New Zealand Medical Association
Te Hauora mō ngā Iwi Katoa

4 June 2021

Ministry of Health

By email: ncsp@health.govt.nz

National Cervical Screening Programme: HPV Primary Screening Clinical Pathway to Introduce Self-Testing

Dear Colleague

The New Zealand Medical Association (NZMA) wishes to provide feedback to the Ministry on the above consultation. The NZMA is New Zealand's largest medical organisation, with about 5,000 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. We recognise the principles of te Tiriti o Waitangi and the special obligations to Māori, particularly to ensure equity and active protection. Current disparities in health outcomes between Māori and non-Māori are unacceptable. The NZMA is committed to advocating for policies in health and the social and wider determinants of health that urgently address these disparities and contribute to equity of health outcomes. Our submission has been informed by feedback from our Board, Advisory Councils and members.

We note that the main objective of the consultation is to refine the HPV primary screening clinical pathway to include the option of self-testing, as part of planning for implementing HPV primary screening. We have previously conveyed our support for primary HPV testing in the screening pathway to prevent cervical cancer,[1] and we welcome the option of self-testing. However, we have some concerns regarding the steps on the pathway following a positive HPV test. We elaborate on these concerns in our responses to the specific consultation questions below.

Responses to consultation questions

4. What is your feedback on the proposed revised HPV primary screening clinical pathway?

We support HPV primary screening and welcome revision of the HPV primary screening clinical pathway to include the option of self-testing. Having self-testing in addition to clinician-taken tests will improve patient choice and acceptance, and opens the door to the further use of home-based testing with the opportunities to improve screening uptake, particularly in marginalised

[1] Submission on National Cervical Screening Programme: Changing the primary laboratory test. 20 October 2015. Available from https://bit.ly/34wGYJi

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groups. New Zealand research has found that the offer of an HPV self-test could increase the uptake of cervical screening by almost three times for under-screened Māori women.[2]

Our main concerns with the pathway relate to the steps following a positive HPV result which appear to reflect an approach that is system-centred rather than patient-centred. For example, a person with a positive HPV self-test will require a speculum examination to collect a cytology sample before colposcopy. While direct referral by a screening provider to colposcopy will be at the clinician's discretion, this is to be regarded as an exception, to support those with an identified higher risk of cervical cancer rather than as an option for all. The arguments for needing cytology before referral for colposcopy are not strong. The literature suggests that this intermediate step is not necessary but is being introduced primarily to reduce pressure on colposcopy services. Our view is that requiring a speculum examination to collect a cytology sample following a positive HPV test could increase the risk of inequity as there is already reluctance to undergo smears among the most vulnerable population groups. Requiring a person to come back for a smear adds the very barrier that self-testing is designed to overcome. It may, however, be appropriate to give women the choice of having a smear or direct referral for colposcopy after a positive self-test.

There are also concerns that the revised pathway does not make it clear as to whether a clinician-taken sample will be routinely used for cytology or whether a person with a positive result will be required to return for a Liquid Based Cytology (LBC) sample. If a return visit is required, we suggest this be made explicit on the flowchart.

5. What is your feedback on self-testing vs clinician-taken HPV tests?

We understand that the evidence demonstrates that HPV self-testing has similar sensitivity to clinician-collected samples, as long as a PCR assay for detecting HPV DNA is used. We note that modelling in Australia to assess the impact of self-testing concluded that offering even a single HPV self-test has considerable potential to improve outcomes for screening and under-screened participants. Accordingly, we are strongly supportive of giving people the option of self-testing in addition to clinician-taken HPV testing.

6. Do you foresee any problems with self-testing in a clinical setting, as part of the transition of the programme? What do you perceive as benefits?

We do not envisage any harm with HPV self-testing in a clinical setting, given the data that are presented. The transition process from one testing programme to another will need to be well managed and include a comprehensive information campaign. The main benefit should be to increase access to cervical testing, but this will require a correctly structured and well rolled-out implementation plan. Another potential benefit would be a reduction in material use in primary care, particularly of single-use plastic speculums.

7. Do you foresee any likely impact on access and equity?

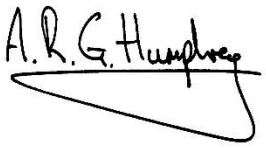
We believe that the option for HPV self-testing could increase participation in cervical screening and should lead to more equitable outcomes. However, this will depend on how the programme is implemented and ensuring there is comprehensive support at all stages in the pathway. It is unclear why HPV self-testing will be treated differently than self-testing screening for colorectal cancer. We have previously suggested that invitation and recall for primary HPV testing sits best with General Practice, with backup provided by the National Cervical Screening Programme register. If there are pressures on colposcopy services, then a triage system would need to be

[2] MacDonald EJ, et al. Reaching under-screened/never-screened indigenous peoples with human papilloma virus self-testing: A community-based cluster randomised controlled trial. Aust N Z J Obstet Gynaecol 2021; 61: 135–141. Available from https://obgyn.onlinelibrary.wiley.com/doi/epdf/10.1111/ajo.13285

implemented. This could include ethnicity as a risk factor, but we would hope that colposcopy workforce considerations are addressed as a priority.

We hope our feedback is helpful and look forward to learning the outcomes of this consultation.

Yours sincerely



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