to put more effort into demystifying / removing fear regarding examination and sampling. |
| Invitation and recall to screening: | The biggest problem I see (which we already see in our area with so many Sth African immigrants) is the worried well being really concerned about extending to 5 yearly screening. I see many women who are used to annual (or even 6 monthly) screening in their home country and really struggle with the concept of 3 yearly. For our young kiwi born women we should invite them all on their 20th birthday (allowing them to decline of course if they are not sexually active) and of course continue to have all primary carers offering screening as we do currently. We will also need to run National TV campaigns explaining the changes and whanau/community centre meetings etc for rural women. |
| Cervical screening workforce: | A simple aid such as the Mirena cardboard flip cards or the WHO 10 successful steps to breastfeeding which explains the research and rationale behind the screening and briefly how it is done would be great. |
| Do you have any other feedback? | Can I just emphasize - please leave the screening age at 20. This is New Zealand and we are small and looking after kiwi women. Please do not make the same mistakes UK have made resulting in huge adverse publicity and derision of the NHS cervical screening programme. We do not want our young women having their cancers diagnosed too late when they may require extended hysterectomy or even die of their disease vs a simple LLETZ or cone biopsy. They are small in numbers but incredibly important to our country. We are all "worth it". Thanks for the opportunity to provide feedback. |

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| In addition to the modelling work done to date, are there any other options that you believe the NCSP should investigate further? | No, the efficiency makes sense |
| What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway? |  |
| On the proposal to routinely screen women every five years: | I wish to express that current standard of recall makes no allowance for those whom are very low risk therefore I would welcome a graded testing criteria |
| On the potential change in age range for cervical screening from the current 20–69 years to 25–69 years: | Not of those with a low risk history |
| Referrals to colposcopy: |  |
| Screening equity: |  |
| Self-sampling: | The hard to reach are most likely to minimise the value of testing for HPV, but certainly self-testing for some groups might improve up take. |
| Invitation and recall to screening: | GP's through PHO support should be the main providers of the screening service |
| Cervical screening workforce: |  |
| Do you have any other feedback? | As a consumer I feel a high degree of resource has been used chasing false positives with more frequent testing and time and time again it resolves to a negative. I feel there needs to be better understanding of low risk women and those who are immunised via HPV vaccine. |

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| In addition to the modelling work done to date, are there any other options that you believe the NCSP should investigate further? |  |
| What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway? |  |
| On the proposal to routinely screen women every five years: | I would be a little concerned that because it's less often, it might drop off the radar for some people. It's harder to remember when the last test was done when it's so long along. There could be a tendency for people who move frequently to get lost in the system because they have moved. |
| On the potential change in age range for cervical screening from the current 20–69 years to 25–69 years: |  |
| Referrals to colposcopy: | The main thing is that you have to be prepared and have enough capacity in the workforce to deal with this. It would be really bad if the work quality dropped due to high workload and tests were done incorrectly. It would also be bad if there were huge delays, leading to high anxiety for the patient. Ensure that before you roll this out, you have the work capacity. (I am not a clinician but have had experience in this area and the negative impacts) |
| Screening equity: | Ensure you have enough screeners who can communicate with those groups of people who do not feature well in your statistics and engage service providers accordingly to reach the targets. Then you won't have to play catch up or worse still, fail in servicing those groups. |
| Self-sampling: | Perhaps people who have had issues in the past and people who are proactive about their health. At home is best but there needs to be good guidelines around hygiene and other things which could affect the quality of the sampling. If a person tested positive, I think the uptake for follow-up would be good but she should be asked by a clinician or nurse -- "I gave you the kit last week, how did it go? Did you find the lab we suggested?" Perhaps there should be a trial period of self-sampling at home and at a clinic so you can see what the uptake has been and the success of both methods. Then opt for the better one for the roll out. |
| Invitation and recall to screening: | I think you should use some sort of database so you can keep tabs on who has been screened etc. I think that the PHOs should invite and recall women. This has worked well for me in the past for breast screening. |
| Cervical screening workforce: |  |
| Do you have any other feedback? |  |

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| In addition to the modelling work done to date, are there any other options that you believe the NCSP should investigate further? |  |
| What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway? |  |
| On the proposal to routinely screen women every five years: | New HPV infection can occur at any stage, particularly among the unvaccinated population or by strains not vaccinated against. Furthermore, a small proportion of cervical cancer is not caused by HPV infection. For this reason, my view is that the screening interval should not be increased to five years. |
| On the potential change in age range for cervical screening from the current 20–69 years to 25–69 years: | New HPV infection can occur at any stage, particularly among the unvaccinated population or by strains not vaccinated against. Furthermore, a small proportion of cervical cancer is not caused by HPV infection. The consultation document states that 23 women aged 20 to 24 were diagnosed with cervical cancer between 2008 and 2013, but does not state how diagnosis would have occurred without cervical screening of this age group. In the face of these statistics, it appears that the only way that raising the age range could "reduce cervical cancer cases and mortality by 3-15%" (the conclusion of modelling cited in the consultation document) is if such cancer cases were never detected. For these reasons, my view is that the age range for cervical screening should not be changed from the current range of 20-69 years. |
| Referrals to colposcopy: |  |
| Screening equity: |  |
| Self-sampling: |  |
| Invitation and recall to screening: |  |
| Cervical screening workforce: |  |
| Do you have any other feedback? | I am concerned that the change in focus of cervical screening to a HPV test would not detect the small proportion of cervical cancers that are not caused by HPV infection. The proposal does not appear to propose a method of detection for such cancers. |

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| In addition to the modelling work done to date, are there any other options that you believe the NCSP should investigate further? | No I feel the preferred pathway is the one of greatest benefits both to the individual and society |
| What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway? |  |
| On the proposal to routinely screen women every five years: | Routinely screening every five years appears to be more sensible and more cost effective. NZ should look at other countries and the evidence in these countries when making a final decision. |
| On the potential change in age range for cervical screening from the current 20–69 years to 25–69 years: | Evidence seemed to indicate that the age range 25-69 is the most optimal. The only reason for an exit test I would imagine is if a positive smear result were found at age 69 |
| Referrals to colposcopy: | It would only be a temporary impact on services, it could be rolled out over a period of 1 - 2 years so as not to impact to greatly. I would imagine it is preferred to have a cytology result but may not be 100% necessary, but I do not work in a colposcopy department. |
| Screening equity: | I would suggest that the laboratories send out the result of the test directly to the patient (with a copy to the practice for records), rather than rely on surgeries to follow up on positive and negative tests. The patient should then be contacted directly by colposcopy, in cases of positive results, with a follow up appointment as required. This would reduce waiting times for the patient and avoid the risk of results being missed by the surgeries. This may help to eliminate inequalities in screening |
| Self-sampling: | I think self-sampling should be properly tested before thinking about using this as a screening tool. I would imagine that there would be many inadequate samples using this method. Would the woman obtain enough cells, would she not bother to send the sample off. Where is the safeguard in obtaining a result. |
| Invitation and recall to screening: | I believe that a national register should be in place and that this should be used to invite women in for screening. The register should hold each individuals past results and this should be available on computer for a clinician to access with correct login and password security. Surgeries should also be responsible as I can see that the national register may become out of date with addresses, although a surgery could advise the national register each time it enrols a women of cervical screening age onto its practice register to ensure that addresses are up to date. |
| Cervical screening workforce: | As a smear taker, I would need the evidence that HPV testing is the best way forward to ensure screening of this type is adequate. My understanding is that the evidence is out there and this is the reason for now thinking that HPV testing is the way forward and most cost effective |
| Do you have any other feedback? | With new evidence based practice and need to cut costs in the health service, I feel that the way forward is to reduce the number of cervical smears a woman needs in a lifetime without increasing the number of cases of cervical cancer. |

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| In addition to the modelling work done to date, are there any other options that you believe the NCSP should investigate further? | The time to result will be less for HPV screening, when compared with current screening. This will reduce the waiting time for patients, for which some may be anxious for a result. |
| What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway? |  |
| On the proposal to routinely screen women every five years: | Screening every 5 years will undoubtedly make some patients and HCP nervous, however with the increased sensitivity of PCR screening for HPV when compared to traditional pap smears will need to be well communicated. Most women would not object to the physical process of an exam being less frequent. |
| On the potential change in age range for cervical screening from the current 20–69 years to 25–69 years: | In many cases, screening from 20-69 years is appropriate. However, in this day and age, where young women are becoming sexually active at a much younger age, moving the screening to 25 years as a minimum could mean 10+ years since sexual debut. Perhaps the screening age for vaccinated women could start at 25, but for unvaccinated women, screening should start at 20 years? |
| Referrals to colposcopy: |  |
| Screening equity: | The proposal to allow self-collected specimens may help in getting screening in to populations that are reluctant to undergo an exam |
| Self-sampling: | Self-sampling should be offered to those women who refuse an exam, however a disclaimer will need to be made. Other observations made during an exam could point to other issues, e.g. infections etc. Either sampling at home or at clinic are acceptable, some women may feel uncomfortable doing the test in clinic. However it would be better for these to be collected in clinic to make sure specimen integrity etc. is maintained. There will always be patients that do not return for follow up testing, for a variety of reasons. The rate will likely stay the same as follow up testing now. There is a possibility that self-sampling will not be adhered to properly, as long as the HPV test also tests for specimen quality (e.g. human Betaglobin gene detection) also, false negatives will be avoided. |
| Invitation and recall to screening: |  |
| Cervical screening workforce: |  |
| Do you have any other feedback? |  |

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| **8** | Submitter name | [redacted] |
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| In addition to the modelling work done to date, are there any other options that you believe the NCSP should investigate further? |  |
| What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway? | I think you would need a screening test that is clinically validated and has a very high positive predictive value and sensitivity, as you would not want people worrying unnecessarily from false positives neither would you like comfort in false negatives and then wait another 5 years to find actually the disease started a while back. In this space there are not many clinically validated diagnostic tests and as a medical lab scientist, I am only aware of the Roche Cobas HPV test as the only validated test so far. You can read about it in this publication; Primary cervical cancer screening with human papillomavirus: End of study results from the ATHENA study using HPV as the first-line screening test (Gynecologic Oncology 136 (2015) 189–197). |
| On the proposal to routinely screen women every five years: | I think 5 years is appropriate, however, depending on the test selected, you may want people with results in the indeterminate range to have a repeat sooner. This can be avoided by selecting the best test with the highest sensitive and negative / positive predictive values. |
| On the potential change in age range for cervical screening from the current 20–69 years to 25–69 years: | 20 - 69 years better and after 69 years perhaps if someone has had no signs of change in results in many previous tests there may be no need but have the option if someone showed a low grade change in results even still within the negative range, then repeat at 74. |
| Referrals to colposcopy: | That's why you need the best test so that other services aren't impacted eg false positives from tests that have not been validated would unnecessarily overload the clinicians. It's important to have a high level of confidence in the test selected. |
| Screening equity: |  |
| Self-sampling: | I think self-sampling should be offered to everyone who can to encourage uptake. At home sounds good as it removes the inconvenience of going to a clinic which might discourage some people. Positive tests - it's important to have no false alarms as it might mean if someone test themselves in the evening they may have an anxious sleepless night worrying and Googling - a validated test is what you need to ensure at least the worry will be justified. Anything not clinically validated is not good. Self-sampling will need emphasis on the importance of good sample quality to avoid false negatives. |
| Invitation and recall to screening: |  |
| Cervical screening workforce: |  |
| Do you have any other feedback? |  |

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| **9** | Submitter name | V Maiava |
| Submitter organisation | Turuki Health Care |

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| In addition to the modelling work done to date, are there any other options that you believe the NCSP should investigate further? |  |
| What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway? |  |
| On the proposal to routinely screen women every five years: | We have a very successful screening service and would want it to be maintained. As long as the research shows that this is an adequate time frame then we should utilize it. However it is difficult to get women in every 3 years and extending it by another two years is a concern. Keeping track with patients could become more difficult as many of our patients are transient and we are left with no forwarding addresses. |
| On the potential change in age range for cervical screening from the current 20–69 years to 25–69 years: | I believe the change in age range may be to the advantage as many of our 20 - 24 yr old patients come back with abnormalities which when referred are not and then these are added to their risk factor. |
| Referrals to colposcopy: | It is important that Colposcopy clinics are able to manage any increase and that the DHB's would support this by providing funding to cover this. It is very important that we receive any cytology results as our women need to feel safe that all care needed has been provided. We have had to re-refer patients as referrals have not been received or actioned and having NCSP contact us to check is a good back up service. |
| Screening equity: | This is a hard area due to the cultural and personal views of women. Declines by patient's are also a concern as when do you recall would you want to wait another 5 yrs before recalling? Awareness for screening has increased but meeting the targeted population of women who do not attend clinics continues. Providing a free service does not automatically take away the barriers for women to attend clinics either. Maybe an awareness needs to start at school and be part of the health education that is delivered. An awareness of HPV also needs to be increased and an understanding of how it works regarding cervical cancer. Male awareness of HPV also needs to be highlighted at a younger age as this could be where change may happen. |
| Self-sampling: | This service should be available to all women the obvious problem is women who do not seek help if the test comes back positive if completed at home. Currently we have women who do not attend colposcopy although they have been given the news that they have to so I do not think this will change much. What it will do is make more women aware of their status which currently they do not have. Those who are/will be pro-active will always look after their health. Too many women currently present late for treatment already. |
| Invitation and recall to screening: | I believe the NCSP needs to have more authority regarding recalls for women. Breast screening is completed at various locations but has the responsibility of contacting all women who are due to be re-examined. Could NCSP not have authority to do the same? That notification be sent to the women's home address as well as the smear takers/clinic recall and this may have a bigger response. |
| Cervical screening workforce: | As a smear taker we need to be well informed of the information regarding HPV we would need to be updated on testing and what the requirements are and how to do it. We would need to attend training and then add this to our work as part of the normal routine moving forward. Having these training sessions in local areas at sensible times will also need to be looked at. I believe that updates are not considered an important part of the work whereas for immunization's nurses need to update every two years. Will this affect the cost of becoming a cervical smear taker also? |
| Do you have any other feedback? | As a cervical smear taker the responsibility is huge regarding continuity of care. Attempting to contact, recall and complete smears is time consuming and frustrating but also rewarding. Engaging with the current age group of 20 yr olds can be challenging as their knowledge is minimal. |

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| In addition to the modelling work done to date, are there any other options that you believe the NCSP should investigate further? |  |
| What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway? |  |
| On the proposal to routinely screen women every five years: | Immunosuppressed women? |
| On the potential change in age range for cervical screening from the current 20–69 years to 25–69 years: | By not screening those less than 25 there is a risk that the small number of micro invasive cancers in this group will be larger when screened at 25 and larger treatments that may affect fertility and result in poorer outcomes could result. Are there recognisable factors in these young woman that would enable women with certain risk factors to be screened earlier? |
| Referrals to colposcopy: |  |
| Screening equity: |  |
| Self-sampling: | Ideally anyone with abnormal bleeding or any vaginal symptoms should have their cervix looked at. I would hope self-screening could be done in consultation with a health professional to consider other sexual health issues. Cervical screening leads to opportunist STI screening particularly in younger age groups. |
| Invitation and recall to screening: | Current system of primary care workers recalling their patients with back up of NCSP works well. |
| Cervical screening workforce: |  |
| Do you have any other feedback? |  |

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| What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway? |  |
| On the proposal to routinely screen women every five years: |  |
| On the potential change in age range for cervical screening from the current 20–69 years to 25–69 years: | Given the progression rate for cervical cell changes and the increased rate of HPV immunisation in the younger population of women it seems reasonable to increase the age at which screening starts to 25. Exit test for screening between 69 -74 would be essential for those who have not had regular screening in the previous 10 years as there may have been new exposure to HPV with new sexual contacts. |
| Referrals to colposcopy: |  |
| Screening equity: | Cost is not the only barrier. There are cultural issues and embarrassment for women around exposing the most intimate part of their body to a stranger. I think the work around normalising smears in different cultural settings and having more female, culturally diverse smear takers is essential. |
| Self-sampling: | I think self-sampling should be processed through clinics. The sample may be taken at home but the provision of the sampling kit or the receiving of the sample should be at a clinic so that a health professional can explain the screening process and the implications and next steps for a positive vs negative result. |
| Invitation and recall to screening: | It is my belief that the personal approach of identifying women for screening because you are their chosen health care provider is always going to be more effective than a national organisation invitation or recall. As a practice nurse smear taker I have had an increase in uptake of smears when I have personalised recall letters with details such as when the last smear was, why the recall is 1year rather than 3. Mentioning why hrHPV testing is being done. What the expected recall timeframe will be following their next result. |
| Cervical screening workforce: | I am a smear taker: I would like a clear explanation that I can pass on to patients of how this new screening test is better. How it is different. Good posters and pamphlets to refer to and give out. |
| Do you have any other feedback? | I think most women will welcome the longer gap of 5 years between tests. |

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| **12** | Submitter name | [redacted] |
| Submitter organisation | Private |

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| RespondentID | 4262306710 |
| Release of personal details? | I do not want my personal details to be released |
| Publication of personal details? | I do not want my personal details included in the published summary of submissions |
| Name: | [redacted] |
| Organisation (or Private): | Private |
| Address/ email: | [redacted] |
| In addition to the modelling work done to date, are there any other options that you believe the NCSP should investigate further? | I am in support of the proposed pathway. There is no doubt that HPV should be the primary test followed by cytology. The clinical evidence is overwhelming. |
| What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway? | All HPV tests are not created equal and I strongly encourage the NCSP to endorse tests that have been tested in primary screening populations in large clinical trials. |
| On the proposal to routinely screen women every five years: | I am supportive of a 5 year recall after a negative HPV test. |
| On the potential change in age range for cervical screening from the current 20–69 years to 25–69 years: | I do think there needs to be close consideration on starting age, I feel 20 may still be appropriate given the young age of sexual maturity in NZ. I am also supportive of extending the program to an exit age of 74. |
| Referrals to colposcopy: |  |
| Screening equity: |  |
| Self-sampling: | Self-sampling should be offered to groups with cultural objections to an invasive sampling to address inequalities in some groups. Also to women with disabilities that can make getting on a table difficult. I feel a clinic visit would still be preferred so that education can be given at the same time and to make sure they understand the next steps if the test is positive. There is a danger that the population self-sampling would be lost to follow up, especially if the test was done at home and they have not interacted at all with a health practitioner. Self-sampling is not yet clinical validated in a large international trial. This may change by 2018, but the same criteria used to pick the HPV tests endorsed should also be met by a self-sampling product. |
| Invitation and recall to screening: | I believe HPV vaccination status, doses received etc should be integrated into the cervical screening programme register. In general I think the GP is the right person to invite a woman to be screened, but I understand that this may lead to inequalities in groups of women less likely to go to a doctor regularly. Therefore there may need to be a hybrid approach, or invitations direct to women from the NCSP and a reminder notice sent to GP practice. Therefore there may be cases where women get a letter from the NCSP and a GP. But 2 reminders isn't really a bad thing. |
| Cervical screening workforce: | Movement to high volume HPV testing at limited sites does not require any significant further training in the laboratories, depending on the test method endorsed. In fact greater efficiency will be seen versus current testing in small batches across many sites. |
| Do you have any other feedback? | A fantastic next step for the NCSP and a great advancement for women. Thank you. |

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| **13** | Submitter name | [redacted] |
| Submitter organisation | Private |

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| RespondentID | 4262687364 |
| Release of personal details? | I do not want my personal details to be released |
| Publication of personal details? | I do not want my personal details included in the published summary of submissions |
| Name: | [redacted] |
| Organisation (or Private): | Private |
| Address/ email: | [redacted] |
| In addition to the modelling work done to date, are there any other options that you believe the NCSP should investigate further? | I feel that the options for primary screening are good but the timeframe is very long - other countries are introducing this much earlier. |
| What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway? | They should consider the reasons why the Netherlands have elected to go with the Roche Cobas HPV assay and not others. There is a clear advantage for this to be solely the only assay used! |
| On the proposal to routinely screen women every five years: |  |
| On the potential change in age range for cervical screening from the current 20–69 years to 25–69 years: | 25 - 69 but also an exit test too. |
| Referrals to colposcopy: |  |
| Screening equity: |  |
| Self-sampling: |  |
| Invitation and recall to screening: |  |
| Cervical screening workforce: |  |
| Do you have any other feedback? | The Roche Cobas HPV test is the only assay that should be funded and approved. The Netherlands have already gone with this assay as the only one for their country. |

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| **14** | Submitter name | [redacted] |
| Submitter organisation |  |

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| RespondentID | 4266002307 | |
| Release of personal details? | I do not want my personal details to be released | |
| Publication of personal details? | I do not want my personal details included in the published summary of submissions | |
| Name: | [redacted] | |
| Organisation (or Private): |  | |
| Address/ email: | [redacted] | |
| In addition to the modelling work done to date, are there any other options that you believe the NCSP should investigate further? | |  |
| What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway? | Sensitivity of HPV testing on self-sampled specimens. I am concerned about the lesser sensitivity of the HPV test on self-sampled specimens. I cannot see in the consultation document clearly presented data about the comparative sensitivity of HPV testing on self-sampled specimens compared to HPV testing on samples taken by a trained smear taker. | |
| On the proposal to routinely screen women every five years: | 5 years is too long an interval between tests, a high risk infection may be present between sampling, but not detected. Those who may have a higher risk would be immunocompromised women, unvaccinated women and those who have multiple sexual partners. | |
| On the potential change in age range for cervical screening from the current 20–69 years to 25–69 years: | First test at 25 years of age is too late, a woman could be at risk if exposed to high risk HPV, but at the time of her test, she has a negative result, as she has cleared the virus or it is laying dormant. Younger women are at a higher risk, especially those who are not vaccinated. I feel 20-69 years is a more realistic age range. | |
| Referrals to colposcopy: |  | |
| Screening equity: |  | |
| Self-sampling: | Self-sampling is suited to women in geographically isolated areas, who do not have easy access to medical practitioners and those who feel it is taboo to have their gynaecological area examined. I think follow up of these patients would be difficult due to the reasons mentioned above. The issues I see with self-sampling are the adequacy of the sample and the sensitivity of the HPV test on these samples. Also, there is the drawback that there is an absence of visualisation of the cervix by a trained professional. | |
| Invitation and recall to screening: | Recall should primarily come from the GP's | |
| Cervical screening workforce: | Maintaining a gynaecological workforce in the interim will be extremely difficult. Uncertainty will be rife. Cytology screeners will leave the workforce over the next couple of years. Many will feel the need to commence retraining in another field and not continue to work in cytology feeling they are unsure whether they will have a job or not in the future, as minimal numbers of screeners will be required once HPV testing commences, and knowing that cytology is a specialised skill and they will have to gain new skills to obtain another job. Keeping the current cytology workforce informed as much as possible, such as plans for future laboratory or laboratories, will ease uncertainty. Unease will be common as no one has any idea as to numbers of staff required in the future and where cytologists as individuals will fit in to this. Maintaining expertise would be achieved by workshops, training school and sharing of information between the small numbers of staff that will remain. | |
| Do you have any other feedback? | Cervical cytology screening has the ability to pick up other diseases, such as herpes, and other carcinomas, such as endometrial and ovarian, particularly when clinical indications are absent. I feel that insufficient time was given to making a submission on such a lengthy and important document. Ultimately, the outcome has to be the best one for the patient. | |

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| **15** | Submitter name | [redacted] |
| Submitter organisation | Private |

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| RespondentID | 4266731552 |
| Release of personal details? | I do not want my personal details to be released |
| Publication of personal details? | I do not want my personal details included in the published summary of submissions |
| Name: | [redacted] |
| Organisation (or Private): | Private |
| Address/ email: | [redacted] |
| In addition to the modelling work done to date, are there any other options that you believe the NCSP should investigate further? |  |
| What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway? |  |
| On the proposal to routinely screen women every five years: |  |
| On the potential change in age range for cervical screening from the current 20–69 years to 25–69 years: | Strongly agree that screening should remain at 20 - 69 years. Also agree that there should be an exist test for screening between the ages of 69 - 74 years. |
| Referrals to colposcopy: |  |
| Screening equity: |  |
| Self-sampling: | Agree that all women should undergo testing at a clinic only to ensure that the procedure is carried out correctly. |
| Invitation and recall to screening: |  |
| Cervical screening workforce: |  |
| Do you have any other feedback? | I strongly recommend that the Cobas® HPV test is considered for use in New Zealand because it is the only clinically validated, FDA-approved and CE-IVD marked assay for first-line, primary screening of cervical cancer. |

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| **16** | Submitter name | Beth Henderson |
| Submitter organisation | Well Women and Family Trust |

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| RespondentID | 4274600208 |
| Release of personal details? |  |
| Publication of personal details? |  |
| Name: | Beth Henderson |
| Organisation (or Private): | Well Women and Family Trust |
| Address/ email: | PO Box 41021 St Lukes/ bethhenderson@wons.org.nz |
| In addition to the modelling work done to date, are there any other options that you believe the NCSP should investigate further? | No |
| What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway? | No |
| On the proposal to routinely screen women every five years: | Any woman who changes partners or has a partner who isn't monogamous. |
| On the potential change in age range for cervical screening from the current 20–69 years to 25–69 years: | I am concerned for women who have become sexually active at a young age for example, survivors of child abuse. I don't think an exit test is necessary. |
| Referrals to colposcopy: | Unless more staff are employed at colposcopy, it will obviously have an impact of delaying women being seen. The best way to limit the impact is to employ more staff perhaps on short term contacts or putting some public work out to private gynae if they have any extra capacity which I doubt. |
| Screening equity: | More money put into providing mobile screening services like Well women and Family trust |
| Self-sampling: | Self-testing should be offered to women who live in remote areas. Women who haven't had a smear in over 10 years or never had a smear and are over 35 years. At any venue. I think if you look at what has happened overseas, then the take up will be good. The issues I see are that every woman will be saying that she wants one unless very strict criteria is in place and that is well publicised. There is always the risk of someone submitting a sample that isn't theirs. |
| Invitation and recall to screening: | That all screening history is transferred over. Getting the register on line please rather than having to phone in. Recall by text, letter or email directly from the register. |
| Cervical screening workforce: | New up to date booklets. I personally don't need anything as I teach this so I am well informed. I think primary health care will need education updates at their practices. Our company is in a good position to offer this in the Auckland region. |
| Do you have any other feedback? | It is fantastic that we are moving to HrHPV testing - it will pick up cell changes and cancers that were previously undetected. |

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| **17** | Submitter name | [redacted] |
| Submitter organisation | Private |

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| RespondentID | 4274788858 |
| Release of personal details? | I do not want my personal details to be released |
| Publication of personal details? | I do not want my personal details included in the published summary of submissions |
| Name: | [redacted] |
| Organisation (or Private): | Private |
| Address/ email: | [redacted] |
| In addition to the modelling work done to date, are there any other options that you believe the NCSP should investigate further? | Yes - there needs to be a focus and ring fenced budget to include adolescent males in the HPV vaccination. This cost "Up front" will show huge benefits in the future - herd immunity, health care costs related to treatment etc |
| What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway? | No comment |
| On the proposal to routinely screen women every five years: | Excellent - as the research provided suggests this is a safe interval, it would reduce the cost of resources used for recalls, screening episodes, lab tests etc and will have no greater adverse outcomes for the women. |
| On the potential change in age range for cervical screening from the current 20–69 years to 25–69 years: |  |
| Referrals to colposcopy: | Resources for colposcopy would have to be anticipated and filled - and this could be planned for in advance. It would be a 'bump' that will seem huge and be looked back on as worthwhile in the long term. |
| Screening equity: | This is very difficult to address - and needs to be looked at carefully and is something we deal with day to day within our work. Overall there needs to be a more responsive workforce - hours, cost, accessibility etc. The 'Ego' of who the patient belongs to needs to be removed - these women belong to NZ and they should be able to access FREE cervical smears on an almost 24/7 basis. Too many providers want women to fit their office hours - and then complain the women are not compliant..... |
| Self-sampling: | Any women who wish to do self-sampling - and have been given the opportunity to be shown (and for them to learn) the best technique to obtain the swab correctly with no repeats needed. Engagement with the service and Health Care Professional at the time of offering / supporting self-testing would impact on the uptake for colposcopy. |
| Invitation and recall to screening: | Making HPV 'Ordinary' - not a big nasty thing.... Too many people (especially from other, more conservative cultures) see intimate contact as shameful - and therefore younger generations won't speak up. Make HPV relevant to NZ society - Measles- we talk about!! - Pertussis - we talk about. HPV - just another vaccine preventable disease... :-) Start at those turning 25 - and engage them as they do not have preconceived ideas about screening - 1st time - no sweat. Then move through the age group year by year. Often women talk about when they are due for Mammogram and KNOW it starts at 45yrs and they should have the screening... make this testing the same - but start with the young and willing!! |
| Cervical screening workforce: | Smear takers: - just education on why, what and how and access to resources to support our practice Innovative ways of delivery service - across NZ - to meet needs. |
| Do you have any other feedback? | Please please please ... get the funding for HPV vaccination for adolescent boys to be vaccinated on the National Schedule. This cost now will reduce far higher costs in screening / health care / awareness in the future. Don't always focus on the number of deaths per year from Cervical Cancer - it is the time between diagnosis and death that is important - loss of quality of life, advanced cancer that may spread / has spread, high (very high) health care costs in the last years or months of a woman's life - cost to individual, family, Government. Government costs can be looked at from: WINZ for Sickness Benefit, possible Benefit for other parent to take time off work to care for woman / children etc Hospital (interventions, surgery, Chemo, Radiotherapy, recovery, medications) community and Palliative Care for the women. Cancer Society for support of family, driving to appointments... So much to consider if you don't vaccinate the boys!!! |

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| **18** | Submitter name | Margaret Pittaway |
| Submitter organisation | Rural Women New Zealand |

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| RespondentID | 4274824511 |
| Release of personal details? |  |
| Publication of personal details? |  |
| Name: | Margaret Pittaway |
| Organisation (or Private): | Rural Women New Zealand |
| Address/ email: | margaret.pittaway@ruralwomen.org.nz |
| In addition to the modelling work done to date, are there any other options that you believe the NCSP should investigate further? | No |
| What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway? |  |
| On the proposal to routinely screen women every five years: | Given the research that has been done and the documentation provided, a five year time frame is reasonable. Shorter screening intervals may be advisable where patients have been referred for colposcopy and/or treatment for cancer, and for those women in the sex industry. |
| On the potential change in age range for cervical screening from the current 20–69 years to 25–69 years: | We feel that the screening age should still commence at age 20. An exit screening test between 69 and 74 is desirable. |
| Referrals to colposcopy: |  |
| Screening equity: |  |
| Self-sampling: | We see the main issue of self-sampling in the quality of the sample taken. |
| Invitation and recall to screening: | RWNZ is reassured that there is good uptake from the rural population for the cervical screening programme. We do however, have concerns for the migrant workforce and the fact that it appears that 75% of them have been victims of a scam to allow them entry into NZ. Wives/partners have possibly missed out on initial screening. We believe that the recall system should be administered by Medical Centres. Text messages, email and phone calls are all acceptable and a cheaper option than post, which can still be used if that is the only contact available. |
| Cervical screening workforce: |  |
| Do you have any other feedback? | No |

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| **19** | Submitter name | [redacted] |
| Submitter organisation | Private |

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| RespondentID | 4274827446 |
| Release of personal details? | I do not want my personal details to be released |
| Publication of personal details? | I do not want my personal details included in the published summary of submissions |
| Name: | [redacted] |
| Organisation (or Private): | Private |
| Address/ email: | [redacted] |
| In addition to the modelling work done to date, are there any other options that you believe the NCSP should investigate further? | I support the NZ government’s continued interest in improving the cervical cancer screening program as new studies come to light. This is best for NZ women and their families. Changing the primary laboratory test to hrHPV makes sense based on all the information presented in the technical appendix. |
| What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway? | Am nervous about any changes and why is the South Island looking at using an unproven and different test than North Island |
| On the proposal to routinely screen women every five years: | A 5 years screening interval would only be ok if the HPV test gives the correct result. The National Screening Unit needs to ensure that laboratories are held to a high standard in which HPV test they use otherwise women’s health is at risk. What standard will be set for laboratories for choosing the best HPV test? What assurance will the government give me that the HPV test result is correct and safe for me to return in 5 years? I hope that the National Screening Unit is taking this aspect of the program very seriously. Any history of cervical cancer more frequent. |
| On the potential change in age range for cervical screening from the current 20–69 years to 25–69 years: | If sexually active prior to 25 need to be tested. Why stop at 69? Need to keep going if can still be diagnosed in the 70's - people are living longer. |
| Referrals to colposcopy: |  |
| Screening equity: | How does NSU plan to ensure equity between North Island and South Island in terms of the quality of the HPV test being used? North Island is using the cobas HPV test which is the gold standard and women can be assured that they are getting the correct result. In comparison, the South Island is using the Abbott test which has little evidence to support its use as the first test. If the country switches to HPV testing then the NSU must assure the public that laboratories are doing their utmost to use the best proven test eg. FDA approval when used as the first test. Otherwise, the NSU must allow women the right to choose for themselves to get the best test rather than risk their future health because a lab has chosen to use a test that has not been proven to be safe or effective in NZ screening population. Please do not compromise women's health!! |
| Self-sampling: |  |
| Invitation and recall to screening: |  |
| Cervical screening workforce: |  |
| Do you have any other feedback? | If the Parliamentary review of the NCSP recommended that NZ give priority to recommendations to change over to primary HPV screening, why does it take so long to be implemented - 2018? There needs to be a process in place that women can get access to primary HPV testing earlier. |

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| **20** | Submitter name | [redacted] |
| Submitter organisation | [redacted] |

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| RespondentID | 4274840568 |
| Release of personal details? | I do not want my personal details to be released |
| Publication of personal details? |  |
| Name: | [redacted] |
| Organisation (or Private): | [redacted] |
| Address/ email: | [redacted] |
| In addition to the modelling work done to date, are there any other options that you believe the NCSP should investigate further? |  |
| What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway? |  |
| On the proposal to routinely screen women every five years: |  |
| On the potential change in age range for cervical screening from the current 20–69 years to 25–69 years: |  |
| Referrals to colposcopy: |  |
| Screening equity: |  |
| Self-sampling: |  |
| Invitation and recall to screening: |  |
| Cervical screening workforce: |  |
| Do you have any other feedback? | The process of accessing information on Cervical Smear testing history requires streamlining and should be seamless as the MOH is expecting PHOs to show how well they are performing when the NSU (an arm of MOH) already has that information. If PHOs are expected to accurately indicate stats / performances, they should have 'authorised' electronic real time access to the NSU's repository (as we do with Testsafe) where they can access any patients (NHI specific) smear test history. Leaving a foot print and security are acceptable. At present the process is tedious and consumes a lot of time and resources at both ends |

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| **21** | Submitter name | [redacted] |
| Submitter organisation | private |

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| RespondentID | 4274916215 |
| Release of personal details? |  |
| Publication of personal details? | I do not want my personal details included in the published summary of submissions |
| Name: | [redacted] |
| Organisation (or Private): | private |
| Address/ email: | [redacted] |
| In addition to the modelling work done to date, are there any other options that you believe the NCSP should investigate further? | As an experienced RN and mother of three kids now in their early twenties - I feel it is imperative that we follow best practice evidence (as demonstrated in Australia) and vaccinate both males and females against HPV. This must drastically reduce associated health care costs in the long term as HPV (and therefore cervical, oral and anal cancer) numbers decrease. In discussion with other parents and colleagues, it is apparent that many younger people falsely believe that they are protected from HPV by engaging in only oral /anal sexual activity. HPV vaccination to both adolescent boys and girls will improve our healthcare outcomes for all. Many conservative parents in our increasingly culturally diverse population contribute to this problem - by being in denial of the potential sexual activity of their kids. This further impacts on our healthcare costs as embarrassment/shame delays intervention. |
| What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway? |  |
| On the proposal to routinely screen women every five years: | great idea |
| On the potential change in age range for cervical screening from the current 20–69 years to 25–69 years: | great idea also |
| Referrals to colposcopy: |  |
| Screening equity: |  |
| Self-sampling: | Everyone - I have seen many patients in my work environment that are much happier if they can do self-swabs when appropriate |
| Invitation and recall to screening: |  |
| Cervical screening workforce: |  |
| Do you have any other feedback? | as above - we should follow the excellent example provided in Australia |

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| **22** | Submitter name | [redacted] |
| Submitter organisation | private |

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| RespondentID | 4275012623 |
| Release of personal details? | I do not want my personal details to be released |
| Publication of personal details? | I do not want my personal details included in the published summary of submissions |
| Name: | [redacted] |
| Organisation (or Private): | Private |
| Address/ email: | [redacted] |
| In addition to the modelling work done to date, are there any other options that you believe the NCSP should investigate further? |  |
| What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway? |  |
| On the proposal to routinely screen women every five years: | I would be concerned that other issues that might be picked up during a smear might be missed for longer eg stds and endometrial health. |
| On the potential change in age range for cervical screening from the current 20–69 years to 25–69 years: | My daughter who worked in a university clinic was astounded at the level of ignorance in terms of sexual health and their own physiology. The smear test “consultation" was a good opportunity to address some of those issues. She felt that younger age group, especially among Asian students was particularly at risk and it would therefore be disadvantageous to raise the smear age. |
| Referrals to colposcopy: |  |
| Screening equity: | I believe the South Island currently has a less rigorous screening regime than the North Island. If this is true, it is totally inequitable. |
| Self-sampling: | If sample quality can be guaranteed, I think this could potentially be useful to some groups, especially older women and rural women, provided adequate education surrounding the sampling taking and handling was available. Speaking only for myself, if I had a positive test I would be keen for follow up asap. |
| Invitation and recall to screening: |  |
| Cervical screening workforce: |  |
| Do you have any other feedback? |  |

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| **23** | Submitter name | Lorelle George |
| Submitter organisation | Comprehensive Care / Waitemata PHO |

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| RespondentID | 4275095548 | |
| Release of personal details? |  | |
| Publication of personal details? |  | |
| Name: | Lorelle George | |
| Organisation (or Private): | Comprehensive Care / Waitemata PHO | |
| Address/ email: | lgeorge@comprehensivecare.co.nz | |
| In addition to the modelling work done to date, are there any other options that you believe the NCSP should investigate further? | Appears thorough, and we have no further options to propose | |
| What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway? | |  |
| On the proposal to routinely screen women every five years: | \* The screening interval would seem to be advantageous for women, if all pertinent information, including those aspects covered in this consultation process, are taken into consideration. \* Groups of women to consider for prioritisation and a shorter screening interval: Maori, PI, previous high grade, some social demographic groups (eg prostitutes) | |
| On the potential change in age range for cervical screening from the current 20–69 years to 25–69 years: | \* In the short term, if screening is not recommended till 25, are we missing those young women who did not have an HPV vacc? \* Would prefer to keep age @ 20 years as captures early risk, and supports an holistic approach to positive sexual health behaviour \* Suggest an exit test for women 69-74 would be advantageous, with individual assessment by a clinician | |
| Referrals to colposcopy: | \* Requires national potential volume to model impact, plus feedback from current colposcopy services. \* Suggest prioritisation would assist in limiting impact: HG, Maori, PI, never screened, LG, other ethnic risk \* Cytology test - critical; together with consistent communications and integrated messaging to all health providers and for patients | |
| Screening equity: | Ensure as much congruence/alignment for women migrating from overseas Provide guidance for smear takers around process HPV vacc mop-up to increase coverage | |
| Self-sampling: | \* Agree with the thinking in this regard, as noted in the consultation document (p.14) \* Prioritisation and a clear process required - it's about access \* Ensure an ethical framework \* Suggest proof of concept process (6 months) - 2 cohorts (Maori/PI and general population) \* Check risk mitigation / margin of error \* Undertake independent evaluation \* Consider health literacy of patients and providers \* Insufficient information at this stage to comment on uptake, but believe women would be proactive in following up a positive result \* Propose a phased roll-out and stepped approach | |
| Invitation and recall to screening: | \* The interface between national, regional and primary care, and the frequency and reliability of data provided \* Continue with a blended approach with clinicians/providers primarily responsible, NCSP as back-up. | |
| Cervical screening workforce: | \* Update courses for smear takers - perhaps at change to HPV test, and then every 2 years \* Accessible presenters; PHOs tasked to enable this for Primary Care; and FPA and NGOs also enabled \* Volume dependent analysis of ramifications of changes may be required \* Effective communication package for providers/smear takers and patients | |
| Do you have any other feedback? | Overall good changes proposed Be cognisant of change process and uptake, acknowledging that it takes time | |

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| **24** | Submitter name | [redacted] |
| Submitter organisation | private |

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| RespondentID | 4275317867 |
| Release of personal details? | I do not want my personal details to be released |
| Publication of personal details? |  |
| Name: | [redacted] |
| Organisation (or Private): | Private |
| Address/ email: | [redacted] |
| In addition to the modelling work done to date, are there any other options that you believe the NCSP should investigate further? | Did the modelling work look at Pacific or Maori Screening pathways? The NSU need to really look or investigate further how the preferred pathway could benefit priority women (the ones who have the highest incidence and mortality rate in cervical cancer), the screening programme has been around for more than a decade now, surely any monitoring or audit reports should have something about Pacific and Maori. Small numbers is no longer a valid reason, we don't want to be quoting small numbers as barrier in twenty years time. |
| What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway? | The NCSP should look at questions such as “Will these proposed changes improve inequities in screening women for whom the burden of disease is greatest? If unknown then do some evidence gathering or research. The NCSP should look at what's happening in the South Pacific Island nations, saying there is no data or limited data is not a reason to not do anything, the Cook Islands, Niue and Tokelau are within the realm of NZ, ignoring those populations will have continue to have an impact on the NCSP in NZ, Does the NSU know how many women from these countries come here for treatment or screening tests. As a lay person I have no idea what documents the NCSP have considered or not considered. |
| On the proposal to routinely screen women every five years: | From a busy women's perspective five years interval is great - however what are the risks if any, for such a long break. Also, if a women is not immunised is it possible to be infected with the cancer causing HPV in the five years between screenings. I feel that these changes will benefit women who are immunised against HPV, so what about the older age groups the 40 to 70 year olds and the unimmunised????? |
| On the potential change in age range for cervical screening from the current 20–69 years to 25–69 years: | If boys and men are also immunised then I won't be worried about the change in the age range, so what I want to know is if a young women engages in sexual relationship at 14 or 15 and assuming she didn't finish the 3 courses or did not get immunised for one reason or another and she picked up HPV 16 or 18, it will be 10 years before she gets on to the programme, will serious cell changes have happened then??. Yes. |
| Referrals to colposcopy: | N/A |
| Screening equity: | See question 4. What are your suggested strategies for eliminating inequities? Given Maori and Pacific are a young population, our biggest population bulge is in the 15 - 25 year olds and in the next 10 years they will form the majority of the NCSP screening cohort, so what are some of the thinking the NSU have in regards to eliminating inequities. For Pacific ensuring that Pacific populations get Pacific workers to deliver the cervical screening messages in a way that will ensure they understand and are informed (increased health literacy) so they can make informed decisions - look at how BSA have worked with Pacific organisations, and women in making sure Pacific women are part of the solution. Increased health literacy plus effective service providers who are willing to work with Pacific women to make access to cervical screening less onerous can only lead to a respectful relationship that ensures Pacific women's screening rate increases. |
| Self-sampling: | There is a potential that HPV self-sampling will only be one step too many, if done at home then the women will need to post or take the sample to the clinic and then if she tests positive a smear test will have to be done anyway, that is two test plus posting or delivering the sample. If done at the clinic the posting or delivering of the sample is one step not needed plus if taken by a professional only one test is needed even if HPV positive. And some women especially older Pacific women (50-70 year olds may not feel comfortable with self-sampling. However giving the women a choice is a good thing, not sure it's about one test versus the other. The issue for Pacific women not having a smear is really a failure of the service providers in making sure the screening services they offer are accessible and appropriate for all women. |
| Invitation and recall to screening: | Having a register, (only accessed by the screening register and not shared by other government departments), that identifies 25-70 year olds and letter of invite, or incentivising GP services to send letters of invites out to eligible women to be screened. For Pacific face to face works best, but that strategy should be used after a letter of invite has been sent by the GP or PHO, and then followed up, however all that hard work can be lessened if Pacific are given all the information they need to make an informed choice, in a way that they can understand that information, and the best way is a face to face interaction in the most appropriate language and setting. |
| Cervical screening workforce: | N/A |
| Do you have any other feedback? | Thank you for the opportunity to feed into this process. Suggestion next time have separate questionnaire for health professionals and lay people. Hope to get some feedback, even if it's a summary of the submissions. Thanks |

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| **25** | Submitter name | Diane Van de Mark |
| Submitter organisation | Tairawhiti District Health (Gisborne Hospital) |

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| RespondentID | 4275333335 |
| Release of personal details? |  |
| Publication of personal details? |  |
| Name: | Diane Van de Mark |
| Organisation (or Private): | Tairawhiti District Health (Gisborne Hospital) |
| Address/ email: | diane.vandemark@tdh.org.nz |
| In addition to the modelling work done to date, are there any other options that you believe the NCSP should investigate further? | I support primary HPV screening and repeat every 5 years, but ONLY once we have a well vaccinated population. If we suddenly change to first screen at 25 without a "bridging" policy, there will be a small but significant number of unvaccinated women who will develop cervical cancer as a result. |
| What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway? |  |
| On the proposal to routinely screen women every five years: | In my experience HPV screening is not 100% reliable. Especially in women with a history of high grade lesions which have been treated, I think that screening every 5 years is not adequate. Perhaps a shorter screening interval for older women, especially if they have new partners. |
| On the potential change in age range for cervical screening from the current 20–69 years to 25–69 years: | In our population it is not unusual to have first sexual exposure in pre-teen years. Do we have experience in first screening at 25 for women in this category? They might well have had their transient HPV infections in the teen years, so a +HRHPV at age 20-25 might well mean a true high grade lesion from persistent virus. Definitely an exit test for screening between ages 69 and 74. |
| Referrals to colposcopy: | We would cope with an increase in referrals, just as we coped with the "tidal wave" of women who came to us after the Gisborne Investigation. Moderately important, but colposcopic mpresson and HR HPV test would suffice. |
| Screening equity: | We need a well thought-out publicity campaign to get much better "buy-in" for HPV vaccinations. Hopefully this would greatly improve the percentage of women vaccinated, and provide some herd immunity for the rest. High vaccination rates seem to me to be absolutely key. |
| Self-sampling: | We need to beware of giving the impression that self-sampling is as accurate as any other method ....it should not be thought of as an acceptable alternative for most women. We find it is difficult to get women to come for colposcopy even when they have a high-grade smear result....frequent DNAs. I think we would find the same with HPV tests. I would prefer immediate referral to colposcopy, otherwise a woman would have had 3 vaginal exams by the time a biopsy is done, rather than 2. Many women, particularly older women are not comfortable with their bodies...don't know how well the sample would be obtained. |
| Invitation and recall to screening: | Would need to have good communication between vaccination register and HPV results. Do we have to reinvent the wheel? Have women enter the programme the same way they do now - publicity, word of mouth, GP and screeners. Don't know how the current recall programme works but should be able to have a similar system. Would need to be sure that transient women are not lost to follow-up. |
| Cervical screening workforce: |  |
| Do you have any other feedback? | VACCINATE, VACCINATE, VACCINATE and transition into the new system gradually until vaccination rates are appropriately high. 80%? |

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| **26** | Submitter name | [redacted] |
| Submitter organisation | private |

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| RespondentID | 4277031247 |
| Release of personal details? | I do not want my personal details to be released |
| Publication of personal details? | I do not want my personal details included in the published summary of submissions |
| Name: | [redacted] |
| Organisation (or Private): | Private |
| Address/ email: | [redacted] |
| In addition to the modelling work done to date, are there any other options that you believe the NCSP should investigate further? | I believe the NCSP will have reviewed and chosen the most appropriate preferred pathway using the most accurate test available. The NCSP should firstly ensure that patient safety remains at the forefront of all decisions made. The NCSP could investigate all available options to ensure cancer and pre-cancer detection is increased over current standard practice. The NCSP could investigate criteria for inclusion of specific HPV tests. The cobas® HPV test is the only clinically validated, FDA-approved and CE-IVD marked assay for first-line, primary screening of cervical cancer. There is a risk of utilising any other test which may not meet certain standards. The NCSP could investigate NZ specific experience utilising HPV testing (such as the COMPASS study which utilises the cobas® HPV test); to help understand operational components. |
| What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway? | Please refer to the following studies: • Primary cervical cancer screening with human papillomavirus: end of study results from the ATHENA study using HPV as the first-line screening test. ATHENA (Addressing the Need for Advanced HPV Diagnostics), a prospective, multicenter US cervical cancer screening trial which was the basis for FDA approval of the cobas® HPV test in which over 47,000 women were enrolled http://www.ncbi.nlm.nih.gov/pubmed/25579108 • Primary screening for cervical cancer based on high-risk human papillomavirus (HPV) detection and HPV 16 and HPV 18 genotyping, in comparison to cytology - HEllenic Real life Multicentric cErvical Screening (HERMES) http://www.ncbi.nlm.nih.gov/pubmed/25793281 • The need to show prospective primary screening data for any test that enters the NZ market place - COMPASS trial information and findings; in which NZ specific information can be quantified https://www.anzctr.org.au/Trial/Registration/TrialReview.aspx?id=366577 • MSAC has provided recommendations on new approaches to cervical screening in Australia – these will be useful and relevant here in NZ www.cancerscreening.gov.au/internet/screening/publishing.nsf/Content/MSAC-recommendations • Guidelines for human papillomavirus DNA test requirements for primary cervical cancer screening in women of 30 years and older http://www.ncbi.nlm.nih.gov/pubmed/18973271 |
| On the proposal to routinely screen women every five years: | • 5-yearly screening appears to be less intrusive to women, whilst balancing benefits to HPV testing • It is important to ensure that patient benefit is not sacrificed for longer screening intervals (e.g. 3 vs. 5-years) • Determination of high risk groups can be stratified by reviewing the ATHENA data which shows age groups and varying levels of high-risk HPV. There also may be available data locally in NZ such as data from the COMPASS study. |
| On the potential change in age range for cervical screening from the current 20–69 years to 25–69 years: | • It would be helpful to know if there is any screening of younger women aged 20-24? There is a risk of missing some high-risk HPV that could lead to cancer. • I believe an exit test should be provided to ensure we pick up all HPV whilst ensuring overall success of the program – an option for older women could overcome the question. |
| Referrals to colposcopy: | • It is of the utmost importance that patient safety and care is at the forefront of all changes in health technology • It is essential that NZ staff are appropriately trained and managed accordingly • It is my understanding that the increase/decrease/neutrality of number of colposcopies has yet to be quantified and will be dependent on individual testing sites |
| Screening equity: | • Engagement in community activities to ensure awareness, training, and education are available in the lower screened/never screened populations (e.g. maori, pacific islanders, and Asian communities) |
| Self-sampling: | • Self-sampling should be reviewed by looking at feasibility studies first. The Australian iPAP study can provide helpful insights: http://www.biomedcentral.com/1471-2407/14/207 • Follow-up is essential and must include all relevant stakeholders to ensure success • Issues may include operational feasibility (e.g. courier/transport, samples not being returned, samples incorrectly taken, etc) |
| Invitation and recall to screening: | • The process must remain easy to use • Clear and succinct messaging • Engage advocacy groups, media, social media, and various outlets to increase reach • There are various stakeholders involved to invite and recall women into screening – GPs, nurses, smear takers, NCSP, NSU, MoH, community members, independent service providers, industry, patients, advocacy groups, and the general public. |
| Cervical screening workforce: | N/A |
| Do you have any other feedback? | • The NCSP and its partners should be very proud on progress to date to ensure NZ women are appropriately screened – it now has the opportunity to strengthen this progress even further • Can you please explain why we must wait until 2018 when other countries have already moved to HPV primary screening? How will women access the HPV testing primarily prior to implementation of the new screening program? • Only validated and approved HPV tests should be used in NZ. Strict inclusion/exclusion criteria should be included for tests as patients could be at risk if un-validated tests are utilised • Strong evidence for the FDA approved cobas® HPV test is available and should be strongly considered for primary screening • Input from patients and women is essential in ensuring the continued success of the cervical screening programme • All stages of cervical cancer must be taken into account: prevention via immunisation, screening via primary HPV screening, and treatment via various means • It would be great to understand the procurement process for HPV testing (sole supply, awarding labs individual tenders, etc). Also is the intent to have once test universally to ensure consistency? |

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| **27** | Submitter name | [redacted] |
| Submitter organisation | private |

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| RespondentID | 4277039456 |
| Release of personal details? | I do not want my personal details to be released |
| Publication of personal details? |  |
| Name: | [redacted] |
| Organisation (or Private): | Private |
| Address/ email: | [redacted] |
| In addition to the modelling work done to date, are there any other options that you believe the NCSP should investigate further? | Living in Auckland means that my smear currently is not looked at in Auckland, but is sent to Dunedin. I also understand that the HPV test used in Dunedin is of inferior quality compared to other assays available in NZ and is not FDA clinically validated for mass screening. I gather there is only one assay that meets this criteria. This ,makes my HPV assay result subject to doubt for accuracy |
| What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway? |  |
| On the proposal to routinely screen women every five years: | currently 3 years, but with the best high quality clinically validated PCR based assay this can be extended to 5 years |
| On the potential change in age range for cervical screening from the current 20–69 years to 25–69 years: |  |
| Referrals to colposcopy: |  |
| Screening equity: | The assay used must be clinically validated for purpose and FDA approved |
| Self-sampling: |  |
| Invitation and recall to screening: |  |
| Cervical screening workforce: |  |
| Do you have any other feedback? |  |

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| **28** | Submitter name | eun jung kim |
| Submitter organisation | SCL(Dunedin) |

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| RespondentID | 4277060724 |
| Release of personal details? |  |
| Publication of personal details? |  |
| Name: | eun jung kim |
| Organisation (or Private): | SCL(Dunedin) |
| Address/ email: | eunjungkaiser@gmail.com |
| In addition to the modelling work done to date, are there any other options that you believe the NCSP should investigate further? | The NSU critically underestimated cytology sensitivity in nz. The most progress in the quality of health care can be provided by combing successful current methods and supplementing them. Semi-automated LBC cytology is the only way successfully validated and an effectived the effectiveness of primary hpv testing while continuing providing critical safety net. |
| What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway? | For any variation that had not been considered such as; different population composition and high number of migrant female from country without vaccination program. Percentage of unvaccinated female due to reluctance (anti-vaccination), negligence (simply forgot or were forgotten) and vast of number of female still alive that had not been vaccinated. |
| On the proposal to routinely screen women every five years: | co-testing (current cytology and hpv testing) is possibly good or better option for every 5 years. |
| On the potential change in age range for cervical screening from the current 20–69 years to 25–69 years: | As a cytoscientist, my own experience has shown evidence that low grade and high grade changes are far more frequent and under 25. Then the current cytology allowed. |
| Referrals to colposcopy: |  |
| Screening equity: |  |
| Self-sampling: |  |
| Invitation and recall to screening: |  |
| Cervical screening workforce: |  |
| Do you have any other feedback? | Current cytology refers significance number of cases other than 16 or 18 hpv for further treatment. That would remain undetected: such as; cin3 high grade changes, atypical glandular cells favouring a neoplastic process with hpv testing not detected. In a future, these womens aren’t going to refer to colposcopy. How would you do? |

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| **29** | Submitter name | [redacted] |
| Submitter organisation | private |

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| RespondentID | 4277110274 |
| Release of personal details? | I do not want my personal details to be released |
| Publication of personal details? |  |
| Name: | [redacted] |
| Organisation (or Private): | Private |
| Address/ email: | [redacted] |
| In addition to the modelling work done to date, are there any other options that you believe the NCSP should investigate further? | I live in Wellington and given the changes to the laboratory testing in the region, have found out that my cervical screening test will be sent down to Dunedin for screening and HPV testing. The South Island uses an inferior HPV test compared to what was being used in Wellington, which is FDA approved. Is there any control over what test laboratories are using and how can I make sure that my sample is being tested with the cobas HPV test? What is NCSP doing to make sure that the HPV test result is correct? How is the NCSP ensuring that there will not be another Gisborne Inquiry because an inferior test is being used? |
| What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway? |  |
| On the proposal to routinely screen women every five years: | Changing the screening interval and age range for screening will only work if the test used to for this screening is sensitive enough. Women will need to be confident that less screening will not mean later detection |
| On the potential change in age range for cervical screening from the current 20–69 years to 25–69 years: |  |
| Referrals to colposcopy: |  |
| Screening equity: | I believe that HPV testing is the right decision to improve the NZ cervical screening program but there must be government oversight with the HPV test being used. Otherwise, allow women the right to choose for themselves to get the best test rather than risk their future health because a lab has chosen to use a test that has not been proven to be safe or effective in the NZ screening population. |
| Self-sampling: | Self-sampling should only be offered when an exam is refused. The exam is important for also identifying other types of infection e.g. STI, bacterial vaginosis, and candidiasis. If self-sampling is requested, it would be more beneficial to insist this be done at clinic to ensure testing is actually performed and that the sample makes it to the lab in a timely manner |
| Invitation and recall to screening: |  |
| Cervical screening workforce: | Testing volumes for the molecular tests will increase, sufficient training to run the assays will be required, but as the testing is largely hands-off and the results are definitive, on-going training will be relatively basic |
| Do you have any other feedback? |  |

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| **30** | Submitter name | [redacted] |
| Submitter organisation |  |

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| RespondentID | 4277134939 |
| Release of personal details? | I do not want my personal details to be released |
| Publication of personal details? | I do not want my personal details included in the published summary of submissions |
| Name: | [redacted] |
| Organisation (or Private): |  |
| Address/ email: | [redacted] |
| In addition to the modelling work done to date, are there any other options that you believe the NCSP should investigate further? | I believe that the option of co testing at a five yearly interval along with semi-automated screening is an option which should be considered more fully. Although vaccination numbers are increasing now there are still vast numbers of under 25 years old unvaccinated and virtually no one over the age of 25 is currently vaccinated. There is also the point that we do not really know how long the HPV vaccine lasts for, current opinion that I have found seem to suggest that it may only last for eight years. In implementing a programme basing itself on a vaccinated population with nothing in place to prepare for these other eventualities is in my opinion dangerous. Co-testing HPV test with cytology every five years is the only way that can guarantee screening performance to be as good or better than the current three yearly screening with LBC. |
| What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway? | The sensitivity of current cytology in NZ should not be underestimated, many studies used refer to overseas data in which the cytology processes and results are not the same as they are here. Many of these numbers come from countries using conventional cytology not LBC and countries where the cytology isn't done to such a high standard as we are used to here. I suggest that accurate figures for sensitivity of our cytology test should be used and also realise that the difference in sensitivity from LBC to HPV is probably only somewhere in the vicinity of 0.5% |
| On the proposal to routinely screen women every five years: | I think the move to a five yearly interval in a mostly unvaccinated population needs to be managed carefully. Co testing HPV with LBC at this five yearly interval is of particular benefit in a under screened population. The problem with moving to five years isn’t so much the five years gap but the people who put it off. If a person puts her smear off in a three year recall she normally reappears within five years, if the interval is already five years these people will likely return at seven, eight or nine years. |
| On the potential change in age range for cervical screening from the current 20–69 years to 25–69 years: | I think raising the start time for cervical screening is dangerous. Anecdotally there are increasing numbers of cancers occurring in women under 30 and in particular under 25. I think something needs to be looked at to protect these women, possibly cytologic screening of the 20 to 30 age group. I think the idea of an exit smear between the ages of 69 and 74 years is a good idea. This would stop a little old lady having a smear at 64 or 65 forgetting or putting it off for a bit then thinking "Oh I'm 70 now I don’t need smears anymore" and never coming back. An exit smear would catch lots of these women I think. |
| Referrals to colposcopy: |  |
| Screening equity: |  |
| Self-sampling: | I think self-testing in a mostly unvaccinated population is dangerous. While self-testing may be good in an area with very poor cytology, screening registers etc in an area with good cytology and registers I think it is a bad idea. |
| Invitation and recall to screening: |  |
| Cervical screening workforce: | This is a very big issue. Even if going down this route in its entirety cytology staff, screeners in particular, will still be required in even 20 years (although not in large numbers). We are training very few new graduates and with all this upheaval current staff are looking for other employment. Where are these future cytology scientists and technicians going to come from? Who is going to do this highly skilled job in the interim and stay around on the off chance that they will keep their jobs in the long term? You have a great resource of highly skilled cytology staff in New Zealand, be careful that you don't lose this resource. |
| Do you have any other feedback? |  |

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| **31** | Submitter name | [redacted] |
| Submitter organisation | [redacted] |

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| RespondentID | 4277219815 |
| Release of personal details? | I do not want my personal details to be released |
| Publication of personal details? | I do not want my personal details included in the published summary of submissions |
| Name: | [redacted] |
| Organisation (or Private): | [redacted] |
| Address/ email: | [redacted] |
| In addition to the modelling work done to date, are there any other options that you believe the NCSP should investigate further? | Investigation should definitely continue. In my opinion a pilot study using a data base of more than 500 NZ women should begin immediately. SLC Dunedin has a fairly substantial workload from a wide demography and should be considered in the pilot study. Also, semi-automated LBC is an effective test in a vaccinated environment. Prior studies has used a majority of conventional based smears but the use of LBC has shown to increase the sensitivity of cervical tests and also reduce workload. |
| What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway? |  |
| On the proposal to routinely screen women every five years: | In my experience with screening intervals, I have noticed that women leave testing to the very last minute and many overdue tests are also seen. With the 5 year proposal we would probably screen women as late as 6 to 10 years, increasing the risks of undetected pre-cancerous or cancerous lesions. With NZ's promiscuous young population, under 25 year old are seen increasingly to have HG lesions. Also the under screened population (namely Maori and Pacific Islanders) should be given consideration and should therefore have a shorter screening interval. |
| On the potential change in age range for cervical screening from the current 20–69 years to 25–69 years: | As I have mentioned above <25s should be tested due to the high HGSIL rates. A lot of gandular lesions eg. endometrial adencarcinomas in older women, test HPV negative. These women will therefore be lost in the system and not be managed appropriately. |
| Referrals to colposcopy: | Increased referrals to colp will not only affect timeliness of service delivery but also increase costs. Co-testing (LBC with HPV testing) will increase the sensitivity of the test giving the clinician a more informed picture to make a cost effective decision on patient management. |
| Screening equity: | Co-testing has a high sensitivity and negative predictive value (NPV) than HPV testing alone and should be should be considered the preferred route for routine testing. |
| Self-sampling: |  |
| Invitation and recall to screening: |  |
| Cervical screening workforce: | Co-testing will guarantee the existencing workforce will continue to have employment. No-one wants to go into a work sector that has an uncertain future and therefore young people entering tertiary institutes would not want to pursue a career in cytology. So in order to keep this profession 'alive' co-testing is the only option. |
| Do you have any other feedback? | There is no need for NZ to rush into this new screening pathway. We need to do specific research using NZ data as NZ has a unique population with unique challenges. If the initial groundwork is done properly eg. pilot studies using NZ data, we can go into this new venture with confidence that it will be for the better for all concerned. In my option, using semi-automated LBC in a vaccinated environment is the way to go. |

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| **32** | Submitter name | [redacted] |
| Submitter organisation |  |

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| RespondentID | 4277304088 |
| Release of personal details? | I do not want my personal details to be released |
| Publication of personal details? | I do not want my personal details included in the published summary of submissions |
| Name: | [redacted] |
| Organisation (or Private): |  |
| Address/ email: | [redacted] |
| In addition to the modelling work done to date, are there any other options that you believe the NCSP should investigate further? |  |
| What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway? |  |
| On the proposal to routinely screen women every five years: |  |
| On the potential change in age range for cervical screening from the current 20–69 years to 25–69 years: |  |
| Referrals to colposcopy: |  |
| Screening equity: |  |
| Self-sampling: |  |
| Invitation and recall to screening: |  |
| Cervical screening workforce: |  |
| Do you have any other feedback? | Correction to my previous mail; the last line should read: In my opinion, co-testing (LBC and HPV) using semi-automated LBC in a vaccinated environment is the way to go. |

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| **33** | Submitter name | [redacted] |
| Submitter organisation | Private |

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| RespondentID | 4277436996 |
| Release of personal details? | I do not want my personal details to be released |
| Publication of personal details? |  |
| Name: | [redacted] |
| Organisation (or Private): | Private |
| Address/ email: | [redacted] |
| In addition to the modelling work done to date, are there any other options that you believe the NCSP should investigate further? | It's great to live in a country with a working cervical screening program and one which appears to continually seek to improve it. As an individual I have read about cervical screening and how molecular testing is so much more sensitive, however it appears that even moving this way could be a failure if the incorrect laboratory test is used. As a women, I urge the NCSP to fully understand the implications of this decision. |
| What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway? | The ATHENA (Addressing the Need for Advanced HPV Diagnostics) study using HPV as the first line screening test, a prospective, multi center US cervical cancer screening trial where 47,000 women were enrolled. (Wright et al - Gynaecology Oncology 2015) Which high risk HPV assays fulfil criteria for use in primary cervical cancer screening? (Arbyn et al - 2015 Clinical Microbiology and Infection) MSAC has made available some recommendations on novel approached to cervical screening in Australia. www.cancerscreening.gov.au/internet/screening/publishing.nsf/content/MSAC-recommendation  The NZ COMPASS study, assessing the operational aspects of implementing HPV Testing as a first line screening method. https://www.anzctr.org.au/trial/registration) |
| On the proposal to routinely screen women every five years: | I would propose that since NZ has been using the PAP screening method which has very poor sensitivity, an initial period should be considered of testing every 3 years until such a time as the vaccinated generation is at a screening age. Women who have been screened with a poor sensitivity test should be allowed access to better care to ensure radiation of cervical cancer in NZ. |
| On the potential change in age range for cervical screening from the current 20–69 years to 25–69 years: | The information available reflects on HPV infections which are prevalent in women age 20 - 25 but the disease rate is low. As the period from infection to cervical cancer is assumed at 10 years, a screening age of 25 and older should be sufficient to capture most of the incident disease at a relatively early stage. Additionally with the vaccination program in the country, the disease rate will go down in the population. There are studies to suggest that women should be screened >65 yrs of age. (Foley G, Alston R, Geraci M, Brabin L, Kitchener H, Birch J (2011) |
| Referrals to colposcopy: | Perhaps initially there may be extra colposcopies required as the program will be using a much more sensitive test but this should not be a reason to delay. However if the program is due to start only in 2018, the country will also have a higher number of vaccinated population. |
| Screening equity: | The country needs to improve on targeted education programs and develop champions for population groups with low screening uptake or never screened. Self-sampling may be one approach but if education and mentoring is not in place this too will fail as observed in African countries. |
| Self-sampling: | Self-sampling should be offered to groups of people where there may be cultural barriers to testing. Should the education program not be effective, it is most likely that women will not follow-up. Most women would elect to self-sampling if asked, however trained sample collection will always be more effective and may end up in less repeat testing due to poor sampling from self-sampling. |
| Invitation and recall to screening: | The registry should be designed in a way that can accommodate any required changes over the next decade. |
| Cervical screening workforce: | No Comment |
| Do you have any other feedback? | New Zealand has done an outstanding of offering an effective screening program. Going forward, as a woman that relies on this healthcare system, I urge the NCSP to think of the following: - 2018 is too far to implement, especially when Australia is thinking of a screening program much earlier - ensure the program is set up with a flexible registry - ensure that testing is done with regulatory approvals (FDA) even though this is not required in NZ, why should the women in this country not have the best available? - an effective education program - consider who to partner with to ensure a successful transition of the program |

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| **34** | Submitter name | Dr Rachael van der Griend |
| Submitter organisation | Private |

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| RespondentID | 4277437009 |
| Release of personal details? |  |
| Publication of personal details? |  |
| Name: | Dr Rachael van der Griend |
| Organisation (or Private): | Private |
| Address/ email: | rachael.vandergriend@cdhb.health.nz |
| In addition to the modelling work done to date, are there any other options that you believe the NCSP should investigate further? | The greatest benefits will be achieved by screening all eligible women. NZ currently has some of the best results for cervical cytology screening, for women who participate. The big issue for NZ is the poor participation by Maori, Pacific and Asian women in cervical screening. There is no data presented in the consultation document that indicates that primary HPV screening will lead to increased participation in these under screened populations. A NZ pilot study should be done to address this. |
| What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway? | There is insufficient local knowledge of the natural history of HrHPV "other types" to know whether the proposed investigation/treatment pathway is safe. This is particularly common in older women. In Canterbury, of those women age 60 and older, who are HrHPV positive, more than 75% have "other" type. Many of these women have histologically proven high grade lesions. Consideration should be given to extended HPV genotyping rather than just 16/18 or "OTHER." |
| On the proposal to routinely screen women every five years: |  |
| On the potential change in age range for cervical screening from the current 20–69 years to 25–69 years: | I have grave reservations about not screening women in the 20 - 24 year age group, given that there is a high rate of histologically proven CIN 3 in this age group in New Zealand. |
| Referrals to colposcopy: |  |
| Screening equity: | Many populations in New Zealand are currently under screened, in particular Maori, Pacific Island and Asian communities. There is no data presented in the consultation document that indicates that primary HPV screening will lead to increased participation in these under screened populations. A NZ pilot study should be done to address this. |
| Self-sampling: | Self-sampling is a goal to aim for, and a major potential plus for this scheme - if it can be achieved with equivalent sensitivity, specificity and safety when compared to samples collected by health professionals. The consultation document does not provide any evidence as to how this may be achieved and is currently falsely raising expectations of being able to self-sample. |
| Invitation and recall to screening: |  |
| Cervical screening workforce: |  |
| Do you have any other feedback? | The consultation period of less than 4 weeks seems very rushed for such a major change in policy, particularly as the consultation document contains several errors of fact and omissions. For example: pg 11 of the Technical appendix, the current practice screening algorithm, boxes pertaining to HR HPV triage test are incorrect. pg 49 of the Technical appendix, Table 17: Sensitivity and specificity of LBC in detecting high-grade lesions does even include a category for HSIL The English, whose cervical screening program is most comparable to NZ’s, are running pilots of primary HPV testing, despite having the same UNSW modelling. Australia is also doing a pilot. NZ should too. |

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| **35** | Submitter name | [redacted] |
| Submitter organisation | [redacted] |

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| RespondentID | 4277467978 |
| Release of personal details? | I do not want my personal details to be released |
| Publication of personal details? | I do not want my personal details included in the published summary of submissions |
| Name: | [redacted] |
| Organisation (or Private): | [redacted] |
| Address/ email: |  |
| In addition to the modelling work done to date, are there any other options that you believe the NCSP should investigate further? |  |
| What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway? | I think a pilot study, in line with those being done overseas, is required to validate the predicted outcomes from the modelling work that has been undertaken. |
| On the proposal to routinely screen women every five years: |  |
| On the potential change in age range for cervical screening from the current 20–69 years to 25–69 years: | I do not recommend excluding women in to 20-24 year age group from cervical screening. This is because there were 515 histologically confirmed CIN3 lesions in this age group in 2012. |
| Referrals to colposcopy: |  |
| Screening equity: |  |
| Self-sampling: |  |
| Invitation and recall to screening: |  |
| Cervical screening workforce: |  |
| Do you have any other feedback? | The consultation period has been too short and given my workload this has made it difficult to give an adequate response. |

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| **36** | Submitter name | Linda Moir |
| Submitter organisation | Southern DHB Cervical Screening Programme Leader |

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| RespondentID | 4277605095 |
| Release of personal details? |  |
| Publication of personal details? |  |
| Name: | Linda Moir |
| Organisation (or Private): | Southern DHB Cervical Screening Programme Leader |
| Address/ email: | Linda.moir@southern.dhb |
| In addition to the modelling work done to date, are there any other options that you believe the NCSP should investigate further? | The current programme is working well. If the proposed changes are to occur offer boys the opportunity to have the Guardasil ( HPV Vaccine) This should be cost benefit or cost neutral related to savings from the screening frequency etc |
| What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway? | The document (released Oct 2015) Cervical Cancer deaths for 2012 to 2014 link. The concern is that there are still deaths in the 20 to 24 yr age which appear to be reducing, however perhaps wait until the death statistic figure is at zero for 6 years before changing from age 20 to 25. The other consideration is the age group 70 to 79 who have similar death rates as the 20 to 69 cohort. Link: http://www.health.govt.nz/publication/selected-cancers-2012-2013-2014 |
| On the proposal to routinely screen women every five years: | Consider: a staged approach to screening eg 1 year for 'n' years then one at 3yrs to progress to 5 years. plus consider changing the end age to 79 years for sexually active ladies review proposed frequency for any immuno-suppressed ladies for increased frequency plus those that smoke, |
| On the potential change in age range for cervical screening from the current 20–69 years to 25–69 years: | As above potential to include an exit test at 80 against current cervical death statistics. If a women has not been sexually active for the latent period of the 16 & 18 HPV should she still be screened. |
| Referrals to colposcopy: | Consider a one off national roving Colp resource available for the potential referral increases. To deal with the hump Review the Colp time frame criteria as this is a stressful time for women and produce quality KPIs for each services for those seen in the time frame against those deferred into a subsequent timeframe that is to be seen in one month but are then deferred to two months. Plus include follow ups. |
| Screening equity: | Equity of access and the subsequent inequalities to screening occur due to existing barriers which are complex. Remove/reduce barriers to increase uptake |
| Self-sampling: | Self-sampling should be offered at a clinic or at home to suit the women to ensure those with disabilities or knowledge deficits are supported the quality of self-sampling may be an issue, a trial pilot may help to understand and address errors |
| Invitation and recall to screening: | Re register redesign: Report capability at local level, read only access for Practices. Register to reflect laboratory findings with more detail and to include whether the lady has had the HPV vaccination Change the statement for those at 69yrs to reflect they are no longer part of the NSCP rather than none required. the current recall system works well, the gaps occur when the guidelines are not applied consistently |
| Cervical screening workforce: | Any changes and updates to be communicated via screening co-ordinators and on the NSCU web site |
| Do you have any other feedback? | Potentially interesting site to promote HPV Vaccinations: http://www.otago.ac.nz/news/news/otago121821.html Establish quality assurances/controls across the proposed service delivery changes Link activity to the existing MoH strategies for example cancer strategy |

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| **37** | Submitter name | [redacted] |
| Submitter organisation | Private |

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| RespondentID | 4277650324 |
| Release of personal details? | I do not want my personal details to be released |
| Publication of personal details? | I do not want my personal details included in the published summary of submissions |
| Name: | [redacted] |
| Organisation (or Private): | Private |
| Address/ email: | [redacted] |
| In addition to the modelling work done to date, are there any other options that you believe the NCSP should investigate further? | I think co-testing of semi-automated LBC and HrHPV as the primary screening test would provide a better alternative to the current LBC test alone. NZ laboratories have high sensitivity and specificity rates when compared to many other countries and this may have been under-estimated by the NCSP. HrHPV is more sensitive and picks up disease earlier but a number of people will be HrHPV positive and colposcopy negative. How are these people to be managed? Co-testing will eliminate the need for referring HrHPV positive but cytology negative women to colposcopy but will still identify the group that needs to be more closely monitored. This would decrease the need for over treatment of women with the associated costs, anxiety etc, and decrease the costs associated at this stage. If a specific specialist laboratory/laboratories were used it is possible that the current costs for both of these tests could be driven down lower than it currently is. |
| What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway? | The NCSP should conduct more research on the NZ population which is unique and not a subset of Australia. New Zealanders are sexually active at an earlier, have a secondary peak of HPV rates at a higher age and currently have an under vaccinated population. All of this needs to be studied and taken into consideration before implementing a test that relies on modelling data that uses many assumptions that are not necessarily relevant to the targeted population. Recently a study on euthanasia was conducted by people who had personal views that support voluntary euthanasia. They have been widely criticised in the media and from other interested groups as biased. The NCSP seems very determined to bring about primary HrHPV testing in a short timeframe and seem equally sure that no studies of the NZ population will add any information of value. Modelling work has been conducted using data from Australia and other studies from countries around the world have been sited as best practice. Is the NCSP's lack of interest in conducting research on the local population an example of a similar bias, in not wanting their views contradicted? |
| On the proposal to routinely screen women every five years: | A 5 year interval could possibly be safe for women who are engaged with the NCSP. However people who currently extend the interval to beyond 3 years could potentially become more apathetic and extend the interval to beyond 5 years if it were to be extended. It would be an issue for the NCSP to try and keep the public engaged in the screening programme. |
| On the potential change in age range for cervical screening from the current 20–69 years to 25–69 years: | High grade lesions and rarely cancers are being detected in the under 25 age group. The media tend to report on deaths of young people from such a preventable disease. While currently some people in this age bracket may be HrHPV positive as many are still unvaccinated, co-testing with LBC will eliminate the need for a lot of people to be sent for colposcopy, if they are cytology negative. The increase in cost of screening from the age of 20 could be offset by the decrease in the amount of referrals to colposcopy. |
| Referrals to colposcopy: |  |
| Screening equity: |  |
| Self-sampling: |  |
| Invitation and recall to screening: |  |
| Cervical screening workforce: | Once this process is confirmed cytoscientists and technicians will start to leave this filed and this body of knowledge will be lost. It is unrealistic to think that it will be possible to recruit from Australia or other countries that have already been through this process as few people will commit to the expense and effort of relocating to another country for a temporary job. Co-testing would ensure that the screening workforce will continue. |
| Do you have any other feedback? | The current system in NZ is working. Why does the change need to occur before proper studies of the local population can be carried out? There is no need for urgency because we have only one chance to get this right. If the process is flawed there can be no going back as we will lose a significant amount of knowledge and experience from this field. |

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| **38** | Submitter name | [redacted] |
| Submitter organisation | [redacted] |

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| RespondentID | 4277656461 |
| Release of personal details? | I do not want my personal details to be released |
| Publication of personal details? | I do not want my personal details included in the published summary of submissions |
| Name: | [redacted] |
| Organisation (or Private): | [redacted] |
| Address/ email: | [redacted] |
| In addition to the modelling work done to date, are there any other options that you believe the NCSP should investigate further? |  |
| What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway? |  |
| On the proposal to routinely screen women every five years: | Concern over women who are poor attenders. Missing one screen with a 5 year recall period may mean a 10 year or more gap. Too long. At risk patients eg, immune compromised, sexual abuse victims and unvaccinated population. |
| On the potential change in age range for cervical screening from the current 20–69 years to 25–69 years: | Age of first smear, missed opportunity for STI checks in under 25's. Early age of first intercourse/multiple partners would be better served by the present age range due to higher risk of HPV infection. Aging population, new sexual partners in middle and old age introducing new risk to unvaccinated age group. |
| Referrals to colposcopy: |  |
| Screening equity: |  |
| Self-sampling: |  |
| Invitation and recall to screening: | Regardless of changes to the programme more education is needed about Cervical Screening. Many teenagers are unaware of the importance and potentially lifesaving aspects of Cervical/HPV screening, education at secondary level is sorely needed. |
| Cervical screening workforce: | Communication. Please, open and timely channels for information. There are 50 plus very concerned, highly skilled practitioners in our Cytology laboratories who need prompt information on how the proposed changes will affect them. If this workforce is reduced in the near future, before HPV testing is implemented, it will become very difficult to provide an adequate service to patients. Non-Gynae screening needs to be included in the discussion, without screeners, the workload will fall to already overstretched Pathologists to pick up, without the expert knowledge of cytology staff. Lack of new staff, there is little reason for Med Lab Scientists to specialize in this discipline. |
| Do you have any other feedback? | Cytology picks up incidental findings frequently. These range from STI's and infections like Trichamonas and Actinomycese, to Ovarian and Uterine cancerous and pre-cancerous changes which are otherwise asymptomatic. This will be lost on introduction of HPV testing, possibly a dangerous path in an aging population. |

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| **39** | Submitter name | [redacted] |
| Submitter organisation | Individual / private |

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| RespondentID | 4277700353 |
| Release of personal details? | I do not want my personal details to be released |
| Publication of personal details? | I do not want my personal details included in the published summary of submissions |
| Name: | [redacted] |
| Organisation (or Private): | Individual / private |
| Address/ email: | [redacted] |
| In addition to the modelling work done to date, are there any other options that you believe the NCSP should investigate further? | Possibly investigating self-sampling |
| What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway? | Only approved tests should be used. In NZ diagnostics should have increased restrictions |
| On the proposal to routinely screen women every five years: | Please show the data of comparisons from 3 vs. 5 year routine screens. |
| On the potential change in age range for cervical screening from the current 20–69 years to 25–69 years: | Maximum age range would be assumed to be best for women in New Zealand. |
| Referrals to colposcopy: |  |
| Screening equity: | Ensure all women are offered screening. |
| Self-sampling: | Offer self-sampling to everyone. Increased inequalities could become evident if not. |
| Invitation and recall to screening: | Easy to use, mobile phone texts, emails, letters. |
| Cervical screening workforce: |  |
| Do you have any other feedback? | The best test must be chosen and should remain the same across New Zealand. I have heard Wellington testing has changed recently. There is no notification of such. Please explain what test will be used. |

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| **40** | Submitter name | [redacted] |
| Submitter organisation |  |

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| RespondentID | 4277768151 |
| Release of personal details? | I do not want my personal details to be released |
| Publication of personal details? |  |
| Name: | [redacted] |
| Organisation (or Private): |  |
| Address/ email: | [redacted] |
| In addition to the modelling work done to date, are there any other options that you believe the NCSP should investigate further? |  |
| What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway? |  |
| On the proposal to routinely screen women every five years: | My concern with increasing the screening interval to five years is that those women who at the moment only come in for screening every four or five years will extend that period out to eight or nine years, increasing the risk of developing a high grade lesion in the intervening years. |
| On the potential change in age range for cervical screening from the current 20–69 years to 25–69 years: | Young New Zealanders are sexually active earlier than anywhere else in the world, consequently having more sexual partners and an increased risk of exposure to HPV, our uptake of the vaccine is also very low. Data from overseas sources cannot be relevant, which makes the reliability of a screening model which begins at 25 questionable. The statistical validity of the study of 500 young women from an area in this country which has an unusually high vaccine uptake is also doubtful. I believe cervical screening of young women from 20 years, if not younger, is essential in picking up both precursor and malignant lesions in this age group. I do believe an exit test for the 69 to 74 age group would be appropriate to catch any women whose screening history has lapsed. |
| Referrals to colposcopy: |  |
| Screening equity: |  |
| Self-sampling: |  |
| Invitation and recall to screening: |  |
| Cervical screening workforce: | The cytoscientist and cytotechnician population is highly skilled but also very small. The perceived hurried and almost clandestine implementation of primary HPV testing has created uncertainty, and these skilled individuals are going to be lost to the industry. More open discussion is needed on exactly the chosen model is going to work and how this will effect staffing numbers, because once these people leave they won't come back and no one is being trained to take their place. |
| Do you have any other feedback? | I believe more studies need to be carried out in New Zealand and the data be collated on our unique population before any irreversible change is made to the way we screen women in this country. If history with reference to cervical screening has taught us anything, it is to err on the side of caution. I believe co-testing HPV with conventional cervical screening will be successful, but I think more time needs to be taken with investigation and implementation. |

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| **41** | Submitter name | [redacted] |
| Submitter organisation | Private |

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| RespondentID | 4277796328 |
| Release of personal details? | I do not want my personal details to be released |
| Publication of personal details? |  |
| Name: | [redacted] |
| Organisation (or Private): | PRIVATE |
| Address/ email: | [redacted] |
| In addition to the modelling work done to date, are there any other options that you believe the NCSP should investigate further? | NO |
| What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway? | UTUBE |
| On the proposal to routinely screen women every five years: | \* I DONT AGREE WITH THE PROPOSAL TO SCREEN EVERY FIVE YEARS. I THINK SMEARS ARE VERY IMPORTANT AND SHOULD STAY AT 20YRS OF AGE. |
| On the potential change in age range for cervical screening from the current 20–69 years to 25–69 years: | \*IF ANY CHANGE, THEN BE IT TO 18YRS IF SEXUALLY ACTIVE. THE YOUNGER GENERATION ARE HAVING SEX AT AN EARLY AGE. THEREFORE THEY SHOULD NOT BE LEFT TILL 25. AS NOT EVERYBODY SUPPORTS THE HPV VACCINE. |
| Referrals to colposcopy: |  |
| Screening equity: | JUST KEEP SCREENING AT 20 |
| Self-sampling: | ......OFFER TO EVERYBODY. ......AT HOME ......GOOD, BECAUSE AT LEAST WOMEN WAS CAUGHT AND WOMEN IS AWARE OF IT ......INSTRUCTIONS. IT WOULD BE GOOD TO EDUCATE HEALTH PROMOTERS/NURSES TO DEMONSTRATE ON HOW TO DO THIS |
| Invitation and recall to screening: | ANY ONE THAT WORKS FOR THE NCSP |
| Cervical screening workforce: | EMAIL & MEDIA |
| Do you have any other feedback? | \* AFTER RESEARCHING ON THE INTERNET ABOUT THE HPV VACCINE, I HAVE COME TO THE CONCLUSION THAT THE HPV VACCINE IS NOT 100% SAFE. WITH THAT I WOULD NOT RECOMMEND IT TO ANYBODY. I AM ALL FOR SMEAR TESTS AND THE SOONER A GIRL CAN HAVE A SMEAR THE BETTER. I DO NOT AGREE TO THE CHANGE AT ALL. AS THIS CHANGE IS OPENING A PATHWAY TO MORE HEALTH CHALLENGES AHEAD. |

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| **42** | Submitter name | [redacted] |
| Submitter organisation | Private |

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| RespondentID | 4277796817 |
| Release of personal details? | I do not want my personal details to be released |
| Publication of personal details? | I do not want my personal details included in the published summary of submissions |
| Name: | [redacted] |
| Organisation (or Private): | Private |
| Address/ email: | [redacted] |
| In addition to the modelling work done to date, are there any other options that you believe the NCSP should investigate further? | I support the preferred pathway |
| What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway? | Need to choose a primary screening test which published clinical outcome data. |
| On the proposal to routinely screen women every five years: | In favour |
| On the potential change in age range for cervical screening from the current 20–69 years to 25–69 years: | In favour of 25-69 age range with an exit test |
| Referrals to colposcopy: |  |
| Screening equity: |  |
| Self-sampling: |  |
| Invitation and recall to screening: |  |
| Cervical screening workforce: |  |
| Do you have any other feedback? |  |

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| **43** | Submitter name | [redacted] |
| Submitter organisation | [redacted] |

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| RespondentID | 4277830303 |
| Release of personal details? |  |
| Publication of personal details? | I do not want my personal details included in the published summary of submissions |
| Name: | [redacted] |
| Organisation (or Private): | [redacted] |
| Address/ email: | [redacted] |
| In addition to the modelling work done to date, are there any other options that you believe the NCSP should investigate further? | Co-testing of Cytology and HPV testing for the first smear and last smear. |
| What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway? | I think the NCSP should analyse the percentage of women who are late for their first smear. If this is high this should be taken into account when deciding what age to start screening. If there is a large number of people who are late for their first smear and we start screening at 25 this would really mean women are starting screening in their late 20's. They therefore could have contracted HPV over 10 years previously. |
| On the proposal to routinely screen women every five years: | -I think this is too risky as a woman could contract HPV the day after her last test and 5 years is long enough for this to develop into a high grade lesion. I think it would be safer to start with 3 yearly and then review sometime later if HPV primary screening is working safely and effectively then look at going out to 5 yearly screening. -Or keep 3 yearly for younger women and 5 yearly for older women with a normal history. |
| On the potential change in age range for cervical screening from the current 20–69 years to 25–69 years: | - I disagree with changing the start entry age to 25. I think this is dangerous as some women could have been sexually active for close to 10 years by this point without being tested. - I think it is easier to encourage women to join the screening programme at 20 when they are often still in a form of education and promotion can be targeted ie. Through student health, hall’s of residence or school health classes - I think it would be safer to stop screening earlier instead. You could finish at 65 if you have been normal for 10 years and have a final normal cytology and HrHPV test. |
| Referrals to colposcopy: |  |
| Screening equity: | - Have self-sampling devices for primary HPV. This would reduce cultural barriers and cost as women would not have to pay for an appointment with a Dr. |
| Self-sampling: | - Everyone should have the option. - At home for cultural and cost purposes then drop the sample directly at the laboratory. - Should be followed up with a cervical smear as this is less invasive than colposcopy. Also then if the cytology is normal a repeat HPV test could be done from the vial. - Issues I think could be writing clear easy to follow instructions and language barriers/interpretation of instructions. - Storage before and after use, - Clear labelling of sample |
| Invitation and recall to screening: | - It should auto reject any recall mismatches so the report doesn’t get realised to the Doctor until it has cleared the register. Therefore it will eliminate confusion and work for practices and laboratories. - Could be good if a women could log onto register to check when she will be next recalled. -It should be the screening programmes role to invite women and recall them for screening. On turning 20 women could receive a ‘Welcome package’ with a self-sampling device and information on the screening programme. After that they remain in the programme and get e-mailed or a text as a reminder. |
| Cervical screening workforce: | Cytoscientists: - Keep them well informed and updated of plans for future. Make it a priority to decide if you will have cytology triage and if you do will it be done by scientists or pathologists. You need to give scientists an idea of job prospects long term. - Ensure they have optimum health and safety set ups so they remain healthy. - pay them more than they would get in other Medical Laboratory roles (to help keep them in this speciality). - Add an incentive (eg. a bonus if they remain till HPV testing comes in), - Don't speak negatively of cytology and the work they currently do. Appreciate/acknowledge all the work and how effective it has been at reducing cervical cancer in NZ up till HPV testing. - Encourage study leave or distance education to up skill for the next stage in their lives. - Do not centralise further at this stage, as every time you do you risk losing staff. -When you move to HPV testing centralise cervical cytology so there are enough staff to collaborate on opinions and then do training and continuing education with Australia. - Have New Zealand staff do the ASC to ensure they are internationally qualified. |
| Do you have any other feedback? | I have a concern at how quickly this is being brought in. Although cervical screening has it’s flaws we know what those are and can manage them. We do not yet know all of the flaws for HrHPV primary screening and until we do we cannot fully manage them. The newest thing isn’t always the best. With the reduction in screening staff there will be no going back so it should not be rushed. |

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| **44** | Submitter name | [redacted] |
| Submitter organisation | Private |

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| RespondentID | 4277863133 |
| Release of personal details? | I do not want my personal details to be released |
| Publication of personal details? | I do not want my personal details included in the published summary of submissions |
| Name: | [redacted] |
| Organisation (or Private): | Private |
| Address/ email: | [redacted] |
| In addition to the modelling work done to date, are there any other options that you believe the NCSP should investigate further? | I agree with the government's decision to use HPV testing as the first test for cervical screening based on the information provided in the consultation document. HPV testing is the best standard for cervical screening and NZ needs to move in this direction. |
| What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway? |  |
| On the proposal to routinely screen women every five years: | I would prefer a longer screening interval but want assurance that the HPV test result is correct. There is not much information regarding the HPV test itself in the consultation documents and how laboratories choose which HPV test to use. Will the NCSP require FDA approval AND clinical studies so that I can be confident that 5 years is a safe screening interval? |
| On the potential change in age range for cervical screening from the current 20–69 years to 25–69 years: |  |
| Referrals to colposcopy: |  |
| Screening equity: | As a Pacific Islander, I appreciate that the NCSP is trying to increase screening participation in this group. Self-sampling may be one way of increasing participation but the quality of HPV test is also very important with regards to screening equity. How will the NCSP make sure that all New Zealand women have equal access to a high quality HPV test? |
| Self-sampling: | I would prefer to test myself at home. This would avoid cost and time needed to go to the doctor. The self-sampling would need to give the same results as a doctor collected sample. This should be proven in clinical studies. Self-sampling would be a good development for cervical screening and encourage more women to be tested. |
| Invitation and recall to screening: | A phone call reminder from my GPs office is effective. |
| Cervical screening workforce: |  |
| Do you have any other feedback? |  |

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| **45** | Submitter name | [redacted] |
| Submitter organisation | private |

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| RespondentID | 4277871478 |
| Release of personal details? | I do not want my personal details to be released |
| Publication of personal details? | I do not want my personal details included in the published summary of submissions |
| Name: | [redacted] |
| Organisation (or Private): | private |
| Address/ email: | [redacted] |
| In addition to the modelling work done to date, are there any other options that you believe the NCSP should investigate further? | The preferred pathway is only a model, and studies should be done to confirm this is a safe proposal for New Zealand women. This has seemed to be rushed and not enough time has been given to understand this countries unique differences. We have young women at high risk of HPV with early onset of sexual activity and multiple partners. Vaccination rates are not high enough yet proceed to primary HPV testing testing’s testing Hpv and LbC would be of particular benefit and should be studied. |
| What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway? |  |
| On the proposal to routinely screen women every five years: | It will be seen to be not as important. As now many women miss their 3 year screen, it is likely these will wait longer than 5 years also. Those starting sexual activity early and with multiple partners and unvaccinated are at high risk. |
| On the potential change in age range for cervical screening from the current 20–69 years to 25–69 years: | screening should continue 20-69 years. Cytology exist screening could also diagnose cancers of the endometrium in asymptomatic women as it does presently Continuing to screen under 25years is necessary presently due the high numbers of high grade lesions found. These numbers have risen in recent years and until vaccination rates rise these young women are at high risk of developing cervical cancer. A young woman could be HPV tested one day, next day contract an HPV infection and not be tested again for 5 years. |
| Referrals to colposcopy: |  |
| Screening equity: |  |
| Self-sampling: | Women should be tested in a clinic to ensure adequate sampling and identification. If a woman has a problem with having a smear, the same issue will most likely delay follow-up of a positive hpv test. |
| Invitation and recall to screening: | women go for contraception advice these primary healthcare workers should be the ones to invite and recall |
| Cervical screening workforce: | If primary HPV testing is adopted, nz will lose its experienced cytoscientists and cytotechnicians as they will seek employment elsewhere in other areas as positions become available .As few are presently being trained there are no new workers coming on. Co-testing would guarantee the existing workforce continues to have cytology employment. |
| Do you have any other feedback? | I am concerned about the efficacy of the vaccination .Before accepting HPV primary screening recent study on the length of protection needs to be evaluated carefully. As 12 year olds are immunised will they be still be immune @ 22, 32 etc? this pivotal research needs to be done before any changes to screening pathways .Rubella vaccination has shown not to have provided protection when many childbearing age women need it. HPV testing diagnoses the virus not a lesion or where it is, only cytology can do that. women with HPV positive and colp negative may have endocervical cancer which can be diagnosed by cytology. Co-testing 5 yearly is the only option that can guarantee screening performance as good or better than 3 yearly LBC. |

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| **46** | Submitter name | [redacted] |
| Submitter organisation |  |

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| --- | --- |
| RespondentID | 4279766527 |
| Release of personal details? | I do not want my personal details to be released |
| Publication of personal details? | I do not want my personal details included in the published summary of submissions |
| Name: | [redacted] |
| Organisation (or Private): |  |
| Address/ email: | [redacted] |
| In addition to the modelling work done to date, are there any other options that you believe the NCSP should investigate further? | Despite what they told us at the presentation last week, the information only went up on the website on the 29th September. And the feeling was with the presentation, that it was already decided. We're told its not a money saving exercise but that it will save money! |
| What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway? |  |
| On the proposal to routinely screen women every five years: | How well will the NCSP communicate the changes – we have enough difficulty getting the women to come every 3yrs for a smear. Then when they’re told its 5 yearly it won’t feel so important. especially as the screening program has been so successful. Women hear more via the media re breast screening and many feel that cervical changes are no longer a problem. What if they have a change in partner – very common now for a variety of reasons. If their new partner hasn't been immunised, especially as boys are not vaccinated in NZ. And most days in clinics we see women, who because of a smear being taken, have had vaginal and significant vulvar changes picked up. Yes the HPV typing appears to be very accurate, but there’s more to a women’s pelvis than just a cervix! For herd immunity to occur, we need the herd to be fully immunised! At the presentation we were told that its not necessary for boys to be immunised but Australia are doing so. Studies are now coming through showing that HPV is being found in head and neck, and anal cancers. |
| On the potential change in age range for cervical screening from the current 20–69 years to 25–69 years: | Sexual activity is not the prerogative of the young. Ask staff who work in rest homes and requirement villages! Women should continue to be screened until no longer sexually active. |
| Referrals to colposcopy: |  |
| Screening equity: |  |
| Self-sampling: | Self - sampling could take place provided the person doing so knows which orifice the swab needs to be put into. We tend to think the young are well informed but that its not necessarily so. Most women we see do not like touching "down there" unless they absolutely have to. Good education would need to be the key to making sure the self-sampling is done correctly. And at the same time good education as to the process for follow up if positive. |
| Invitation and recall to screening: | Smear takers |
| Cervical screening workforce: | Media email public meetings |
| Do you have any other feedback? | We were reassured at the presentation that good information was already disseminated amongst the health professionals. That took us by surprise! Whilst it has been up on the website since 29th September not all smear-takers have time at their workplace to troll through the computer for information that may or may not be there. If you have all health professionals well informed then the transition should be relatively smooth. But good, timely information will be key to acceptance. The time frame has been too short to make a decent submission. |

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| **46** | Submitter name | [redacted] |
| Submitter organisation |  |

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| **47** | Submitter name | Geoff Werkmeister |
| Submitter organisation | Southern Canterbury District Health Board |

From: Geoff Werkmeister

Date: 02/10/2015 08:53 a.m.

Subject: RE: NCSP Public Consultation: Changing the primary laboratory test for cervical screening

Dear Robyn

I think this is the system that should be adopted as long as pilot studies have shown it to be the most effective way of screening for Cervical Cancer.

Thanks

Dr Geoff Werkmeister

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| **48** | Submitter name | Barbara Robson |
| Submitter organisation | Federation of Women’s Health Councils |

Dear Robyn and Helen

I have had an opportunity to view the consultation document via the link provided on the NSU webpage, Primary HPV testing consultation. On behalf of the Federation of Women’s Health Councils (FWHC) I wish to raise a number of queries re the background information on the webpage/’frontpage’ and the consultation document itself.

**Background information provided on the webpage/front page**

We have no particular issues with the 2nd paragraph:

HPV testing to prevent cervical cancer is 60-70% more effective at detecting pre-cancerous lesions than cytology. It can also be performed less frequently: HPV testing may allow the screening interval to be extended from three to five years and improve coverage.

But we have problems with an aspect of the 3rd paragraph:

HPV testing is better at testing for cervical cancer in women ~~to~~ who (?) have been immunised against HPV. HPV immunisation was introduced in New Zealand in 2008 for women under 20 years of age. Internationally it is well recognised that a change from cytology screening to HPV screening will be needed as HPV immunisation rates continue to increase. In spite of immunisation, it is still important that women take part in cervical screening as vaccination does not offer complete protection, and not all women are vaccinated.

As written, the first sentence in para 3 suggests the HPV test is going to be used to test/screen for cervical cancer [in women who have been immunised against HPV]. This appears to contradict para 2 which indicates HPV testing is going to be used to prevent cervical cancer because it’s better at detecting pre-cancerous lesions. This apparent contradiction is potentially misleading and creates a level of confusion about what the test is for – to prevent cervical cancer by detecting pre-cancerous lesions [and treating them before they become cervical cancer] or to test for cervical cancer.

From reading pg 14 of the consultation document we note:

By detecting the virus, a health provider can identify women at **higher risk** of developing cervical cancer and can treat any pre-cancerous changes before they become cervical cancer.

Is this what is meant to be reflected in the first sentence of para 3?

The use of ‘immunisation’ and ‘vaccination’ interchangeably also creates some confusion as vaccination doesn’t always confer immunity, and vaccination using Gardasil will, at best, confer immunity to only 2 HPV types that cause cervical cancer. Is vaccine induced immunity to HPV types 16, 18 [significantly] different from naturally acquired immunity to these HPV types?

Should the 2nd sentence begin, HPV ~~immunisation~~ vaccination….?

While these queries may seem trivial at first glance, they are being raised because this information is on the ‘front page’. It is important that the correct information is provided at the outset and correct terminology is used consistently throughout the consultation document. We strongly recommend you revise the wording, at the very least, on the web-page.

**Consultation document**

Herd immunity pg 4

The document states there would need to be a vaccination coverage rate of around 75 -80% to achieve herd immunity. It is noted the overall vaccination coverage rate **for girls** is about 55%. To achieve herd immunity, wouldn’t the boys need to be vaccinated as well?

HPV Self-sampling

The question is asked if women would find self-sampling more acceptable yet you do not provide any information about what the self-sampling procedure actually involves.

Will you please provide some additional information about the procedure at the earliest opportunity so we can make a better informed response. This information should probably be available on the NSU website as well.

The Federation has also communicated with the Minister of Health’s office regarding the confusing/poorly worded media release that went out from his office about the change to the primary laboratory test for cervical screening. We were dismayed by the mis-statements it contained.

There is a responsibility for authoritative sources to ensure they consistently provide accurate information to the women of NZ about such important matters.

We look forward to your response.

Regards

Barbara Robson

Co-convenor

Federation of Women’s Health Councils

65 Fairview Avenue

Feilding

Ph: 06 323 8357

Hello Robyn. It is great to get a response from you. I have already noted the changes made to the **webpage**. Thank you.

**Re vaccination/immunisation**

Having re-read the Technical Document a bit more thoroughly I have particularly noted its use of ‘vaccinated cohort’ and ‘unvaccinated cohort’; and occasionally within the consultation document the terms ‘vaccinated women’ and ‘unvaccinated women’ are used. I guess these – vaccinated/unvaccinated -are my personal preference.

I have since taken a look at the HPV section in the MOH’s Immunisation Handbook – starts at pg 257 or thereabouts. I think there are a number of very well written sections that assist understanding and could be lifted out and used in this particular consultation.

These are some ‘bits’ that I found particularly helpful:

HPV infection, while essential for the development of cervical cancer, is not, by itself, sufficient. Other factors have been described that may be associated with HPV persistence and high grade lesions including smoking, early onset sexual activity, older age, contraceptive use, multiple sexual partners and genetic factors.3, 4

Most episodes of infection are eradicated within two years of acquisition; the average duration of infection is one year. Previous infection does not necessarily create long-term immune memory so does not prevent future re-infection with the same HPV type. At any one time, approximately 10 percent of women have at least one HPV infection. The HPV serotypes that cause more prolonged infection tend to be those that more frequently result in the development of histological abnormalities.10, 11

Immunisation with three doses of HPV4 vaccine (Gardasil) produces antibody responses against HPV16, HPV18, HPV6 and HPV11 in more than 99 percent of vaccine recipients. The height of the antibody titres following three doses of HPV vaccine is greater than that following clearance of natural infection.

**HPV self-sampling**

Thanks for providing the information. For further clarity, and pardon me for some really dumb questions:-

Could a woman do this test at home?

If yes, would she be sent a kit comprising x, y and z and a clear set of instructions? How would she return the swab to the laboratory – by post, or would she have to take it to a health centre or laboratory?

If a woman was to do the test at her health centre, would a nurse provide her with a kit, give the woman instructions and send her to a room/toilet where the woman could do the test in privacy? And the health centre sends the swab to the laboratory?

I know this probably seems unnecessary but I think if women have a clear understanding of what is involved with self-sampling, rather than leaving it up to uncertainty, imagination and speculation [if you will pardon the pun], we/they are better able to determine how acceptable it might/will be.

Thanks again for getting back to me.

Regards

Barbara Robson

Public consultation on implementation of HPV screening in NZ.

Thankyou for the opportunity for consultation

I agree with the large body of evidence that HPV screening with partial genotyping and cytology triage as per the Australian model represents a potential cost beneficial improvement in screening practice.

The results of implementation into a large currently successful cytology program are yet to be seen and I suggest there may be lessons to be learned from other screening programs that are undergoing this change and ongoing further research.

Modelling may overestimate the benefit and underestimate the cost of implementation. Specifically the sensitivity of cytology may be underestimated and the sensitivity of HPV screening outside a research environment may be overestimated. The major cause of screening failure is screening behavior and over servicing may have a major impact on cost, we are unsure how these factors will change. In addition failure of the screening pathway following detection of an abnormality is a significant contributor to failure of prevention. We have no information on how this may change.

With regard to younger women it is likely that a few of the thousands of women with CIN3 treated would have developed cancer if untreated, (we have seen such progressions in young women with screen detected abnormalities who have not had adequate treatment). Although data from the uk is reassuring it can be interpreted in different ways. In addition there is no evidence that women with early screen detected cancers would not have progressed. (Our as yet unpublished (but available on request) research suggests that growth of micro invasive tumours is close to exponential and there is no evidence of latency). Another consideration may be that the incidence of screen detected cervical cancer in maori women may be higher than for non maori women

It is likely therefore that deferring screening to the age of 25 is of personal risk to a small number of women. While small in number the occurrence of cancer even at an early stage has a major impact on womens lives and of course may be fatal. In the NZ environment occurrence of cancer in young women may be attributed to lack of screening which could result in significant adverse media attention.

The HPV vaccination holds great promise as an additional strategy in the prevention of cervical cancer and especially with the newer multivalent vaccines it may overtake screening as the most efficacious intervention. Currently vaccination rates in NZ are disappointing. The poor therapeutic ratio of screening as prevention of cancer in women under 30 is such that vaccination is a vastly superior strategy for prevention in young women.

The introduction of HPV screening is an ideal opportunity to emphasize the importance of this but requires an integrated vaccine and screening strategy and closer strategic and operational engagement within the ministry.

I suggest the greatest current priority is increase of vaccination rates. To minimize risk of adverse outcomes in some young women with and associated adverse publicity the following strategies should be considered.

1 a major hpv vaccination campaign with renewed catch up to the age of 25 followed by delayed introduction of HPV screening from age 25

2 a major hpv vaccination campaign alongside introduction of hpv screening from age 25 while still offering cytology screening for women under 25 for a fixed time period.

Regardless of the implementation strategy carful current and public monitoring of the NCSP is required including I would suggest prospective data collection from women with a new diagnosis of cancer.

Assc prof Peter Sykes

Dept obs and gynae

University of Otago Christchurch

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| **49** | Submitter name | Assoc Prof Peter Sykes |
| Submitter organisation | Private |

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| **50** | Submitter name | Bridgette Jackson |
| Submitter organisation | New Zealand Gynaecological Cancer Foundation |

# Submission form

**Top of Form**

#### Answer this question only if you are submitting as a private individual, and you do not want your personal details released or published

I do not want my personal details to be released

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**2.** Your contact details:

Name:

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| --- |
| Bridgette Jackson, General Manager |

Organisation (or Private):

|  |
| --- |
| New Zealand Gynaecological Cancer Foundation |

Address/ email:

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| Level 1/272 Parnell Road  Parnell 1151  bridgette@nzgcf.org.nz |

**3.** The modelling work done to date supports the preferred pathway as the one likely to achieve the greatest benefits. However, are there any other options that you believe the NCSP should investigate further?

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**4.** What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway?

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#### 5. Screening interval

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#### 6. Age range for screening

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#### 7. Referrals to colposcopy (for clinicians)

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**8.** Screening equity  
Please comment on suggested strategies for eliminating inequalities in screening.

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#### 9. Self-sampling

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#### 10. Invitation and recall to screening

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11. Cervical screening workforce

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**12.** Do you have any other feedback?

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| The New Zealand Gynaecological Cancer Foundation (“NZGCF”) fully supports the proposed changes to the National Cervical Screening Programme (NCSP). NZGCF concurs with the many advantages of the HPV test including the following:   * More sensitive test; * Allows for an increase in the time period between tests; * Can be self-collected by women; * HPV triaging; * More cost effective that existing programme. |

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| **51** | Submitter name | Clare Coles |
| Submitter organisation | Waikato District Health Board |

#### 1. Answer this question only if you are submitting as a private individual, and you do not want your personal details released or published

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**2.** Your contact details:

Name:

|  |
| --- |
| Clare Coles, Dr Narena Dudley and Dr Jane Morgan |

Organisation (or Private):

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| Waikato DHB |

Address/email:

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| Private Bag 3200  Hamilton 3240 |

**3.** The modelling work done to date supports the preferred pathway as the one likely to achieve the greatest benefits. However, are there any other options that you believe the NCSP should investigate further?

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| Using the principle of “first do no harm”, we suggest that a more cautious approach is taken to pilot the proposed model, prior to national roll-out of large-scale change. It is imperative that women remain confident in the NCSP.  We advocate a local pilot to test the impact of the proposed model for example selecting one DHB or region to implement the proposed changes first. This will help identify real or potential issues and mitigate any risk to changing the screening pathway, especially the proposed pathway for younger women and the resource impact on colposcopy.  We also suggest that the new model will have fewer associated-harms if introduced once a higher rate of HPV vaccination is achieved, noting there is about a 13 year delay between the age of vaccination and the commencement of HPV testing at age 25. Low vaccine uptake in NZ in the early years of the vaccine being available and hence, unlike Australia, no herd immunity effect for the initial vaccine cohort, means likely high HPV prevalence in the current 25-29 year old cohort. In contrast, Waikato DHB HPV vaccination coverage is estimated to be 65% this year. Changing to primary HPV testing from 2018 will likely result in a high rate of colposcopies among these younger women, given that HPV is an incredibly common infection in that age group, with the real possibility of greater harm from colposcopy +/- biopsy. Waiting until a greater percent of the cohort is vaccinated makes sense. We need to ensure we prevent harm and balance the potential gains of changing to HPV primary screening.  Cytology results currently assist colposcopy services to prioritise demand and risk-manage any waitlist. The proposed model omits cytology triage for HPV 16 and 18 and therefore there is a real risk that women may not be prioritised appropriately as it will be guesswork as to which women are at greatest risk. The high sensitivity and low specificity of the HPV test will result in a high number of colposcopy referrals without significant pathology if HPV primary screening is introduced too soon before the HPV vaccination programme has taken fuller effect. |

**4.** What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway?

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| The proposal does not demonstrate a strong evidence base in the NZ environment.  We are concerned about the model relying on high HPV test sensitivity with lower specificity. Most of our cancers in New Zealand are in the under screened population. The model test sensitivity assumptions favour HrHPV. The NZ Princes study data shows a HrHPV false negative rate of 10% for HSIL. Noting this 10% false negative rate, the issue of any reduction in screening coverage becomes very important as does any significant increase in the screening interval. The data included in the technical document supports the current reality that achieving adequate coverage means using five year screening interval data, not three years. There is a significant risk that promoting a 5-yearly screening interval will mean women are screened every 6-7 years in reality, and, contrary to the NSW/NCSP model, that HrHPV screening will not reduce cancer rates. Further, it must be considered if the end result could be more invasive cancer (because of false negative HPV tests) and this would disproportionately impact those most likely to be under screened, namely Māori and Pacific women.  If a pilot implementation is not proposed, then we strongly suggest an anonymous HrHPV prevalence study of, for example, several hundred LBCs already being collected from current 25-29 year olds to get a better idea of likely impacts on largely unvaccinated women and on colposcopy services before trying to implement the proposed change.  As mentioned already, we are surprised to learn that the NSU is considering HPV test direct to colposcopy for HPV 16/18 without triage for 25-29 year olds from as early as 2018, given the relatively low level of vaccine uptake for many in that cohort. Given HPV vaccination coverage may be around 65% this year, it will not be until around 2023 that coverage gets to a point that would mitigate colposcopy blow-out. Using the proposed model from 2018, we would expect potential HUGE increases in colposcopy for 25-29s. Has this issue really been fully costed into the model? And what impact would there be on women not getting a timely referral to colposcopy?  We suggest that women aged 20-30 should continue to have cervical smears using cytology.  We are concerned about the 20-24 year olds not being screened because the impact on delayed high-grade treatment for them has such consequences on their future fertility. The existing screening programme works for this age group and it is not entirely honest to tell them there is no risk in a delayed diagnosis. Even though the number of 20-24 year old women with significant disease is small, there is a significant impact for the individual due to delayed diagnosis which may change the treatment option from a cone biopsy to a hysterectomy in a young woman who likely has not yet had children. We advocate that a research study is undertaken to review the clinical histories of the young women aged 20-24 who have been diagnosed with cervical cancer in recent years to determine whether there are identifiable risk factors, signs or symptoms that could be promoted to smear takers and young women to ensure appropriate early diagnosis and treatment for the few that are affected. The volumes are small and therefore obtaining information from the smear takers should not prove difficult.  We also suggest that the model and ideas proposed need input from women sooner rather than later from an acceptability perspective. We believe there is risk to the unit that the proposed changes could be seen as cost-cutting, based on “best-guess” models (given no other country has yet implemented the proposed changes) and disadvantaging young women. |

#### 5. Screening interval

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| Current NCSP guidance recommends annual cytology for immunocompromised women, including women living with HIV/AIDS and those receiving immunosuppressive treatments for cancer or organ transplants or high-dose steroids. There is limited published data on primary HPV screening for such women or their optimal screening interval. These women will continue to require a shorter screening interval, until there is clear evidence to the contrary. |

#### 6. Age range for screening

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| If not screening 20-25 year olds, it will be important to have very clear statements for smear takers as to what diagnostic pathway to follow for any young woman with symptoms suggestive of cervical cancer (e.g. undertake HPV + cytology or refer for colposcopy) and also whether there are any exceptions to the age range of 25-69 years, for example should immunocompromised women be screened from a younger age?  A common question from smear takers as to earlier screening reflects often strong beliefs that teenagers with early sexual debut or childhood sexual abuse may be at greater risk. Increasing the age to 25 years for unvaccinated women is likely to raise a lot of concern for smear takers. As noted already, it would be helpful to have NZ-based data to give further insights around risk of young women and cervical cancer, in other words, as to whether women aged less than 25 years with a recent diagnosis of cervical cancer have any identifiable risk factors or predictors of disease (for example, strong family history, heavy smoker, immunosuppression, multiple parity, unvaccinated, childhood sexual abuse, etc.) that could inform if/when to make exceptions and screen early.  If an exit test is promoted, there needs to be clear guidance around management of elderly women with positive HrHPV. The current screening guidelines give little guidance around the management of women over the age of 69 with persistent LGSIL cytology. The expectation for management of women with persistent HrHPV would be helpful. |

#### 7. Referrals to colposcopy (for clinicians)

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| Waikato DHB currently struggles to consistently meet demand for colposcopy within the recommended timeframes. It would not be able to manage any increase in demand that this proposal would create without further resource.  If there was resource to train and fund, then nurse colposcopists could be an option to meet some of the shortfall in resource.  The best way to limit impact would be to delay this proposal until our vaccination rate is improved. The only other way to cope with increasing demand without extra resource is for the Ministry to accept longer wait times for women with presumed low risk of pathology; however this has the real risk of delaying treatment for women with high grade disease with low risk HPV subtypes.  As above, cytology results are critical for prioritising women at highest risk of cervical cancer and should be considered for all HPV types, at least until vaccine coverage is higher amongst the screened cohort. |

**8.** Screening equity

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| Waikato DHB advocates that HPV testing is free to all women. This approach was also supported in the previous Parliamentary review. We would like to see whether the reduction in age range and frequency (and cheaper screening test?) would make it viable to offer a free screening programme to all women.  In addition to exploring strategies such as free-to-user self-sampling for HrHPV testing, we strongly advocate that NZ urgently needs adequate HPV vaccination coverage to achieve herd immunity and hence protect virtually all women: this is the most effective way to reduce inequities in cervical cancer. |

#### 9. Self-sampling

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| If cytology is part of the pathway, then we do not believe self-sampling should be an option.  If cytology is not part of the pathway, we believe that a self-sampling programme for all women should be investigated further. It could be designed along the same lines of the bowel cancer screening pilot.  The issue of uptake for follow up for positive stool samples has generally not been an issue and colonoscopy could be considered a more invasive procedure than colposcopy.  Self-sampling could be an issue if only available under certain conditions or criteria. We believe the administration of a self-testing system could be confusing and difficult to manage if offered only to a sub-set of women. |

#### 10. Invitation and recall to screening

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| If the programme was based solely on self-testing, then we think this should be a centrally managed and administered programme, possibly alongside bowel cancer screening as the model should be similar.  We promote more consistency in how each screening programme is run; not making each one unique in its administration but instead a focus is made on making efficiencies across the administration of the screening programmes and communication to women. |

#### 11. Cervical screening workforce

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| The current flowcharts are complex and smear takers struggle to employ the correct pathways in terms of HPV testing management. Throughout the NSU has remained upper hand in its approach to managing this aspect of non-compliance. Any changes to the model need robust testing with the ‘average’ practice nurse smear taker (e.g. not a nurse practitioner, GP, person with a special interest, etc.) We advocate for at least one “average” smear taker to be on every working group associated with clinical pathways related to the NCSP / HPV testing programme.  The e-learning module on HPV would also need updating. |

**12.** Do you have any other feedback?

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| **52** | Submitter name | Barbara Holland |
| Submitter organisation | Federation of Women’s Health Councils Aotearoa Inc |

#### 1. Answer this question only if you are submitting as a private individual, and you do not want your personal details released or published

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**2.** Your contact details:

Name:

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| --- |
| Barbara Holland |

Organisation (or Private):

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| --- |
| Federation of Women’s Health Councils Aotearoa Inc |

Address/ email:

|  |
| --- |
| 17 Weenink Rd,  Karoro,  Greymouth 7805  [fedwhc@xtra.co.nz](mailto:fedwhc@xtra.co.nz) |

**3.** The modelling work done to date supports the preferred pathway as the one likely to achieve the greatest benefits. However, are there any other options that you believe the NCSP should investigate further?

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| FWHC supports using the best test available relevant to any screening programme.  While HPV testing alone is better than just a Pap test, there is evidence that co-testing is best.  We note: “...the detection of grade 3 cervical intraepithelial neoplasia (CIN), a positive Pap test is better than either a positive HPV test alone or positive co-tests (26.3% vs 25.6% vs 10.9%; P < .0001).  Also, "there are some cancers without underlying HPV, and not all types of HPV are included in the standard test."  Further, that “some patients may test HPV –ve because of a low viral load.”  Ref: **HPV Screening Alone May Miss Cervical Cancer. Medscape. Apr 22, 2015.**    We must repeat our long time concern, with particular note to the impact of under-screened populations (especially Maori), that morbidity and mortality rates would more likely be reduced even further overall by introducing free cervical screening. FWHC is aware of outrageous prices being charged for cervical smears in some General Practices which most certainly contributes to women’s choices to be screened less frequently or even not be screened at all. Choosing a ‘best practice test’ will do little to reduce health status inequalities arising from income inequality where cost is a barrier to any testing at all. |

**4.** What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway?

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| FWHC has multiple concerns about the impacts of the proposed changes, especially about messaging.   1. We note in the consultation document that cervical cancer is discussed within an international context rather than the NZ context where the impact of the very successful cervical screening programme means that cervical cancer, while still important, is not of epidemic proportions and doesn’t feature in the list of the top ten cancers for NZ women, either by incidence or mortality. 2. Information to women must explain that the primary HPV test is not specific, and it may miss some cancers. Just because a woman has tested –ve for hrHPV 16/18 doesn’t mean she won’t get cervical cancer. Although we support using the primary hrHPV test, we caution that this new test regime must not be ‘oversold’. 3. What will women who test positive for hrHPV16/18 and are then referred to colposcopy be told – that they are at high risk of cervical cancer; higher risk of cervical cancer; higher risk of pre-cancerous lesions? What might ‘high’ and ‘higher risk’ actually mean and how will these differences be explained? 4. We are pleased there is a proposed watchful wait and 12 month rescreen for women with +ve HPV tests (plus added cytology testing), there is also a risk of more active intervention from colposcopists occurring despite the evidence that many pre-cancerous lesions will never progress to cancer. 5. We do have concerns about the assumed reliance by women on the currently funded vaccine as providing sufficient protection against cervical cancer risk. The FDA approved Gardasil9 in Dec 2014 which includes HPV6, 11, 16, 18, 31, 33, 45, 52, & 58. When will NZ get this broader range vaccine? |

#### 5. Screening interval

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| FWHC supports the proposal to routinely screen every five years as there is good evidence that a negative hrHPV test indicates a much lower risk of abnormal cells developing within a further 5 yr time frame.  But women still need to be well informed that they should present to a doctor immediately if they experience symptoms of concern meantime, whether they have had the Gardasil vaccine or not.  Given that many young girls are sexually active at a very young age, and some have been sexually abused, they should not be turned away from seeking a cervical smear checkup simply because of their young age/or having previously had a negative smear if they are having problems. |

#### 6. Age range for screening

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| FWHC supports the move to raise the screening age to commencing at 25yrs, but we must be very sure that the few women < 25 who do develop symptoms that may be/are cervical cancer are taken seriously, with symptoms investigated and appropriately treated. We don’t want to hear about young women being fobbed off because they ‘are too young’ to have cervical cancer.  We are uncertain about an automatic exit process for upper age women but agree it could be offered, especially if the last two or three tests are negative. Many women are re-starting relationships in mid-life and may acquire new hrHPV infections at this time. Given that cervical cancer is generally slow growing there may have to be an assurance of more routine direct questioning by smear takers to reduce the risk of assumptions made around previous negative histories. |

#### 7. Referrals to colposcopy (for clinicians)

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| While we note there are implications for the colposcopy workforce with the projected increased demand FWHC also worries about the poor current track record rates for attendance at colposcopy clinics. No immediate solution offerings though! |

**8.** Screening equity  
Please comment on suggested strategies for eliminating inequalities in screening.

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| Free cervical smears. |

#### 9. Self-sampling

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| FWHC accepts that HPV self-sampling may be more acceptable to some women, and this would be an advantage overall if those women are in the currently unscreened/under-screened populations. However, this option may introduce further risks. We note the current information to women from NSU states:  Self-sampling involves a woman taking a sample of the vaginal mucosa with a swab, and this is returned to the laboratory for analysis.  This could be under clinical supervision, or on her own.  It is not intended that the swab reaches the cervix, although it may do.  A sample of the vaginal wall is sufficient.  Other research suggests that ensuring cervical cells are included in the swab sample is important. So will women who opt for this self-sampling method be given different information pre-and post-sampling regarding about the associated risks for accuracy of results?  We also presume that costs of accessing testing materials and sending samples away will be covered by NSU.  Who will manage the reporting of results on the Register for women who self-test?  We have no evidence to show that women who self-test will be any more/less likely to follow through with attendance at a colposcopy clinic if the need for this is indicated. |

#### 10. Invitation and recall to screening

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| The responsibility of inviting and recalling women into the programme should remain with the NSU. All regions must have a cervical screening co-ordinator to oversee and report on the operation of cervical screening in their region. |

#### 11. Cervical screening workforce

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| No informed recommendations. |

**12.** Do you have any other feedback?

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| FWHC strongly recommends there be a separate consultation on the changes to the NCSP-Register once a decision on the primary screening test is made. And there will be a big piece of work developing high quality/accurate information to be provided to women. FWHC will certainly seek to be closely involved with both. |

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| **53** | Submitter name | Dr Stephen Child |
| Submitter organisation | New Zealand Medical Association |

20 October 2015

National Screening Unit

PO Box 5013 Lambton Quay

Wellington 6145

By email: primaryhpv@moh.govt.nz

**National Cervical Screening Programme: Changing the primary laboratory test**

Dear Sir/Madam

The New Zealand Medical Association (NZMA) wishes to provide feedback to the National Screening Unit (NSU) of the Ministry of Health on the above consultation. The NZMA is New Zealand’s largest medical organisation, with more than 5,500 members from all areas of medicine. The NZMA aims to provide leadership of the medical profession, and to promote professional unity and values, and the health of all New Zealanders. Our submission has been informed by feedback by our Advisory Councils and Board.

1. We congratulate the NSU for the important work it is doing in the area of cervical screening. We note that the consultation proposes changing the primary laboratory test for the National Cervical Screening Programme to one that identifies whether or not a woman has high-risk human papilloma virus (hrHPV).1 We also note that the consultation discusses the implications of moving towards such a pathway, while raising a number of questions that are still in the process of being addressed.

1 National Screening Unit. National Cervical Screening Programme: Changing the primary laboratory test. Wellington: Ministry of Health. September 2015.

2 Ibid

2. The NZMA is fully supportive of introducing testing for hrHPV types as the first test (primary HPV testing) in the screening pathway to prevent cervical cancer. We are aware that this approach is convincingly supported by the international evidence and has been endorsed by the World Health Organization. We note that some of the potential benefits of adopting primary HPV testing are that it could:

* reduce cervical cancer cases and deaths
* improve the ability to detect risk of pre-cancerous cervical cell changes
* provide an effective test both for women who have had the HPV vaccine and those who have not
* provide safe but less frequent screening (every five years rather than every three)
* allow a more independent assessment as test results are either positive or negative, in contrast to the more subjective laboratory interpretation that is needed to identify cell changes with liquid based cytology
* open up the possibility of introducing the option of HPV self-sampling for women who currently find it difficult to access screening services
* keep the New Zealand programme in line with internationally recognised best practice
* potentially be more cost-effective than the current programme.

3. We welcome the input the NSU is seeking on this proposed change from a wide range of experts in epidemiology, cancer modelling, colposcopy, pathology, cytology, microbiology and primary care, as well as from members of the community. We understand that the NSU has commissioned modelling on the implications of moving to primary HPV testing to inform its work, and that the favoured model has been extensively peer reviewed and used as the basis for the renewed Australian cervical screening programme. However, there is little information provided in the consultation document or the accompanying technical appendix (which was difficult to find) on the basis of the modelling (eg, model structures, assumptions, limitations, etc). This makes it difficult to assess the validity of some of the underlying justifications for the technical report’s conclusions. We also note that modelling is still not complete for higher risk populations (eg, Māori, Pacific, and Asian) and that further work is being commissioned by the Cancer Council of New South Wales to address this. We encourage the Ministry to provide further information on the modelling used, and to disseminate this information in the public domain for maximum transparency. We also encourage the Ministry to ensure that supporting documents such as the technical appendix to this consultation are made more accessible, and are linked/sent out with the relevant consultation as a matter of course.

4. Our main concern relates to the proposed shift from 20 to 25 years as the age at which screening commences. The risk of acquiring hrHPV begins when a person becomes sexually active. In New Zealand, the median age of first sexual intercourse for young women was 16 years in a recent study of university students.3 This age is similar to that found in young women in the Dunedin cohort study.4 The early age at first sexual intercourse has been shown to be significantly associated with HPV infection, particularly with high risk oncogenic HPV types 16 and 18, and with CIN I or worse in women referred because of an abnormal cervical smear.5 There is also evidence that the younger less mature cervix is more susceptible to HPV infection and to more lasting damage from an infection.6 Many GPs in New Zealand report seeing young women (eg, at 17 or 18 years of age) with CIN grades I, II and III.

3 Psutka R, et al. Sexual health, risks, and experiences of New Zealand university students: findings from a national cross-sectional study. N Z Med J. 2012 Sep 7;125(1361):62–73

4 Dickson N, et al. First sexual intercourse: age, coercion, and later regrets reported by a birth cohort.BMJ. 1998 Jan 3;316(7124):29–33

5 Ribeiro AA, et al. HPV infection and cervical neoplasia: associated risk factors. Infect Agent Cancer. 2015 May 26;10:16

6 Castle PE, et al. Age-related changes of the cervix influence human papillomavirus type distribution. Cancer Res. 2006 Jan 15;66(2):1218–24

7 IARC. 2005. IARC Handbooks of Cancer Prevention Volume 10: Cervix Cancer Screening. Lyon, France: IARC Press; Sasieni P, et al. Effectiveness of cervical screening with age: population based case-control study of

5. While we note that the international evidence cited in the technical appendix suggests that primary HPV screening should probably not be initiated for women aged less than 25 years,7 we urge caution in the applicability of international data to our local population. New Zealand has a very high rate of teenage pregnancy (with even higher rates in Māori and Pacific populations) which is consistent with younger exposure to HPV. We note that further research is being commissioned by the NSU on whether the starting age for screening can be safely raised to 25 years. We request to be kept apprised of this research. Ultimately, when more girls (and boys) have received HPV vaccination before becoming sexually active, and when herd immunity is attained, we consider that it may be reasonable to safely delay the age of first hrHPV screening to 25 years. At the present time, however, we do not support the proposed extension to the age of first screening to 25 years – at least not until we see more detail, including responses to the points we have raised in paragraphs 4 and 5.

prospectively recorded data. BMJ 2009 Jul 28;339:b2968. Erratum in: BMJ. 2009;339:b3115; Landy R, et al. Benefits and harms of cervical screening from age 20 years compared with screening from age 25 years. Br J Cancer. 2014 Apr 2;110(7):1841–6

8 Details of this programme available from http://www.bowelscreeningwaitemata.co.nz/

6. We note that the consultation proposes the introduction of an exit screening test for women between the ages of 68 and 74 years. We are comfortable with this proposal.

7. We note that the consultation proposes that women be routinely screened every five years, with those at high risk of developing cervical cancer being screened more frequently. We are comfortable with this approach. Given that primary HPV testing is more effective than current liquid based cytology testing, women are not likely to need to be screened as often as at present (every 3 years). Furthermore, regardless of their sexual history, most women will welcome a longer interval between screening tests. However, it is imperative that well funded follow-up procedures are in place to treat cervical abnormalities found with the proposed extended hrHPV screening protocol.

8. With respect to follow up after self-sampling, we suggest that this could be modelled along the lines of the immunochemical faecal occult blood test (iFOBT) community bowel screening programme that has been running in Waitemata as a trial for the past 4 years.8 A positive result would need to be followed by a consultation with a patient’s GP and referral for colposcopy (as opposed to colonoscopy). We believe that invitation and recall should remain with General Practice, with backup provided by the National Cervical Screening Programme register.

9. We consider that an important omission from the consultation document is any discussion on how a proposed new screening pathway will be evaluated. We submit that it is necessary to prospectively define some agreed key performance indicators as well as timeframes. With respect to Figure 2 showing the proposed pathway, we suggest that there needs to be a loop around from colposcopy (eg, to repeat the process in 5 years in the event of a negative colposcopy).

10. While we acknowledge that the proposal is likely to lead to shrinkage in the cytology workforce, we are pleased to note that the Workforce Stream is looking at how to support and retain a lower number of highly specialised cytology staff. We consider that maintaining expertise in a shrinking group will entail some challenges but should not be insurmountable.

11. Finally, we believe that it is important to reiterate that only women who have ever had vaginal sexual intercourse require cervical screening (including HPV testing). Many female patients that have never had sexual intercourse admit to feeling embarrassed because they have received a recall letter inviting them to attend for a cervical smear. Other patients report confusing publicity around the topic of cervical screening. The consultation document appears to presume that all women are sexually active at some stage in their lives, yet this is not the case for a cohort of women. We recommend that the Ministry of Health make it clear in all relevant communications that any cervical screening programme applies only to women who have ever had vaginal sexual intercourse.

We hope our feedback has been helpful and would welcome further opportunities to engage with the NSU as it progresses this important initiative. In particular, we look forward to further consultation on the proposed starting age for primary HPV testing. We request that further information be provided on this aspect, including responses to the issues we raise in paragraphs 4 and 5.

Yours sincerely

Dr Stephen Child

NZMA Chair

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| **54** | Submitter name | [redacted] |
| Submitter organisation | [redacted] |

Private and Confidential

1. Thanks for the printed literature that was available onsite and including the Overview, Consultation paper and Technical appendix that I have completed reading today.

2. I am from the age cohort group that has historically had 3 yearly smears. I went onto privately have Cytology and Histology, along with Colposcopy and Biopsy work back in 1984, along with D&C, Biopsy, Iodine Stain, Cautery Cervix using Melbourne Technique, I was 20. My records do not show that I have a Maori heritage by choice. I followed up with more regular smears and am currently due for a 3 year check this year.

3. My wish is for a best case scenario that takes into account the Holistic approach mentioned at the meeting. To have informed consent for our youth to know what the HPV vaccination covers and what it doesn’t. To understand what choices and situations will require a smear test to be a good idea relating to sexual activity and when. For anyone to be able to access a free 1st comprehensive smear test that means HPV and other risk cancers are checked to ensure risk factors are taken into account and resources are not wasted at the best time for that person. For people both male and female to be included in the programme and know where to find unbiased, up to date, easy to read web based literature as well as printed material topic related, that has been peer reviewed and literacy based for non medical and medical folk alike to understand and research into more depth if necessary. This is not an easy topic to cover, nor do I take lightly the change to the workforce and systems that will be required. By reading the documents provided and trusting people to do the right thing and negotiate in good faith as well as put people first – not profit or costs – I think the on going changes can be managed well and fairly.

4. However, having the 1st smear is a priority as long as the factors that relate to each individual are taken into account – not so much age as possible criteria involved. Whether that be through their GP, local health provider, Marae or community based NGO and be fully funded to stop inequity or as a self-test model mentioned and what criteria people would qualify for that option proves important and something to work thru as this process continues. I really hope that the barrier of cost does not preclude a genuine need to get a check as I know people who do not use the current health services because of the cost to them either as an immigrant, non resident or low socioeconomic person. Somehow NZ needs to change this model to be more like UK than US or at least have a better understanding that inequity is a bigger problem that just individual situations. It crosses over a lot of areas in society and collectively we need to continue to work on improving that reality for all. I understand there are some places available that cover these needs.

Documents that proved most towards my above reasoning with personal circumstances taken into account.

5. Primary screening strategy 2 HPV testing with partial genotyping and cytology triage for non 16/18 HPV positive samples, ref 2.9 page 16 tech appendix public consultation paper document October 2015

6. Strategy 4 group S4a, ref table 15 page 43 tech appendix public consultation paper

7. Figure 6 Modelled screening pathway for Scenario 4a, ref figure 6 page 44 tech appendix public consultation paper

I really value the opportunity to be invited and included in the request to comment, and hope that what has been shared is understandable and relevant. My email is on the list to be kept advised with the on going project.

Thank you.

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| **55** | Submitter name | Lynda Williams |
| Submitter organisation | Auckland Women’s Health Council |

#### 1. Answer this question only if you are submitting as a private individual, and you do not want your personal details released or published

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**2.** Your contact details:

Name:

|  |
| --- |
| Lynda Williams |

Organisation (or Private):

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| --- |
| Auckland Women’s Health Council |

Address/ email:

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| --- |
| PO Box 99-614, Newmarket, Auckland 1149  awhc@womenshealthcouncil.org.nz |

**3.** The modelling work done to date supports the preferred pathway as the one likely to achieve the greatest benefits. However, are there any other options that you believe the NCSP should investigate further?

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| Given that around 160 women in New Zealand are diagnosed with cervical cancer each year, and about 50 women die of cervical cancer, greater benefits for Maori, Pacific and Asian women are much more likely to be achieved by publicly funding cervical screening. It may even cost less than what is being proposed. |

**4.** What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway?

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| The consultation document does not provide an accurate picture of the incidence of cervical cancer in NZ, nor the expected benefits of what is being proposed. The AWHC notes that NSU constantly refers to the incidence of cervical cancer in a global context which creates the impression that it is a big problem in New Zealand. It is misleading to provide international statistics on cervical cancer without stating the incidence of cervical cancer in New Zealand and the number of deaths. In response to a question at one of the Auckland consultation meetings, one of the speakers referred to the potential of the new HPV test to bring about a 5% reduction in mortality from cervical cancer in New Zealand. This is an incredibly small benefit – one or two women per year – when considering the financial cost to the NCSP of implementing HPV screening.  The consultation document also does not clearly acknowledge that 80%-90% of women clear HPV infections within a couple of years without the need for any intervention or treatment. This is another important piece of information that people making a submission on the document needed, and that women having cervical screening need to understand when making an informed decision about HPV screening.  When the National Cervical Screening Programme was established, many women who were told they had one of the three stages of cervical intraepithelial neoplasia believed they had cervical cancer. The AWHC fielded many phone calls from very distressed women who did not understand that CIN indicated the presence of abnormal cell changes but this did not mean they had cervical cancer.  The AWHC is therefore concerned that women who are told they have tested positive for hrHPV16 or hrHPV18 may interpret this to mean they are very likely to develop cervical cancer or even that they are already well down the pathway of developing cervical cancer.  The importance of the negative impact on women that information on their positive hrHPV status is likely to have cannot be overstated. Under the current screening pathway women clear HPV infections without being aware they have one. The proposed changes to the cervical screening pathway will result in far more women being identified as being potentially at risk of developing cervical cancer than the current screening pathway does. It is difficult to estimate what effect this will have on women, their commitment to keeping colposcopy appointments, etc. |

#### 5. Screening interval

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| The move to a routine screen every five years may benefit some women but result in others turning up for cervical screening much less often, eg 7 – 10 years. A one-size fits all cervical screening programme that is based on HPV screening may not address the inequities that exist in the current screening programme.  Of course there are groups of women who have a higher risk of developing cervical cancer – those who cannot afford to pay for cervical screening and who do not have regular screening tests, eg Maori and Pacific and Asian women and those living in poverty. These are the women that go on to develop cervical cancer. Unless HPV screening is publicly funded then this is unlikely to change. |

#### 6. Age range for screening

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| Beginning cervical screening at 25 instead of 20 is a logical change given that the HPV vaccine is protecting an increasing number of women from the most common forms of HPV infections.  However, the NCSP’s educational resources must provide women with information on the very rare forms of aggressive cervical cancer that can occur, especially in young women, who may or may not have had the HPV vaccine and who go on to develop cervical cancer in their early 20s. The media carries many stories of such cases in which the families of the young women who have died subsequently embark on campaigns to lower the age at which cervical screening begins.  More information is needed before an exit screen is introduced for women between the ages of 69 and 74 years. What is the incidence of newly acquired HPV infections in older women? Do older women take longer to clear an HPV infection than much younger women? Does cervical cancer develop more quickly in older women? |

**7**. Referrals to colposcopy (for clinicians)

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| The current DNA rate is of concern and many DHBs are currently not meeting their colposcopy targets. Increasing the referrals to colposcopy would exacerbate the problem for both the women and the colposcopy services. |

**8.** Screening equity  
Please comment on suggested strategies for eliminating inequalities in screening.

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| The most important strategy for eliminating inequalities in screening is to publicly fund cervical screening and thus bring it into line with other screening programmes in New Zealand, but this strategy is not included in the consultation document.  If the government is serious about improving access to cervical screening for Maori, Pacific and Asian women then it will ensure that these women are able to access free screening.  **Other inequities in cervical screening**  Women with physical and sensory impairments have to overcome a number of obstacles to screening. These include:   * Access to disabled parking close to those doctors who have their practices in shopping or shared parking areas * Getting into those clinics which  don’t have ramps for wheelchairs * Some clinics don’t have accessible toilets, or beds that go up and down. |

#### 9. Self-sampling

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| Self-sampling should be offered to all women.  The best way is for many women to test themselves may be at home, especially for those for whom transport is an issue. Others may prefer to test themselves at a clinic. Women should have a choice, and self-sampling must be free of charge to the women.  Another possibility for the future is for NSU to negotiate with LabTest to play a role in increasing access.  The NSU could do the invitation and recall (the population register would be necessary for that), with LabTest providing easy access to HPV testing, and ISPs managing the conversations and follow up with women who then are advised to go for further tests at Colposcopy.  This would mean there was no need for the General Practices with their wide range of consultation fees to be involved.  This would only be for diagnostic purposes in the event of symptoms that need investigation.  One of the issues with self-sampling is that the uptake of follow-up for a positive test is likely to be much lower than the NSU expects, and as already noted significantly increase the DNA rates above what they already are. |

#### 10. Invitation and recall to screening

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| The NCSP Register will need to be redesigned to meet the rapidly changing IT environment and be accessible to GPs and other screening providers to enable them to check both the screening history and the HPV vaccine status of their patients. Women will presumably also have access to this information via their patient portals.  The responsibility of inviting and recalling women into the programme should remain with the NSU. All regions must have a cervical screening co-ordinator to oversee and report on the operation of cervical screening in their region. |

11. Cervical screening workforce

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| Well before HPV screening is introduced all the cervical screening workforce issues must be clearly identified and strategies implemented to ensure that the problems identified in the consultation document do not adversely impact on women’s access to cervical screening, as well as the cervical screening programme’s ability to provide the services. |

**12.** Do you have any other feedback?

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| The importance of accurate information being provided to women about cervical screening and the proposed benefits and drawbacks of HPV screening cannot be overstated.  The NSU does not have a good track record of providing women with evidence-based information on the risks of screening programmes, and this must change before a new primary screening test is introduced that has the potential to turn many thousands of well women into anxious patients who think they are in imminent danger of developing cervical cancer. |

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| **56** | Submitter name | Jane Grant |
| Submitter organisation | Metro Auckland Cervical Screening Coordination Service |

#### 1. Answer this question only if you are submitting as a private individual, and you do not want your personal details released or published

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**2.** Your contact details:

Name:

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| --- |
| Jane Grant and Pauline Proud |

Organisation (or Private):

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| --- |
| Metro Auckland Cervical Screening Coordination Service |

Address/ email:

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| [pproud@adhb.govt.nz](mailto:pproud@adhb.govt.nz)  jane.grant@waietematadhb.govt.nz |

**3.** The modelling work done to date supports the preferred pathway as the one likely to achieve the greatest benefits. However, are there any other options that you believe the NCSP should investigate further?

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| --- |
| 1. Investigate how self-testing as an option for all women with a simple dry swab as a primary test would enable a universally free screening service through reducing the laboratory costs (supported by reduced costs associated 5 year intervals and the anticipated “temporary” increase in colposcopy) 2. Investigate how a move to nurse-specialist services including outreach would improve service deliver and cost benefits. |

**4.** What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway?

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| 1. Acceptability of this pathway to priority group women should be investigated, if they are still unlikely to participate then other options should be considered. 2. Cost benefit analysis of this and other options should be made public 3. Expected benefits in terms related to the New Zealand context should be clear. For example would this mean 2-5 less deaths per year for New Zealand women? 4. Further research into any potential negative impact of positive HPV results on women. For example will a 30 year old with a positive hrHPV test be offered the HPV vaccine as a privately funded vaccine that is not really indicated? Will she agree to this based on fear and anxiety? Will she request it? 5. Further research in to regression and progression rates of human papilloma virus across the lifespan is required to determine where greatest risk lies. 6. Research into how to communicate changes to women and how to link information about HPV testing to information about HPV vaccination. 7. This review assumes that screening can be improved through a reasonably long term plan/do/review process as in the past. It may be that changes in the eligible population, aetiology and strategies in response to ongoing research will require more of an ongoing cyclical approach to maintaining best practice in cervical screening. 8. There will be the need to monitor the changing levels of immunity to the different strains of the virus, selective typing of HPV + ve results and incident HPV infection among vaccinated women. |

#### 5. Screening interval

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| 1. This is likely to be more acceptable to women. 2. It may be harder to maintain accurate contact details for women over a longer time period. 3. This may result in women being screened considerably less frequently than at present. 4. Women who are exposed to HPV via sexual abuse prior to vaccination may be at risk if not screened until age 25. Especially if this group have other risk factors related to maintaining a healthy immune system e.g. smoking, poor diet, and frequent infections. It may be that this group of women require more regular monitoring. HPV testing may need to be incorporated into guidelines for management of children and adolescents who are sexually abused. 5. A question to consider is should HPV testing be offered as part of a sexual health consultation? This would have a different emphasis to screening. A 24 year old woman may present for a sexual health check have a vaginal examination and then be required to attend a few months later for screening. This may not be acceptable to her. 6. A young woman who presents for a sexual health check and is not tested for HPV and thinks she is ‘all clear’ could be surprised to attend for screening subsequently and find she does have an STI – the human papilloma virus. 7. It may be appropriate to suggest 5 years as a screening interval but make HPV testing available based on risk. If a women has inter-menstrual bleeding or post coital bleeding it would be prudent to test for HPV as part of diagnostic work up. How this will be funded will need to be considered. 8. Sex workers may have a higher risk as the virus is spread by skin to skin contact and using a condom does not necessarily give protection from HPV. This group may need to be screened more frequently. |

#### 6. Age range for screening

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| 1. More work is needed on HPV regression vs progression in older adults to determine appropriate exit age and risk to older women. 2. Testing, if not screening, needs to be available for those women under 25 who are at increased risk for rapid hrHPV progression |

7. Referrals to colposcopy (for clinicians)

#### If the number of referrals to colposcopy increased temporarily, how would it impact on the capacity and timeliness of colposcopy service delivery?

#### What would be the best way to limit any such impact?

#### How important is it to your clinical practice to have a cytology result for the women you see at colposcopy?

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| 1. Will a corresponding increase in funding be available to manage the predicted spike in referrals to colposcopy? 2. Will an increase in capacity for ISP’s to provide support to services be funded? 3. Will appropriate resources based on a health literacy model be made available to women explaining why they need to go to colposcopy and what is different? |

**8.** Screening equity  
Please comment on suggested strategies for eliminating inequalities in screening.

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| --- |
| 1. Universally free cervical screening must be considered as part of any change to the programme. 2. If the experience of having a test is the same as currently it is hard to see how the proposed changes will impact on equity, as barriers to screening will remain. |

#### 9. Self-sampling

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| Who **could** self-sampling be offered to?   1. Women with serious illness, disability or mental health diagnosis. 2. Women who have been sexually abused 3. Pregnant women as opportunistic screening if they have not participated in the programme 4. Women with a high BMI 5. All women to whom having a vaginal examination is a barrier to participating in screening   Women who are testing themselves must have a discussion with a trained health worker about:   * What the test is for and why they should have it * Informed consent * How they will receive their results * What will happen if they have an abnormal result * Who has access to their results * When they should see a doctor – if abnormal bleeding or other symptoms are present.   Is it possible to offer self-sampling alongside other screening where trained health workers are –if a very hard to reach woman (never screened before) presents for mammography – this would be an ideal opportunity to provide self-sampling.  Uptake for cytology/colposcopy for a woman who has self-tested will be determined by how good the explanation of the test is by the health worker. If women understand what is involved with a positive result prior to taking the test and what support is available for them, they may be more likely to attend follow up colposcopy/cytology.  A one size fits all approach to self-testing may not be the best way forward. Women deserve access to screening that is acceptable to them.  Self-sampling must be free. There is potential for screeners to charge extra to women for a test that is more acceptable and this needs to be mitigated.  E.g. Women declines an HPV test by vaginal exam and then the GP offers self-sampling as an alternative at an increased cost. |

#### 10. Invitation and recall to screening

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| 1. Health Platform integration needs to be widely considered across the Ministry. 2. Consideration needs to be given to whether NCSP register should integrate with National Immunisation Register 3. There is the opportunity to have a registry of HPV prevalence and associated lesions. Selective typing of HPV +ve results could monitor occurrence of incident HPV infection among vaccinated women and the duration of vaccine efficacy. 4. Preparation needs to be made to ensure that EVERY dose of HPV vaccine is entered on to NIR in a timely manner. 5. Over time evidence may change and it is possible that at risk women may be those who are not vaccinated. 6. It is possible that management of women may depend on vaccination history this will need to accessible. 7. The benefit of a population based register is that women can be invited to join the programme in a clear and consistent manner which aligns with NCSP policies standards and guidelines. 8. Direct query capability of the NCSP register at practice level will enhance coverage and reduce/remove necessity for data-matching. 9. Trained health workers who sit within the register team and alongside/within support to services/ISP’s would be the ideal group to provide invitation, recall, and advising results and follow up. 10. More anxiety about being HPV positive may be generated. More women will get this result than currently get an abnormal smear result. It might be confused with HIV. A media campaign will be necessary. 11. Real integration and collaboration between HPV screening and HPV vaccination need to be led from the top down, at Ministry, Programme, DHB, PHO and practice level. Within primary care there is a significant crossover of knowledge which should be considered. |

#### 11. Cervical screening workforce

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| 1. Good education for primary care about proposed changes needs to be considered – simply sending out written guidelines or advising PHO’s will not be sufficient as seen by last changes to guidelines. 2. A compulsory workshop or online update for “smear/sample takers” should be considered, ability to provide smear/sample taking service should be contingent upon completion of training – this need not be long or arduous. 3. Practice management systems will need to be upgraded to match guidelines. Laboratory request forms, diagnostic and screening coding systems will need to align. 4. Terminology used in resources, recall letters and invitations will need to be considered. Suggest the term “smear” is no longer be used. |

**12.** Do you have any other feedback?

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| 1. The best means of reducing disparity is to make screening universally free. 2. Will HPV results from other countries be acceptable to the NCSP? Given high specificity of the test. We suggest this would be useful especially for the Auckland migrant population. 3. It is worth considering that HPV exposure and infection can occur in the absence of penetrative vaginal sex? Does more work need to be done to consider guidelines definitions and terminology of women exempt from screening due to being “never sexually active”? 4. Significant consideration will need to be given to public understanding of HPV infection, cervical cancer and immunisation. 5. Social marketing will be required to start soon to ensure necessary public awareness/understanding and health literacy 6. The word SMEAR will no longer be accurate – a new language needs to be considered to describe HPV screening. “Tests” and “Samples” are more appropriate. 7. All resources will need to be updated and available as printed material that can be ordered at no cost. |

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| **57** | Submitter name | Leonie Walker |
| Submitter organisation | New Zealand Nurses Organisation |

Tēnā koe,

The New Zealand Nurses Organisation (NZNO) welcomes the opportunity to comment on the proposed changes to the New Zealand Cervical Screening Programme. NZNO has consulted widely with member groups and professional nursing and policy staff. We welcome such adoption of internationally accepted best practice when new and evidentially better tests and procedures are developed. The document was largely very positively viewed, however, we do have some very specific feedback from Te Rūnanga related to issues of specific concern for Māori and Pacific women and health workers.

Te Rūnanga o Aotearoa, New Zealand Nurses Organisation (Te Rūnanga), along with our te Tiriti o Waitangi relationship with the New Zealand Nurses Organisation (NZNO), represents Māori health professional members. Te Rūnanga membership comprises over 3000 nurses (nurse practitioners, registered, enrolled and student nurses), midwives; kaimahi hauora, health care assistants and allied health professionals. Our aim is to enhance the health and wellbeing of all people of Aotearoa New Zealand and we are united in their professional and industrial aspirations to achieve a safe, sustainable and accessible system of public health care for all New Zealanders.

Te Rūnanga shares NZNO’s vision; “Freed to care, Proud to nurse”, our aims include being a lead voice for Māori health in Aotearoa New Zealand, strengthening our own bicultural partnership, and opposing injustice and inequality wherever it impacts upon the health and wellbeing of New Zealanders. It is extremely important to Te Rūnanga that our member’s voices are heard and that we are responsive to their needs.

Te Rūnanga also welcomes the opportunity to comment on the Ministry of Health cervical screening document. As health professionals, we agree that a national standard of cervical cancer screening and care is vital in addressing the significant inequalities in New Zealand’s healthcare system for Māori and Pacific women with regard to cervical cancer, screening, diagnosis, treatment and health outcomes, and we welcome adoption of new and effective technology.

1. Te Rūnanga o Aotearoa, New Zealand Nurses Organisation (Te Rūnanga) welcomes the opportunity to comment on the Ministry of Health National Cervical Screening Programme: Changing the primary laboratory test consultation document.

2. Te Rūnanga has consulted widely with staff and members, in particular expert members and nursing, research and policy advisers.

3. While we see the increased benefits for Māori in the uptake of HPV and in the proposed screening programme, we do have concerns with how the screening stages and transition will be implemented. We seek further information on how the National Screening Unit (NSU) plans to disseminate these proposed changes to Māori; in particular to ensure that Māori (as a priority group) are well informed and knowledgeable about the proposed changes at hapū, whānau, iwi and wider communities around the motu.

4. Our members feedback include:

o ‘*HPV vaccine rates for Māori in particular and the new proposals will support a more equitable reduction of the incidence of cervical cancer for Māori but it will be in managing the transition period to HPV primary testing that will be key’*.

o *Given that currently Māori in particular are at around 90%+ for 5 yearly screening rates, there is a concern that 5 yearly may then extend out to 7 years*

o ‘*There is the potential for exciting developments’.*

5. As priority population groups, Māori, Pacific and Asian womens’ perspectives are essential in informing all future screening and modelling projects. We do however have concerns that as an international agency, the Cancer Council of New South Wales may need local support to ensure that in Aotearoa New Zealand, bicultural principles are the underlying basis for all future New Zealand NSU proposed modelling.

6. We also seek further information on who or what agency will ensure that a Māori perspective is included in all future work and in monitoring and evaluation of external services.

7. Our members are very disappointed that the NSU does not take a proactive approach or investment in training to ensure that the existing Māori and Pacific health workforce is a more visible and skilled workforce, and members have said:

o ‘*Even the Māori and Pacific existing workforce has been largely neglected and kaimahi forums and national screening hui have become a thing of the past!!’*

o *NSU has “paid lip service” to the Māori and Pacific workforce and suggest that the Māori and Pacific workforce need to take an active and leading role in screening and the development of its future workforce.*

8. It is unacceptable that the discussion document suggests that Health Workforce New Zealand (HWNZ) is the only agency responsible to engage more Māori and Pacific students in training to become health professionals. Increasing the Māori and Pacific workforce should be a priority of every government department and should not be left solely in the hands of HWNZ. NZNO recommends that NSU should be proactive, in increasing and supporting a Māori and Pacific workforce by enticing Māori and Pacific students into the health and screening workforce by providing scholarships, training and other skill based courses.

9. We recommend that guidelines be developed to highlight NSU ‘gold standard’ approach to cervical screening and best practice ‘wrap around services’ that cater for Māori and Pacific women.

Nāku noa, nā

**Léonie Walker** BSc MSc PhD MBAcC

**Principal Researcher**

**Adjunct Professor, Graduate School of Nursing & Midwifery, Victoria University Wellington**

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| **58** | Submitter name | Jackie Edmond |
| Submitter organisation | Family Planning New Zealand |

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**2.** Your contact details:

Name:

|  |
| --- |
| Jackie Edmond |

Organisation (or Private):

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| Family Planning |

Address/ email:

|  |
| --- |
| PO Box 11-515  Wellington 6142  Jackie.edmond@familyplanning.org.nz |

**In the last financial year, Family Planning doctors, nurse practitioners and nurses took 20,569 cervical smears**

**In the same year, 323 external doctors, nurses and midwives attended either a 3 day Family Planning cervical smear taker training course or a cervical screening update. This is in addition to teaching undergraduate doctors and midwives on cervical screening.**

**3.** The modelling work done to date supports the preferred pathway as the one likely to achieve the greatest benefits. However, are there any other options that you believe the NCSP should investigate further?

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| This looks like a good pathway balancing effectiveness in picking up abnormalities and resources. Some modifications discussed below |

**4.** What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway?

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| Whether it is worth differentiating between vaccinated and unvaccinated 20-24 year olds re starting age given that unvaccinated girls are predicted to have more positive hrHPV tests and so are more likely to need more investigation and treatment.  Accuracy of self-taken cervical screening compared to clinician taken sampling |

#### 5. Screening interval

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| Change to 5 yearly great for women.  Is there evidence that it will be harder to remind women in this longer time interval in our very mobile society?  Immunosuppressed women are likely to need more frequent screening |

#### 6. Age range for screening

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| See comment above re whether it could be beneficial for unvaccinated 20 year olds to start screening at that age. Generally support starting at 25. Many postmenopausal women find cervical screening uncomfortable and even painful and may need to use a course of vaginal oestrogen cream before a speculum examination. An exit test at a later age would therefore need strong evidence of benefit to warrant the discomfort. Of course women of all ages may need a diagnostic cervical smear test if symptomatic. |

#### 7. Referrals to colposcopy (for clinicians)

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| Family Planning does not do colposcopies.  Colposcopy services may need to triage referrals by whether client is symptomatic, according to age and vaccination history. Presumably at first the older women would need to be prioritised as they will be unlikely to have been vaccinated and are therefore more likely to have a malignant lesion. |

**8.** Screening equity  
Please comment on suggested strategies for eliminating inequalities in screening.

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| Continue to train nurses to provide cervical screening.  While Maori and Pacific nurses should be trained in smear taking, many Maori and Pacific women prefer to have this intimate history and examination done by someone who is not from their ethnic community. Maintain access to free smear taking for priority women, including providing mobile screening units for remoter communities. Consider incentives for women who have never had a cervical smear or who are overdue for a repeat smear. |

#### 9. Self-sampling

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| Self-sampling is only applicable for asymptomatic women. Women with symptoms MUST have a speculum examination to allow an accurate assessment on whether they need further investigations to reach a diagnosis. If symptomatic women self-sample, other pathology is likely to be missed.  Self-sampling should be reserved for those where it is difficult to get a cervical smear such as those with a disability or weight issue, post-menopausal women and those who will not agree to having a speculum examination particularly those who have not had cervical screening for many years.  It is essential that when a woman does take a self-sample, that she agrees that if there is a positive result, she will have a speculum examination or colposcopy. When told that this is the pathway, it is much more likely that she will agree to have the subsequent examination.  It would be better if the self-sampling was done at a clinic so that if necessary she can have a speculum examination there e.g. if it is discovered that she does have symptoms. However there may be women who are not prepared to come in to the clinic. In this case a phone consultation may be used to determine if self-sampling at home can be safely done.  The main issue is that most women are likely to prefer self-sampling and it may not be appropriate so that other pathology may be missed.  There would need to be good public education about symptoms alerting women to when they require a full examination. |

#### 10. Invitation and recall to screening

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| It should be the clinic practice or smear taker who invites and recalls women for cervical screening using practice registers and recall systems.  The NCSP-Register is valuable in providing information on the history and due date for cervical screening and this will be more important with a longer timeframe between smears.  It is also a valued safety net for the practice/smear taker’s records |

#### 11. Cervical screening workforce

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| As smear takers, invitation and recall staff:  Education of all involved staff  Dissemination of new pathways – flowcharts are very useful  Evidence to support the changes  The power point presentation on the NSU website is excellent as have been presentations to primary health care workers and opportunities for community discussion  Ensure that understandable information is available to health promoters as well as clinicians with coaching on how to convey the new programme to women |

**12.** Do you have any other feedback?

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| Great move forward. Continue information on the screening programme website for health literate women to read May need more low literacy information/brochures. The current promotional poster re smears being the best not nice thing continues to stigmatise gynaecological exams rather than promote them as health positive and encouraging women to take control of their health by seeking services so future information should be more positive |

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| **59** | Submitter name | Dr Sandy Hall |
| Submitter organisation | Women’s Health Action |

**Submission on The proposed changes to the National Cervical Screening Programme (NCSP) National Screening Unit**

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**Email primaryhpv@moh.govt.nz**

**Compiled on behalf of Women’s Health Action Trust.**

**By Dr Sandy Hall and Holly Coulter**

**Contact:**

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**64 9 5205295**

**Women’s Health Action**

Women’s Health Action is a women’s health promotion, information and consumer advisory service. We are a non-government organisation that works with health professionals, policy makers and other not for profit organisations to inform government policy and service delivery for women. Women’s Health Action is in its 31st year of operation and remains on the forefront of women’s health in Aotearoa New Zealand.

We provide evidence-based analysis and advice to health providers, NGOs and DHBs, the Ministry of Health, and other public agencies on women’s health (including screening), public health and gender and consumer issues with a focus on reducing inequalities. We have a special focus on breastfeeding promotion and support, women’s sexual and reproductive health and rights and body image.

**Introduction:**

The World Health Organisation (WHO) developed six principles which underpin cervical screening programmes, including our own. They include the overall benefits of screening outweighing the harm, the programmes being people centred, provide equity and access, have informed consent as a priority and respect autonomy and confidentiality, be monitored and evaluated regularly and have continuous quality improvement[[1]](#footnote-1). Women’s Health Action would expect any changes to screening programmes in Aotearoa New Zealand to be made in this context. Consequently our submission is made with these principles in mind.

In general, we support the move to use the HPV testing but only as part of the primary screening test being initially undertaken in tandem with continued smear testing and that the use of HPV testing as the primary test needs to be thoroughly investigated in the New Zealand context using independent researchers.

We believe both the ATHENA study and the incomplete COMPASS study in Australia do not completely demonstrate the safety of converting completely to HPV testing, particularly for women under 30 who are not immunised. The levels of immunisation uptake in Aotearoa New Zealand have been relatively low and certainly differ from Australia. We believe that concerted efforts need to be made to improve the HPV immunisation programme in New Zealand alongside any changes to the cervical screening programme.

We also believe that the differences in health system access and costs must be taken into account, particularly in terms of the provision of acceptable free services in a timely manner to ensure equitable outcomes. We are also concerned about the possibility of skill loss in regards to cytology and histology services as well as their capacity to cope with a short term rise in demand.

Independent, New Zealand based research needs to be done before making a decision about changing screening age or interval as there is currently a lack of sufficient research to establish what the impact of these changes would be.

1. **The modelling work done to date supports the preferred pathway as the one likely to achieve the greatest benefits. However, are there any other options that you believe the NCSP should investigate further?**

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| We are not sure which modelling or research you are referring to. However, we believe there is not enough independent evidence to support a complete move away from current testing models to solely HPV testing. We are also concerned that the research is not completely independent and there has been considerable lobbying by immunisation and test manufacturers around changes to our screening programme. We suggest more consumer involvement is required, both as advisors, and to provide feedback about the proposals and that changes should not be made in haste. We therefore suggest testing should be done in tandem for a period of evaluation and research. This would also allow time for education around HPV and the tests themselves.  The rapid roll-out of the proposed new pathway would result in the loss of much of New Zealand’s skilled cytology workforce, and mean that if the new pathway proved unsuitable for New Zealand women, there would be a significantly reduced capacity to meet demand of cytology services. Further, if HPV-testing is shown to be unacceptable to New Zealand women, a switch to offering HPV-testing only could lead to a drop in screening uptake, which could potentially have serious negative consequences for women. Independent research is needed not only into the efficacy of HPV testing, but also its acceptability to women in Aotearoa New Zealand, before a change is made to offer HPV-testing as the primary screening tool and eliminate the current pathway. |

1. **What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway?**

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| We believe independent research must be undertaken in the New Zealand context across a range of issues including:   * Access by different population groups; * Safety of the vaccines and effectiveness over time; * Acceptability of the vaccines and the HPV testing to consumers; * Safety of stopping cervical smear testing and other risks including missed diagnosis or over diagnosis; * Workforce issues in cytology and colposcopy services; * The safety and efficacy of self-tests including the possibility of other health issues not being identified in the absence of doctor - patient contact; * Acceptability of self-testing to women; * Access and waiting times for colposcopy; * Workload of histology services; * The potential impact of increasing the screening age to 25 for women who become sexually active at a younger age; * The potential impact of increasing the screening interval to 5 years for women who are under screened or DNA for follow-ups.   Research needs to be Aotearoa New Zealand based and relevant to the diversity of New Zealand women rather than adapting international models as has been used for the current proposal. |

1. **Screening interval**

* Please comment on the proposal to routinely screen women every five years.
* Are there any groups of women who may have a higher risk and require a shorter screening interval?

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| In theory we think it would be beneficial to have less screening but we believe that this should be done only after further research is completed to ensure there are no risks of harmful outcomes as a result of increasing the screening interval. This will hopefully also identify women who are at higher risk and require additional or more frequent screening.    Given records of high “Did Not Attend” (DNA) rates for colposcopy services, and the amount of time that it can take to follow up on a client who has DNA for an appointment, we have concerns that there may be harmful consequences of increasing the screening interval in cases where there is a long delay between an abnormal result and engaging in follow-up. |

1. **Age range for screening**

* Please comment on the potential change in age range for cervical screening from the current 20–69 years to 25–69 years.
* Should there be an exit test for screening between the ages of 69 and 74 years?

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| We note that the United States does not recommend hrHPV testing for screening of women aged less than 30 years, as the transient nature of HPV infections in this age group, may mean unnecessary referral to colposcopy[[2]](#footnote-2), [[3]](#footnote-3).  We are concerned about making any changes to our current programme before adequate research in the New Zealand context is undertaken. We have a relatively low immunisation uptake and boys have not been offered immunisation. In addition, many New Zealanders become sexually active prior to 15. We would suggest that at least one screening test should be undertaken before the age of 25 unless there is definitive research to prove testing at 25 poses no risks.  We agree there should be an exit test done by a health practitioner in the context of information about the end of testing and any risks. |

1. **Referrals to colposcopy (for clinicians)**

* If the number of referrals to colposcopy increased temporarily, how would it impact on the capacity and timeliness of colposcopy service delivery?
* What would be the best way to limit any such impact?
* How important is it to your clinical practice to have a cytology result for the women you see at colposcopy?

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| We note this is targeted towards clinicians but suggest it is imperative to get feedback from women. We have serious concerns about the possibility of increased waiting times for colposcopy results and possibly for histology. We also believe this may further could contribute to inequities, with women with lower incomes being less able to access private services in cases of long wait times. We also acknowledge that currently, targets for time interval between receiving an abnormal result and colposcopy are not being met[[4]](#footnote-4), and that this could be exacerbated by the new pathway.  We have some reservations about the women who test positive for HPV 16, 18 [the HPV types responsible for 70% of cervical cancers] being referred directly to colposcopy, given that it is a relatively invasive procedure. Because HPV testing has less specifity than liquid-based cytology[[5]](#footnote-5), there is the risk of false-positives, which could lead to women unnecessarily undergoing colposcopy. A better pathway would be to complete liquid-based cytology before colposcopy for women who test positive for HPV 16, 18. It is vital that the chance of false-positives is identified, and made clear to women, to ensure they are fully informed and can make an informed choice about whether to undergo colposcopy.  We also believe the sensitivity of the HPV tests may lead to women presenting at colposcopy with smaller lesions that colposcopists have trouble finding or knowing where to look. We believe there must be investigation of the potential impact of alternative pathways including cytology. We should also consider cytology for women > 30 years who may have increased risk.  There are implications for the colposcopy workforce with the projected increased demand as well as a record of high DNA rates for attendance at colposcopy clinics. |

1. **Screening equity**

Please comment on suggested strategies for eliminating inequalities in screening.

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| Women’s Health Action strongly recommends that screening be fully funded and free to all women to ensure equitable outcomes. Cost has been consistently identified as a barrier to screening, and it is important to acknowledge both direct and indirect costs such as transport, childcare, and lost income from taking time off work[[6]](#footnote-6). Reducing the number of tests over a woman’s lifetime may reduce the total cost of screening, but will have no impact on women discounting health in favour of more urgent expenditures.  We believe it is important to ensure accurate, detailed information on HPV immunisation, screening, and cervical cancer is made available to all women, and that this needs to be done prior to any changes to the screening programme. Knowledge of the purpose of screening varies greatly across women[[7]](#footnote-7), and may impact on their decision to participate or not participate. This will be a particularly salient issue if we move to HPV testing as the primary screening method, and it should be an imperative to ensure that women understand that HPV testing is still important even if they have been HPV-immunised, and to ensure any stigma around HPV being associated with sexual activity is addressed.  It is important to ensure that current services are equipped to meet the needs of diverse women in New Zealand. If self-testing becomes an option, it is vital that is a choice that can be made by women freely and not because of a lack of acceptable services to meet their needs. Those who currently have lower access rates include some refugee and migrant populations, rural women, lesbians and women with disabilities. For example, women with physical disabilities are often met with barriers to screening because of inadequate facilities[[8]](#footnote-8).  It is also important that screening providers reflect the choices of different women, and are not organised on the basis of what it is expected they would prefer. For example, in a small community, a Pacific smear taker may be seen as inappropriate to Pacific women[[9]](#footnote-9).  Culturally and linguistically diverse clients should be offered appropriate resources and education and a trained health interpreter if needed. For example, the Asian population in New Zealand has low screening rates and language has been identified as a barrier to screening[[10]](#footnote-10). |

1. **Self-sampling**

* Who should self-sampling be offered to?
* What is the best way for women to test themselves (e.g., at home or at a clinic)?
* If a woman tests positive for HPV during self-sampling, she will need either follow-up cytology or referral to colposcopy. What do you think the uptake of follow-up for a positive test would be?
* What issues do you see with self-sampling?

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| There is insufficient research to evidence whether HPV self-sampling will be acceptable to those women who are in the unscreened/under-screened populations. We need to assess this by talking with women.  While the possibility of self-testing may seem to offer the possibility of increased access to screening, we must ensure access to a full range of screening services for all women until there is sufficient evidence to support this hypothesis.  We need to have a clearer understanding of what’s involved with self-sampling, the sensitivity and accuracy of self-testing, as well as likely costs for the woman, before we can provide any advice. We also need to know if there are any possible side effects or potential for injury and in exactly what circumstances have self-test kits been tested. We therefore think this requires more investigation but believe that there is a role for self-testing in the context of oversight by a health practitioner and in the context of some women feeling more comfortable with self-testing. Self-testing would need to be a targeted approach, be fully funded, and an option that is provided as an alternative to free, appropriate, and accessible screening through a health practitioner.  We need to evaluate the effects of self-testing removing the opportunity for observation other health issues that is provided when undergoing screening by a health professional, and the risk of perpetuating disengagement with health services, particularly in groups with currently low access rates.  We believe these and other questions need to be fully investigated with women, in particular those from groups with lower screening rates, to establish whether self-testing is acceptable to them. We also need to evaluate the risks of women testing positive and not pursuing testing. |

1. **Invitation and recall to screening**

* What should be taken into account when re-designing the NCSP-Register for HPV primary screening?
* What is the most reliable way of systematically inviting women into the programme and recalling them at the appropriate time?
* Whose role should it be to invite and recall women into screening?

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| We recommend there be a separate consultation on the changes to the NCSP-Register once a decision on the primary screening test is made. High quality/accurate information to be provided to women must be developed with consumer involvement |

1. **Cervical screening workforce**

* Smear takers: What information do you need to confidently engage with your patients if HPV primary screening is introduced?
* Cytopathology workforce: How do we retain gynaecological cytopathology professionals (existing cytopathologists, and anatomical pathology registrars) and maintain their expertise in the long term?
* Cytoscientists and cytotechnicians: What can we do to maintain a gynaecological cytology workforce in the period before HPV primary screening is introduced?
* What should we do to ensure New Zealand has an adequate number of expert gynaecological cytology staff in the long term?
* Histology and molecular biology staff: Does the molecular biology workforce have any additional training requirements?
* How much capacity do histology laboratories have to process a 10–30 percent increase in gynaecological histology specimens?
* Regional coordination, and invitation and recall staff: What is the best way to ensure you are well informed about the changes resulting from HPV primary screening?

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| We wonder whether a survey of this workforce should have been completed separately so public and health practitioner comments could be based on more information. We have serious concerns about the loss of skill and practitioners in this workforce. |

1. **Further Questions:**

We believe the following questions need to be resolved before any permanent changes are made to the current screening programme.

* What will women be told if they test positive – that they are of high risk of cervical cancer; higher risk of cervical cancer; higher risk of pre-cancerous lesions?
* What might ‘high’ and ‘higher’ risk actually mean? How will this be determined? Will it be specific groups or populations?
* If a women is a ‘higher risk’ and requires a shorter screening interval, how will you ensure that this does not marginalise communities who are deemed high risk?
* What impact will this have on women?
* Won’t there be a large number of women who have been sexually active before the age of 15, who are not immunised who could in theory develop cell changes or even cancer before the age of 25?
* What will be done to ensure women < 25 who do develop symptoms that may be/are cervical cancer are taken seriously, with symptoms investigated and appropriately treated?
* The pilot study[[11]](#footnote-11)

What are the results of this programme so far?

What is the level of consumer advisory involvement?

Why is it only a service evaluation study?

How will you measure the success of the programme?

Will coverage be the sole measure, or will issues such as informed consent be given priority?

Thank you for the opportunity to provide this feedback.

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| **60** | Submitter name | Louise Sanford |
| Submitter organisation | Cancer Society of New Zealand |

Cancer Society NZ Cervical Screening submission: 

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| **61** | Submitter name | [redacted] |
| Submitter organisation | Private |

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Name:

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| [redacted] |

Organisation (or Private):

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**3.** The modelling work done to date supports the preferred pathway as the one likely to achieve the greatest benefits. However, are there any other options that you believe the NCSP should investigate further?

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| In the chosen scenario 2a my understanding is that a woman testing positive for hr-HPV 16 or 18 will be referred directly to colposcopy in the new New Zealand programme. The Dutch health council has recommended that screening commence at age 30 “with an HPV test and cytology will only be performed in the event of a positive hr-HPV result. Referral for colposcopy will take place in the event of a positive HPV test in combination with abnormal cytology. When cytology is normal at baseline and after 6 months, the HPV test will be repeated first after 5 years.” (Ref. HPV Today No 24 Aug 2011).  The proposed screening start age in the new New Zealand programme is 25, not 30 as in The Netherlands, which will lead to many more women testing positive for high risk strains 16 and 18 than in The Netherlands. At 30 the prevalence of hr-HPV is 8% in the Dutch programme. (Ref. HPV Today No 24 Aug 2011). With HPV testing in the Dutch programme “the higher sensitivity and somewhat lower specificity from CIN2+ will result in a three-fold higher referral rate to colposcopy compared to the current cytology based program.” (Ref. HPV Today No 24 Aug 2011).  This will be a significant problem in New Zealand if the screening age is 25 and if there is no cytology triage following a hr-HPV test positive for 16 or 18. In my opinion unnecessary colposcopy and presumably biopsy will cause psychological angst for many young women who have transient HPV infections. |

**4.** What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway?

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#### 5. Screening interval

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| A further question might be “are there any groups of women who have a lower risk and for whom a longer screening interval is appropriate should they wish to screen?” Some women, if they were given proper informed consent, might decide to have screening every 10 years from 40 until 60 as the Dutch will do. It is also a perfectly valid decision for some women to forego screening altogether, for example a woman in a long term mutually monogamous relationship with a negative pap smear or liquid based cytology screening history who is hr-HPV negative and negative for other oncogenic HPV sub-types. A woman could choose to revisit her decision and resume screening should her risk profile change. This might result in resources being direct to those who need extra care or treatment. |

#### 6. Age range for screening

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| It is appropriate to raise the screening age to 25 and long overdue. In my opinion a screening starting age of 30 would be even better and reduce over-diagnosis and over-treatment. The Dutch and the Finns do not commence screening until a woman is 30. The UK raised the screening age to 25 in 2004. Scotland will follow suit in 2016 and Australia in 2017 when they introduce primary HPV testing.  From Australian Doctor 28 July 2006 (Associate Professor Margaret Davy and Dr Lesley Shorne) “No country has reported any decline in the incidence of, or mortality from, cervical cancer in women under 30, irrespective of cervical screening.” See also Screening in women under 25 is not associated with decreased incidence of cervical cancer, P Sasieni, BMJ 2009; 339:b2968.  From National Screening Programme: Changing the primary laboratory test, Technical Appendix to the public consultation paper (page 31 section 3.42): “Warner et al, 2015, concluded that primary HPV screening should not be initiated prior to 25 years of age. This panel had concerns regarding the potential harms of beginning HPV primary screening at age 25 years particularly with regard to the number of colposcopies, despite the increased detection of disease. The panel concluded that progression to cancer is uncommon and the detection of most of the disease found in the 25-29 year age groups can be safely deferred until age 30 and older.  Page 53 section 5.2 “colposcopy referral and histology evaluation rates may increase initially after a transition to primary HPV screening but will drop over time as cohorts offered vaccination grow older and enter the new HPV screening programme.” In my view, the fact that “cohorts are offered vaccination” does not mean that they will accept the offer and be vaccinated so colposcopy referral rates may not decrease.  On the NHS cervical screening website under frequently asked questions there is “Why can’t women have cervical screening until they are 25?” Part of the answer is “Cervical cancer is linked to persistent infection with the human papillomavirus (HPV). This is a very common, symptomless virus, which can cause minor abnormalities in the cells of the cervix. In the great majority of women, the immune system clears the infection and the abnormalities go away naturally. However, in a small number of women the HPV infection persists. In a few rare cases the abnormalities it causes can develop into something more serious, and if they are not caught and treated, they may eventually turn into a cancer.  Cervical abnormalities associated with HPV infection are very common in women under 25, but are rarer in older women. Abnormalities in young women go away by themselves in the great majority of cases. Therefore, the consequence of screening younger women is that many would test positive for abnormalities and would subsequently be sent for unnecessary treatment to remove the affected cells. This treatment may increase the likelihood of a woman having a pre-term delivery if she goes on to have children and the whole process can cause significant anxiety. Cervical cancer is extremely rare in women under the age of 25 with just 2.6 cases per 100,000 women. Therefore, the harms of screening women under the age of 25 are currently thought to outweigh the benefits.” See http://www.cancerscreening.nhs.uk/cervical/faq08.html for full text and references.  From the Technical Appendix to this public consultation paper page 23 In New Zealand between 2008 and 2011 there were two deaths in the 20-24 age group. “Many young women with CIN2/HSIL will undergo spontaneous regression”, Dr Peter Sykes NCSP Colposcopy Symposium 2012.  Dr Peter Sykes and Dr Bryony Simcock are running PRINCess: The Prediction of Regression in CIN2, a prospective multi-centre trial of conservative management of CIN2 in women under the age of 25. From the protocol of this study, “Currently the routine management of CIN2 on the cervix is a LLETZ biopsy (large loop excision of the transformation zone of the cervix). The LLETZ procedure has been associated with complications in future pregnancies. Studies have shown an increased risk of preterm rupture of membranes and preterm delivery. Repeat procedures significantly increase the risk for pregnancy complications.”  “Issues regarding fertility and other treatment related morbidities also are relevant in women in ages 20-25. A large number of women in this age group are diagnosed with CIN2. Currently there are no guidelines that recommend conservative management.” There are many studies detailing the harms of LLETZ procedures (LEEP as it is known in the US – Loop Electrosurgical Excision Procedure). In the Journal of the American Medical Association (JAMA 2004 May 5; 291(17): 2100-6) Treatment for Cervical Intraepithelial Neoplasia and Risk of Preterm Delivery the conclusion was “LEEP and laser cone treatments were associated with significantly increased risk of pPROM (premature rupture of membranes before 37 weeks gestation). Careful consideration should be given to treatment of CIN in women of reproductive age especially when treatment might reasonably be delayed or targeted to high risk cases.” In my opinion it is bordering on the unethical to perform LLETZ procedures for CIN2 which will likely regress in women under the age of 25. I think that if the cervical screening programme was geared towards protecting women and there was no political interference screening would commence at the age of 30 in line with medical evidence. |

#### 7. Referrals to colposcopy (for clinicians)

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**8.** Screening equity  
Please comment on suggested strategies for eliminating inequalities in screening.

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#### 9. Self-sampling

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| Self-sampling, quite simply, should be available to all women who choose to undergo screening. The new Australian and the Dutch programmes will offer this method to the “under-screened or never-screened.” In my view many women who hear about this test will choose it rather than the speculum test. Should you choose to reserve this for the under-screened etc, women might put themselves in the under-screened category or just refuse the speculum and demand the self HPV test. The Dutch have found from their studies that “the highest yield and fraction of cervical cell material was obtained with the Delphi screener”. Delphi Screener, Delphi Bioscience, HPV Today No 24 August 2011.  An individual woman should be able to use a self HPV test in her own home should she wish. If she is not confident she could enlist the advice/help of a smear-taker. Göte M et al – HPV testing on self-collected cervicovaginal lavage specimens as screening method for women who do not attend cervical screening: cohort study – BMJ 2010, Mar 11;340:1040. This study has shown that offering self-sampling for hr-HPV testing to non-attendees is a feasible and effective method of increasing coverage in a screening programme. |

#### 10. Invitation and recall to screening

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#### 11. Cervical screening workforce

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**12.** Do you have any other feedback?

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| In view of the fact that the truth about over-diagnosis and over-treatment that occurs with screening is becoming more public, I think it is about time that women got some true, unbiased, information in New Zealand. Breastscreen Aotearoa are having to finally put some truthful information about over-diagnosis and over-treatment in their literature. Can we expect something similar from the NCSP? In my view it is not acceptable to over-treat and harm so many young New Zealand women, in an attempt to save the few, without telling those young women that they risk that harm. Every woman has a right to unbiased information so that she can decide whether the benefits of stepping on to the screening pathway outweigh the harms for her. In Screening Matters issue 3 Feb 2005 the checklist for smear takers mentions telling women about the importance of smears, the NCSP register, the procedure for taking a smear, etc. There is no mention of the true incidence of cervical cancer, the fact that it is and always has been uncommon, in fact rare in women under 25. There is no mention that once a woman is enrolled in the programme her entire medical history and her notes are accessible to evaluators from the programme, researchers, etc, all without her consent. There is also no mention that women under 30 are very prone to false positives and should they have CIN2 or greater it will be treated by LLETZ procedure in spite of the research that shows regression of these lesions. Women are also never told that doctors are incentivised via the IPIF to hit a screening target. 80% of their eligible patients must be coerced, pushed to screen because 25% of their PHO payments are dependent on it. Doctors will opportunistically screen in order to achieve this. This negates informed consent in my view. It is paternalistic and these payments need to stop. It is a legal requirement to give all women informed consent and it neither is, nor has been, happening. |

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| **62** | Submitter name | Dr. Lara Hashimoto |
| Submitter organisation | Roche Diagnostics NZ Ltd |

**Top of Form**

#### 1. Answer this question only if you are submitting as a private individual, and you do not want your personal details released or published

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I do not want my personal details included in the published summary of submissions

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**2.** Your contact details:

Name:

|  |  |
| --- | --- |
| |  | | --- | | Dr. Lara Hashimoto | |

Organisation (or Private):

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| --- | --- |
| |  | | --- | | Roche Diagnostics NZ Ltd | |

Address/ email:

|  |  |
| --- | --- |
| |  | | --- | | 15 Rakino Way, Mt Wellington 1060  lara.hashimoto@roche.com | |

**3.** The modelling work done to date supports the preferred pathway as the one likely to achieve the greatest benefits. However, are there any other options that you believe the NCSP should investigate further?

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| Roche Diagnostics NZ Ltd supports the NCSP’s proposal to use HPV testing as the first line cervical screening method in NZ. Numerous peer-reviewed studies have shown that cytology testing consistently has a lower clinical sensitivity than HPV DNA testing. Compared to cytology, a single negative HPV DNA result predicts a much lower risk of developing invasive cervical cancer over extended periods as demonstrated in an analysis of 4 randomized control studies (Ronco et al – Lancet 2014). Published data from Kjaer et al (JNCI 2010) and Khan et al (JNCI 2005) also clearly show that HPV genotypes 16 and 18 are the highest risk HPV genotypes for progressing to pre-cancerous cervical lesions based on a single positive result.  Findings from the ***ATHENA*** trial, the largest prospective cervical cancer study conducted in the United States, were highly consistent with the data presented in the aforementioned studies. In a sub-analysis of over 42,000 women aged 25 years and older, Wright et al (Gynecologic Oncology 2015) concluded that HPV primary screening with 16/18 genotyping (identical to the proposed pathway of the NCSP) provided the most appropriate balance of increasing sensitivity and the number of colposcopies as compared to Pap or co-testing strategies. Clinical data from this trial was also used to support the first and only FDA approved HPV primary screening claim and the first US professional guidance on the use of HPV primary screening (Huh et al – Gynecologic Oncology 2015). Both supported the use of HPV primary screening with 16/18 genotyping.  Although cytology and HPV 16/18 DNA co-testing may ease the transition from Pap to HPV testing as the first line test, this algorithm provides minimal clinical benefit at significantly greater cost (Cox et al, 2013 – “*Comparison of cervical cancer screening strategies incorporating different combinations of cytology, HPV testing, and genotyping for HPV 16/18: results from the Athena HPV Study”*).  The efficacy and safety of the NCSP proposed screening algorithm will depend on which HPV test laboratories choose to use. Given that *in vitro diagnostics* are unregulated in NZ, it is essential that strict clinical criteria are established for the selection of the HPV test in order for NZ to maintain one of the most successful cervical screening programmes in the world.  New HPV DNA positive reflex algorithms that can improve on the performance of traditional LBC testing have been a focus of a growing number of large and controlled clinical trials across the world. Already, a significant amount of clinical data has been generated for the dual stain p16 / ki-67 biomarkers (CINtec *PLUS*). When compared to Pap, CINtec *PLUS* has been shown to be both more sensitive and reproducible without loss in specificity. These biomarkers provide an objective aid to cytology that is not dependent on subjective morphology interpretation and has been included in the trial design of Compass (Australia) and FRIDA (Mexico) studies, two of the largest ongoing prospective cervical cancer studies in the world. Because CINtec *PLUS* also utilizes the same processing method for creating a liquid-based cytology slide, the NCSP should consider replacing traditional LBC with CINtec *PLUS* or allowing it as an LBC option in the future. |

**4.** What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway?

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| The NCSP public consultation and technical appendix do not address requirements for HPV test specifications for laboratories contracted to receive NCSP public funding to offer HPV testing. Given that HPV tests are not regulated in NZ, NCSP guidelines and laboratory contracts should set minimum requirements to ensure efficacy and safety of the proposed HPV testing algorithm.  The ***Compass*** study is a NZ feasibility study to assess operational aspects of implementing HPV testing as a first line screening method. Included in ***Compass*** is a time in motion study comparing the NCSP proposed HPV first line testing algorithm to the current NCSP algorithm to reveal impact on the cervical screening workflow. Compass is the first NZ study that has explored women and clinicians attitudes and level of understanding of HPV testing and the adequacy of information provided as part of the Compass study. Dr. Mee Ling Yeong is the Principle Investigator and can be contacted for further information on study findings (https://www.anzctr.org.au/Trial/Registration/TrialReview.aspx?id=366577).  Below are clinical references that may be relevant to the NCSP proposal.   Primary cervical cancer screening with HPV: end-of-study results from the ***ATHENA*** study using HPV as the first-line screening test. ATHENA (Addressing the Need for Advanced HPV Diagnostics), a prospective, multi-center US cervical cancer screening trial was the basis for FDA approval of the **cobas®** HPV test in which over 47,000 women were enrolled. (Wright et al – Gynecologic Oncology 2015) http://www.ncbi.nlm.nih.gov/pubmed/25579108   * Primary screening for cervical cancer based on hrHPV detection and HPV 16 and HPV 18 genotyping, in comparison to cytology - HEllenic Real life Multicentric cErvical Screening (***HERMES***) (Agorastas et al – PLoS One 2015) http://www.ncbi.nlm.nih.gov/pubmed/25793281 * MSAC has provided recommendations on new approaches to cervical screening in Australia. http://www.cancerscreening.gov.au/internet/screening/publishing.nsf/Content/MSAC-recommendations * Guidelines for human papillomavirus DNA test requirements for * primary cervical cancer screening in women of 30 years and older (Meijer et al – International Journal of Cancer 2009) http://www.ncbi.nlm.nih.gov/pubmed/18973271 * Which high risk HPV assays fulfil criteria for use in primary cervical cancer screening? (Arbyn et al – 2015 Clinical Microbiology and Infection) http://www.ncbi.nlm.nih.gov/pubmed/25936581 * Accuracy of human papillomavirus testing on self-collected versus clinician-collected samples: a meta-analysis (Arbyn et al – Lancet Oncology 2014) http://www.ncbi.nlm.nih.gov/pubmed/24433684 * Transcript “FDA Microbiology Devices Advisory Committee for premarket approval application for the cobas HPV Test” (March 12th, 2014) http://www.fda.gov/downloads/AdvisoryCommittees/CommitteesMeetingMaterials/MedicalDevices/MedicalDevicesAdvisoryCommittee/MicrobiologyDevicesPanel/UCM393482.pdf * Court summary decision, Hologic Netherlands vs The State of Netherlands, March 25, 2015 (Dutch only) * http://uitspraken.rechtspraak.nl/inziendocument?id=ECLI:NL:RBDHA:2015:3422 * Court summary decision, Hologic Netherlands vs The State of Netherlands, June 9, 2015 (Dutch only) http://uitspraken.rechtspraak.nl/inziendocument?id=ECLI:NL:GHDHA:2015:1456 * Court summary decision, Hologic Netherlands vs The State of Netherlands and Roche Diagnostics Netherlands, October 8, 2015 (Dutch only) http://uitspraken.rechtspraak.nl/inziendocument?id=ECLI:NL:RBDHA:2015:11786 |

#### 5. Screening interval

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| The best risk mitigation for a longer testing interval is to set stringent guidelines for HPV test requirements to ensure the correct HPV DNA result is provided. There are over 100 HPV tests commercially available, only one meets minimal criteria that should be considered for a government funded cancer screening program. Minimal HPV test criteria should include the following:   * **Clinically validated HPV test cutoffs**   *Rationale:* The goal of an HPV primary screening test is to detect clinically relevant HPV infections at an optimal balance of sensitivity and specificity that have been clinically validated in a robust, prospective and controlled clinical study in an unbiased screening population using histologically confirmed endpoints of ≥CIN2 or more stringently ≥CIN3 lesions.   * **Internal Cellular Control**   *Rationale:* Unlike cytology which directly visualizes the sample, molecular testing cannot verify if a sample is present unless there is an internal cellular control present. Lacking this control could result in false negatives. This is of particular importance for a primary screening test where a woman with a negative result would not be retested for 5 years. Process or “spiked” controls that are used by some HPV tests do not meet this criteria as they do not detect whether sample is present.   * **Simultaneous detection of pooled high risk HPV with individual HPV 16 and 18 genotyping with demonstrated clinical utility and performance data.**   *Rationale:* HPV genotyping tests that are performed as separate reflex tests to the primary HPV test add unnecessary cost and time to the laboratory. They may also generate discrepancies between the 2 assays which could result in inability to resolve 16/18 results that may be missed or overcalled when 2 separate tests are combined. Reporting out specific genotypes beyond 16/18 does not provide clinically relevant information and may cause unnecessary confusion for the clinicians following management guidelines. Finally, because HPV 16/18 positives will go directly to colposcopy, it is important that the clinical utility and performance of the test’s 16/18 results have been validated in a robust clinical trial.   * **FDA approved for HPV primary screening**   *Rationale:* HPV tests are designated as class III, the most stringent classification, under the FDA medical device regulations and require independent review and approval of clinical claims being made by the manufacturer as well as GMP quality manufacturing and ongoing post-approval surveillance. CE-IVD would be insufficient given that the manufacturer’s conformity requirements that are certified by a notified body are self-declared by the manufacturer and does not go through a review and approval process.   * **DNA-based HPV test**   *Rationale:* For HPV primary screening, only DNA-based assays have demonstrated the long term safety of a negative result that is required to safely extend screening intervals to 5 years. Assays that target other HPV related markers such as mRNA should not be considered. This position is supported by most experts in the field and was one of the key criteria in the Netherlands HPV tender for primary screening, the recent supplement to the cervical screening guidelines issued by the European Commission in September 2015, and in evaluation of which HPV tests fulfil the international criteria for primary screening (Arbyn et al – Clinical Microbiology and Infection)   * **Automation for HPV analytical and preanalytical steps**   *Rationale:* A key advantage of PCR-Based HPV DNA testing over Pap is the improved consistency and reproducibility of results. Requiring highly automated systems for analytical and preanalytical processes reduces the opportunity for operator error, fatigue, contamination, and inter-operator variability while improving the overall efficiency of the healthcare system.   * **Clinical evidence supporting self-sampling using PCR**   *Rationale:* Given the importance of HPV self-sampling to the screening program, the HPV test should have clinical evidence that demonstrates equivalent performance to clinician-based sampling. Different technologies have demonstrated varying levels of performance in previous studies (Arbyn et al – Lancet Oncology 2014). In the Netherlands HPV primary screening tender only PCR-based technology was considered for the program based on this analysis of self-sampling studies. |

#### 6. Age range for screening

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| There is a higher burden of >CIN3 in women 25-29 years of age which is not being found using cytology (UK screening audits and ATHENA data). The ***ATHENA*** 3 years follow-up data revealed that fewer young women in this age range would be referred to follow-up using HPV 16 and 18 genotyping (6.9%) than by cytology alone (9.5%) thus striking the right balance of maximising sensitivity to detect disease and maximising specificity to minimize the number of unnecessary colposcopies.  Numerous studies have confirmed that younger women aged 21-24 who present for cervical screening have the highest % HPV positivity (30.5% in Athena). In these younger women, HPV infection clears more rapidly resulting in a higher HPV false positive rate or referring too many women to follow-up due to clinically insignificant HPV infections. The implementation of HPV testing as a first line screening method in women aged 20-24 yrs would therefore cause undue harm and stress.  While prevalent HPV infections are very frequent in women age 20 -25 the disease rate (CIN2 or greater) is relatively low. In general it is assumed that the period from infection to cervical cancer development takes about 10 years. Thus a screening starting age of 25 and older should be sufficient to capture most of the incident disease at a relatively early stage. In addition it can be assumed that with the high rate of vaccination in NZ the disease rate will go down in the younger population.  Many screening programs in other countries have set the upper age limit to 65. However recently there is some controversy about whether this ends screening too soon given the shift of the second peak in disease prevalence in the older age group (Foley, G., Alston, R., Geraci, M., Brabin, L., Kitchener, H., & Birch, J. (2011). Increasing rates of cervical cancer in young women in England: an analysis of national data 1982-2006. Br J Cancer, 105(1), 177-184). Adding an additional exit test between 69 and 74 might provide additional safety without significantly increasing the number of screening tests.  In NZ, giving women the option, accompanied by evidence-based recommendations may be the most appropriate approach. |

#### 7. Referrals to colposcopy (for clinicians)

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| In the ATHENA trial (Wright et al - Gynecologic Oncology 2015), the HPV primary screening strategy with 16/18 genotyping required 3,767 colposcopies compared to 1,934 colposcopies for the strategy of Cytology with HPV triage. Although this is a relatively large increase in colposcopies the number of colposcopies required to find each disease case only increased by 1 colposcopy (8.1 vs 7.1). In terms of the absolute number of colposcopies, it should be noted that these numbers do not account for differences in the screening interval. If the New Zealand HPV screening program extends the interval to 5 years vs the current program of 3 years, the number of women attending the program would be reduced by 40%. This means that the actual increase of colposcopies will not be as dramatic as reported by Wright et al since it would be largely offset by the fewer women attending per year. Also, in the ATHENA trial cohort, only a minimal number of women were vaccinated for HPV 16/18. In a highly vaccinated population such as that of New Zealand, the net impact of the vaccination and interval extension would likely mean only a small difference in colposcopies when comparing current practice to the HPV primary screening proposal. This also assumes that screening invitations would be staged across the age categories (e.g. first year age 25, 30, 35 etc., second year age 26, 31 etc. and fifth year age 29 and 25, 34 and 30 etc.) which would help reduce a potential peak in colposcopies and might further on contribute to a more balanced utilization of screening resources. |

**8.** Screening equity  
Please comment on suggested strategies for eliminating inequalities in screening.

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| Targeted education in the lower screened / never screened populations (eg. Maori, Pacific Island and Asian people) should continue. Results from self-sampling studies indicate that this may be one approach for improving participation in these communities.  Roche Diagnostics NZ Ltd is committed to play a responsible role in achieving equitable women’s health in NZ. Roche would welcome the opportunity to partner with NCSP on cervical cancer awareness or educational programs, particularly if this is towards addressing access inequalities. |

#### 9. Self-sampling

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| Some studies have shown that self-sampling can increase participation or previous non-responders therefore may be an effective means of achieving better screening equity in NZ. (Arbyn, M. and P. E. Castle (2015). Cancer Epidemiol Biomarkers Prev 24(5)) Roche is committed to developing simple and practical self-sampling solutions for use and has supported a number of self-sampling studies with the cobas HPV Test globally. These studies include evaluation of different self-sampling collection devices, specimen stability, intra- and inter-lab reproducibility and clinical performance compared to clinician-collected ThinPrep LBC using cobas HPV Test. It should be emphasized that only PCR-based tests show adequate sensitivity and mRNA tests lack published data to demonstrate long-term safety.  Several self-sampling pilot studies with the cobas 4800 HPV test have been recently published (Stanczuk, et. al. J Clin Pathol 2015; Sultana, et. al. J Clin Virol 69, 2015; Sultana et. al. BMC Cancer, 2014.) Additional self-sampling studies using the cobas 4800 HPV Test are in various stages of completion and their results will be published in peer-reviewed journals. In the meantime, Roche has permission from study investigators to share the preliminary results in advance of publication with government health officials. Please contact Roche Diagnostics NZ Ltd if NCSP would be interested in an advanced viewing of these studies results. |

#### 10. Invitation and recall to screening

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| Registry should have flexibility to accommodate any future changes in reflex testing methods  NCSP should accommodate informed NZ women who request a specific HPV test brand. NZ women should have the autonomy to require that the best test be given and that NCSP reimburses at a standard rate across laboratories. |

#### 11. Cervical screening workforce

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**12.** Do you have any other feedback?

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| The NCSP has developed one of the best cervical screening programs in the world as evidenced by the high participation rate and low cervical cancer rate. Roche commends the NCSP’s willingness to further improve the cervical screening program based on recent scientific and clinical literature. In summary, Roche would request that the NCSP take the following key points into consideration:   * Include minimum technical and clinical requirements for HPV Tests selected by laboratories that are contracted with NCSP funding. This is essential for the cervical screening program to be safe and efficacious. * HPV DNA tests have the largest and most robust evidence base supporting its use in primary screening program. mRNA based tests have not yet been clinically validated in prospective and controlled studies in a screening population. * Strict quality control is critical to maintain safety of women testing negative to assure they are at low risk for disease during the screening interval. Internal controls which assure appropriate sample collection and not just successful assay completion reduce risk of false negative results due to insufficient sampling. * Self-sampling may improve screening inequities, however, only PCR-based DNA tests have adequate sensitivity and evidence-base for this sampling method. * NCSP should be prepared to accommodate informed NZ women who wish to have HPV primary screening in advance of 2018 and are willing to pay privately. The current NCSP workflow does not allow this option for women. * Informed women should have the autonomy to request a specific HPV test through inter-laboratory send-aways. Since cervical screening laboratory testing is funded nationally, women should have the right to become informed and choose. |

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| **63** | Submitter name | Tira Albert |
| Submitter organisation | Mana Wahine |

#### 1. Answer this question only if you are submitting as a private individual, and you do not want your personal details released or published

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**2.** Your contact details:

Name:

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| Tira Albert |

Organisation (or Private):

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**3.** The modelling work done to date supports the preferred pathway as the one likely to achieve the greatest benefits. However, are there any other options that you believe the NCSP should investigate further?

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| * When reading the Technical appendix and the modelling work it is not clear that women who do not participate in screening have been accounted for. So how does the pathway address non-screeners to ensure they are included?   Secondary policy question 7 page 75 of the appendix, comments:   * Who does the pathway achieve the greatest benefits for if equity has not been achieved across all ethnicities? * Does this risk increasing inequities in NCSP? * There may be high rates of Māori and Pacific being HPV immunised this does not match with Māori and Pacific women participating in NCSP. * Ethnic inequities already exist by increasing the screening age and frequency of screening will increase mortality and morbidity in these groups. This is not the aim of NCSP.   There appears to be no research strategies or response to increasing participation of indigenous peoples into NCSP in Australia or New Zealand from reading these documents except for 3 paragraphs on p75. Where is the commitment to the Treaty of Waitangi for ALL New Zealanders? In accordance with NCSP policies and standards section 3 providers must:   * understand that priority group women have a higher risk of developing, and dying from, cervical cancer than other groups * implement a process for identifying these women within their own populations by age range * implement systems and strategies for inviting and recalling these women, acknowledging that they may need to use additional or alternative strategies * Provide information and services for priority group women that are culturally appropriate to individual women. (NCSP policies and standards section 3 revised 2014 NSU website)   NCSP need to retain the 20 year screening start age sub-strategies C & D (p16) preferred, frequency of screening should only be extended to 5 years for regular screeners only. |

**4.** What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway?

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| Impacts of proposed changes will greatly affect Priority groups of women please consider the following literature:   1. A Brief Narrative on Māori Women and the National Cervical Screening Programme (MOH June 1997) 2. Determinants of inequalities in cervical cancer stage at diagnosis and survival in New Zealand (P Priest, L Sadler, P Sykes, R Marshall, J Peters & S Crengle 22 October 2009, Cancer Causes Control (2010) 21:209-214) 3. Achieving equitable outcomes for Māori women with cervical cancer in New Zealand: health provider views (M McLeod, D Cormack, R Harris, B Robson, P Sykes & S Crengle, The New Zealand Medical Journal 13 May 2011 Vol 124, No 1334 p 52-62) 4. Improving Māori Access to Cancer Health Care: Literature Review (Fiona Cram For Katoa Ltd MOH 2014) 5. Does screening history explain the ethnic differences in stage at diagnosis of cervical cancer in New Zealand (N Brewer, N Pearce, M Jeffrey’s, B Borman & L Ellison-Loschman) International Journal of Epidemiology 2010 39 (1) p156-165) 6. NCSP Annual Report 2012 (report prepared by M Smith; R Walker; K Simms, & K Canfell, Lower Cancer Research Centre, Prince of Wales Clinical School, UNSW Australia) |

#### 5. Screening interval

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| This proposal will contribute to an increase in mortality and morbidity of those women who do not participate in the screening programme on a regular basis.  These are the women who are at high risk and will require a shorter screening interval.  See other comments above also |

#### 6. Age range for screening

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| * If the age range is raised to 25 years this will put younger people at high risk   **BECAUSE:**   * **Young people aged** 15 to 24 **are more at risk of physical, psychological and sexual victimisation than any other age group.** * Three in four **teenage girls in New Zealand reported at least one incident of unwanted sexual activity.** * **In New Zealand, it is estimated that** one in four **females and** one in eight **males are likely to experience sexual violence or abuse in their lifetimes, many before the age of 16.** * **Around** one in four **girls and** one in 10 **boys in New Zealand have experienced sexual abuse.** * SOURCES: * Fanslow, J and E Robinson (2004) “Violence against women in New Zealand: prevalence and health consequences”; The New Zealand Medical Journal, 117(1206): 1173 * Jackson, S, F Cram and F Seymour (2000) “Violence and sexual coercion in High School student's dating relationships”; Journal of Family Violence, 15(1): 23–36 * Morris, A and J Reilly  (2003) The New Zealand National Survey of Crime Victims 2001 * The 2006 New Zealand Crime and Safety Survey. * I see no benefits of an exit screening test for 69-74 years. |

#### 7. Referrals to colposcopy (for clinicians)

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**8.** Screening equity  
Please comment on suggested strategies for eliminating inequalities in screening.

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| Ensure that contracts with Māori providers are retained especially those with Direct contracts with the NSU most importantly Independent service providers. Equity has not been achieved for wahine Māori. For equity to be achieved more human resource is required. They are the most at risk of not being screened. Māori providers are able to work best with these wahine they understand the barriers wahine face; they can offer a holistic service. Again referring to the Treaty of Waitangi this needs to be aligned to any re-design of a screening programme. From reading the documents it is difficult to see where the HEAT tool has been applied. Health Equity Assessment Tool. |

#### 9. Self-sampling

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| 1. Self-sampling should be offered to all women. However be mindful that not all women would be able to self-sample. These would be obese women; arthritic women; women with balance issues; women with mental health issues; women who have limited movement or flexibility; disabled women. 2. For priority groups it needs to be with a their provider 3. Provided the women as been fully informed educated and offered support 100% 4. That it is technically not the best type of test to carry out. That it may increase false positives or false negatives. Not enough research has been completed in Aotearoa/New Zealand. |

#### 10. Invitation and recall to screening

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| 1. Information needs to mirror the information currently collected 2. The register and a women’s provider 3. Everyone |

#### 11. Cervical screening workforce

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| * Training that needs to be regular and with updates; opportunities to meet regionally and nationally with kaimahi and smear takers, to increase learning and innovations; culturally appropriate resources for both smear takers and the women; appropriate funding for all work and workers |

**12.** Do you have any other feedback?

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| * Screening needs to remain free * Screening needs to be inclusive of all providers in the design and delivery * Screening needs to acknowledge the Treaty of Waitangi * Screening needs to continue to work towards achieving equitable outcomes for wahine Māori * Screening needs Māori health providers, smear takers and kaimahi to support the NCSP to achieve equity for wahine Māori and all priority women. |

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| **64** | Submitter name | Leani Sandford |
| Submitter organisation | Planning, Funding and Outcomes – Pacific health, Auckland DHB, Waitemata DHB |

#### 1. Answer this question only if you are submitting as a private individual, and you do not want your personal details released or published

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**3.** The modelling work done to date supports the preferred pathway as the one likely to achieve the greatest benefits. However, are there any other options that you believe the NCSP should investigate further?

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| No, we support the preferred pathway. |

**4.** What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway?

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| If the Ministry of Health is proposing to offer the self-sampling option to especially those women that are not currently engaged with or accessing screening through traditional health services it is strongly recommended that the quality of the self-sampling test is of a sufficient standard that there is minimal chance of a error. We understand the current self-sampling test is not as sensitive as the current cervical smear test, and therefore want to ensure that those that are offered a self-sampling kit, will not experience any possible adverse outcome. |

#### 5. Screening interval

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| Consideration must be given to the women that fall within the 20-24yrs age group, that have not received HPV vaccinations, are sexually active and do not access the traditional health services. |

#### 6. Age range for screening

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| * Consideration should be given to how to engage and improve access for those Pacific women that did not receive the HPV vaccinations at school, are sexually active and aged between 20-24yrs old. * An exit test would also appear advisable for those women who have not been screened in the 5 years preceding them turning 69. |

#### 7. Referrals to colposcopy (for clinicians)

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**8.** Screening equity  
Please comment on suggested strategies for eliminating inequalities in screening.

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| HPV programme:   * Continue to promote and increase awareness amongst Pacific families of the benefits of HPV vaccinations. * HPV vaccinations - increased integration of school-based and primary care delivery.[[12]](#footnote-12) Improve data matching between schools, NIR and primary care. * Continue to support the information needs of those with low health literacy.[[13]](#footnote-13) * Continue to build the capacity and capability of the Pacific health and disability workforce * Continue to support and increase the responsiveness of the non-Pacific health workforce when engaging with Pacific women & their families.   Cervical screening:   * Health education & promotion of cervical screening to include the whole family, including husbands/partners. Their support may strongly influence a woman’s decision to be screened. * Social marketing to target the Pacific family, not just the woman. * Synchronise mass media campaigns with local community awareness raising activities.[[14]](#footnote-14) * Pacific Workforce – increase the capability and capacity of the Pacific workforce in this area.[[15]](#footnote-15) * Non Pacific workforce - increase the capability, capacity and responsiveness of the non-Pacific workforce working with Pacific women and their families.[[16]](#footnote-16) |

#### 9. Self-sampling

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| Further research is required to understand the implications of implementing self-sampling amongst Pacific women in the New Zealand context.  Key areas that require further research include:   * It needs to be established if women would prefer home testing to clinic testing * What invitation and recall methods are most effective for Pacific women * Do Pacific women from the different Pacific ethnic groups find self-sampling acceptable * What information / education will be required for Pacific women and their families, the community and health professionals * How can the information on Primary HPV testing be provided * What level of support will be required to ensure a high follow up rate for women who test positive for hrHPV – the ultimate aim being a 100% follow up   Will self-sampling be acceptable to Pacific women? It may increase access for those Pacific women that do not access cervical screening because it can be administered at home and not in the clinic which can be a barrier for some taking into account the cost of travel, clinic fees, child care responsibilities etc, however, further research or feedback should be undertaken with Pacific women representing the different Pacific ethnic groups to get a better understanding.  Co design with Pacific women - consider the pathway from the vulnerable Pacific women that experiences barriers to care, does not engage with health services to Pacific women that are self-motivating and access care appropriately. For some women, the self-sampling option will improve their readiness and desire to undertake the test, however, the messenger or those that promote the use of the self-sample test will need to be able to engage with Pacific women and their families and be trusted.  We suggest the Ministry of Health receive feedback from Pacific consumer groups on this proposal.  The robustness of the self –sampling test compared to the existing cervical smear test ie we understand that currently the self-sampling test is not validated and there is a risk of less sensitivity. |

#### 10. Invitation and recall to screening

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| Uptake is more likely to increase if the recall, invite is undertaken by the clinics that have a relationship with the woman and her family. However, a centralised system that is robust and accurate will be very important also. |

#### 11. Cervical screening workforce

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**12.** Do you have any other feedback?

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| If changes to the existing programme are implemented, it should include a research and evaluation component that considers the resulting outcomes for Pacific women. |

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| **65** | Submitter name | Paul Spek |
| Submitter organisation | Private |

#### 1. Answer this question only if you are submitting as a private individual, and you do not want your personal details released or published

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| Paul.spek@sclabs.co.nz |

**3.** The modelling work done to date supports the preferred pathway as the one likely to achieve the greatest benefits. However, are there any other options that you believe the NCSP should investigate further?

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| I believe there are too many assumptions being made from the model. I think before any significant change there should be at the very least a pilot study which could be conducted from one or more regions within NZ. I think co testing is a viable and the safest option. This could be done every 5 years. |

**4.** What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway?

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| * Pilot study * Use NZ data. There is time to gather this given the low vaccination uptake in NZ. |

#### 5. Screening interval

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| I believe there is a risk here with the under 30's given the high rates of HPV, poor vaccination rates, and the numbers of HSIL in younger women we see every day. There is also a small number of NZ women under the age of 25 developing cervical cancer. This cannot be ignored. There are false negative associated with HPV testing in cervical cancer that needs to be considered in this age group.  There is also inequity with the vaccinated and unvaccinated population. The unvaccinated women are actually at a disadvantage and at more risk, yet they are not eligible for free HPV vaccination due to their age. Age however does not discriminate when it comes to HPV infection. Are we disadvantaging these women by not offering them the protection of vaccination? Should we maintain a shorter screening interval for these women? |

#### 6. Age range for screening

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| Given what we know about cervical cancer in young women in NZ, we should not change the current age range. |

#### 7. Referrals to colposcopy (for clinicians)

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| From a lab perspective there will be significant temptation for labs to 'overcall' with knowledge of a positive HPV test. This will not be helpful for colposcopy. It is essential that quality reporting of cytology is ensured through careful monitoring. |

**8.** Screening equity  
Please comment on suggested strategies for eliminating inequalities in screening.

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| HPV vaccination must be made available to all women (free). This inequity has been created by the current vaccination programme. |

#### 9. Self-sampling

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| Self-sampling should be considered very carefully. There is no guarantee that a self-sample will increase participation for those who are not active participants. Instead there is a risk that over screening will occur on women who are already active participants.  I do not think self-sampling is as good as a smear. There is no clinical impression. How do patients interpret there results? How do they get their results? How are the results managed on the register? How do you get a 'non responder' with a positive result in for colposcopy?  How do you stop companies pushing their self-sampling products resulting in over screening? How are these products regulated?  We have an excellent programme now. Why risk lowering the quality with self-sampling?  NZ is not that geographically diverse that we need to go down this path. |

#### 10. Invitation and recall to screening

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#### 11. Cervical screening workforce

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| Cytoscientists/technicians.  The simple answer is to co test. This will give the optimum screening performance and maintain the workforce. Ultimately the workforce have families and lives to live. The NCSP cannot expect loyalty to the programme. Staff will move on. Once this workforce is gone they will not return. The only way to realistically maintain a workforce in the interim is with some form of financial incentive.  The other side of this is there are NO new screeners coming through. I know this first hand from the University teaching I do for the BMLSc programme at Otago.  To maintain a cytology workforce there needs to be cytology work to do. You cannot do this under a primary HPV programme only. This may work in larger countries where volumes are greater but NZ is too small. A volume of 40,000 smears across NZ is too low to maintain a workforce particularly in attracting graduates to the course. If this goes ahead careful consideration is required on the numbers of labs needed to provide a cytology service. Given the anticipated volume, the lab providers should be kept to a minimum. The volume is also not substantial enough to support ‘regionalisation’ of the workload.  NZ will not benefit from Australian cytology scientists made redundant in their respective programme. NZ will have a small pool of scientists left after redundancies here. By the time these people move on the Australian scientists will have moved on to other things as well. |

**12.** Do you have any other feedback?

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| I think NZ needs more time to consider going down this path. There is no rush. Vaccination rates are still low. Even in a vaccinated environment with high compliance NZ has the advantage of image guided screening. This counters the effect of a lower performing cytology due to a smaller abnormal pool. This technology is designed to pick out abnormals from large numbers of normal slides and the BD system has the advantage of 'no further review' which could be utilised very effectively in a vaccinated environment.  Endometrial adenocarcinoma is ignored in this model. I accept that it is not part of the NCSP however we cannot ignore the high number of these cases that we detect relative to cervical cancer. We see many more of these than we do SCC of the cervix, often in asymptomatic women.  Observe the problems that will/may arise from other countries and learn from them. We have a excellent and effective programme. Don't experiment with it. Once you go down this path there will be no going back, the workforce will be gone. |

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| **66** | Submitter name | Vanessa Buchan |
| Submitter organisation | Canterbury Health Laboratories |

#### 1. Answer this question only if you are submitting as a private individual, and you do not want your personal details released or published

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Name:

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Organisation (or Private):

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| |  | | --- | | **Canterbury Health Laboratories**  Collated by:  Kirsten Beynon, Interim Laboratory Manager  Vanessa Buchan, Interim Business Development Manager  Greg Devane, Anatomical Pathology Cluster Manager  Professor Peter George, Clinical Director  Dr Lance Jennings, Clinical Virologist  Dr Andrew Miller, Anatomical Pathologist  Dr Rachael van der Griend, Anatomical Pathologist  Mary Webster, Cytology Technical Lead  Dr Anja Werno, Microbiology Medical Director  Sheryl Young, Section Head Serology/Virology | |

Address/ email:

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| Point of contact:  Vanessa Buchan  Vanessa.buchan@cdhb.health.nz |

**3.** The modelling work done to date supports the preferred pathway as the one likely to achieve the greatest benefits. However, are there any other options that you believe the NCSP should investigate further?

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| For reasons outlined below, we recommend that the National Cervical Screening Programme should continue to start screening at the age of 20. We support the notion that primary HPV testing is not suitable for woman under 25, therefore we propose a crossover model with the current cervical cytology (LBC) protocol starting at age 20 (cervical smear cytology at 20, 21 and 24) changing over to HPV testing starting at 25. |

**4.** What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway?

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| Given the extensive and complex changes proposed for the NZ cervical screening programme we strongly recommend a pilot study in New Zealand, in line with those being done overseas. Modelling work has been undertaken to predict what is likely to occur, however we would strongly recommend that these predicted outcomes would benefit from verification/validation through a suitably designed NZ pilot. A pilot would have additional benefits, providing NZ specific data regarding other key questions, including whether a move to HPV screening will increase coverage amongst our most vulnerable under screened populations, as well as determining the general acceptability of HPV testing to women in different population groups in NZ. The pilot should include a head to head comparison of HPV testing on self-collected samples to those taken by smear takers, to ensure that self-collection is a viable option moving forwards and self-collected samples are of a sufficient standard to produce meaningful results.  We recommend consideration of key documents related to the English pilot studies of HPV screening, particularly well summarised in the “Report to the National Screening Committee” Professor HC Kitchener, Chair Advisory Committee for Cervical Screening, June 2015. http://legacy.screening.nhs.uk/cervicalcancer |

#### 5. Screening interval

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| We agree that “there are limited data to select the optimal screening interval for primary HPV screening” (Huh,W. Use of Primary High-Risk Human Papillomavirus Testing for Cervical Cancer Screening: Interim Clinical Guidance. Obstet Gynecol 2015).  Most trials, including ATHENA and three of the four European trials analysed by Ronco et al, utilised three yearly screening intervals.  Kitchener, commenting in June 2015 on the English pilot studies, states “A ‘safety check’ requires routine recall at three years to ensure prior to moving to the anticipated extension of the screening interval to six years the detection of CIN3 is sufficiently low” (Kitchener, 2015).  We therefore recommend three yearly HPV screening from the age of 25 until there is sufficient robust (preferably NZ, though other studies may be published) data to confirm the safety of a longer screening interval for HPV screening, which is generated directly rather than extrapolated from a three year screening interval investigation.  We recommend further work to determine the optimal screening interval for immunosuppressed women and for women post treatment of cervical glandular lesions.  A further risk to consider, when reviewing screening frequency, is the compliance with screening in different populations. If a robust recall system is not in place and a patient misses a screening point and is only captured at the next time point, this may increase the screening interval from six to ten years. |

#### 6. Age range for screening

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| We do not recommend excluding women in the 20-24 year age group from cervical screening. There were 515 histologically confirmed CIN3 lesions in this age group in 2012 (and 357 other HSIL NOS). Cervical cytology has been very effective in detecting these lesions, allowing appropriate treatment. “CIN3 may regress in a small proportion of cases but non treatment of CIN3 would be regarded as clinically negligent, even though not every case of CIN3 would progress to cancer.” (Kitchener, June 2015).  Although vaccination will reduce the CIN3 rate in the 20-24 age group, the current uptake of vaccination has been suboptimal in many cohorts. Our expectation is that there will continue to be several hundred CIN3 lesions in the 20-24 year age group for many years to come.  Please refer to our response to question 3 for a proposed approach for this population.  We are currently unable to comment on the option for an exit test in the 69-74 bracket, we would recommend ongoing monitoring of abnormality rates in this cohort, as the incidence may change as life expectancy increases. |

#### 7. Referrals to colposcopy (for clinicians)

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| As a laboratory provider we are not able to comment on the capacity of our colposcopy colleagues, however, current practice for most colposcopists at Christchurch Women’s hospital is to consider the smear cytology in conjunction with the colposcopic findings, and any histology, as part of the complete evaluation of women referred for colposcopy. It would be our recommendation that reflex cytology on all high-risk HPV positive smears should occur as opposed to direct referral to colposcopy based on HPV genotyping alone. If these two results were considered in tandem then there is the possibility to reduce the number of biopsies and unnecessary colposcopies. |

**8.** Screening equity  
Please comment on suggested strategies for eliminating inequalities in screening.

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| We consider poor screening coverage amongst hard to reach population groups as the top priority for the NCSP to address.  We note that the consultation document presents no firm and specific data to indicate that the suggested strategies are likely to eliminate inequities in screening. This policy question could be comprehensively answered as part of a pilot study. A change in primary testing methodology is unlikely, we suggest, to eliminate inequalities in screening. We would ask that, when considering a change of primary screening method (which we agree with in principle) that careful consideration is also given to the stigma that some populations may associate with the presence of HPV, which may be viewed to some as being tested for an STD.  The 2015 report by Phoenix et al (8.14, secondary policy question 7) raises questions about the potential negative effects, for a key under screened/vulnerable population, of the increased awareness of the association between HPV infection and sexual activity - this definitely warrants further investigation. |

#### 9. Self-sampling

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| Prior to consideration of introduction of self-sampling we would strongly recommend that a robust comparison between sampling methods be undertaken to ascertain whether self-sampling results in an appropriate sample for HPV testing, which is equivalent to that collected by a health professional, being submitted for testing. We are not aware of any data that proves that such an approach will yield the correct sample from the required site. Potential suboptimal samples could result in inaccurate results and a waste of health resource if retesting is required, in addition to reduction of faith (by both self-sampling participants and potentially some health professionals) in the screening programme.  Self-sampling should only be offered to women who have major difficulties/anxiety/antipathy to having smears taken by a smear taker.  For the purposes of correct labelling, sampling, handling/transport of samples a smear at a clinic should be strongly favoured; this will also offer benefits for follow-up of results, advice about follow up and sample intervals and, in some instances, the need for colposcopy.  There will need to be a whole set of new NCSP protocols to: verify patient identity on self-taken samples, logistics of specimen transport, communication and follow up of results and the interface with GPs and/or other health services.  Unfortunately the consultation documents may have resulted in the expectation amongst many women that a switch to HPV screening will allow them to readily opt for self-sampling. There are likely to be logistical issues if large numbers of woman opt for self-sampling.  Many of the issues outlined above could be addressed as part of a well-designed pilot study. |

#### 10. Invitation and recall to screening

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| The register should include both the high-risk HPV genotypes detected on positive samples, as well as any others identified as the programme and testing technology matures.  We would highly recommend engagement with consumer groups and GP practices to gather information on systems for invitation and recall into a screening programme that is efficient and designed to work for as many woman and services as possible.  We would propose that the national screening unit should have overall oversight as to the invitation and recall processes. These should be coordinated nationally. |

#### 11. Cervical screening workforce

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| Concerns around the cytopathology workforce (pathologists, screeners, registrars) can only be addressed by providing certainty on laboratory contracting and predictability of laboratory work volumes. This contracting should take into consideration the requirements for regional colposcopy units and diagnostic support at secondary/tertiary hospitals. It is important to recognise that both gynae and non-gynae cytology is delivered by the same specialist workforce therefore the impact needs to be considered in this context. Specifically in relation to maintaining skills and expertise, ongoing competency and the provision of key cancer related services and initiatives eg: FCT and MDM/MDTs.  Given the release of the NCSP Public Consultation Paper and the concerns within the workforce, we recommend that the NCSP provide clarity on the desired number of laboratory contract holders and the contractual arrangements with those providers as soon as possible. There is now a potential significant risk, nationally, of an accelerated exit of staff from the cytopathology workforce which could result in an inability to deliver the current service volumes. There will potentially be great difficulties in recruiting staff into any vacancies, given the small pool of trained staff nationally. Furthermore, existing laboratory contract holders will be reluctant to recruit into these vacancies whilst uncertainty in the programme exists. We would recommend that the present highly competitive and commercial model of the laboratory contracts be reviewed with consideration of the whole health system and patients stepping seamlessly from primary care through to the secondary/tertiary care environment. This includes support for MDM meetings and local cyto/histology correlations.  Training for molecular biology/virology staff would benefit from some clear requirements recorded in the Operational Standards, as currently occurs with the cytology screening staff.  It would be advantageous to give long term consideration on how to support the training of new cytology staff to support the programme into the future. Nationally no new staff have viewed cytology as a viable career option over the past few years and the educational providers have accordingly stepped away from providing these courses.  The local AP (histology) laboratory has no spare capacity to accept additional referrals from colposcopy. Nationally there is an acknowledged shortage of pathologists and any additional referrals will be competing with pathology growth across all disciplines. We note that the timing of the NCSP programme changes may overlap with the rollout of a National Bowel Screening Programme, which also places significant additional resourcing requirements on pathology. We recommend issues on the pathology workforce are raised and directed to the National Pathology Round Table group for a more formal response on the national impact on the workforce.  Consideration also needs to be given for ongoing registrar training particularly in the hospital setting and overlap with other pathologist capacity and expertise. The loss of cytology expertise from among hospital pathologists will have a detrimental effect on the registrar training programmes primarily conducted through the hospital based laboratories in NZ. There are seven AP registrars employed in Canterbury, all are being trained through the hospital laboratory. Further, the loss of this referral work would also have an effect on our ability to deliver non gynae cytology services. |

**12.** Do you have any other feedback?

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| We would appreciate ongoing engagement around this proposal. With a short time frame for consultation, significant issues are likely to be missed as services struggle to respond with full due diligence due to other workload pressures (including extended periods of leave during the school holidays which were encompassed in this consultation period).  A comprehensive review of new data and verification of how that could apply within our unique NZ setting will be crucial in shaping the use of HPV testing as part of a safe and robust screening programme moving forwards.  To our knowledge, not all of this information is currently available, particularly local data, though we would welcome further discussion and presentation of relevant work in this area.  We note that the comparable consultation period in England is 3 months.  The process undertaken during this consultation phase appears substantially different to the considered approach being conducted for the proposed Bowel Screening Programme, which includes a NZ pilot. We recognise that there are differences, as there is already a cervical screening programme in place. However this is a major modification impacting many points in an already existing, successful, screening cervical screening programme and we strongly encourage a similar level of scrutiny to be applied with respect to quality and safety review (including the screening interval and eligible populations). Pathology sector screening initiatives have a strong history of providing high quality services that are in the best interest of public safety, NSU objectives whilst providing incredibly value to the health sector. We strongly advocate wise use of the single health dollar, whilst maintaining an equitable level of screening services (including quality and safety for patients) across the board.  We wish to reiterate, that a change in primary testing methodology alone, is unlikely to address the current challenges we all face with respect to uptake of screening in identified high risk populations. |

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| **67** | Submitter name | Rae Duff |
| Submitter organisation | National Council of Women NZ |

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| 23 October 2015 | S15.28 |

**Submission to the National Screening Unit on the Primary HPV testing consultation**

The National Council of Women of New Zealand, Te Kaunihera Wahine o Aotearoa (NCWNZ) is an umbrella group representing 288 organisations affiliated at either the national level or to one of our 20 branches. In addition to our organisational membership, about 260 women are individual members of branches. NCWNZ’s function is to represent and promote the interests of New Zealand women through research, discussion and action. This written feedback has been prepared by the Health Standing Committee.

NCWNZ welcomes the opportunity to participate in this consultation process. Our response is from the Health Standing Committee. Consultation with our wider membership has not been possible due to the short time frame allowed for responses.

NCWNZ has previously made submissions on the National Cervical Screening Programme (NCSP): 2000 submission to the Health Funding Authority on the Policy and Quality Standards for the National Cervical Screening Programme.

NCWNZ has been fully supportive of the NCSP since it was introduced in 1990. We wish to compliment the National Screening Unit on the success of the Cervical Screening Programme which has achieved a significant reduction in the number of cases of cervical cancer and the number of women who die from it in New Zealand since its establishment. It has proved to be one of the most successful programmes of its kind in the world.

NCWNZ supports the National Screening Unit’s proposal to change the first step in the laboratory screening pathway from primary liquid based cytology screening to HPV testing which we understand is 60 – 70% more effective in detecting pre-cancerous lesions than cytology.

We believe an across the board education programme is essential. Women must understand why the change is being made, that cervical smear is still necessary, that the screening is effective for women who have had the HPV vaccine and for those who have not and that it is safe even though screening will be reduced (currently every three years screening will extend to every five years). The various forms of modern technology, the media, visual and auditory tools must be used to capture the attention of women of all ages across the community as well as the health professionals.

Mobility will be the key to taking the message and the service to the women. The community has become accustomed to mobile health services over the last decade and are familiar with specially equipped caravans such as the mobile dental clinics, the blood donor service and the pink caravan promoting mammograms for breast cancer. The NCSP could provide a mobile service to educate and promote. By moving through the suburbs, going to marae and rural communities, having appropriately trained personnel involved “on the ground”, Māori, Pacific and other ethnicities would be captured and the uptake of the service would increase.

NCWNZ stresses the importance of reviewing and making changes to the programme from time to time in order to ensure that the quality of the service is maintained and the effectiveness of the programme improved. Voluntary HPV immunisation introduced in 2008 for women under 20 years of age was a big step forward. While we are pleased there is a reduction in harm for these young women, we also realise the vaccination does not offer complete protection. Therefore it is important that these women take part in cervical screening. The NSCP needs also to reach out to the many young women who have not been immunised.

NCWNZ supports the proposed option for self- sampling as a forward step towards an equitable outcome for all women. A diverse group of women which includes women with disabilities, rural women and women whose cultural / religious beliefs discourage them from taking part in the current programme, may be willing to self- sample if the option is offered to them. The move to self-sampling will require very careful and thorough planning to ensure a pathway is developed to ensure safety and hygiene standards are established and enforced.

NCWNZ works towards a gender equal New Zealand. Since the NCSP programme was introduced in 1990, it has focused only on women, yet some males are spreaders of the virus and can also be victims through the development of genital warts and anal cancer. The Ministry of Health should also be considering HPV vaccinations of men. We believe the promotion of HPV vaccinations and HPV swabbing and education should be targeted at both men and women.

Changes in laboratory testing will impact on the laboratory workforce. It will be important to ensure technical training is provided. The potential for career development for young women with an interest in sciences in laboratory work should be encouraged.

**Conclusion**

NCWNZ is pleased to have the opportunity to contribute to the consultation about changing the primary laboratory test used in the Cervical Screening Programme from cytology to a test for human papillomavirus (HPV). NCWNZ support the proposed change if it will help improve the quality, safety and effectiveness of the programme, while at the same time help to reduce the risk of developing cancer.

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| Rae Duff  National President | Ailsa Stewart Convener, Health Standing Committee |

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| **68** | Submitter name | Jenny Barrett |
| Submitter organisation | Manaia PHO |

#### 1. Answer this question only if you are submitting as a private individual, and you do not want your personal details released or published

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**3.** The modelling work done to date supports the preferred pathway as the one likely to achieve the greatest benefits. However, are there any other options that you believe the NCSP should investigate further?

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| --- |
| Not at this time. |

**4.** What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway?

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| Nothing we are aware of at this time. |

#### 5. Screening interval

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| Based on the proposed pathway, which retains the current recall process for women who require further follow-up, we support this move to a 5-year screening interval.  Our current screening coverage shows that while we are yet to reach target for 3-year coverage, our 5-year coverage is good. A challenge will be to retain good 5-year coverage at the adjusted screening interval. There is a danger in the coverage rate slipping, and women attending even later for their smears (ie. Good coverage at 6-7 years, and not at the 5 year mark). We hope that this can be managed through well-crafted and appropriately targeted messaging implemented by MoH during the transition to HPV primary testing. |

#### 6. Age range for screening

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| We support the change to the age-range for screening especially raising the commencement age to 25 years to assist with false positives common for younger women. We suggest there could be a ‘preparation’ for screening focused aimed at the 20 – 24 year old women through social media to socialise key health promotion messages about screening so when the young women turn 25 they are well informed and ready to ‘join the club’ for their ongoing cervical health.  We also support the addition of an exit test for women aged 69-74 years - based on recent MoH cancer data, it appears this could be beneficial for this group. |

7. Referrals to colposcopy (for clinicians)

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| N/A |

**8.** Screening equity  
Please comment on suggested strategies for eliminating inequalities in screening.

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| * Implementation of a sustained, well-crafted, and appropriately targeted communication campaign, both national and local using key community people to connect with the priority population * Adequate Support-to-Services funding to ensure programmes are resourced to educate women, and support them to attend for screening * STS funding to assist us in being more flexible in our approach, and being able to deliver services in some of the smaller, isolated pockets of Northland. Geography is a challenge in our region – self-sampling could possibly help with overcoming this barrier. * Continue providing free screening for all priority group women in general practice as well as in a range of community settings * Stronger links/collaboration with the National Breast Screening Programme, and any other health services that target priority group women * Increase number of Maori, Pacific, Asian smear-takers or health professionals within the programme to support work undertaken in reaching priority group women |

#### 9. Self-sampling

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| Self-sampling to be offered to:   * hard-to-reach priority group women, and * women in-clinic as an option (in place of having a nurse do it for them)   Possible issues perceived by our smear takers include:   * Smear taker is not there to visualise the area and identify any other issues that may require treatment * Conversation between smear taker and patient is important in terms of education but is absent in the self-sampling scenario   However, if a women is not responding to invitation/recall communication, then having the test via any available method is more important than not.  Communication included with the self-sampling kit could provide information also, about any other symptoms/visual signs that a women should look for that require follow-up. |

#### 10. Invitation and recall to screening

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| * Greater use of technology could assist with the invitation and recall process – text, email (with consent) and social media. Communication channels need to be flexible, with capability for the message and channel to be adapted to best suit the target population. We should be allowing women to choose how they would like us to communicate with them. * Invitation and recall processes should sit with general practice or the provider who performed a woman’s most recent smear. The women need a range of options for accessing the screening service, and be helped to identify who is their primary care smear provider and how to keep in touch with them. This information could be part of an ‘info package’ available on the women’s ‘patient portal’ in their general practice. * Data availability needs to continue to improve, to ensure that health professionals can easily determine whether a woman is due, and to prioritise them based on previous results. |

#### 11. Cervical screening workforce

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| Smear takers: Support with communication resources on social media and via national networks to signal changes as there is currently a lot of misinformation about HPV immunisations / requirements for ongoing smears. This needs to commence at the first ‘point of contact’ with young women when engaging them in the school-based HPV immunisation programme. Public Health Nurses have a great influence at this point and need to be supported with their work through a national information campaign. |

**12.** Do you have any other feedback?

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| An essential component of any successful campaign is the need to connect and engage with the priority population. Maori / Iwi providers are well placed to provide this to their population but require the financial support and recognition to do this effectively and efficiently. Outreach services running alongside practice based screening is the ideal model.  The communication to women around this change is vital. As discussed at the recent Northland Smear takers Update CNE, HPV needs to be explained well. This will ensure that women do not panic at the idea of having an STI or are even further deterred from screening due to their perception of the test and what might be found. |

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| **69** | Submitter name | [redacted] |
| Submitter organisation | Personal submission |

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**3.** The modelling work done to date supports the preferred pathway as the one likely to achieve the greatest benefits. However, are there any other options that you believe the NCSP should investigate further?

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| A pilot study prior to the roll out of HPV primary testing, a pilot study for self-sampling. A study in areas of high vaccination coverage and a comparison with a low vaccination coverage area. |

**4.** What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway?

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| The Danish HORIZON Study  The European BD Onclarity™ HPV Assay CE-IVD trial  The Copenhagen Self-sampling study |

#### 5. Screening interval

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| I would recommend retaining the screening interval to remain at 3 years initially, roll out the changes over time gradually as data and confidence levels are recorded.  Immunosuppressed women, abnormal bleeding, in particular intermenstrual bleeding after the age of 40 years to monitor endometrial and endocervical bleeding.  Women with a history of high grade or cervical endometrial cancer.  Unvaccinated or partly vaccinated women, women with high risk sexual behaviour. |

#### 6. Age range for screening

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| Cyto Screeners are concerned that the unvaccinated group in particular and all women in general are at risk of developing high-grade lesions between the ages of 20-29 years, and recommend the screening age in particular for unvaccinated women remain 20-69 years of age.  I would recommend an exit test at 69 years. |

#### 7. Referrals to colposcopy (for clinicians)

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**8.** Screening equity  
Please comment on suggested strategies for eliminating inequalities in screening.

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| --- |
| As a senior scientist in the workforce I see Māori smear taker’s in both rural and urban areas collecting LBC from Māori women who have not had a regular smear (3 yearly) or over five years, this is encouraging, culturally building a relationship in the community as a Māori smear taker is priceless, equally I believe as I go out into the community FPA smear taker sessions there is a response also to Māori Kaupapa presence in the medical laboratory.  Going forward with molecular testing create a culturally inclusive strategy from the invitation to participate, attending clinician or self-sampling, explain process of testing, what happens to the treasured sample taken from te whare tangata –house of procreation – that which without humanity is lost. Women are considered sacred in Maori culture. Be seen to take care of the sample once in the diagnostic laboratory and also the discarding of sample.  And no more over weight laughing wahine playing cards or receiving a ride in a big people mover. Where is the dignity in this image?  Me aro koe ki te haa o Hine-ahou-one Pay heed to the dignity of women.  If we attend to this Whakatauaki (proverb) from the begin to end of the cervical screening pathway I believe we are employing a strategy for success in reducing the inequalities for all New Zealand women but in particular Wahine Māori. |

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#### 9. Self-sampling

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| New Zealand women who are currently no-responders to invitation to participate in screening programme. Care in sending out invitations from register that all who receive invitations are alive and have not formally withdrawn from the programme, all women who have not had a smear for over 5 years.  Invitation that may be sent out via cell phone/email and letter format inviting women to either visit the GP/clinic or their Marae, or I they prefer self-sample, instructions given. |

#### 10. Invitation and recall to screening

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| NHI data base on register, making sure women are removed when they die, perhaps birthday contact to maintain correct data, link this with a women’s wellbeing register.  A choice of invitation offered, email, facebook, txt, letter or phone call. |

#### 11. Cervical screening workforce

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| In reference to cytoscientists and cytotechnicians I refer to my response to question 3, to retain interest and develop skills taking part in pilot studies may be a rewarding and beneficial exercise for workforce, NCSP and indirectly the women of New Zealand.  In regard to how to ensure NZ has an adequate number of expert gynaecological cytology staff - treasure them, build on the scholarships and funding offered by the NCPTS and support quality professional meetings and gatherings. |

**12.** Do you have any other feedback?

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| No  Thank you and Good Luck |

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| **70** | Submitter name | Dr Debbie Holdsworth |
| Submitter organisation | Auckland DHB and Waitemata DHB |

National Cervical Screening Programme

The National Screening Unit

Ministry of Health

20 October 2015

**Primary HPV Screening Public Consultation**

Thank you for the opportunity to provide a submission to the public consultation on the transition to primary Human Papilloma Virus (HPV) testing for cervical screening.

Auckland District Health Board (DHB) and Waitemata District Health Board (DHB) together serve one in four of the women eligible for cervical screening in New Zealand. The metro Auckland region (including Counties Manukau) has put substantial energy into activities that have improved cervical screening coverage for the women in our region. This activity has been coordinated through the Metropolitan Auckland Cervical Screening Advisory Group (MACSAG) and the associated working groups. Through this mechanism we have worked closely with our partners in primary care, our Independent Service Providers (ISPs) and other relevant stakeholders. We have made significant progress in working together to address the range of challenges in improving cervical screening coverage and we have now seen a sustained improvement in primary care results.

Through MACSAG the issue of moving from cytology to primary HPV as a primary screening test has been raised on a number of occasions over recent years. To ensure MACSAG members and our wider primary care colleagues were informed on primary HPV screening, we have already undertaken education sessions about this topic. The MACSAG chair, Dr Karen Bartholomew, is involved at a national level and has championed education and discussion sessions in our region.

In Auckland DHB and Waitemata DHB we have seen primary care coverage improve for priority group women along with total population, however we recognise that the equity gap remains significant (with the exception of Pacific women in Auckland DHB). Our refreshed MACSAG Strategic Plan centralises our focus on the Maori, Pacific and Asian women we serve. The plan contains a number of actions to address coverage inequity including:

* how we use the data-matched lists in primary care
* facilitating opportunistic screening opportunities in general practice and in other locations (eg. pop-up clinics)
* develop a best practice guide for non-clinical staff involvement in invitation and recall
* optimising ways to utilise free screens.

In addition we have responded to requests from primary care and other providers that we investigate self-sampling as an approach to improving coverage for priority group women. We have developed two project proposals to conduct locally relevant research on the feasibility and acceptability of this novel technology that could be enabled in a primary HPV screening programme.

We are pleased to submit a response to the public consultation and confirm that we support the transition to primary HPV screening within the National Cervical Screening Programme (NCSP). We have reviewed the consultation paper and the technical appendix, and have already reviewed the evidence for HPV self-sampling as part of our project proposal development. In addition we have strong links to national and international researchers involved in HPV self-sampling, including investigators in Australia.

We would like to take the opportunity of this submission to note that cervical screening remains anomalous among screening programmes in New Zealand in that it is not free. Cost is one of the key challenges to improving coverage, and as proposed this will remain in a primary HPV programme. This issue is raised vocally by MACSAG members, care providers for priority groups, consumers and at every education forum on primary HPV. We believe that the transition to primary HPV provides the Ministry of Health with an opportunity to review this anomaly and to clarify the additional cost of providing a free service to women.

We support the proposed pathway selected, which has an entry age of 25, a five year interval, and retains the current exit age. We support the proposed HPV results management pathway, which is the same as the Australian algorithm currently being implemented. This pathway has immediate colposcopy referral for HPV 16 and 18 and cytology triage of other high risk HPV type (undertaken on the same cytology sample as the HPV test).

We acknowledge that moving to primary HPV screening will have implications for women, the primary care sector, the colposcopy service and the laboratory workforce. We are committed to working closely together to ensure the change is implemented robustly. We believe that the proposed pathway provides the optimal balance of reduction in cervical cancer incidence and mortality in the context of a HPV vaccination programme, cost effectiveness and impacts on other services such as colposcopy. We have asked our colposcopy and laboratory services to provide their own detailed feedback to the consultation.

Yours sincerely,

Dr Debbie Holdsworth

Director of Funding

Planning, Funding and Outcomes Unit

Auckland DHB and Waitemata DHB

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| Dr Debbie Holdsworth, Planning, Funding and Outcome Unit, Waitemata DHB |

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| Planning, Funding and Outcomes Unit, Auckland DHB & Waitemata DHB |

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| [Debbie.Holdsworth@waitematadhb.govt.nz](mailto:Debbie.Holdsworth@waitematadhb.govt.nz)  Private Bag 93503, Takapuna 0740  Auckland |

**3.** The modelling work done to date supports the preferred pathway as the one likely to achieve the greatest benefits. However, are there any other options that you believe the NCSP should investigate further?

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| No, we do not consider that there are other options that should be further investigated.  We support the preferred pathway as this is clear and concise and makes it easy for clinicians to comply with the guidelines. It also aligns with the Australian pathway/recommendations which have recently been developed through a large scale evidence based review and consultation. |

**4.** What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway?

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| We recommend that the NSU review and consider information gained through the iPAP study in Australia. Through this research a substantial body of evidence (including meta-analysis) is now available that supports the safe and effective inclusion of self-sampling in to the transition to primary HPV screening.  We also recommend undertaking research into the feasibility of implementing HPV primary screening in the local context, including a careful review and assessment of the resources required to ensure acceptability and follow up of positive results for HPV tests. This should include consideration as to how this is reflected on the NCSP register.  The evidence from the iPAP trail suggests that self-sampling is as good as a clinician test and in many cases is preferred by women. We would support further research in the New Zealand context to examine the feasibility and acceptability of self-sampling for priority women in particular and to determine the pathway requirements for follow-up for HPV positive women. |

#### 5. Screening interval

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| Some of our stakeholders have questioned the proposed 5 year screening interval, specifically they question if a more frequent interval should be implemented for high risk women e.g. those unvaccinated. We have reviewed the evidence for the proposed pathway and whilst we would like to acknowledge the issues raised by our stakeholders we consider that the evidence supports the proposed 5 year interval. The practicality of having a standard consistent screening interval is also important.    The proposed pathway option of 5 yearly screening also enables the optimal balance of consideration for younger women; cost effectiveness; reduction in cervical cancer in the context of a vaccination programme and ensures alignment with other countries that have implemented HPV primary screening, e.g. Australia. |

#### 6. Age range for screening

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| Having reviewed the technical reference material, the starting age of 25 appears sensible and pragmatic; it also aligns with overseas programmes. Including women younger than 25 years in the program has the potential for creating more harm than benefit. There is a low disease detection rate in this age group but a high HPV infection rate. This could lead to a high number of women being referred unnecessarily to colposcopy and having unnecessary invasive investigations. This not only impacts on the lives of young women but also has significant resource implications.  An exit test would appear advisable for women who have not been screened in the 5 years preceding them turning 69 years old. |

#### 7. Referrals to colposcopy (for clinicians)

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| We have requested feedback from the DHB colposcopy teams for this section. We are also aware from the modelling work completed that the transition to primary HPV testing will initially increase colposcopy activity. This increase will be offset to some degree by the increase in age of commencing screening and the increase in screening interval.  We will ensure we work with our colposcopy service to develop change management plans for the implementation of primary HPV screening. |

**8.** Screening equity

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| To reduce the inequities that currently exist, the MoH should consider transitioning to a fully funded screening programme as we know cost is a significant barrier for many women. This would ensure all women could access screening where as currently only unscreened and under screened women can access funded screening through Primary care and ISPs. This is out of line with other organised screening programmes in New Zealand. If the programme cannot be fully funded it would be beneficial if the NSU could provide the detail of the cost assessment. This would provide key stakeholders and DHBs with the rationale for not providing a funded programme.  If the programme cannot be fully funded then we would recommend reconsideration of ways to optimise targeting of funded screens for priority women, this is especially significant in the Auckland region where there are a large number of priority women.  Another key strategy to consider is self-sampling for priority women (unscreened and under screened women). The results of the iPAP trail indicate that priority women find the test acceptable and are more likely to be screened using this approach. Auckland DHB and Waitemata DHB are currently developing a proposal to address local the local knowledge gap regarding feasibility and acceptability of self-testing, especially for Maori women.  We also recommend consideration be given to the role of the ISPs with the transition to Primary HPV screening. They will have a critical role in ensuring women with a positive test result are appropriately followed up. The model they currently work under may need review to ensure their activity achieves the desired outcomes and there are appropriate outcome measures in place. The role of the community health workers and whanau ora could also be considered to ensure support to services are strengthened under the new programme. |

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#### 9. Self-sampling

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| Further work is required to understand the implications of implementing self-sampling in the New Zealand context. Although learnings can already be taken from the large body of international research and the Australian iPAP study it is important to understand the implications for New Zealand women. Key areas that require further understanding include:   * Invitation and screening location * What invitation methods will be most effective for women (especially priority women) * Do Maori women find self-sampling acceptable * What information / education will be required for women, the community and health professionals * What is an appropriate method to provide information on Primary HPV testing * What level of support will be required to ensure a high follow up rate for women who test positive for hrHPV e.g. > 90% follow up   Initially the test could be offered to women who are unscreened or under screened by 5 years or more, but how this would occur and be implemented in practice would require careful consideration with clear parameters set.  The results of the iPAP study indicates that women who have a positive test on self-sampling are more likely to access follow up if they are supported to do so. Processes and support to service providers need to be developed to ensure this can occur.  Consideration will need to be given to women who may choose to opt for self-sampling but they do not fit the definition of ‘priority’ women. How will consumer demand be managed and addressed?  We highly recommend the inclusion of self-sampling into the 2018 implementation of the NCSP transition to HPV as an adjunctive strategy to increase participation for priority women, informed by further local research. We also support in principle further consideration of self-sampling for all women, including at home. |

#### 10. Invitation and recall to screening

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| When designing the NCSP-register consideration should be given to providing accurate timely data to primary care and other key stakeholders. There should also be the ability to link to the NIR, so that vaccinated and unvaccinated cohorts of women can be monitored to inform the programme.  The new NCSP register should be designed as a population register with centralised invitation and recall (similar to the bowel screening pilot at Waitemata DHB). With a screening interval of 5 years and a highly mobile population (as is the case in New Zealand) there is a risk that women will become lost or fall out of the Primary Care system. If the invitation and recall can be coordinated by the register it will ensure a more streamline process with less opportunity for women to fall through the cracks. It will enable one central source of truth.  How the new register will interface with primary care and the primary care involvement in invitation and recall will require further work and discussion with key stakeholders. But learnings can be taken from the bowel screening programme and the new MoH primary care National Enrolment service. |

#### 11. Cervical screening workforce

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| We have asked the Laboratory to provide direct feedback. |

**12.** Do you have any other feedback?

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| Will women have the option of choosing self-sampling over a clinician test? If they can, will they have to pay for the test if they are not under screened or un screened? How will their results be recorded and managed by the register?  If self-sampling becomes the preferred method of testing, there may be a risk that women will wait to be overdue if they know this is the criteria for accessing self-sampling, how will this be managed?  Consideration needs to be given on how the register will interface with primary care and other key stakeholders to ensure accurate timely data is available to support increased coverage rates. |

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| **71** | Submitter name | Dr Peter Fitzgerald |
| Submitter organisation | Private |

Dr Peter Fitzgerald submission: 

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| **72** | Submitter name | Andrew Miller |
| Submitter organisation | Private submission |

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**3.** The modelling work done to date supports the preferred pathway as the one likely to achieve the greatest benefits. However, are there any other options that you believe the NCSP should investigate further?

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| A crossover model with the current cervical cytology (LBC) protocol starting at age 20 (cervical smear cytology at 20, 21 and 24) changing over to 3 yearly HPV testing starting at 25 years of age.  Cervical screening should continue to start at the age of 20 in NZ. I agree that primary HPV screening is not suitable for cervical screening in the 20-24 age group. But cervical cytology in NZ has been very effective in detection of HSIL in the 20-24 age group and should continue. |

**4.** What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway?

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| A pilot study should be done in New Zealand, in line with those being done in similar jurisdictions overseas. The modelling work done for the NCSP needs to be validated by a NZ pilot study, as in England (Kitchener, 2015), which also commissioned modelling.  A suitably designed NZ pilot study would also provide NZ specific data for other key policy questions for which there is little data currently.  A key reference, which I cannot see in the Consultation document references, is  “Report to the National Screening Committee” Professor HC Kitchener, Chair Advisory Committee for Cervical Screening, June 2015. <http://legacy.screening.nhs.uk/cervicalcancer> |

#### 5. Screening interval

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| There is currently insufficient evidence for the safety of a 5 yearly screening interval. A 3 yearly screening interval is therefore recommended.  The 2015 interim clinical guidance from an expert US panel (Huh, W et al Gynecological Oncology 136 February 2015, Pages 178–182) states, “There are limited data to select the optimal screening interval for primary hrHPV screening.” The conclusion of the panel, after summarising the existing data, is “Thus, screening should not occur at intervals shorter than 3 years among women with negative screening results. Although the rate is unlikely to increase sharply after 3 years, the panel believed that there are currently insufficient prospective U.S. data to recommend screening intervals beyond 3 years.”  Professor Kitchener, commenting in June 2015 on the English pilot studies of HPV screening, states “A ‘safety check’ requires routine recall at three years to ensure prior to moving to the anticipated extension of the screening interval to six years the detection of CIN3 is sufficiently low” (Kitchener, 2015).  Until there is sufficient data for an evidence-based recommendation for 5 yearly screening, then a 3 yearly interval for HPV screening should be followed.  A NZ Pilot study of HPV screening would safely assess compliance amongst different population groups for an extended screening interval. It could provide the necessary local data to inform any recommendation for extending the screening interval. |

#### 6. Age range for screening

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| Women in the 20-24 year age group should not be excluded from cervical screening. There were 515 histologically confirmed CIN3 lesions in this age group in 2012 (and 357 other HSIL NOS). Cervical cytology has been very effective in detecting these lesions, allowing appropriate treatment. “CIN3 may regress in a small proportion of cases but non treatment of CIN3 would be regarded as clinically negligent, even though not every case of CIN3 would progress to cancer.” (Kitchener, June 2015).  Although vaccination will reduce the CIN3 rate in the 20-24 age group, the current uptake of vaccination has been suboptimal in many cohorts. Therefore it is likely that there will continue to be several hundred CIN3 lesions in the 20-24 year age group for the foreseeable future. |

#### 7. Referrals to colposcopy (for clinicians)

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| It is routine at Christchurch Womens’ Hospital Colposcopy Unit for the cytology findings on the index referral smear(s) to be included in the full assessment at colposcopy.  Smear cytology predictive of a high grade lesion is particularly important for women for whom the colposcopy findings (and any subsequent histology) are discordant or incomplete.  Because of this, reflex cytology on all HrHPV positive smears should be done to improve the effectiveness and efficiency of colposcopic services. |

**8.** Screening equity  
Please comment on suggested strategies for eliminating inequalities in screening.

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| Missed targets for screening coverage amongst key population groups in NZ continue to be the top priority for the NCSP to address in order to reduce cervical cancer rates. Given the key importance of improving equity, it is surprising how limited and incomplete the relevant sections are in the consultation documents.  The consultation documents present no significant firm and specific data to indicate that the suggested strategies are likely to eliminate inequities in screening. There are references to work that has been commissioned and/or will follow at a later date.  One questions how useful consultation can be on this key issue, given the limited and incomplete material available at this time.  All of the “secondary” policy questions related to achieving equity could be comprehensively answered as part of a NZ pilot study.  The 2015 report by Phoenix et al (8.14, secondary policy question 7) already raises questions about the potential negative effects, for a key under-screened population, of the increased awareness of the association between HPV infection and sexual activity - this definitely warrants further investigation. |

#### 9. Self-sampling

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| Self-sampling should only be offered to women who have major difficulties/anxiety/antipathy to having smears taken by a smear taker.  For the purposes of correct labelling, sampling, handling and transport of samples, a smear at a clinic should be strongly favoured; this will also offer benefits for follow-up of results, advice about follow up and sample intervals and, in some instances, the need for colposcopy.  There will need to be a whole set of new NCSP protocols regarding: verification of patient identity on self-taken samples, logistics of specimen transport, communication and follow up of results and the interface with GPs and/or other health services.  A New Zealand study should be done to establish whether there is equivalence between HPV testing on samples collected by smear takers and self-sampling specimens. The study should also investigate the acceptability of self-sampling amongst under-screened populations.  Unfortunately the consultation documents may have created the expectation amongst many women that a switch to HPV screening will allow them to readily opt for self-sampling. There are likely to be logistical issues, and potentially burgeoning costs, if large numbers of woman opt for self-sampling. |

#### 10. Invitation and recall to screening

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| HrHPV genotyping.  Recall methods should be an important part of a NZ pilot study. |

#### 11. Cervical screening workforce

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**12.** Do you have any other feedback?

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| A consultation period of less than 4 weeks is unreasonable for such a major and complex change, which would have major impacts at many points in the cervical screening pathway. The comparable consultation period in England is 3 months. |

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| **73** | Submitter name | Carolyn Jones |
| Submitter organisation | Counties Manukau Health |

#### 1. Answer this question only if you are submitting as a private individual, and you do not want your personal details released or published

I do not want my personal details to be released

I do not want my personal details included in the published summary of submissions

Bottom of Form

**2.** Your contact details:

Name:

|  |
| --- |
| Carolyn Jones (Portfolio Manager, Primary Care), Sarah Sharpe (Public Health Physician, Population Health Team), Elizabeth Powell (GM Pacific Health) , Riki Nia (GM Maaori Health), Louise McCarthy (Senior Portfolio Manager, Primary Care), Sue Tutty (GP liaison Women’s Health), Sarah Tout (Clinical Director, Women’s Health), Jyoti Kathuria,( Consultant Gynaecologist, Women’s Health), Karyn Sangster (Director of Nursing, Primary Care), Mary Christie( Clinical Head, Histopathology lab ) |

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| Counties Manukau Health |

Address/ email:

|  |
| --- |
| [Sarah.sharpe@middlemore.co.nz](mailto:Sarah.sharpe@middlemore.co.nz)  Louise.McCarthy@middlemore.co.nz |

**3.** The modelling work done to date supports the preferred pathway as the one likely to achieve the greatest benefits. However, are there any other options that you believe the NCSP should investigate further?

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| We think the opportunity should be taken at this time to consider and investigate ways to reduce barriers to participation for women, particularly Maaori, Pacific, and Asian women, and women living in deprived areas. Although the preferred pathway supported by the modelling work seems sensible, provides a good balance in relation to harms and benefits of screening, and is likely to lead to a more efficient screening programme, it will not alter the actual experience for women of getting screened (apart from starting later at age 25 and being conducted less frequently). Although coverage figures are estimated to improve there will still be large and unacceptable inequities in coverage figures (Point 8.7 and Table 26, Technical Appendix). Elimination of these inequities should be a priority for the NCSP.    Counties Manukau staff consulted for this submission think that self-sampling may provide an acceptable and effective way of increasing participation for women living in CM. We strongly support options for self-sampling to be further investigated and trialled as soon as possible. There should be a focus on building a robust evidence base for effectiveness and acceptability among groups with lower screening coverage, including Maaori women.  Concern has been expressed that women with positive hrHPV ‘other types’ tests, whose reflex LBC tests show ‘LG or less’ changes may be at clinical risk as, in the proposed pathway, they will not be referred to colposcopy, but rather will have the HPV text repeated in 12 months. NCSP should further consider the option to refer LG cytology cases to colposcopy, as outlined in Figure 14, Scenario 2b (Technical Appendix p63). |

**4.** What further evidence and/or research should the NCSP consider to gain a comprehensive understanding of the impacts of proposed changes to the screening pathway?

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| Regarding self-sampling specifically, we think it would be sensible to consider and investigate self-sampling at this stage and incorporate self-sampling options into the proposed changes if possible. We think careful review of the meta-analysis by Marc Arbyn from Belgium in 2014. is warranted. This study suggests that self-sampling is as good as a clinician test and in many cases is preferred by women. Women also may prefer the self-sampling option as it is likely to increase access to opportunities to screen. There are often barriers to accessing primary care during business hours as many of our women are working. In order to attend primary care for screening, many women must take time off work which can be very difficult (or not possible at all).  The NCSP should also consider evidence related to reducing inequities in access to cervical screening and inequities in cervical cancer outcomes. We note that further modelling has been commissioned to understand how HPV primary screening could affect outcomes for Maaori, Pacific, and Asian women (Point 8.1, page 72, Technical Appendix) and we strongly support this work as a priority. We would be very interested in the results of this work and think the information should be made publically available.  As noted in Point 8.2, Technical Appendix, it is very important to be cognisant that introduction of an improved test will not, by itself, reduce inequities. We would be concerned if the proposed changes were implemented without comprehensive consideration of both 1) the impact of the proposed new test and pathway on inequities and 2) current and unacceptable inequities that will not change just because a new test and pathway are implemented.  Concern has also been expressed at CM Health about financial cost of cervical screening as a barrier to access for women. Many women in the CM district access free smears and this has been an important factor in improving coverage in CM. Does the NSU have any plans to consider/model more extensive or universal access to free smears?  If the NCSP has not already accessed these articles/resources, we would recommend that they are considered:   * Cram F. 2014. Improving Māori access to cancer health care: Literature review. Auckland: Katoa Ltd. * Hill S, Sarfati D, Robson B, Blakely T. Indigenous inequalities in cancer: what role for health care? ANZ J Surg 2012, doi: 10.1111/ans.12041 * Foliaki S, Matheson A. Barriers to Cervical Screening among Pacific Women in a New Zealand Urban Population. Asian Pac J Cancer Prev 2015; 16(4):1565-1570 * Thomson RM, Crengle S, Lawrenson R. Improving participation in breast screening in a rural general practice with a predominately Māori population. NZMJ 2009;122(1291)39-47. (This is obviously related to breast screening, but learning about the barriers is transferable to cervical screening.) * Ministry of Health. Equity of Health Care for Māori: A framework. Wellington: Ministry of Health; 2014 |

#### 5. Screening interval

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| Having reviewed the summary of evidence on clinical safety and cost-effectiveness of primary HPV testing (Technical Appendix Points 3.56-3.65), we support the proposed screening interval of 5 years.  We think having the same consistent screening interval for all eligible women is less confusing for both women and health professionals.  Have you considered aligning the screening interval to other health screens such as breast screening. For example, a cervical screen could be conducted with every second mammogram and these two events could be linked. |

#### 6. Age range for screening

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| The decision about whether to screen women aged 20-24 years is about weighing up the benefits and harms of screening. With screening programmes, we often do not fully consider and communicate well to women and other stakeholders that screening is associated with significant harms including over-diagnosis/false positives. This is particularly important in the 20-24 year age group, in whom HPV is prevalent but in whom most HPV infection regresses naturally. Screening this age group could lead to much harm, such as unnecessary colposcopy/tests/ treatments accompanied by unnecessary stress and anxiety for women. This age group will also have a decreasing risk over time due to HPV immunisation.  This must be balanced against the benefit of detecting early cervical cancer and preventing (the small numbers of) deaths in this age group. Although the balance of benefits and harms appears to be in favour of not screening this age group, there has been concern expressed at CM Health that even though the numbers of deaths in this age group are low, the consequences of cervical cancer death(s) in this age group are so significant (obviously devastating for the woman and family/whaanau, and also for the NCSP) that a change to the age range would not be advisable at this point in time. If the change to the age range is implemented, we strongly support close monitoring and evaluation of this change.  (Also note: health providers and women need more information/education/socialisation regarding the fact that cervical screening is designed to pick up precancerous changes and prevent cancer. Women with symptoms (e.g. vaginal bleeding/discharge, post-coital bleeding etc) must always seek, and be facilitated/enabled to seek, advice, investigation and treatment from health providers if they have symptoms. It is not clear that this knowledge is wide-spread.)  We support the proposal of an exit test. We think the NCSP needs to consider and provide guidance on what would happen for women who have a positive ‘exit’ test. |

#### 7. Referrals to colposcopy (for clinicians)

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| We understand from modelling provided, and the experience in Australia, that at CM Health there is likely to be an initial rise in colposcopy rates and then a levelling off, or lowering, of colposcopy rates due to the cohort of immunised women coming through the screening programme. For the initial predicted increase in colposcopy numbers, additional resources will need to be allocated towards colposcopy services.  Information from the Pilot of the Compass trial done in NZ  shows that, out of 450 women initially recruited, there were an additional four women who were referred to colposcopy during the pilot (i.e. a relatively low number).  However, there is still considerable uncertainty, so we strongly recommend that the NCSP closely monitor, evaluate the changes over time, and provide support for colposcopy services as required.  An algorithm for follow up of women who have had a normal colposcopy will need to be developed.  The knowledge of cytology at present helps grade the referrals appropriately. The history also helps guide future management especially if there is disparity between cytology and colposcopic directed biopsy. |

**8.** Screening equity  
Please comment on suggested strategies for eliminating inequalities in screening.

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| As previously discussed in Questions 3 and 4 above:   * Current inequities in cervical cancer screening coverage and cancer outcomes for Maaori, Pacific, and Asian women are significant and completely unacceptable, yet are avoidable and fixable. * The proposed changes to the screening test and pathway, whilst they are likely to lead to improved coverage figures and a more effective and efficient screening programme overall, will not necessarily lead to a reduction in inequities (and may even worsen inequities if these are not considered comprehensively). * The NCSP needs to prioritise work and actions to eliminate inequities in the cervical screening programme.   The NCSP should conduct (or commission) a formal Health Equity Assessment of the proposed changes, including consideration of implementation issues. This Assessment should be shared and made publically available. Inequity hotspots right along the cervical screening pathway need to be identified and initiatives developed to address them.  Overall, there needs to be a clear equity focus, with leadership and commitment to this, as an integral part of the new screening programme/pathway.  We think consideration should be given to the following issues/aspects:   * Cost as a barrier for women.   + Consider the potential provision of a fully-funded programme.   + If a fully-funded programme is not possible due to financial constraints, it would be helpful if the NCSP could provide an assessment and rationale for this decision.   + Consider costs other than the cost of the screen, e.g. loss of wages (if need to take time off work) and cost of travel. * Improving cultural competence and health literacy competence of smear providers. * Development of resources for women (developed keeping in mind the need to reduce health literacy demands on women) to facilitate informed consent. * Ways to reduce barriers to screening for obese women. * Support for cervical screeners to provide screening for obese women, e.g. appropriate equipment (including beds) * Ways to reduce barriers to screening for women with disability * The role of the community health workers and whanau ora workers in supporting access to screening. * Co-location of breast and cervical screening services, to enable access for women. * Review support to Service providers, with consideration given to the proposed new programme so that priority women can be appropriately supported to access screening.   In addition, and as commented on in other sections of this submission, CM Health strongly supports options for self-sampling as an important emerging mechanism for improving participation in screening and reducing inequities. CM Health Maaori and Pacific leaders strongly support trials of self-sampling for women in the CM district, as there are large numbers of high priority (unscreened and under screened) women. The current model of cervical screening is failing many women in CM. The results of the iPAP trial indicate that priority women find the test acceptable and are more likely to be screened using this approach. More research in the NZ context needs to be undertaken as soon as possible. Maaori and Pacific teams in CM Health have requested that further work on self-sampling be conducted with urgency, and to include self-sampling as an option within the new screening pathway if appropriate. |

#### 9. Self-sampling

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| Counties Manukau Health (CMH) strongly supports further investigation and trials of self-sampling. Intuitively this test is likely to be more acceptable to women and be relatively easy to perform, increasing participation and reducing barriers to screening. It may encourage women to self-care, i.e. perform their own screening. Providing ongoing evidence confirms that self-sampling is as effective as clinician collected samples in detecting HPV, we would like to see the introduction of self-sampling as an option for all women.  As CM Health recognises that further work is required to understand the issues and implications of self-sampling in the New Zealand context, some initial scoping is being carried out to determine whether there may be an opportunity for CM Health to provide resource for a trial in the CM district.  There is experience within General Practice related to self-sampling for Chlamydia, with the move of Chlamydia screening from and endocervical swab to a self-swab. In our experience, this has proven very acceptable to patients.  While it would be possible to mail out self-swabs, it is envisaged that the self-swab would be available in general practice (which is the woman’s medical home) and where there is the capacity for follow- up. Practice based screening has many advantages, including:   * established systems for recalling patients. * Knowledge about women who do not have English as their first language, who would have more difficulty understanding a mail out. * Knowledge about woman who do not require screening; i.e. those women who have never been sexually active and women who have had hysterectomy. * Not being reliant on mail deliveries, which may not reach women (particularly mobile women and those living in socioeconomically deprived areas).   The needs of women who are not familiar with western style sanitary protection has been raised as an issue that requires further consideration.  A positive self-sample is an inducement for the practice and the woman to ensure she undertakes further testing. The results of the iPAP study would indicate that women who have a positive test on self-sampling are more likely to access follow up if they are supported to do so. Processes and support to service providers need to be developed to ensure this can occur. |

#### 10. Invitation and recall to screening

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| When designing the NCSP-register consideration should be given to providing accurate timely data to primary care and other key stakeholders. There should be a focus on improving the quality of ethnicity data. This is particularly important for monitoring of inequities by ethnicity.  The register should have the functionality to link to the NIR, so that vaccinated and unvaccinated women cohorts can be monitored to inform the programme.  We support having the NCSP register designed as a population register with some centralised functions, including the ability to invite all eligible women, not just those engaged with a general practice, and keep track of women who move location or over time become disengaged with primary care. However, we think this should be balanced with the benefits of having recalls for women coming from their trusted primary care provider/medical home. Therefore a system with a population register, integrated with primary care, would be optimal. Learnings should be taken from the bowel screening programme and the new primary care National Enrolment Service. |

#### 11. Cervical screening workforce

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| The Histopathology Lab at Middlemore Hospital does not report cervical cytology smears or do HPV testing on thin prep specimens.  We report the cervical biopsies and cervical Lletz specimens from colposcopy.  The results of all cervical and vaginal histology specimens are reported to the National cervical screening programme.  Therefore we have no cytopathologist, cytoscientist or cytotechnician staffing feedback regarding the first 4 dot points as we have no staffing relating to this. The histopathologists and laboratory technical staff need no extra training for our current workload.   The molecular biology workforce stated here does not affect the Middlemore Histopathology Laboratory as we will not be doing the liquid based HPV screening test. 10 – 30 percent increase represents a significant increase in workload. With current staffing we have no capacity to process and report an increase of cervical histology in our histopathology laboratory.  The limitation is laboratory technician and histopathologist staffing.  There will be a significant impact of the proposed changes on the screening workforce, particularly for laboratory staff and colposcopy service staff.  There should be a national media strategy around the transition from cervical screening to Primary HPV screening which would include the development of resources and website links for information.  Current smear takers will need to undergo a refresher course to update them on the changes so that all smear takers (for Primary HPV) would be informed and would therefore be able to have informed discussions with women. |

**12.** Do you have any other feedback?

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| The suitability of new testing systems available in new Zealand need to be considered (e.g Ubiquitome PRO testing system). |

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| **74** | Submitter name | James Hunt |
| Submitter organisation | Taranaki Med Labs |

The phone submission was from James Hunt, Pathologist Taranaki. He said that there is no reason to split gynaecological histology out from other histology specimens, and the status quo should remain with regard to laboratory processing of cervical biopsies and treatment specimens.

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| **75** | Submitter name | Karen Bartholomew |
| Submitter organisation | Waitemata DHB |

# Questions from Primary HPV cervical screening – Discussion Session for Primary Care 6th October

**Vaccination**

* Is there immunity from natural infection? If not why not?
* Why does the vaccine give potentially lifelong protection but natural infection doesn’t?
* When is HPV-9 valent vaccine and the 2 dose regime coming?
* When are boys being vaccinated?
* What sort of immunity to men get from the vaccine?
* How integrated is the vaccination programme with the new pathway?
* Should there be a separate pathway / program for vaccinated and unvaccinated women?
* Vaccination status is a key element of the new programme, how will this be addressed?

**Primary HPV Screening**

* Is there any evidence regarding HPV infection having a HPV negative (ie non-detectable, false negative) latent phase leading to cancer following infection?
* Why do all women with HPV 16 and 18 have to be referred to colposcopy? How much will increase numbers to colposcopy for women who may self-clear?
* Is the 5 yearly recall interval required for the younger population? Should it be more frequent ie higher risk of HPV infection?
* Will there be groups of women who require more frequent testing (5 yearly)?
* Some groups of women might need more consideration in guideline development:
  + Immunosuppressed women?
  + Pregnant women
  + Smokers
* What is the current cost of an HPV test?
* Cost is a big barrier for women. Is this an opportunity to make this a universal free program? Will this be costed out as part of this process?
* Please clarify the ‘exit’ test?

**Self-sampling**

* If self-sampling is implemented where does the legal and professional responsibility lie, particularly around positive results?
  + Who ensures follow up, and how much effort should a practice put in to get follow up?
  + Would this be different for any positive result screening/diagnostic test (eg HPV16/18 compared with a LSIL)?
* Is self-sampling is cheaper than a smear-taker LBC sample?
* If self-sampling is only available for priority women this may cause issues for the others in the population.
  + Many women may wish to perform self-sampling (many women in the audience indicated this preference for themselves) how will this be managed?
  + If only some women are allowed to self-sample (eg unscreened/significantly overdue) could other women pay a co-payment for ‘private’ self-sampling eg through a GP? Some women may prefer this to a smear. What will happen if women request to pay for a private self-sampling test?
* Will self-sampling be free and smear-taker samples cost women?
* How will you manage the risk of women putting off a smear-taker sample if they know they can get a self-sample option if they become overdue?
* Could self-sampling be used with older women where vaginal dryness and discomfort is problematic for women?

Primary HPV Consultation Primary Care Presentation 6 October 2015: 

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| **76** | Submitter name | Alan Johnston |
| Submitter organisation | Ti Hiku Hauora |

From:        Alan Johnston <[alanj@hauora.net.nz](mailto:alanj@hauora.net.nz)>   
To:        [primaryhpv@moh.govt.nz](mailto:primaryhpv@moh.govt.nz),   
Date:        09/10/2015 10:24 a.m.   
Subject:        Community HPV testing   
  
  
  
Kia ora MOH,   
    
I recently attended a presentation via video link for "Cx Screening VTC update". The presenter was Donna Hardie.   
  
During the presentation there was a mention for funding becoming available to capture women whom are overdue for Cx screening. I am interested in gaining greater detail on this possible proposal.   
  
Te Hiku Hauora operates a mobile nursing team that covers a number of specialties and that operate independently of any particular G.P practice. Within our team of nurses there are three nurses that are compliant in CX screen taking.   
  
I feel that Te Hiku Hauora could offer a structure and model that is community based and that could go along way to capturing those women currently being missed through current screenings.    
  
Yours sincerely,   
Alan Johnston RN   
  
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Alan Johnston ⋅ Wellness Checks Registered Nurse  
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| **77** | Submitter name | Dr Gillian Gibson |
| Submitter organisation | RANZCOG |

**Submission from RANZCOG NZ Committee: Primary HPV screening**

23 October 2015

**2. Contact details**

Dr Gillian Gibson

Obstetrician, gynaecologist and colposcopist

Auckland District Health Board

Member RANZCOG New Zealand Committee

Email contact: jcumming@ranzcog.org.nz

**3. Preferred pathway. Are there any other options we believe NCSP should investigate further?**

RANZCOG fully supports policy to maximise HPV vaccination uptake. We believe that changing to primary HPV screening is necessary in a vaccinated population to achieve the greatest impact in reducing cervical cancer incidence and mortality.

This is an opportunity to fully integrate the National Immunisation Register (NIR) with NCSP. This linkage has been strongly recommended by both NZ gynaecological oncologists Peter Sykes and Lois Eva. Although it was acknowledged that women’s HPV immunisation status will not influence their pathway in the screening programme (as their sexual debut may have occurred prior), vaccination is not just beneficial for this group. Vaccination post treatment of high grade dysplasia is recommended. Maintaining a register to reflect uptake of this would allow prospective audit to monitor quality and safety of the new screening programme.

Professor Peter Stone, who played a key role in the initiation and development of NSU aneuploidy screening in pregnancy, adds his endorsement for prospective audit of HPV screening which linkage of the registers would allow. So much of the Ministry’s work has been directed towards streamlining the management of cancers, creating a central cancer service, and ensuring all cancers are brought to multidisciplinary meetings. It is recommended that resource is directed to linking the NIR to NCSP to enable measurement of the impact of vaccination on cervical cancer incidence and mortality.

**4. Further evidence and/or research**

RANZCOG commends the commissioning of comprehensive modelling work to inform change to primary HPV screening.

**5. Screening interval**

The proposal to routinely screen every 5 years is supported by RANZCOG. HPV testing has a high negative predictive value (compared to cytology alone) and therefore this screening interval is acceptable based on evidence available. This is a safe screening interval assuming good compliance. Systems for follow-up will need to be resourced so DNAs are proactively managed. This will be facilitated by having a population based register.

The key remains to achieve the highest vaccination rates possible and to encourage women who are immune compromised, for example, to be vaccinated. Research into whether HPV vaccination is as efficacious within these subgroups is recommended. A distinction should be made that woman who are symptomatic (postcoital and abnormal vaginal bleeding) must be investigated even if they are still within the five year screening interval.

**6. Age range for screening**

The potential change in age range for cervical screening from the current 20-69 years to delay onset of screening until 25 years is supported in principle by RANZCOG.

The evidence is clear that in vaccinated populations the benefits for starting at 25 years outweighs any potential to detect cervical disease. Morbidity from investigating and treating women under 25 years is significant. The evidence shows that in 20-25 year age group cervical cancer is very rare, it will be a type that was unlikely to be screen detected and that mortality would not be impacted. This is an important education issue and once again the investigation of symptomatic women should be emphasised.

RANZCOG recommends that changing to HPV screening (and the introduction of the two dose nonavalent vaccine) is an opportunity to strengthen the vaccination programme through education and coordination – should it be school based rather than in the primary care setting?

RANZCOG supports the recommendation for an exit HPV test for women aged 69-74 years as a 5% reduction in cervical cancer mortality is achieved if screening is extended to this age range. This is a consideration when life expectancy is increasing. However discretion is needed depending on women’s co-morbidities ie. if a positive screen is unlikely to impact on long term survival.

**7. Referrals to colposcopy**

An increase in referrals to colposcopy is likely, at least initially, in the order of 20-30% following introduction of primary HPV screening.

The impact will be dependent on the vaccination rates with strategy 2a having only a predicted 1% increase in colposcopy referrals for vaccinated women, compared to 18% amongst unvaccinated. Colposcopy services will need sufficient resource to cope with the increased demand.

**8. Screening equity**

HPV vaccination is key to reducing inequalities in screening and cancer incidence and mortality.

Less often screening will contribute. Self-testing, whilst not the preferred option, may allow screening for the hard to reach population groups.

**9. Self-sampling**

RANZCOG recommends that primary HPV screening is ideally performed in the same way as conventional cervical smear testing ie. with direct visualisation of the cervix in case of a visible lesion which is not virus shedding. Self-testing has reduced sensitivity for screening purposes. Liquid based HPV tests, compared to self-tests, offers the opportunity for reflex cytology if HPV testing is positive, whereas self-testing does not and recall for cytological testing would be necessary.

Self-testing may benefit isolated under screened groups such as older women, cultural barriers, women with disabilities. Research is needed in the NZ environment and support services allocated if specific groups are identified as benefitting this method of screening.

**10. Invitation and recall to screening**

A population based register is recommended with linkage to the national immunisation register. Please see response to question 3.

We recommend reflex cytology for positive HPV screened women to avoid need for a second visit to their health professional. Ideally all women referred for colposcopy will have cervical cytology result available before their colposcopy assessment as this increases the positive predictive value ie. if high grade smear the colposcopist more likely to identify the lesion and to perform vaginoscopy in case of a vaginal lesion. Consideration as to the need to be give higher priority to HPV 16 and 18 positive women for triage purposes.

**11. Cervical screening workforce**

Smear takers need to understand the protective effect of HPV vaccination in the first instance (and encourage catch up vaccination as appropriate), the value and reliability of a negative HPV test, but the importance of referring and investigating symptomatic women.

**12. Other feedback**

RANZCOG thanks NSU for the opportunity to give feedback on proposed changes to the NCSP which we fully support in principle.

The success of cervical cancer prevention is directly related to high HPV vaccination rates for the population, preferably boys as well as girls prior to sexual debut. A co-ordinated national programme is key.

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| **78** | Submitter name | Wellington hui 14 Oct 2015 |
| Submitter organisation |  |

**Consultation attendees:**

1. Angela Davies CPHQ
2. Eileen Hollands Hutt Valley DHB
3. Louise Sanford The Cancer Society of New Zealand
4. Robyn Ingleton Te Awa Rarogi Health Network
5. Cassie Elley Mana Wahine Ora Toa
6. Eve Kaimoana Maraeroa Marae Health Clinic
7. Pungaerere Elaine Denton Mana Wahine
8. Josie Reivi-Rongonui Mana Wahine Whaiora
9. Sally Walker Mana Wahine Whaiora
10. Diane Chapman Kokiri Marae
11. Tracy Keelan Kokiri Marae
12. Kuini Puketapu Hutt Valley DHB

**The nine key themes for this consultation:**

1. Self-sampling
2. Starting age limit
3. Ending age limit
4. Screening intervals
5. Workforce impacts
6. Equity
7. Immunisation
8. Further research
9. Additional feedback
10. **Specific issues mentioned during the meeting in relation to broader themes:**Self-sampling
    1. The cost associated with self-sampling or repeat testing in a doctor’s office may prevent Maori women from accessing a screening because of limited funds or bills owed at the doctor’s office. They may also have limited access to transportation or childcare, making repeat testing even more challenging.
    2. Self-sampling may increase inequity issues as wahine won’t do it or may get mokos to take it for them. The samples may also not be properly cared for or delivered after collection.
    3. Women who had a positive result may not do any follow up. How would the programme support them?
    4. Where would self-sampling results go and how will that affect test-taking?
11. Starting age limit
    1. There was strong resistance to the idea of pushing back the start date because it may adversely affect Maori women with earlier sexual debuts.
       1. “Missing even one Maori girl is a life lost.”
    2. There is a perceived risk of women who have cancer not being on the radar.
12. Ending age limit
    1. Older Maori women may not accept the need for screenings later in life, so they may not go.
13. Screening intervals
    1. Many in attendance felt that increasing the screening intervals would increase, rather than decrease, the equity gap.
    2. Increasing the time between screenings to five years may pose a risk for women who are difficult to locate for overdue screenings (i.e. if it takes 1+ years to track them down, it becomes 6+ years since their last screen).
    3. The register will need regular maintenance, because when attempts are made to contact women overdue for screens, their phone numbers and addresses have often changed.
14. Workforce impacts
    1. Will colposcopy facilities be able to cope with the increased workload?
15. Equity
    1. Maori experience unequal access to health services and disproportionately experience poorer health outcomes, including higher mortality rates from disease.
       1. Maori women with disabilities may face additional barriers (including financial) that need to be taken into consideration.
    2. There is a need to improve health literacy among Maori women.
       1. Many Maori women do understand the importance of screening.
       2. Young Maori women may conflate the HPV screen with getting tested for HIV.
       3. Older Maori women may not understand how to take swabs and may feel they can’t because they are “not a doctor.” They also may not understand the reason for getting screened at 65+ years.
    3. Fear and mistrust of the medical profession and associated institutions may be an additional barrier. For instance, Maori women may be embarrassed at owing money to the doctor or may be afraid of the results.
    4. Additional funding will be needed to enable additional community health/support workers to provide healthy literacy education and ensure Maori women get screened.
       1. Face-to-face interactions and korero are more effective than repeat letters about overdue screens. Korero will also empower women to share the information through their informal networks with whanau and other women.
    5. There is a significant need to focus on whanau ora when working with Maori women, and this should be reflected in the screening programme. It should be considered part of a multi-pronged approach.
       1. It is perceived that without this approach, the screening programme will increase rather than reduce the equity gap.
       2. NSU has the ability to encourage the government to provide access through increased funding for a whanau ora approach that addresses wider issues facing Maori women.
    6. The Treaty of Waitangi needs to be recognised in the new screening programme. Maori worldview and ways of working to reach Maori need to be specifically included. A different lens has to be applied when working with Maori. How will their status at treaty partners be respected?
16. Immunisation
    1. There is a need to improve immunisation rates across the board and participants queried whether HPV immunisation would be extended to boys.
17. Further research
18. Additional feedback

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| **79** | Submitter name | Wellington general public meeting 14 Oct 2015 |
| Submitter organisation |  |

**Consultation attendees:**

1. Rosie Stewart Family Planning
2. [name redacted] General public
3. Geraldine Walmsley Capital and Coast DHB
4. Karen Heine The Cancer Society
5. Bev Lawton Women’s Health Research Centre University of Otago
6. Pete Gootjies Southern Community Laboratories

**The nine key themes for this consultation:**

1. Self-sampling
2. Starting age limit
3. Ending age limit
4. Screening intervals
5. Workforce impacts
6. Equity
7. Immunisation
8. Further research
9. Additional feedback

**Specific issues mentioned during the meeting in relation to broader themes:**

* + - 1. Self-sampling

1. Self-sampling should be available to all women.
2. What is the sensitivity of self-sampling? Will it decrease the ability to identify and support priority group women?
3. Starting age limit
   1. Pushing back the start date may adversely affect Maori women, who disproportionately develop cancer before the age of 25.
   2. A later start date may also pose a risk for women between 20 and 25 years of age.
4. Ending age limit
5. Screening intervals
   1. Increasing the time between screenings to five years may pose a risk for women who are difficult to locate for overdue screenings (i.e. if it takes 1+ years to track them down, it becomes 6-10 years since their last screen).
   2. The longer period between screens may increase the equity gap with under-screened women, vulnerable women, or Maori and Pacific women.
   3. One attendee advocated for informed consent that allowed women to choose whether they wanted a screening every 5 years (if low risk) or 3 years (if higher risk).
6. Workforce impacts
   1. There is concern about women who are referred to colposcopy and nothing shows. Are continued tests necessary?
   2. Will labs be centralised?
7. Equity
   1. There is a need to re-frame the cervical screening narrative more positively.
      1. For example, using the phrase “exit smear” shifts the focus from women’s health to the programme, when it should be the other way around.
   2. There is a need to promote informed consent to support women’s control and decision-making abilities.
      1. Included within this is a need to provide information to young women before they start the screening programme.
   3. Support services may need to be increased to ensure proper follow up and care for women, especially if they self-sample.
8. Immunisation
   1. There is a need to get immunisation rates up across the board.
   2. There is concern about older women who may get hrHPV 16/18 and may not be covered by immunisation.
   3. There is a need for immunising young men in additional to young women.
9. Further research
   1. There is a need to examine the longevity of the vaccine because it is not currently known if the HPV vaccination will provide life-long protection.
   2. What is the evidence for other screening programmes? There were calls to slow the Ministry’s plans until more research is made available about the effectiveness of the Australia and Netherlands programmes.
10. Additional feedback
    1. The test is not 100% effective, so there are concerns about sensitivity.
       1. This includes women who receive a false negative and later develop cancer.
    2. Is there a screening plateau in terms of success rates, especially for some groups?
    3. Some commented that they were happy switching to an HPV screening, but had issues around the change in age range and screening interval.
    4. Women’s control over their bodies and what happens to it should remain a key focus of the programme.

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| **80** | Submitter name | Auckland hui 15 Oct 2015 |
| Submitter organisation |  |

**Consultation attendees:**

1. Natasha Iotuo Te Hononga
2. Camilla Tuiraiti Te Hononga
3. Tapina Taniola Raukura Hauora o Tainui
4. Meena Narang Counties Manukau DHB (CMDHB)
5. Dianne Glenn CMDHB and National Council of Women NZ
6. Lorraine Busby Waiparera
7. Tania Pompallier Raukura Hauora o Tainui

**The nine key themes for this consultation:**

1. Self-sampling
2. Starting age limit
3. Ending age limit
4. Screening intervals
5. Workforce impacts
6. Equity
7. Immunisation
8. Further research
9. Additional feedback

**Specific issues mentioned during the meeting in relation to broader themes:**

* + - 1. Self-sampling

1. Self-sampling could be an empowering experience by encouraging self-responsibility.
2. There is a need for an urban and rural trial for self-sampling before implementing.
3. Self-sampling would be great for women in rural areas. It’s the only way to engage wahine on the screening pathway.
4. Women may not perform the self-sample correctly, which happens with STI screens. Outreach workers will be needed to ensure self-sampling is done correctly.
5. The bowel screening programme is a good example of a screening process that works well.
6. Starting age limit
   1. Maori women are sexually active at 15 years of age. If the first screen is not until 25 years of age, there could be a risk.
   2. However, starting at 25 years of age is okay if the decision is based on evidence.
7. Ending age limit
   1. Is an exit smear necessary for low-risk women who have never had HPV?
8. Screening intervals
   1. New Zealand women travel back and forth to Australia quite a bit, which could pose problems with accessing screenings, especially if increased.
9. Workforce impacts
   1. There is a bottleneck with colposcopy clinics. Are there services to support the future increase in demand?
10. Equity
    1. The programme needs both Maori and Pacific responsiveness in terms of how it is delivered. This has been lacking for some time.
    2. The messaging around cervical screens needs to be done differently.
       1. Currently, the messaging is a scientific one and not a community message.
       2. It should be about men looking out for, and protecting, women.
          1. This can be very effective with Asian and Islamic men who can be very influential by encouraging women to get screened.
          2. An example for how this was done effectively was a recent advert with the Raukura Rugby League that encouraged men to take charge and get women in for a screen.
       3. Families should also be considered focus points as grandparents ask questions of moko.
       4. Social responsibility needs to be restored in a culturally-appropriate manner and be linked with restorative value.
    3. More information is needed about screening to address the knowledge gaps that surround it. A media programme could be used, but it needs to include men.
    4. We can’t get equity for women if men are not a part of it. This is especially true for Maori women.
11. Immunisation
    1. Boys should be vaccinated as well as girls. Girls are being picked on as the only targeted group.
    2. Immunisations could be done through Maraes or churches.
12. Further research
13. Additional feedback
    1. What is the accuracy of the data that’s been shared?
    2. Is information being collected with Islamic women? We may be missing an important group.

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| **81** | Submitter name | Auckland fono 15 Oct 2015 |
| Submitter organisation |  |

**Consultation attendees:**

1. Kim Letford Alliance Health Plus
2. Lean Sanford Auckland DHB/Waitemate DHB
3. Vai Naseri Health Star Pacific Trust
4. Juanita To’o Health Star Pacific Trust
5. Alaviola Pomana South Seas Healthcare
6. Juliet Pati South Seas Healthcare
7. Aifai Taupule South Seas Healthcare
8. Irata Passi South Seas Healthcare

**The nine key themes for this consultation:**

1. Self-sampling
2. Starting age limit
3. Ending age limit
4. Screening intervals
5. Workforce impacts
6. Equity
7. Immunisation
8. Further research
9. Additional feedback

**Specific issues mentioned during the meeting in relation to broader themes:**

* + - 1. Self-sampling

1. Self-sampling should be available to all women.
2. Self-sampling may help Pacific women who are not going in for a screen because they are shy. For example, if a Palangi/ European nurse is not available, they may be afraid to get a screen because they know a Pacific nurse through family, church, or other ties.
3. Focus groups with women from the community are needed in order to get their feedback.
4. Starting age limit
   1. Girls who are not immunised will be at a higher risk if the starting screen is pushed back to 25 years of age.
   2. Smears may still be needed at 20 years of age.
5. Ending age limit
6. Screening intervals
7. Workforce impacts
8. Equity
   1. Involving partners/men may help encourage some Pacific women to get screened.
      1. This may not work for Tongan or older Maori women, where the topic is tapu.
9. Immunisation
   1. Clinics/practices are not informed about the HPV immunisation status of their patients who are girls.
10. Further research
11. Additional feedback

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| **82** | Submitter name | Auckland general public meeting 15 Oct 2016 |
| Submitter organisation |  |

**Consultation attendees:**

1. Lynda Williams Auckland Women’s Health Council
2. Ana dos Santos Roche
3. Lava Hashimoto Roche
4. Bill Neville Roche
5. Jen Barnes Roche
6. [name redacted] General public
7. Erin Retter International Accreditation New Zealand (IANZ)
8. Jane Grant Waitemate DHB
9. Lifeng Zhou Waitemate DHB
10. Holly Coulter Women’s Health Action
11. Christine Lipyeat Cairnhill Health
12. Marita Carman Roskill Union and Community Health

**The nine key themes for this consultation:**

1. Self-sampling
2. Starting age limit
3. Ending age limit
4. Screening intervals
5. Workforce impacts
6. Equity
7. Immunisation
8. Further research
9. Additional feedback

**Specific issues mentioned during the meeting in relation to broader themes:**

* + - 1. Self-sampling
  1. Will self-sampling be available to all women or a select few?
  2. Women less than 75 years of age may wish to self-sample.

1. Starting age limit
   1. Young women that have been sexually abused need to be considered for screening within the 20-25 year age.
   2. There needs to be a tailored programme for different ethnic groups. For example, tailored start times for screenings based on ethnicity.
2. Ending age limit
3. Screening intervals
   1. If women do not attend a screening, how will it be managed?
4. Workforce impacts
   1. How are the already stretched colposcopy services going to be managed?
   2. Will colposcopy wait time be longer?
   3. What is the timing of reporting between HPV and cytology tests? Will there be an increase in timeframe?
   4. Is the Ministry of Health looking at integrating the two registers (NCSP and NIR)?
      1. For example, if a woman presents with cancer, there may be questions around when she was immunised and what the length of time was between doses.
         1. There needs to be a proactive approach rather than a reactive one.
   5. Cytologists could be retrained to histology. It may be hard for them to change areas, though.
   6. Universities were not involved in the consultation process.
      1. If cytologist numbers are going to be reduced, conversations will need to happen with universities to alter the training programmes they provide.
5. Equity
   1. Better education in the schools about HPV, the vaccine, and screens is needed. This is important for informed consent.
      1. This includes how it is presented to parents, who are currently told it’s a vaccine for sexually transmitted infections, which is a negative framing.
   2. The rates of screening non-attendance are quite high for Maori and Pacific women, so how will the NSU cope with a potential increase?
   3. 80-90% of women clear the HPV infection, but most women do not understand that may occur naturally without treatment.
      1. Telling them they have the virus creates an environment that carries high anxiety, etc.
      2. Better education is needed to address this issue.
   4. Will screens be free?
      1. If the government was concerned about priority group women, their smears would be free.
   5. Categorising women as “priority women” based on their ethnicity might change to their HPV immunisation status. NSU needs to consider this.
   6. Language used within/about the programme needs to be careful. It won’t be a “smear” test anymore.
      1. It also is not a “cervical cancer vaccine,” which may cause women to think they’re fully protected against cancer.
6. Immunisation
   1. Why not vaccinate boys? Gardasil has been introduced for boys in Australia.
   2. Why not use a two-dose immunisation? Money saved by not administering the third dose could be used elsewhere.
7. Further research
   1. There is a need to examine the immunisation coverage rate for Maori and Asian women.
   2. It will be important to monitor different HPV types to see if there are any changes over a couple of years with increased immunisations, screenings, etc.
8. Additional feedback
   1. What about immune-suppressed women? Is there a different algorithm for them?
   2. With the specificity of the test, would the programme accept HPV tests from overseas?
   3. Will migrant women from overseas be screened as a part of the programme? Overseas smear tests are not currently accepted.
      1. Could this be part of an immigration medical check?
   4. If there is a significant rise in HPV, how will the NSU manage this?

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| **83** | Submitter name | Christchurch general public meeting 16 Oct 2015 |
| Submitter organisation |  |

**Consultation attendees:**

* + - 1. Helen Mcnab Canterbury DHB
      2. Jill Lamb Canterbury DHB
      3. Amy Carry Family Planning
      4. Kate Bridgeman-Smith Family Planning
      5. Sandra Hamilton Family Planning
      6. Allan Shao Canterbury Health Laboratories
      7. Jo Hackman-King Canterbury Health Laboratories
      8. Ruth Love-smith Canterbury Health Laboratories
      9. Hinarata Campin Screen South
      10. Angela Lee Screen South
      11. Jin Cho Screen South
      12. Natasha King Canterbury DHB
      13. Nancy Stewart Canterbury DHB
      14. Vivienne Back Screen South
      15. Julie Haywood Screen South
      16. Joan Miles Screen South
      17. Greg Devane Canterbury Health Laboratories
      18. Barbara Screen South
      19. Rachel Faatili Screen South
      20. Johanne Curtis Screen South

**The nine key themes for this consultation:**

1. Self-sampling
2. Starting age limit
3. Ending age limit
4. Screening intervals
5. Workforce impacts
6. Equity
7. Immunisation
8. Further research
9. Additional feedback

**Specific issues mentioned during the meeting in relation to broader themes:**

* + - 1. Self-sampling
  1. Ideally, self-sampling should be free.
  2. If utilised, the self-sample test must be extremely high quality.
     1. What is the validity and reliability of it?
     2. What is the evidence from self-sampling done in other countries?
  3. Self-sampling is not ideal for everyone, but may be beneficial for those who don’t show to their screens.
  4. Self-sampling could be a good first step to getting women on the screening pathway.
     1. It should be considered one tool in a toolkit for women who wouldn’t otherwise participate in the screening programme.
  5. Low vaginal swab would be a good starting point for women who have not previously participated to build confidence.
  6. There is value in visualising the cervix when conducting cervical smears, so would that be lost if self-sampled?
  7. The negative predicative value of self-sampling is still in the 90s, which is not as good as cervical smears.

1. Starting age limit
   1. Many in attendance did not like the idea of pushing back the start date to 25 years of age.
      1. People younger than 24 years of age have the most partners, potentially meaning their highest risk for contracting the virus is while they are younger than 25. A delayed start date would cut off these young people.
   2. How will the later start date affect women who have been sexually abused?
2. Ending age limit
   1. Doing a screen on a 69 year old woman is much more traumatic than doing it on a younger person.
   2. Is an end screen at 75 really necessary if cervical cancer is slow to develop, meaning they may not develop anything until their 90s?
   3. Women should have informed consent to participate or not at an older age.
3. Screening intervals
   1. Would be great if the test was every six years to tie into breast screening.
   2. What if the patient is not immunised? What is the validity of the 5 year testing?
   3. How will more aggressive types of HPV be affected by the longer screening intervals?
   4. Longer screening intervals may create less harm for women by decreasing their anxiety around so many tests, including unnecessary colposcopies.
4. Workforce impacts
   1. A two lab model has not been proposed by NCSP.
   2. How will colposcopy services be able to cope with the increased pressures?
   3. One cytoscientist in attendance was worried about staff attrition during the transition to the HPV primary screening and how that would affect the ability to manage the current liquid-based cytology workload.
   4. Not every cytologist will be able to be absorbed or re-trained, which is an issue.
   5. The benefit of cytology is that it can tell the difference between a low grade and a high grade lesions. It is important to remember it is more than a screening tool, it is a diagnostic tool.
   6. Workforce issues affect smear takers as well as lab staff. This needs to be taken into consideration.
   7. The register needs to be more functional, especially for health professionals.
      1. For example, it should include immunisation histories and even link to the NIR.
5. Equity
   1. Will the HPV primary screen be cheaper and/or free?
   2. A New Zealand focus must be maintained (and not just relying on Australian data) when considering a new screening programme.
6. Immunisation
   1. Some fully vaccinated women are showing up with high grade lesions. What are the implications of that?
7. Further research
   1. How many non-cervical cancers get detected through the current screening programme? Is that different from what the HPV screen would detect?
   2. With an increasing number of people who have the HPV vaccine, other strains (not 16 and 18) may become more prevalent. How will this be monitored?
   3. Are there any studies looking at a woman’s risk of developing cervical cancer if she had HPV in the past and then cleared it?
8. Additional feedback
   1. What is the reliability and sensitivity of the HPV screening test?
      1. There may be a difference between reliability studies done in a lab and real life experiences with reliability.
      2. Without broad “real life” experience studies, how do we know the true reliability? Should we rush into this?
   2. When women turn up for a cervical smear, staff also perform a sexually transmitted infection screen. Quite a few sexually transmitted infections are detected this way. How would this be taken into account with the new HPV testing programme?
   3. If a woman has been exposed to HPV, what is her risk for later developing cancer?
   4. There is a higher rate of hrHPV 52 in New Zealand. How will that be addressed in the new screening programme?
   5. Will the HPV test the same strains that are screened for now?
      1. Would we extend the range of testing (i.e. the number of strains)?

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| **84** | Submitter name | Wellington fono 20 Oct 2015 |
| Submitter organisation |  |

**Consultation attendees:**

* + - 1. Kay Lavill Massey University
      2. Barbara Varday Compass Health
      3. Vaiata Mitchell Pacifica Women’s
      4. Katarina Crawford Department of Internal Affairs
      5. Kaopaerangi Ngatoko Cook Islands High Commission
      6. Tui Tarao Arthritis New Zealand
      7. Anne A-Moetara
      8. Akaiti Samuel CIM Porirua Community

**The nine key themes for this consultation:**

1. Self-sampling
2. Starting age limit
3. Ending age limit
4. Screening intervals
5. Workforce impacts
6. Equity
7. Immunisation
8. Further research
9. Additional feedback

1. **Specific issues mentioned during the meeting in relation to broader themes:**Self-sampling
   1. Self-sampling may pose issues for older Pacific women who may experience difficulties with insertion of a tampon-based other similar test into the vagina.
      1. What is the uptake with older women and self-sampling?
   2. Self-sampling may be accepted by younger Pacific women, though.
      1. Marketing will need to encourage “taking responsibility.”
   3. There was hesitation around the idea of a two-stage self-sampling process.
   4. A key thing to consider will be a woman’s sense of safety when taking the test.
2. Starting age limit
   1. Pushing the start date to 25 years may be a risk for young women because it may mean connecting with a health professional later.
      1. For example, 16 to 20 year old women head into Family Planning for contraception, so it’s easier to get them to take a screen while in the office.
      2. If they aren’t starting to get screened until 25, they may come in less frequently and may find it challenging to develop relationships with health professionals.
3. Ending age limit
   1. A speculum exam may not be the most comfortable for older women.
4. Screening intervals
5. Workforce impacts
6. Equity
   1. Pacific women are struggling with the existing process. A two-stage process may be even more challenging.
   2. There is a need for health literacy to educate Pacific women about the screening process, risks, etc.
      1. It needs to be “de-mystified” for Pacific women.
   3. Education needs to begin much earlier, perhaps even 12 years of age (such as encouraging them to get ready for their future screening).
   4. Some Pacific women may fear the results and what that means for the next step.
      1. Reducing fear should be a priority with health literacy attempts.
   5. Support services within the community need to be improved so they can encourage participation in the programme. This is especially important for Maori and Pacific women, including older women.
      1. The support service providers need to be well-known, respected, information-sharing members of the community.
      2. The focus needs to be on relationship-building between the support service providers and the women, their families, and their friends.
   6. There is a need to explore the messages that will be used to educate.
      1. What will help the women themselves understand?
      2. What will help their providers understand?
      3. What is communicated is just as important as how it is communicated.
      4. There should also be a focus on the family, not just the individual woman.
   7. Marketing will be crucial for the effectiveness of the new screening programme.
      1. There is confusion around HPV, so “cervical screening” might be more effective.
      2. A social campaign would be a great way to reach younger people and their networks.
7. Immunisation
   1. Immunisation rates of Pacific women need to be improved and remain a key focus.
   2. Will boys be immunised, like in Australia?
      1. Immunising boys could remove the stigma young women feel by being the sole focus of immunisation efforts.
8. Further research
9. Additional feedback
   1. Women need to be fully-informed to be respectful of them and to empower them to make their decisions. In order to do this, it is important to give them lots of information.

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| **85** | Submitter name | Hawkes Bay (Napier) general public meeting 21 Oct 2015 |
| Submitter organisation |  |

**Consultation attendees:**

1. Jenny Cawston Hawkes Bay DHB
2. Sandra Corbett Hawkes Bay DHB
3. Margaret Alexander Hawkes Bay DHB
4. Annette Davis Hawkes Bay DHB
5. Julia Glentworth Lead Colposcopy Nurse, Hawkes Bay DHB
6. Victoria Speers Health Hawkes Bay, PHO
7. Christine Le Geyt Central Health
8. Andrea Burton KHS “Choices”
9. Patrick Le Geyt Maori Health Hawkes Bay DHB
10. Lynda Croft Lead Colposcopist, Hawkes Bay DHB

**The nine key themes for this consultation:**

1. Screening interval
2. Starting age
3. Exit age
4. Self-sampling
5. Workforce impact- Colposcopy volumes and histology tests
6. Payment for testing
7. Register
8. Immunisation
9. Further research

**Specific issues mentioned during the meeting in relation to broader themes:**

1. Screening interval
   1. At present, we call women at 3 years, but they don’t come in for a smear until closer to 5 years. We don’t want this to happen if we move to 5 years – then women will delay until 7 years. Should we recall some groups earlier? We don’t want to increase risk for women who don’t have timely smears now.
   2. Need to consider application of longer screening interval for immunosuppressed women.
   3. There may continue to be women who want to have annual smears. Comment from the Maori Women’s Welfare League in previous meeting with Sandra that women will need to have confidence that the new test will keep them safe.
2. Starting age
   1. We need more research, and to reach herd immunity before we increase the starting age. Support for option of using cytology screening for under 25s.
   2. Understand the implications for increased referrals to colposcopy by using HPV to screen younger women, and the potential harms from over treating.
3. Exit age
   1. Older women at risk of HPV now – are seeing these cases in HB.
4. Self-sampling
   1. We need to be selective about who is offered self-sampling
   2. Informed consent is important – in that women need to understand that self-sampling is not the gold standard test.
   3. Women could be put off by knowing they may need to come back for another test (LBC or colp) – they would be better with one gold standard test
   4. Will all women want self-sampling when they hear about it? Would it be better to focus on why women are not wanting to have clinician collected smears now and how to encourage them to?
   5. Self-sampling could lead to a missed opportunity to take an holistic approach to health care
   6. Could be offered as a last-ditch attempt to get women into screening.
   7. Many women would jump at self-sampling, and may expect self-colposcopy too
5. Workforce impacts
   1. Will colposcopy facilities be able to cope with the increased workload? They are struggling to meet timeliness targets now.
   2. How will the pathologists cope with the increase in histology?
6. Payment for testing
   1. Question asked re who would pay for pathology tests under the new programme (ie any additional costs for DHB)
7. Register
   1. Our timelines for Register redevelopment are unrealistic and we need to be prepared for this. We need to read the “lessons learned” document prepared by Nick Winfield about the last register redevelopment. Choice of IT contractor is important.
   2. Don’t cut corners – make sure the new Register meets the needs of all going forward (particularly primary care).
   3. Whose role is it to invite women for testing – opportunity to have population health screening programme.
8. Immunisation
9. Timeline to implementation of new programme would give an opportunity to increase HPV imms coverage
10. Support for immunising boys equality issue at present
11. Further research
12. Get Register data on women with positive colposcopy findings after treatment
13. The number of woman who have been waiting following referral for a LG and have HG on biopsy
14. The issue where woman who are referred following a positive HrHPV test within three years of treatment, presenting, colposcopied and discharged as nothing to treat could this be an issue with HPV testing.

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| **86** | Submitter name | Gisborne general public meeting 21 Oct 2015 |
| Submitter organisation |  |

**Consultation attendees:**

1. Nicki Dever Tairawhiti DHB
2. Netta Kutia Community Clinic
3. Bill Weidermand Obstetrics and Gynaecology
4. Lynn Mackey Outpatients
5. Karen Staples Midlands Health Network
6. Evelyn Cross Hauora Tairawhiti
7. Missie Winiata Hauora Tairawhiti
8. Sean Pocock Obstetrics and Gynaecology
9. Sandi French Well Child
10. Clare Aitcheson Lead Colposcopy Nurse
11. Molly Para Hauora Tairawhiti MHS
12. Dewe Pawar Hauora Tairahiti MHS
13. Diane Van de Mark Obstetrics and Gynaecology
14. Connie Stephens Ngati Porou Hauora
15. Tiziana Manea Community Clinic
16. Chris Hannah Community Clinic
17. Jo Pere Cancer Society
18. Liz Mackenzie Turanga Health
19. Margaret Thorpe City Medical
20. Debra Bromley Puhi Kaiti – Ngati Porou Hauora
21. Rob Wilkes Uawa Clinic – Ngati Porou Hauora
22. Julia Wanoa Ngati Porou Hauora
23. One name not recorded.

**The key themes for this consultation meeting:**

1. Self-sampling
2. Starting age limit
3. Ending age limit
4. Screening intervals
5. Workforce impacts
6. Equity
7. Immunisation
8. Further research
9. Additional feedback

**Specific issues mentioned during the meeting in relation to broader themes:**

1. Self-sampling
   1. In general, a lukewarm response to self-sampling. Understood the limitations and the arguments for and against. General preference with clinician-collected cervical sample.
2. Starting age limit
   1. Will feel more confident about this change when the immunisation rates are better.
   2. Suggestion for cytology for under 25s.
3. Ending age limit
4. Screening interval
   1. Women may have anxiety about moving to 5 years – give them confidence that it’s okay.
   2. 5 years is great – will help encourage women to have smears as it is less frequent.
   3. There will be cost savings with the 5 yearly tests – can we use the savings to immunise boys?
5. Immunisation
   1. Want to see boys immunised.
   2. Immunisation rates are very good in Tairawhiti – have sent Kiawhina to homes to get consent forms signed – big focus on this.
6. Equity
   1. We need to carefully consider how to introduce the changes to the public – HPV immunisations was not sold well. We need education to give confidence to women about the changes.
7. Immunisation
8. Further research
9. Additional feedback
   1. How will the change effect post hysterectomy women – will they need smears? Will the guidance change?

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| **87** | Submitter name | National Screening Advisory Committee meeting 13 Oct 2015 |
| Submitter organisation |  |

***Question 1. Other pathway options NCSP should consider?***

Investigate continuing LBC for 20-24 year age group (as per current programme) with primary HPV screening from age 25 years.

 Consider running effectiveness modelling with this approach, and include NZ incidence and mortality data so have confidence with the model in terms of raising the screening starting age to 25 years.

 Public feedback is also likely to suggest re-consideration for this age group, noting the risk of adverse publicity if screening is not offered to 20-24 year olds and a rare case cervical cancer death occurs in this age group (recent media coverage of such cases has occurred in the UK).

 Consideration of harms of colposcopy in the 20-24 age group is also required eg over-treatment, evidence of increased risk of premature births, anxiety of repeated recalls.

 Clear outline of harms vs benefits by age, especially the 20-24 year age group would be useful.

Consideration could be given to reviewing how the model manages different age cohorts given there are intergenerational differences in risk, ie, look at modelling different generations versus modelling just the 1997 cohort.

 However, it was also noted that the vaccinated and unvaccinated groups do provide different age ranges, so changing this approach will likely not change the results.

***Question 2. Further research suggested?***

 Investigation of reasons for low vaccination coverage and the extent of associations with parental attitudes eg not supporting vaccination as child not yet sexually active.

 Consider increasing the framing of vaccine as anti-cancer versus anti-HPV infection to reduce negative associations with STIs.

 Emerging evidence was noted of vaccine benefit in older age groups if HPV negative, with a request that the immunisation team consider modelling this scenario.

***Question 3. Are there higher risk groups who require a shorter screening interval than 5 yearly?***

 Yes: immune-deficient or immunocompromised groups, noting such groups would be covered in the clinical guidelines as per current practice

 Consideration should also be given to socially vulnerable groups, eg those who have suffered child abuse or have had a background of Child Youth and Family Services care, with increased risk of early sexual debut and infection with HPV at a young age. Such groups could be covered by the clinical guidelines.

 Given variation in genotype prevalence in different countries, eg HPV52 is more common in Asia, consideration of different LBC triage pathways for some immigrant populations may be warranted.

***Question 4. Exit test between ages 69-74?***

 Worth considering given increases in length of life, and also the Australian programme modelling demonstrates a 5% reduction in mortality with age range extension to 70-74 years.

***Question 5. Temporary increase in colposcopy numbers manageable?***

 Noted that colposcopy numbers will increase 15% in unvaccinated women during the first screening round, as prevalent cases are detected. These figures would drop on the second round, and with increasing immunisation coverage.

 Exit test at age 69-74 years is unlikely to affect volumes.

 Issue is not lack of workforce, but how best to organise current workforce.

***Question 6. Suggested strategies for eliminating inequalities in screening?***

 Inequities occur in all areas of the screening pathway, not just coverage eg colposcopy timing.

 Cost of visit to primary care for a smear may be mitigated in the future by self- sampling (once method is validated).

 Equity in provision of smears for disabled women is important with reports that health professionals see them as asexual.

***Question 7. Issues related to self-sampling****?*

 Self-sampling in on the horizon and is potentially good for the programme once the test has been shown to be reliable, as it reduces costs and will likely improve acceptability.

 As well as a vaginal sample, self-sampling includes options for urine collection eg the Fast HPV Voch trial currently underway overseas.

 It is important that all modalities are of an equivalent standard, with concerns that a two tier system will develop if a less reliable test is introduced for groups currently under-screened eg Māori.

 It was noted that the current programme must maintain expectations of reducing inequity.

***Question 8. Approaches for invite and recall of women?***

 GPs currently send first invite and NCSP register sends reminder at three months where invite fails (for those already on the NCSP register). Given 95% of population is registered with a GP this approach is generally successful.

 However, barriers exist as there is lack of information available to Independent   
 Service Providers (ISPs) on women who are not screened, and ISPs have limited   
 ability to refer these women to another provider if needs be.

1. Andermann, A., Blancquaert, I., Beauchamp, S. and Dery, V. *Revisiting Wilson and Jungner in the genomic age: a review of screening criteria over the past 40 years*. Bull World Health Organ. 2008 April; 86(4): 317–319.

   <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2647421/> [↑](#footnote-ref-1)
2. “The problem with using HPV testing for screening for cervical cancer is that infection with HPV is very common. In the US, the Centers for Disease Control and Prevention estimates that most sexually-active women will acquire HPV at some point in their lifetime.3 However, only a few infected women will go on to develop cervical cancer. Moreover, HPV infection typically occurs in younger age groups whereas cervical cancer usually develops later in life”. At Wright, T. Expert forum. www.researchreview.co.nz accessed October 12th 2015. [↑](#footnote-ref-2)
3. In 2012, new US guidelines for cervical cancer screening recommended Pap smear and hrHPV co-testing as the preferred approach in women aged ≥30 years. All of the screening studies conducted up to this point had been cross-sectional. However, screening is typically done multiple times in a woman’s lifetime so multiple rounds of screening are necessary in an evaluation setting for the benefits of HPV testing versus cytology to become evident. Wright, T. Expert forum. www.researchreview.co.nz accessed October 12th 2015. [↑](#footnote-ref-3)
4. As discussed at the National Cervical Screening Programme Auckland Public Consultation, 19th October 2015. [↑](#footnote-ref-4)
5. Wright, T. C., Stoler, M. H., Behrens, C. M., Sharma, A , Zhang, G., & Wright, T. L. (2015). Primary cervical cancer screening with human papillomavirus: End of study results from the ATHENA study using HPV as the first-line screening test. *Gynecologic Oncology, 136*, 89–197. [↑](#footnote-ref-5)
6. Foliaki, S., & Matheson, A. (2015). Barriers to Cervical Screening among Pacific Women in a New Zealand Urban Population. *Asian Pacific Journal of Cancer Prevention, 16*(4), 1565-1570. [↑](#footnote-ref-6)
7. Lovell, S., Kearns, R. A., & Friesen, W. (2007). Sociocultural barriers to cervical screening in South Auckland, New Zealand. *Social Science & Medicine, 65,* 158-150. [↑](#footnote-ref-7)
8. Peters, K. (2012). Politics and patriarchy: Barriers to health screening for socially disadvantaged women. *Contemporary Nurse, 42*(2), 190-197. [↑](#footnote-ref-8)
9. Foliaki, S., & Matheson, A. (2015). Barriers to Cervical Screening among Pacific Women in a New Zealand Urban Population. *Asian Pacific Journal of Cancer Prevention, 16*(4), 1565-1570. [↑](#footnote-ref-9)
10. Lovell, S., Kearns, R. A., & Friesen, W. (2007). Sociocultural barriers to cervical screening in South Auckland, New Zealand. Social Science & Medicine, 65, 158-150. [↑](#footnote-ref-10)
11. In collaboration with the Australian COMPASS trial organisers, a service evaluation project is being undertaken to trial HPV testing as a primary cervical screening test in New Zealand to test systems and processes to plan for a possible transition to a modified screening programme. [↑](#footnote-ref-11)
12. Litmus Limited. 2012. HPV Immunisation Programme Implementation Evaluation. Volume 1. Final Report.

    Wellington: Ministry of Health, pg8 [↑](#footnote-ref-12)
13. Litmus Limited. 2012. HPV Immunisation Programme Implementation Evaluation. Volume 1. Final Report.

    Wellington: Ministry of Health, pg9. [↑](#footnote-ref-13)
14. Litmus Limited. 2012. HPV Immunisation Programme Implementation Evaluation. Volume 1. Final Report.

    Wellington: Ministry of Health, pg10. [↑](#footnote-ref-14)
15. Ministry of Health. 2014. 'Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014–2018. Wellington: Ministry of

    Health, pg 8. [↑](#footnote-ref-15)
16. Ministry of Health. 2014. 'Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014–2018. Wellington: Ministry of

    Health, pg 8 [↑](#footnote-ref-16)