

# The Transition to HPV Primary Screening

## Introduction

New Zealand has three national cancer screening programmes, for breast, bowel and cervical cancer. Intuitively, most people believe that screening programmes are a ‘good thing’ because they have the potential to detect problems at an early stage, preventing the development of more serious disease. However, it must be also recognised that screening programmes are costly, can cause harm, and have the potential to increase inequalities.

To achieve the National Screening Unit’s (NSU’s) goal of ‘safe, high-quality and mana-enhancing programmes’, close attention needs to be paid to technical, policy, equity and communication aspects. In order to uphold and support the principles of Te Tiriti and the requirements of the Pae Ora Legislation, we have a responsibility to work in partnership with tangata whenua to deliver a programme that meets the needs of mana wāhine and ensures equitable outcomes.

New Zealand’s National Cervical Screening Programme (NCSP) was established in 1991 following the 1988 Inquiry Into Allegations Concerning The Treatment Of Cervical Cancer At National Women’s Hospital (the Cartwright Inquiry). The Cartwright Inquiry was a significant event for public health in Aotearoa. It resulted in the establishment of the Health and Disability Commission and Commissioner, external to the medical profession, the development of a legislated Code of Patients’ Rights and the establishment of independent national ethics committees.

It also recommended the urgent implementation of a nationally-planned population-based cervical screening programme – now the National Cervical Screening Programme. Prior to this, opportunistic screening took place in many general practices and family planning clinics

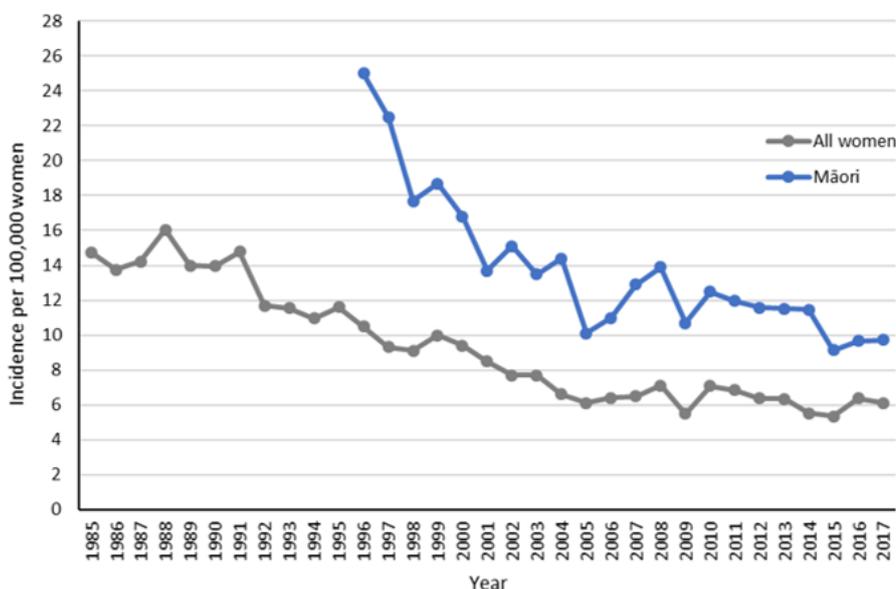
but there was no organised programme and no national standards. A few years after the establishment of the programme, a serious problem was identified, with high under-reporting of abnormal smears in the Tairāwhiti region by a single pathologist. Tragically, dozens of women developed cervical cancer and some women died as a result of this event. This led to the Gisborne Inquiry in 2000, which reviewed the incident and investigated wider systemic issues, including quality assurance around laboratory issues.

It is from these painful beginnings that the current National Cervical Screening Programme (NCSP) was born. Over the 21 years from 1996 to 2017, cervical cancer rates have reduced dramatically, and the gap in the incidence between Māori and non-Māori has reduced.

However, there is more work to be done. Around 160 women are diagnosed with cervical cancer every year in Aotearoa, and 60 die. Māori and Pacific women are still affected disproportionately. Like other public health programmes, screening is a collective effort, including the work of health promoters, kaiawhina, screen-takers and other primary healthcare providers, laboratory scientists, National Screening Unit (NSU staff) policy makers, communicators, advisors, partners, and many others.

With the HPV vaccination, and the support of high-quality screening, cervical cancer can be eliminated, both in Aotearoa and internationally, in line with World Health Organization elimination targets. The new technology of the HPV test, which tests for the virus rather than cellular abnormalities and can be done in private as a self-swab, has the potential to transform cervical screening and achieve equitable outcomes.

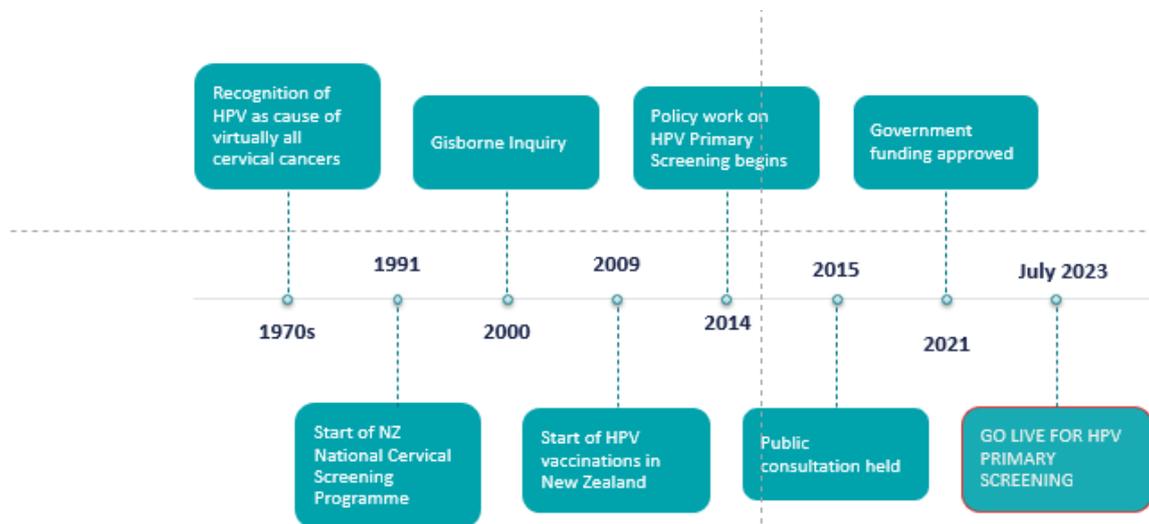
**Age-standardised cervical cancer incidence rates for Māori\* and all women, 1985–2017†**



Rates are per 100,000 women, age-standardised to the WHO Standard Population (all ages).



# Timeline



The discovery in the 1970s that cervical cancer is caused by the human papillomavirus (HPV) revolutionised the understanding of the natural history of this disease. As the evidence emerged over the next decades, highly effective vaccines were developed and introduced. Aotearoa introduced HPV vaccination (initially for girls only) in 2009, in line with other developed countries.

The next big step forward for the prevention of cervical cancer was the development of a test for the HPV virus. This is a better test for population health screening than the examination of cells taken from the cervix (cervical cytology). The HPV test is more sensitive (more likely to pick up abnormalities), and much simpler to do: the participant can take it themselves as a 'self-swab', rather than needing a speculum examination. People who have previously delayed getting a cervical test because of the discomfort, embarrassment and whakamā of having a speculum examination, now have a better option.

In May 2014, the then Associate Minister of Health approved policy work to consider a major change to the NCSP. This looked at changing the Primary Screening test from liquid-based cytology testing to HPV testing, in line with similar changes in other countries.

The NCSP released a public consultation document in September 2015 on changing primary cervical cancer screening from liquid-based cytology testing to HPV Primary Screening.



The 2015 and 2018 Parliamentary Review Committees and Te Rōpū Whakakaupapa Urutā, the National Māori Pandemic Group (2020) recommended that HPV Primary Screening, including self-testing, be funded and implemented as a matter of urgency.

Professional groups (including The Royal New Zealand College of General Practitioners, RNZCGP) and Māori advocacy groups strongly advocated for implementing HPV Primary Screening in order to support more equitable health outcomes.

In 2021, the Government announced funding for the NCSP to move to HPV Primary Screening, with the option of self-testing, from July 2023.

Consultation was undertaken throughout May and June 2021, including 105 written submissions and 11 consultation meetings on the plan for implementing the HPV Primary Screening pathway.

The outcome of this consultation has been the development of a final HPV Primary Screening clinical algorithm, with the option of self-testing.

International input was received into our algorithm that was developed by clinicians specialising in these areas, backed by local research.

Consultation feedback also informed the next steps of planning, including designing a detailed information technology (IT) system for implementing the programme and developing guidelines, policy and procedures.

An HPV Primary Screening Project Delivery Team has been created within the NCSP to assist the NSU clinical team, which is responsible for the safe transition to HPV Primary Screening. The Project Delivery Team is overseeing the planning and implementation of the transition to HPV Primary Screening.

The “go live” for this transition is July 2023.

## Te Tiriti o Waitangi

Our te Tiriti o Waitangi obligations are fundamental to the design of a new programme. This was reinforced by feedback from organisations and individuals consulted around the new clinical pathway, who advised that the pathway needs a strong focus on the principles found in Te Tiriti o Waitangi and must align with the transformations called for in the Wai 2575 Hauora report of the Waitangi Tribunal<sup>1</sup>. Consultation also revealed there is strong support



for New Zealand to move toward self-testing for convenience, privacy, empowerment and autonomy over *whare tangata*<sup>2</sup>.

As identified in the Hauora report, the Waitangi Tribunal proposed the framework of Te Tiriti o Waitangi principles be adopted for the primary health care system, inclusive of *tino rangatiratanga*, equity, active protection, options and partnership. These principles can also be adopted for population-based screening programmes.

**Tino rangatiratanga**, provides for Māori self-determination and *mana motuhake* in the design, delivery and monitoring of care. For the National Screening Unit, this relates to the governance of the programme. We are currently undertaking work to develop a strong partnership and overall governance arrangement – a ‘two house’ model between *tangata whenua* and *tangata Tiriti*.

The principle of **equity**, requires the Crown to commit to achieving equitable health outcomes for Māori. With the ongoing disparity between Māori and non-Māori uptake of screening, incidence of cervical cancer and mortality from cervical cancer, this principle is highly relevant. The increased acceptability of self-testing, especially in the un- and under-screened populations, is likely to lead to increased uptake among people who have been reluctant to screen to date. This results in a more equitable screening programme and a reduction in the number of cervical cancers. A change in the test alone will not ensure equitable outcomes. More also needs to be done to ensure that participants who have a positive test are provided support, if needed, to navigate the system and reach the next follow-up step.

The principle of **active protection**, requires the Crown to act, to the fullest extent practicable, to achieve equitable health outcomes for Māori. This includes active monitoring of Māori health outcomes and efforts to achieve Māori health equity. Active protection implies that programmes are designed with the person and *whanau* at the centre.

The principle of **options**, requires the Crown to provide for and properly resource kaupapa Māori primary health care services. Furthermore, the Crown is obliged to ensure that services are provided in a culturally-appropriate way that recognises and supports the expression of *hauora* Māori models of care.

The principle of **partnership**, requires the Crown and Māori to work in partnership in the governance, design, delivery and monitoring of primary health care services – Māori must be co-designers, with the Crown, of the primary health care system for Māori<sup>3</sup>.



These obligations mean that as the programme develops, there will be an ever-increasing focus on the governance of the programme, and funding, co-design and monitoring of culturally-safe, high-quality services to support the NCSP.

## NCSP and HPV Primary Screening– An Overview

The NCSP is a national public health screening programme that aims to reduce the incidence of and mortality from cancer through early detection of the precursors of cervical cancer. The programme is governed by Part 4A of the Health Act 1956 (the Act) which outlines the key obligations and responsibilities of the programme. Improving outcomes for wāhine Māori and Pacific women is a priority for the NCSP as these groups have a higher incidence of and mortality from cervical cancer.

The programme currently offers a three-yearly cervical screening test to women 25 - 69 years of age, using cytology, which requires a speculum examination to visualise the cervix and obtain a sample of cells for examination in a laboratory. Many women find the speculum examination intrusive or uncomfortable and avoid getting their 'smear test'.

From July 2023, HPV will become the Primary Screening test for the NCSP while liquid-based cytology (LBC) will become a secondary test. The HPV test is quicker and simpler to do, and involves less discomfort, as it does not require a speculum examination, but instead a swab taken from the vagina.

The new screening method will test for the presence of high-risk HPV. About four out of five people have an HPV infection at some time in their lives, but most people will clear the virus within two years. It is the chronic persistence of the HPV virus that can lead to cervical cancer. There are many different types of high-risk HPV and some are more likely than others to lead to cervical cancer. In particular, the 16 and 18 types represent the highest risk at a population level, causing around 70% of all cervical cancers.

HPV testing is very sensitive: if an active virus is present, it is highly likely that the HPV test will detect it. It picks up viral DNA – meaning virus which is active or has left traces of DNA – but doesn't detect evidence of past infections that have been cleared (or a low-level virus that is dormant).



Most participants who test HPV positive will not have cervical cancer but will need follow-up tests to investigate whether early cell changes have occurred. There will be several changes when the new Primary Screening test is introduced. Importantly, all participants will have the option of self-testing. This option is likely to increase participation in the screening programme, particularly for people who are underscreened. A vaginal swab can be taken by the participant in privacy at a health clinic, at home or in a non-clinical setting in the community, or it can be taken by a clinician if preferred. The clinic will be responsible for getting the sample to the laboratory. If the participant prefers, the clinician can take the vaginal swab. The other option is to have a specimen taken by speculum examination. If this option is chosen and the HPV result is positive, then the laboratory will be able to use the same sample to check the cytology, thus avoiding a possible second clinic visit.

Whichever option is chosen, participants will still need to liaise with their health care providers, who will explain the test, get informed consent, and manage the result. This includes informing the participant and arranging follow-up if the test is positive for HPV. It is important that the clinician provides education and support about cervical screening at the time of the test to ensure the participant is fully informed about the test and results, and understands the importance of ongoing participation in the NCSP screening pathway.

Follow-up might include:

- a speculum exam to look at the cervix and check the cells
- a colposcopy, a procedure done in outpatients, where a specialist can inspect the cervix through magnification and may take a biopsy or remove an area of concern.

Guidelines have been developed for clinical follow-up of positive HPV results.

People can be confident that a negative HPV test means they are at very low risk of developing abnormal cells that may lead to cervical cancer within the next five years. This means routine cervical screening will only be needed once every five years, not every three years as it is currently - another significant change for the programme.

Participants will be automatically enrolled for HPV Primary Screening, with an opt-off option.

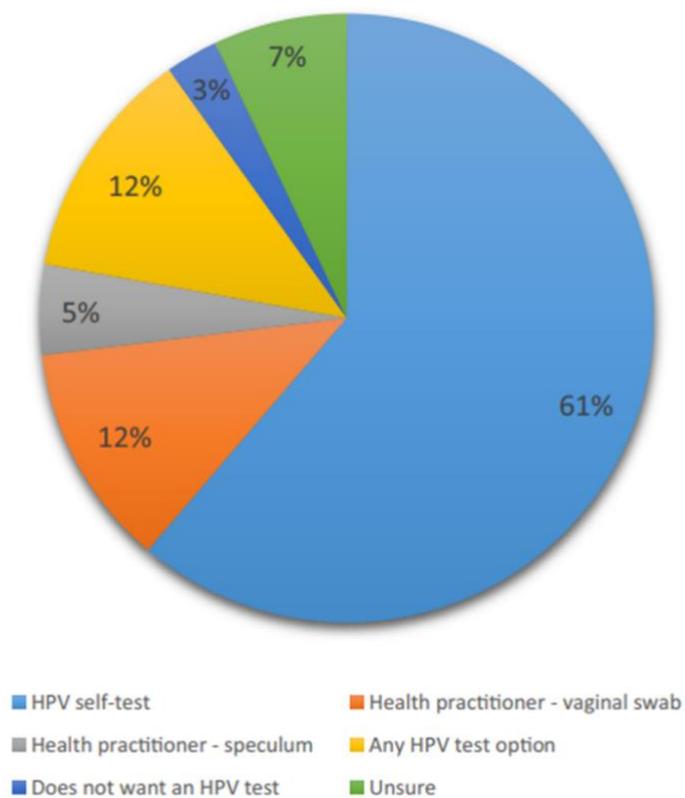
Despite the enthusiasm and impatience for the new screening test to become available, it is important that people who are due for screening continue with the current cervical screening test, and do not wait for the programme change in 2023. The current screening programme is clinically safe and effective and will continue to be so as the programme transitions.

# Uptake of Self-Testing

Modelling in Australia to assess the impact of self-testing concluded that offering HPV self-testing has considerable potential to improve outcomes for under-screened participants.<sup>A</sup>

New Zealand studies also suggest that offering HPV self-testing alongside more comprehensive pathway supports will increase participation and equitable outcomes by reducing barriers to screening.<sup>4</sup>

Research by *Adcock et al, Australian and NZ Journal of Obstetrics and Gynaecology 2019;59:301-307, Acceptability of self-taken vaginal HPV sample among an underscreened indigenous population, revealed 73% said they were likely/very likely to self test.*



**FIGURE 1** Preferences regarding HPV testing (N = 397).

Explanations given included that the self-test was “easier”, “more comfortable”, “less intrusive” and “brilliant”.

<sup>A</sup> Smith M, Lew JB, Simms K, et al. 2016. Impact of HPV sample self-collection for under-screened women in the renewed cervical screening programme. *MJA* 204(5): epub 21 March.

In an online questionnaire completed by screening-eligible women living in England (n=3672), half of participants (51.4%) intended to choose self-sampling, 36.5% preferred clinician screening, 10.5% were unsure, and <2% preferred no screening.

More irregular and never attenders chose self-sampling, compared with regular attenders (71.1% and 70.1% vs. 41.0% respectively).<sup>5</sup>

This supports increased participation by removing one of the key barriers to screening: the need for a speculum examination.

The clinical pathway for high-risk HPV (type 16 or 18) algorithm allows a pathway for direct referral to colposcopy to mitigate high-risk participants being lost for follow-up, with the option of adding cytology if the participant chooses.

During consultation, some organisations recommended that the HPV Primary Screening pathway include home-based self-sampling alongside the option for self-sampling in a clinical setting. This suggestion was adopted.

The scope of the project does not currently allow for test kits to be mailed out nationally. Test kits must be sourced from the health provider, whose clinical oversight responsibilities include ensuring the security of the sample, education and informed consent, and clinical oversight and follow-up of results. Within these constraints, the intention of the programme is to enable health providers to support participants to undertake the test in a way and a location that is most acceptable and comfortable to them.

## Other Factors Driving the Change

- Liquid Based Cytology (LBC) is no longer the most effective or cost-effective method of screening and New Zealand is behind other countries that have introduced HPV Primary Screening.
- The current NCSP Register is approaching the end of life, is inflexible and unsustainable. Replacement is critical to sustaining the NCSP even if HPV Primary Screening was not implemented. Transitioning to HPV Primary Screening is not possible without technology replacement, as the existing Register cannot be adapted.
- Workforce and funding challenges are putting the NCSP at risk. The cytoscience workforce has been declining and the existing cytology-based programme would have become unsustainable due to a lack of workforce capacity.

The HPV Primary Screening Project objectives reflect the wider NCSP goals of improving service quality and increasing equity, namely:

1. Reduce mortality from cervical cancer within 20 years of the programme change with greater relative reduction for Māori people (at least 27.6 per cent) compared to non-Māori people (at least 7.3 per cent).
2. Achieve the WHO elimination target for incidence of cervical cancer ( $\leq 4/100,000$  pop) within fifteen years for Māori and Pacific people.
3. Significantly reduce the equity gap in screening coverage for Māori and Pacific people within ten years of the programme change.
4. Achieve the quality and clinical safety of the NSCP, by maintaining the capacity and capability of the workforce to deliver required services.
5. Ensure the clinical safety and quality of the NCSP through an adaptable and secure ICT infrastructure that enables programme change.

In 2020 the World Health Organization (WHO) launched a global strategy to accelerate the elimination of cervical cancer as a public health problem by 2030.

The strategy targets are: Screening: 70% of women screened using a high-performance test by the age of 35, and again by the age of 45; Treatment: 90% of women with pre-cancer treated and 90% of women with invasive cancer managed. Each country should meet these targets by 2030 to get on the path to eliminate cervical cancer within the next century. <sup>6</sup>

WHO is also emphasising that the first line of defence against cervical cancer is prevention by HPV immunisation – HPV being the virus that causes almost all cervical cancers.

The WHO target is for a 90% vaccination rate by the age of 15. In New Zealand, HPV immunisation is free for everyone aged 9–26 years (inclusive), including boys and young men. It was introduced in 2009 for girls and extended to boys in 2017. It is offered to boys and girls in year 7 or 8 at school and can also be given in primary healthcare. Since 2017 Aotearoa New Zealand has used Gardasil-9, which includes 7 high-risk HPV types that cause 9 out of 10 HPV-related cancers.

Vaccination AND screening are BOTH essential to eliminate cervical cancer.

## Changes made to the Clinical Pathway

As a result of the transition to HPV Primary Screening, there are significant changes to the clinical pathway. The changes clarify that a return visit for cytology and speculum



examination by the primary care provider is required if a participant tests positive for HPV-other (not HPV 16/18) on a swab.

All people found to have HPV 16 or 18 (the highest risk HPV types), need to be referred by their clinician to colposcopy. This can be a direct referral without returning to primary care. Participants with HPV 16/18 on a self-test sample also have the option of returning to their primary care provider for cytology via clinical (speculum) examination before colposcopy. For some women this will be reassuring and enable discussion and support, as well as providing more information prior to colposcopy. This may help with colposcopic examination but is not essential.

Providing the option for direct referral to colposcopy (without cytology) for participants who test HPV 16/18 positive is a pragmatic solution which recognises that for many people, paying or returning to primary/community care for a liquid-based sample for cytology first will be a barrier to colposcopy follow-up.

The model approved by Government does not provide for HPV testing to be free. While there is no procedure involved, clinical oversight is still required by the health provider, who will set any costs for visits to their practice. Looking ahead, the NCSP is exploring different options for funding cervical screening in Aotearoa.

The longer timeframes (five years) between negative tests are more convenient and place less burden on the health system. They reduce the number of appointments, freeing up space in medical centres and reduce costs for participants. The health system can focus more resources on those with a positive test result.

Streamlining cervical screening will help free up general and nurse practitioners and nurse consultations to cope with their demanding workload.

The screening pathways aim to provide a balanced approach to triage to colposcopy while limiting the potential for over-treatment. Pairing positive tests for HPV (other) with cytology, then having the option to repeat this 12 and 24 months later will reduce the load on colposcopy services as some participants will resolve their HPV infection naturally, avoiding the need for colposcopy.



# Groups supporting the NCSP

The NCSP greatly values the input and advice from all stakeholders. In particular we are supported by three important groups, the Māori Monitoring and Equity Group, the National Kaitiaki Group and the NCSP Advisory and action Rōpū.

## Māori Monitoring and Equity Group

The work of the NCSP and its clinical team in the transition to HPV Primary Screening is being assisted by several key groups, one of which is the Māori Monitoring and Equity Group (MMEG). The NSU established the MMEG to provide independent advice to the NSU to achieve its vision, namely: “Saving lives, reducing inequalities, and building the Nation’s health by leading the delivery of screening programmes, uncompromising in their quality and trusted by the communities we serve”.

The objectives of the Group include:

- Provide Māori leadership on the strategic issues in the planning, implementation, monitoring and evaluation of the existing screening programmes and any further screening programmes under consideration
- Provide Māori leadership on strategic issues related to population health screening and its impact on Māori health and inequalities
- Develop a collective equity assessment framework improving equity (reducing inequalities) in health for Māori and therefore for all
- Provide Māori leadership that is clinically and technically sound
- Review new technological advances that may impact Māori Health.

The MMEG takes a population health perspective and an evidence-based approach in the provision of Māori leadership. All decisions of the MMEG are by consensus. The MMEG seeks input from stakeholders to any key decisions. Such input will include whānau, hapū, iwi, Māori communities, Māori providers, Māori consumers, and others as required.



# NCSP Advisory and Action Rōpū

A second key group assisting the transition to HPV Primary Screening is the NCSP Advisory and Action Rōpū, established in 2022 by the NSU. Its membership consists of 13 members with experience from all stage of the cervical screening pathway.

The NCSP Advisory and Action Rōpū provides leadership to deliver high-quality cervical screening outcomes for whānau Māori and Pacific people, and high-risk wāhine through developing knowledge around ways to effectively deliver, monitor, and improve health outcomes with a Māori and Pacific focus.

It provides strategic advice and guidance to the NCSP by helping to build understanding, collecting, and disseminating advice, and maintaining connections with professional and advocacy groups on behalf of the NCSP. This advice is used by the NCSP to inform, improve, and support the NCSP activities and policy.

## National Kaitiaki Group

The National Kaitiaki Group ensures protection of Māori women’s cervical screening data. The Group was established in 1995 by the Minister of Health under the Health (Cervical Screening (Kaitiaki) Regulations 1995. It is appointed by, and accountable to, the Minister of Health.<sup>7</sup>

The Group considers applications for approval to disclose, use or publish ‘protected information’, being information that is on or from the NCSP Register and that identifies the woman or women to whom the information relates as being Māori.

The National Kaitiaki Group protects Māori women’s cervical screening data by ensuring that this data is:

- not used or published inappropriately or in a way that reflects negatively on Māori
- used to benefit Māori women.
- It also provides a way of reassuring Māori women that their data is protected so they continue to participate in the screening programme.

All a participant’s cervical screening results are forwarded to the NCSP Register, as required under Part 4A of the Health Act 1956 (unless the participant asks not to have their results included).



The Register is an important management tool for Programme. It holds:

- the details of enrolled women (such as their name, address, age and ethnicity)
- cervical screening results
- the details of sample takers and their clinics
- test results from colposcopy services.

This information is essential for quality assurance and for monitoring and evaluating the effectiveness of the Programme.

Any person wanting to access, use or disclose Māori women's cervical screening data on the NCSP Register must first make an application to the National Kaitiaki Group, which has certain criteria for assessing applications to access Māori women's data.

The applicant must show how they will:

- use the information for the benefit of Māori women
- address the principle of the sanctity of te whare tangata
- protect the information in a manner that is culturally appropriate.

These criteria ensure the use of data is consistent with the Kaitiaki Regulations. In releasing approved data, the National Kaitiaki Group will ensure that such releases protect the confidentiality of Māori women on the NCSP Register.



# The work underway now

## The HPV Primary Screening Project

### Delivery Team

This Project is being driven by clinical expertise provided by the NSU clinical team, who are taking responsibility for the safe transition to HPV Primary Screening. They are being supported by a Project Delivery Team that is focused on all the operational and training requirements needed for the transition.

The team has specific workstreams in areas such as Cervical Screening Services and Access, Colposcopy, Laboratories Transition, Campaigns and Resources, Monitoring and Reporting, and Information Technology (IT).

This work is being supported by Sector Working Groups formed to support the Implementation Phase of the Project. The Screen Takers Working Group, Register Working Group, Kaimanaaki Working Group and Colposcopy Working Group have already had meetings.

The Laboratory Working Group will be established after the formal RFP process has concluded and we know which laboratories will be involved in the HPV Primary Screening and associated cytology work after July 2023.

These groups have specific tasks to make sure that transition works in a clinically safe way. They will:

- Provide expert advice, guidance and advocacy needed to ensure the successful transition to HPV Primary Screening
- Inform the development of, and provide feedback on, the Register functionality, resources, training materials and delivery approaches
- Identify challenges and opportunities the sector might have to the proposed changes, and
- Act as change champions, advocate for the HPV Primary Screening Project and build trust in the sector for the changes to cervical screening

Helping guide all of this work is an NCSP Advisory and Action Group which provides strategic advice and guidance to the cervical screening Programme, in particular for the implementation of HPV Primary Screening.



The Group includes members with experience of all stages of the screening pathway and is focused on equity. Te Whatu Ora - Health New Zealand will work alongside this group in a partnership model which will inform our approach to all our groups advising the National Screening Unit.

Examples of the main areas of work focus for the Project team are detailed below.

## A New Register

The NCSP is building a fit-for-purpose ICT solution to support:

- clinical pathway changes to enable HPV Primary Screening and HPV self-testing
- the new Register will be a population-based Register sourced from NHI with opt-off option
- participants will be notified when they are due for screening
- centralised identification of the eligible patient population and enable implementation of robust active recall and support campaign management
- direct look-up access to the screening histories of eligible participants for sample takers (this would increase efficiency and support harm reduction by ensuring full relevant clinical information is available to the people screening, diagnosing and treating participants in the NCSP)
- long-term suitability and sustainability – flexibility, adaptability and cost-effectiveness
- a shared technological approach across multiple screening programmes, in line with the NSU strategic vision
- capacity to enable further configurations to support increased efficiency of the screening Programme

In summary, the population-based register, sourced from NHI data, is a core part of enabling the transition to HPV Primary Screening by including both those already enrolled in the NCSP and those who are unenrolled (albeit participants will have an opt-off option). It will provide centralised notification to let participants know it's time to get screened.

Providing direct look-up access for primary healthcare will be a major benefit of the new technology, with varying levels of access and editing depending on the needs of particular categories of healthcare providers.



The new Register will also be central to supporting improved reporting and monitoring of those on the screening pathway.

## Laboratories Request for Proposals

### (RFP)

The transition to HPV Primary Screening will mean a significant reduction in the number of cytology samples handled by laboratories. However, cytology will continue to be an important secondary diagnostic test and requires a highly skilled workforce (cytoscience and cytotechnicians). Therefore, the critical need is to preserve the skillset needed by laboratories to process cytology samples.

NCSP laboratory services must also be provided by more than one laboratory to guarantee business continuity in the event of an incident and to maintain audit processes.

Auckland District Health Board (ADHB) has been directly appointed for the provision of some services, and therefore has been omitted from the Request for Proposal (RFP), which is an open competitive tender for suitably-qualified Respondents to submit proposals.

This RFP will result in contracts between the Ministry and up to two laboratories (not including ADHB) for a proportion of NCSP screening services. The proportion of samples will range between 33% and 66%, depending on whether one or two providers (excluding ADHB) are engaged. Key elements of service delivery include:

- The high quality of results from the screening programme is maintained through technical assurance and quality control
- A mix of New Zealand owned and/or publicly funded laboratory facilities as well as privately owned laboratories are supported where possible
- Ability to maintain a sustainable and flexible workforce and service delivery (noting changing volumes to LBC, HPV and histopathology screening)
- Services are delivered in a way that is consistent with tikanga Māori cultural practices
- A seamless end-to-end process is maintained from primary health care to testing and results management



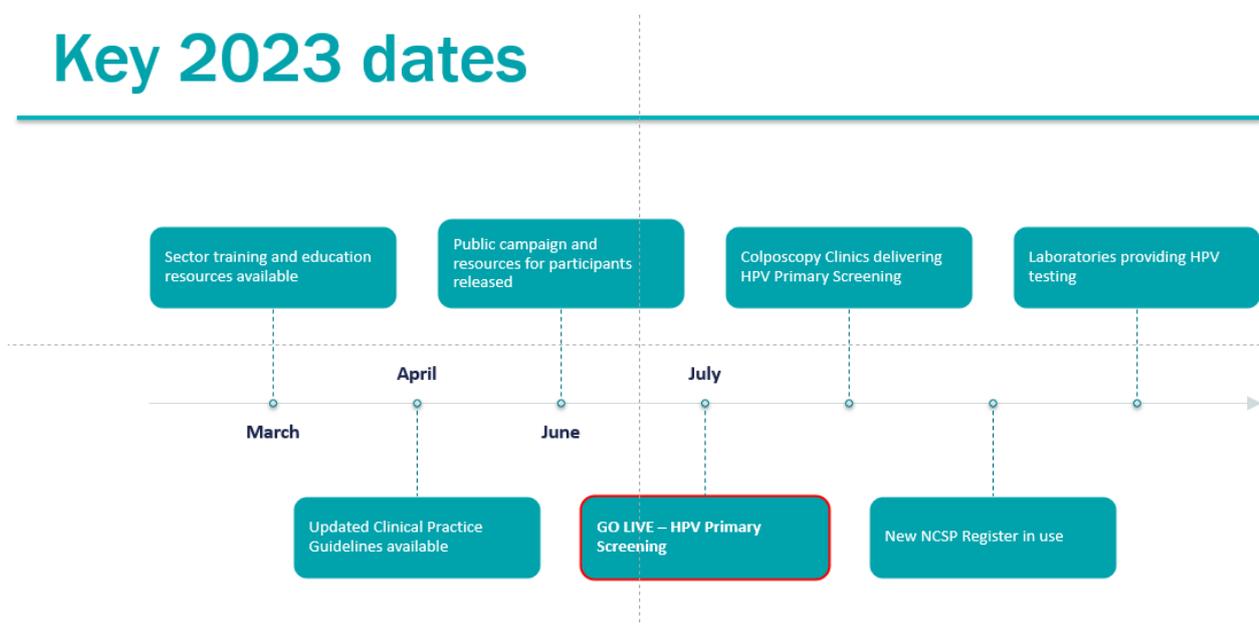
# Change Management Strategy

The Project's Change Management Strategy embodies the major principles of preparing the sector and organisation for change; crafting a vision for that change and a plan for its transition; implementing the desired changes; embodying those changes into the culture and practices of the sector and organisation going forward; and analysing the results of the change to assess if further improvements can be made. The Strategy recognises that the changes are extensive, including new clinical pathways, centralised notification and recall functions, screening tests, and a newly created ICT solution.

The NSU will work with each district to understand their capacity requirements (limits and volumes), to support both the transitional period and the regular cadence of operations. The NSU will provide support to districts to enable a successful transition.

Key timelines are shown below:

## Key 2023 dates



## Education and training

The Project team recognises that the transition process from one testing programme to another requires a comprehensive education training and education campaign.

The goal is to provide clear, accessible information to support clinicians and participants in understanding how the programme has changed and what steps are involved in the new pathway. Training in the use and functions of the new Register is essential, prior to the go-live date.

A thorough needs assessment is being compiled and a full training and education plan will be executed, in advance of “go live” in July 2023. A support model will be in place as we transition, with ongoing training and education provided.

## Stakeholder Engagement and Communications

Stakeholder engagement has intensified since the start of 2022. Main channels for engagement, in addition to the NCSP Action and Advisory Group and Sector Working group meetings mentioned above, include:

- Hui with regional coordinators
- Hui with Kaimahi and Support to Screening Services staff
- Presentations to sector groups and educational organisations within the health sector
- Webinars
- Sector Update monthly newsletter
- Announcements on NSU and Time to Screen websites
- Media releases
- Contributions to media articles and interviews

Further engagement will be extensive in the lead-up to, and subsequent to, Go Live in July 2023.

## Summary

The National Cervical Screening Programme is part-way through a major change process which will include a new and improved Register and a better and more acceptable test by July 2023.

The NSU acknowledges our founding principles of Te Tiriti o Waitangi and the need to focus specifically on equity for whānau Māori and Pacific peoples, and other groups who face barriers to screening. The NSU recognises that to be successful for Māori, the NCSP must



offer screening in ways that Māori feel are accessible, acceptable, and culturally appropriate. The programme must also appropriately promote the benefits of screening for Māori.

The NCSP aims to deliver a best-practice National Cervical Screening Programme that stands up to international comparison, is equitable, safe and of an extremely high quality. The current programme has achieved a marked reduction in cervical cancer incidence and mortality over the years, but it is time to transform the programme, and reach for the WHO goal of cervical cancer elimination.

The HPV screening test is more sensitive and offers a more comfortable and less-invasive choice for participants. This change will be supported by the enhanced Register.

Most important to the success of the programme, however is trust -- trust of participants around the new test, the monitoring and safety of the Programme, and the privacy and respect with which their personal information is treated.

**Any engagement or feedback from PHA members is welcomed and comments can be directed to the Project team's email [HPVScreen@health.govt.nz](mailto:HPVScreen@health.govt.nz)**



## Sources:

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## End Notes:

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<sup>1</sup> Waitangi Tribunal. 2019. Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry. Wellington: Waitangi Tribunal. URL:

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(accessed 1 December 2021).

<sup>2</sup> Whare tangata: The house of humanity, where life is created – the womb or uterus

<sup>3</sup> Waitangi Tribunal. 2019. Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry. Wellington: Waitangi Tribunal. URL:  
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<sup>4</sup> Adcock A, Cram F, Lawton B, et al. 2019. Acceptability of self-taken vaginal HPV sample for cervical screening among an under-screened indigenous population. Australian and New Zealand Journal of Obstetrics and Gynaecology 59: 301–7

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