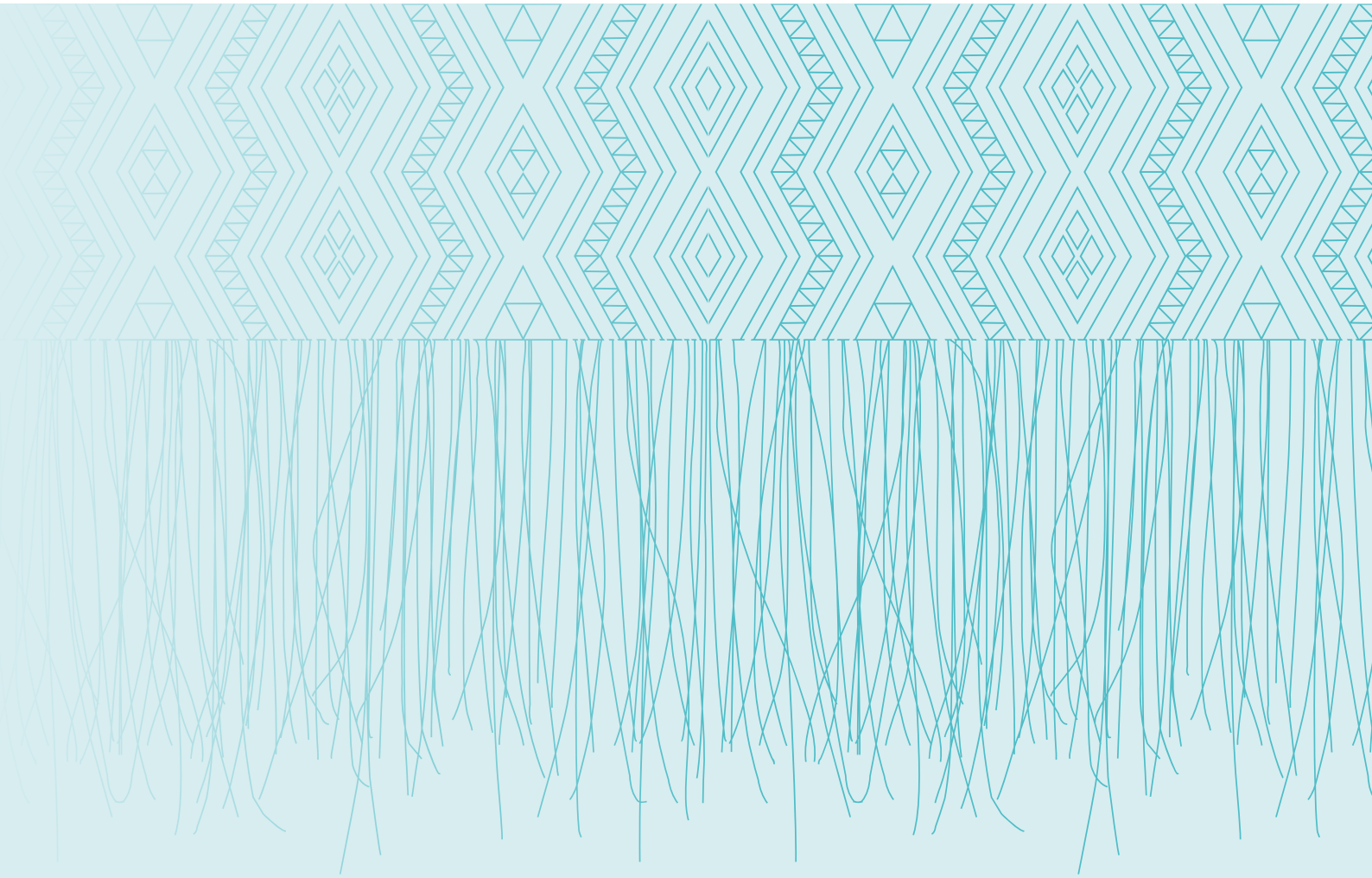
National Screening Unit

Te Whatu Ora
Health New Zealand

NCSP Policies and Standards
Section 3: Cervical Screening Services

Interim v1.0

National Cervical Screening Programme, 2023



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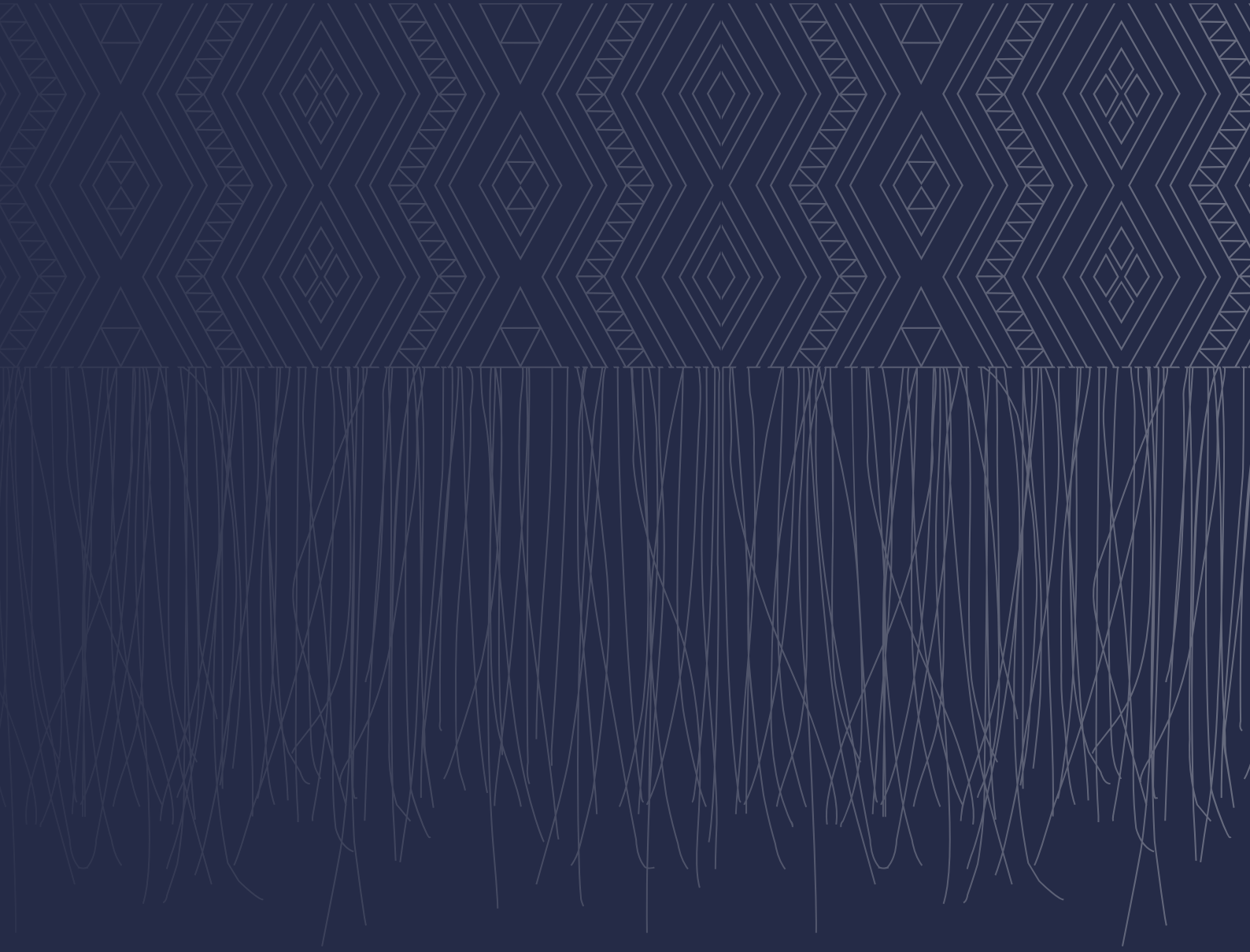

Citation: National Screening Unit 2023.
National Cervical Screening Programme Policies and Standards: *Section 3 – Cervical Screening Services*.
Te Whatu Ora

Published in June 2023 by Te Whatu Ora

ISBN: 978-1-99-106737-1 (online)
HP 6551
V.1.0 June 2023

This document is available at TeWhatuOra.govt.nz

Te Whatu Ora
Health New Zealand

Contents – Rārāngi upoko

Introduction – Te Tīmatanga

The quality and safety of cervical screening services is critical in determining the success of the NCSP.

In addition to ensuring the quality of the clinical environment and procedures, ensuring that participants have a culturally and physically safe experience of screening that supports lifelong participation is essential for equitable health outcomes.

In this standard

Section 3 of the National Cervical Screening Programme (NCSP) Policies and Standards provides information and guidance, and sets the requirements for healthcare providers and health professionals providing cervical screening services.

The purpose is to support all those involved in the NCSP to achieve the programme's aims and objectives by ensuring high standard cervical screening services and nationally consistent service delivery.

Clinical practice guidelines for cervical screening in Aotearoa New Zealand 2023

In this document reference to the *Clinical Practice Guidelines for Cervical Screening in Aotearoa New Zealand 2023* is denoted as the 'NCSP Guidelines' and includes any subsequent updates. The NCSP Guidelines can be found on this link: nsu.govt.nz/system/files/page/clinical_practice_guidelines_final_version_1.1.pdf

Audit – Arotake

Te Whatu Ora reserves the right to audit cervical screening services against this and other applicable NCSP standards.

Providers and sample takers are strongly encouraged to undertake a self-audit of the standards in this document for quality assurance and quality improvement.

Me aro koe ki te hā o Hine-ahu-one
Pay heed to the dignity of women

He aha te mea nui o te ao.
He tāngata, he tāngata, he tāngata

What is the most important thing in the world? It is people, it is people, it is people

Whakataukī/Whakatauākī

Whakataukī / whakatauākī are shared and referred to throughout this standard in honour of our tipuna, ancestors, those who have gone before us. Where the relevance of their words remains culturally profound and relevant through many situations. Within Te Reo Māori, kupu Māori will often have several meanings, pronounced in different ways through different tribal dialects and adds a depth of knowledge that is inherent to Te Ao Māori. Yet equally appropriate and purposeful to the dedicated mahi that is upheld throughout the cervical screening pathway in supporting, caring and advocating for wāhine and whānau.[1]

1. Elder, H. (2020). Aroha: Māori wisdom for a contented life lived with harmony with our planet. Penguin NZ.
Alsop, P & Kupenga, T. (2016). Mauri Ora: Wisdom from the Māori world. Nelson, Potton & Burton.

Te Tiriti and Equity

The National Screening Unit (NSU) has an obligation to uphold the principles of Te Tiriti o Waitangi.

These principles are articulated in the Pae Ora (Healthy Futures) Act 2022. Pae ora encourages everyone in the health and disability sector to work collaboratively, to think beyond narrow definitions of health, and to provide high-quality and effective services.[2] Adhering to the principles of tino rangatiratanga, partnership, active protection, options and equity, and the wider Te Tiriti, is fundamental to the rights of Māori.

The Ministry of Health defines equity as follows: "In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes".[3] The Aotearoa New Zealand Cancer Action Plan 2019–2029 advocates responding to Māori models that are holistic and whānau-centric, addressing racism and discrimination, and achieving equity by design (MOH, 2019).[4] Screening providers must recognise and respect Māori views relating to reproductive health including the importance of te whare tangata, whakapapa, whānau, and wellbeing.

Achieving equitable access to cervical screening is essential to the overall success of the primary HPV screening programme. Currently, around 85% of participants who develop cervical cancer in Aotearoa New Zealand have either never been screened or have been screened infrequently.[5] This is due in part to the fact that people of European/other ethnicity have in the past been privileged by the way screening programmes are designed for the 'mainstream', while Māori and Pacific people have lower rates of screening and higher rates of cancer. Other groups whose needs are not met by a 'mainstream' approach include LGBTI+ people, people with disabilities, people living with mental illness, and people living in rural areas. (For up-to-date screening coverage, please visit: nsu.govt.nz/health-professionals/national-cervical-screening-programme/cervical-screening-coverage/monthly.)

HPV primary screening, effectively implemented, is expected to improve access to screening for participants who are currently under-screened and reduce inequities. However, changing the primary test from cytology to HPV will not achieve equity on its own. The NCSP and providers of screening need to take deliberate steps to progress the goal of achieving equity in all aspects of the programme.

Mahia te mahi hei painga mo te iwi

Do work for the betterment of the people – Te Puea Herangi

2. https://legislation.govt.nz/act/public/2022/0030/latest/LMS575405.html
3. https://www.health.govt.nz/about-ministry/what-we-do/achieving-equity
4. https://www.health.govt.nz/publication/new-zealand-cancer-action-plan-2019-2029
5. Sykes P, Hider P, Innes C et al. (2019) Review of Cervical Cancer Occurrences in relation to Screening History in New Zealand for the years 2013-2017. Wellington, New Zealand: Ministry of Health. https://www.nsu.govt.nz/system/files/resources/cancer-case-review-2013-2017-final-report-29-august-2019.pdf

Definitions – Ngā Kupu Tautuhi

Cervical sample takers	A registered health practitioner, such as a medical practitioner, nurse practitioner, registered nurse, enrolled nurse, or registered midwife who holds a current New Zealand practising certificate and has completed cervical screening training either through: • training as part of a medical degree or midwifery training programme; or • an NZQA accredited course to conduct cervical screening.
Cervical screen	General term for having a cervical screening test. This includes HPV screening tests as well as cytology screening tests (e.g., cytology done after an HPV-found result at primary HPV screening).
Cervical Screening Services	Any service provider, business or organisation that provides any type of cervical screening or employs persons who provide cervical screening services.
Co-test	An LBC sample for both HPV and cytology testing.
Cultural safety	Cultural safety emphasises the importance of self-reflection, and invites health practitioners to become aware of, and address their own cultural biases to understand how this may impact the care they provide to patients from different cultures. It encompasses an approach that requires ongoing self-reflection and accountability.[6]
Clinical Responsibility	Clinical responsibility in the context of screening (including for self-testing) means ensuring: • information is provided and getting informed consent is attained • kits provided and coordinating the return of the samples • all quality assurance measures are met • the lab request information is completed • the test result is received and reviewed • the participant is told of the test result and that the result is followed up.
Cytology test	Cell sample taken where the participant's cervix is visualised, that is processed for cytology (previously known as a smear test).
Eligible participants	People who are within the age range for cervical screening as defined by the NCSP. Refer to 3.3 Identifying and inviting eligible people to be screened.

6. Health Literacy, equity, cultural safety and competence [Internet]. [cited 2023 Jun 15]. Available from: http://hqsc.govt.nz/our-work/leadership-and-capability/kaiawhina-workforce/health-literacy-equity-cultural-safety-and-competence

Equity	"In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes."[7]
Health Facility Number	The unique identifier (ID) number allocated to each health facility.
Health Providers Index (HPI) Number (previously Health Practitioner Index)	CPN (Common Person Number) issued to practitioners (people) who provide health services.
Human Papillomavirus (HPV)	Human papillomaviruses (HPV) are an extremely common group of DNA viruses that have an affinity for skin and mucous membranes.[8] Most infections are asymptomatic. There are 14 high-risk types of HPV that are associated with the development of invasive cervical cancers. These are also referred to as oncogenic HPV types. Persistent infection with one of these 14 types may lead to cervical and other cancers such as anal, oropharyngeal, penile, vaginal and vulval cancers. Over 95% of cervical cancer is caused by these 14 high-risk HPV types.
Immune deficient	Immune deficient, also known as immunocompromised, is a state in which the immune system's ability to fight infectious diseases and cancer is compromised or absent.[9]
Invitation and recall	The entire systems and processes of: • identifying people who are eligible for cervical screening and inviting them to be screened • providing information and support • obtaining informed consent • providing additional support and information to priority groups to be screened • recalling people for further screening, assessment or treatment as necessary • notifying people of their test results • referring people to alternative cervical screening services, as appropriate.

7. Achieving equity [Internet]. [cited 2023 Jun 15]. Available from: http://health.govt.nz/about-ministry/what-we-do/achieving-equity
8. Egawa, N., Egawa, K., Griffin, H., & Doorbar, J. (2015). Human Papillomaviruses; Epithelial Tropisms, and the Development of Neoplasia. Viruses, 7(7), 3863–3890. https://doi.org/10.3390/v7072802
9. Pai, S. Y., Lurain, K., & Yarchoan, R. (2021). How immunodeficiency can lead to malignancy. Hematology. American Society of Hematology. Education Program, 2021(1), 287–295. https://doi.org/10.1182/hematology.2021000261

Priority-group participants	Priority groups are Māori and Pacific people, and under-screened and unscreened people who are over 30. Within this group the highest priority are Māori and Pacific people aged over 30 who are unscreened and under-screened.
Responsible Clinician	Clinician responsible for: • obtaining informed consent • result management • follow-up of participants. Responsible Clinicians are registered health practitioners, such as a medical practitioner, nurse practitioner, registered nurse, enrolled nurse, or registered midwife. They must have a current New Zealand practising certificate and must complete cervical screening training either through: • training as part of a medical degree or midwifery training programme; or • an NZQA accredited course to conduct cervical screening.
Provider	Any health provider involved in the cervical screening pathway.
Surveillance	The process of ongoing and/or more frequent monitoring of an individual following an abnormal result, e.g., participants who are on an annual follow-up pathway after HPV or cell changes are detected, as the participant has an increased risk of developing cervical cancer[10].

10. National Cancer Institute (2023, June 21). NCI Dictionary of Genetics Term. NCI Dictionaries. National Cancer Institute. United States Government. https://www.cancer.gov/publications/dictionaries/genetics-dictionary/def/surveillance

Abbreviations

CIN	Cervical intraepithelial neoplasia
CPN	Common Provider Number
GP	General practitioner
HPI	Health Provider (Practitioner) Index
HPV	Human papillomavirus
IUCD	Intrauterine contraceptive device
LBC	Liquid-based cytology
LMP	Last menstrual period
NCSP	National Cervical Screening Programme
NHI	National Health Index
NPQS	National Policy and Quality Standards
NSU	National Screening Unit
NZQA	New Zealand Qualifications Authority
PHO	Primary health organisation
PMS	Patient management system
SSS	Screening Support Services
STI	Sexually transmitted infection

HPV Primary Screening

The National Cervical Screening programme (NCSP) has saved thousands of lives in Aotearoa New Zealand with the help of the current cytology test by identifying those at a higher risk of cervical cancer.

The NCSP, which started a pap smear-based population-level cervical screening programme in 1990, will begin using an HPV DNA-based test with the option of self-testing, from late 2023 onwards (NSU, 2022). This is in response to the World Health Organization's (WHO) new global strategy for cervical cancer elimination of which the organisation calls for a shift in the recommended approaches for cervical screening from visual inspection with acetic acid and pap smear test to a human papillomavirus (HPV) DNA-based test (WHO, 2021). The rationale for the change in testing strategy is because there is clear evidence that HPV testing is more sensitive than pap smear (pap smear: 55%-79% vs. HPV testing 94%-100%) for detecting high-grade cervical intraepithelial neoplasia (CIN grade 2 and above) and also offers a longer screening interval after a negative test compared to a negative pap smear test (Gilham et al., 2019; Gravitt et al., 2010; Kripke, 2008). In addition to these benefits, there is evidence to show that the change in testing strategy has the potential to increase the coverage of cervical screening, especially among people with a cervix who experience barriers to healthcare and those without healthcare (Gravitt et al., 2011; Schmeink et al., 2011).

Cytology will continue to be used to determine whether cell changes have occurred. This is because cytology is more specific and it works well as a second test for those who have HPV detected, to identify who needs further investigation. An HPV Primary Screening programme can identify those at a higher risk much earlier than cytology only.

Overview – Tiro Whānui

This section (Section 3) of the NCSP Policies and Standards contains information, policies, and standards of practice for both individuals and service providers. It applies to community, primary and secondary healthcare services.

In summary, providers of cervical screening services are responsible for ensuring that:

- information about options for cervical screening is provided to participants and they are supported with a cervical screening test that meets their needs
- informed consent to participate in the programme is obtained
- collection and return of cervical screening specimens follows NCSP Guidelines, policies and standards
- the participant is provided with the test result(s), and results that require follow-up are actioned in accordance with NCSP Guidelines

Cervical screening services should develop a close working relationship with their regional NCSP team for support, queries, education and training, and links into screening and support providers.

Cervical screening services should develop close relationships and arrangements with Screening Support Services (SSS) and other local services (e.g. Kaupapa Māori services, Pacific Health services), which can support participants into screening and through the pathway of follow-up, assessment, and treatment.

Roles and responsibilities for cervical sample takers

People

Role: Cervical sample takers	
Definition: A registered health professional who has a current practising certificate and has completed cervical screening training either through: • Training as part of a medical degree or midwifery training programme; or • An NZQA accredited course to conduct cervical screening. This includes health professionals who are a medical practitioner, midwife, nurse practitioner, registered nurse, or enrolled nurse.	
Responsibilities	**Cervical sample takers** are Responsible Clinicians who take clinical responsibility for the tests they request and can: • provide information about the NCSP and options for cervical screening • obtain informed consent • offer self-testing to participants • obtain a vaginal swab to test for HPV • obtain an LBC sample from the cervix • take responsibility for cervical screening results • provide results to participants • refer to Screening Support Services • refer to colposcopy. **Responsible clinicians** are cervical sample takers who request the cervical screening test, this includes when the sample is taken by the participant. Clinical responsibility in the context of screening (including for self-testing) means ensuring: • information is provided to participants • informed consent to participate in the programme is obtained • participants are supported with a test that meets their needs • kits for self-testing are provided and arrangements are made for the return of samples • the lab request information is completed • the test result is received and reviewed • participants are provided with their test results, and any appropriate follow-ups are actioned • all relevant NCSP Guidelines and NCSP Policies and Standards are met. **Standard 3.1.1** People qualified to take a cervical sample for LBC must complete a recognised educational course before taking cervical samples.
Limitations of role	* Enrolled Nurse Sample Takers Enrolled nurses who have completed an NZQA accredited course to practise cervical screening under the direction and delegation of a registered nurse or nurse practitioner who is an accredited cervical sample taker (Nursing Council of New Zealand 2011). For cervical screening, this also includes under the direction or delegation of a medical practitioner. Direct supervision of enrolled nurses who have completed an NZQA cervical screening course is not required when they are taking cervical screening samples.[11]

11. Nursing Council of New Zealand. 2011. Guideline: Responsibilities for direction and delegation of care to enrolled nurses. Wellington: Nursing Council of New Zealand. URL: www.nursingcouncil.org.nz/Publications/Standards-and-guidelines-for-nurses

Providers

Role: Cervical screening services	
Definition: Any service provider, business or organisation that provides cervical screening or employs persons who provide cervical screening services	
Responsibilities	**Cervical screening services are responsible for ensuring that:** • health practitioners performing cervical screening hold a current New Zealand practising certificate • all staff providing cervical screening services have appropriate training • the screening environment is culturally and physically safe • the service complies with relevant legislation including: – Part 4A Section 112 of the Health Act 1956 – Health Practitioners Competence Assurance Act 2003 – Privacy Act 2020 – Health and Disability Services (Safety) Act 2001 – Health (Cervical Screening (Kaitaiki)) Regulations 1995 • the service complies with: – infection control standards, as outlined in Standards New Zealand NZS 8134:2021[12] – Code of Health and Disability Services Consumers' Rights Regulation 1996 – Code of consumer expectations (for health entities' engagement with consumer and whānau)

Me aro koe ki te hā o hineahuone.
Mai te tīmatanga, ko Papatūānuku,
te whaea whenua, ko Hineahuone
te ira tangata tuatahi, he wāhine.

Tīhei mauriora!

Pay heed to the dignity of Māori.
From the beginning of time was
Papatūānuku, the earth mother, then
Hineahuone the first human created

I sneezed and therefore I live!

12. NZS 8134:2021 Ngā paerewa Health and disability services standard [Internet]. [cited 2023 Jun 15]. Available from: http://standards.govt.nz/shop/nzs-81342021

Screening Support Services

Ki te kotahi te kākaho, ka whati; ki te kāpuia, e kore e whati.

If a reed stands alone, it can be broken; if it is in a group, it cannot.

Purpose: To support participants who experience barriers to access

The purpose of this Screening Support Services (SSS) overview is to raise awareness of the important role that SSS hold in supporting people to screening, assessment and treatment. It is expected that sample takers and cervical screening services will work closely with SSS to support priority participants.

SSS are available for eligible people, wāhine/whānau who are referred to, or who independently access services from, the SSS provider.

This support can assist people, wāhine/whānau who experience barriers to accessing breast and cervical screening, assessment, and treatment services.

Some SSS providers have mobile teams who make community visits and home visits, while others are based in clinics around the motu. The teams are a mixture of clinical and non-clinical staff, inclusive of kaiāwhina, kaimahi (support staff).

SSS serve diverse communities and are experts in supporting their communities.

SSS are equity providers supporting the screening pathways, designed to make "a big difference to a small group of people".[13] They have six objectives:

OBJECTIVES

1. To increase access to screening for priority groups and deliver services in a culturally safe, flexible, and mobile way.
2. To facilitate seamless access to screening services through collaboration.
3. To contribute to reducing equity gaps.
4. To empower people, wāhine/whānau to engage with the health system with improved confidence and health literacy.
5. To support NCSP and BSA to reduce the social and financial burden of breast and cervical cancer.
6. To be innovative.

For further information:
National Screening Unit (https://www.nsu.govt.nz/health-professionals/national-cervical-screening-programme)

13. Shea, S.; Cragg, M.; Ioane, J.; Atkinson, M.; McGregor, S. (2021) Me aro ki te hā o Hineahuone – a national evaluation of breast and cervical Screening Support Services. Shea Pita & Associates Ltd: Auckland.

Training, performance review and professional development

Training – Akoranga Mahi

He rangi tā matawhāiti, he rangi tā matawhānui – A person with narrow vision has a restricted horizon, a person with wide vision has plentiful options

Purpose: ensure cervical screening services are provided by qualified and experienced healthcare providers.

Refer also to:

- Appendix 2 Enrolled Nurse Delegation
- NZQA Unit Standard 29566 version 4 Conduct Cervical Screening
- Nursing Council of New Zealand. 2011. Guideline: Responsibilities for direction and delegation of care to enrolled nurses. Wellington: Nursing Council of New Zealand. www.nursingcouncil.org.nz/Publications/Standards-and-guidelines-for-nurses

TOPIC	DEFINITION	DETAIL	TARGET
Training	**3.1.1** People qualified to take a cervical sample for LBC must complete a recognised educational course before taking cervical samples	People qualified to take liquid-based cytology samples are 'Responsible Clinicians' and take clinical responsibility for swab samples taken by participants. They are referred to as 'cervical sample takers' and are required to complete cervical screening training either through: • training as part of a medical degree or midwifery training programme; or • a New Zealand Qualifications Authority (NZQA) accredited course for cervical sample takers Refer to 3.1.3 below for the requirements for cervical sample takers trained overseas.	100% of Responsible Clinicians are qualified to take LBC samples

Registration of new cervical sample takers	**3.1.2** The cervical sample taker practises under their own HPI health provider index number, and appropriate health facility code	The health professional identification number (CPN) is determined by the health worker's role. The number used by the registration body is used by the programme and a location number (facility code) is designated for each site used by the health professional.	100% of samples are requested under appropriate HPI number
Overseas trained cervical sample takers	**3.1.3** Cervical screening services are responsible for ensuring that any overseas-trained cervical sample taker holds a current New Zealand practising certificate and meets the NCSP training requirements for cervical screening.	Medical practitioners and midwives who have trained overseas should complete training appropriate to the Aotearoa New Zealand NCSP. Cervical sample takers trained overseas must meet NCSP training requirements. These competencies allow for training providers to adapt training and assessment to meet the needs of overseas trained cervical sample takers; they outline competencies of importance to be assessed in overseas trained cervical sample takers. Training providers must consider prior learning in assessing whether a full training course is necessary and should consult with NCSP Coordinators on a case-by-case basis.	100% of medical practitioners and midwives who have trained overseas and are providing cervical screening complete NCSP HPV Primary Screening Modules.
Assessing competence for trainee cervical sample takers	**3.1.4** Trainee cervical sample takers demonstrate competence in obtaining informed consent, taking optimal cervical screening samples, and providing instructions to participants about how to take an HPV self-test.	Trainee cervical sample takers demonstrate competence by: • taking 10 LBC samples from the cervix • facilitating HPV self-testing for 5 participants • maintaining a training workbook.	100% of trainees meet competency standards.

Performance review and professional development

TOPIC	STANDARD	DETAIL	TARGET
Maintaining competency	**3.1.5** Everyone who provides cervical screening services must maintain competency by providing cervical screening regularly and through ongoing professional development activities.	Cervical screening services and everyone who provides cervical screening are responsible for ensuring that competency in cervical screening is maintained. Employers must support the cervical sample taker to maintain their competency by providing the opportunity for ongoing professional development. All current cervical sample takers must complete NCSP training modules for cervical screening. The following are expected activities to maintain competency: • Taking and facilitating cervical screening samples on a regular basis • Attending NCSP updates, at a minimum of once every two years – these are provided yearly and are free of charge, contact the NCSP Coordinator for information; or attending updates provided by other professional bodies or NZQA accredited training establishments • Keeping up to date with information from the NCSP and relevant literature • Completing a peer assessment two yearly see Appendix 1 for peer review • Self-monitoring adequacy of cytology samples Where support is required to maintain competency, this should be discussed with NCSP Coordinators and options considered that may include: • access to a clinical supervisor • professional/cultural supervision • peer supervision and assessment. If the cervical sample taker has not been practising for over two years, it is recommended they: • have a clinical supervisor for the first few samples (e.g, three to five) • review NCSP Guidelines and Policies and Standards • attend a cervical screening update session • seek advice from an experienced cervical sample taker or supervisor about any changes in the intervening period and check the NSU website for this information.	The cervical sample taker: • takes at least 10 LBC cervical samples each year • attends a cervical screening update session no less than once every two years. • completes a peer-assessment every two years.

TOPIC	STANDARD	DETAIL	TARGET
Monitoring the effectiveness of cervical cytology samples	**3.1.6** Cervical sample takers must collect high quality LBC samples. No more than 3 samples are reported as unsatisfactory per year.	**Monitoring the adequacy of cervical cytology samples** Cervical sample takers can monitor the adequacy of cervical screening samples taken by monitoring the adequacy of cervical screening tests against laboratory results received. Sample takers with persistent high rates of 'unsatisfactory' cytology samples over one year (i.e., >3) must undertake a peer review to address the cause or enlist the support of a clinical supervisor.	No more than three cervical samples per year are reported unsatisfactory.

Best practice service delivery principles

Te Tiriti and equity

mauri ora – healthy individuals

whānau ora – healthy families

wai ora – healthy environments

Purpose: All three elements of Pae Ora are interconnected and mutually reinforcing, and further strengthen the strategic direction for Māori health for the future.

Refer also to:

- Pae Ora (Healthy Futures) Act 2022

TOPIC	STANDARD	DETAIL	TARGET
Achieving Pae Ora: For Māori to live with good health and wellbeing in an environment that supports a good quality of life and achieving equity in health outcomes.[14]	**3.2.1** Cervical screening providers and services understand how the principles of Te Tiriti o Waitangi apply to cervical screening. health.govt.nz/our-work/populations/maori-health/he-korowai-oranga/strengthening-he-korowai-oranga/treaty-waitangi-principles.	The cervical sample taker and the provider understand that under Te Tiriti o Waitangi, the principles of self-determination, partnership, equity, active protection and options underpin the relationship between the Crown and Māori. Further details on Te Tiriti principles can be found on the Te Whatu Ora website at: health.govt.nz/our-work/populations/maori-health/he-korowai-oranga/strengthening-he-korowai-oranga/treaty-waitangi-principles **Practice points** The cervical sample taker and cervical screening service: • recognise and respect the unique identity of Māori as tangata whenua in the planning and provision of services • support each Māori participant to access relevant services, support, and resources, such as 'for Māori, by Māori' services, where these are available • engage with iwi and Māori, as appropriate, to provide services that better meet the needs of Māori participants.	Expected best practice.

14. Māori Health Action Plan, 2020-2025 https://www.health.govt.nz/system/files/documents/publications/whakamaua-maori-health-action-plan-2020-2025-a3.pdf

TOPIC	STANDARD	DETAIL	TARGET
Achieving Pae Ora: For Māori to live with good health and wellbeing in an environment that supports a good quality of life and achieving equity in health outcomes. (continued)	**3.2.2** Sample takers and cervical screening services understand the the significance of hauora Māori models as central to the wellbeing of Māori.	The sample taker and/or provider are aware of hauora Māori models and understand their significance. Te Whare Tapa Whā is a well-recognised and endorsed health concept for Māori. It is a holistic approach in which health and wellbeing are described in relation to the four walls of a house. The four dimensions of Te Whare Tapa Whā are: • Te taha hinengaro – mental health and wellbeing • Te taha tinana – physical health and wellbeing • Te taha wairua – spiritual health and wellbeing • Te taha whānau – family health and wellbeing. Using this framework, physical health and wellbeing are integrally linked to spiritual, mental, and social wellbeing. A person is considered unwell if any one of these supports is weak, and healthy if all four components are strong. For example, if the strength of the whānau is disrupted by insensitive practices, this affects all the supports.[15] Māori view these dimensions as being interrelated, with disruption of one part affecting the whole. Using this framework, physical health and wellbeing are integrally linked to spiritual, mental and social wellbeing, and wellbeing is maintained through a balance of all of these dimensions. In Māori terms, the womb is often referred to as 'te whare tangata', or the house of humanity, as this is where human life is created and grows until it is born. The multiple meanings of whānau (family and birth), whenua (placenta and land) and hapū (subtribe and pregnancy) all reinforce this importance. The cervix is a key part of te whare tangata as it is the gatekeeper to all it encompasses. Therefore, it is a pathway to whakapapa (genealogy) and te ao marama (world of light, the physical world). For this reason, it is essential that the NCSP is managed in a culturally safe and appropriate manner. Within the context of cervical screening, the entire female reproductive system is considered holistic and a taonga (a treasure, something of great worth). This view is upheld by the whakataukī (proverb) 'He wāhine, he whenua, kua ngaro he tangata' (Without women or land, people will be lost)*.	Expected best practice.

*This information was developed for National Cervical Screening Programme Policies and Standards by Dr Ripeti Haretuku (Mauri Ora Associates), and Professor Bev Lawton and Kendall Stevenson (Victoria University of Wellington).

15. Durie M. 2004. Whare tapa whā: A Māori model of a unified theory of health. Journal of Primary Prevention 25(1): 41–57. https://www.teakawhaiora.nz/nga-rauemi-resources/te-whare-tapa-wha

Cultural safety - Matatau ki te tikanga ā Iwi

Ka rongo I te ia o te aroha, he ngākau māhaki – to feel genuine intentions is to understand a charitable heart

Purpose: To support positive health outcomes by ensuring the participant's cultural needs are met.

Refer also to:

- Definitions of 'culture' 'cultural safety'
- Priority groups
- *National Cervical Screening Programme Policies and Standards: Section 1 – NCSP Overview*, Cultural context for the NCSP.

TOPIC	STANDARD	DETAIL	TARGET
Culturally competent and culturally safe practices	**3.2.4** Sample takers and cervical screening services ensure cultural competency and cultural safety	People who provide cervical screening must do so in accordance with relevant health practitioner cultural competency and cultural safety standards. **Cultural safety statement** Cultural safety requires healthcare workers and their associated healthcare organisations to examine themselves and the potential impact of their own culture on clinical interactions and service delivery. Individual healthcare workers and health care organisations acknowledge and address their own biases, attitudes, assumptions, stereotypes, prejudices, structures and characteristics that may affect the quality of care provided. Healthcare workers and health care organisations engage in ongoing self-reflection and self-awareness, and hold themselves accountable for providing culturally safe care, as defined by the participant and their communities, and as measured through progress towards achieving health equity. Cultural safety requires healthcare workers and their associated healthcare organisations to influence healthcare to reduce bias and achieve equity within the workforce and working environment. Cultural safety benefits all people and communities. This may include communities based on Indigenous status, age or generation, gender, sexual orientation, socioeconomic status, ethnicity, religious or spiritual belief, and disability.[16]	Expected best practice.

16. Medical Council of New Zealand, (2019) Cultural safety | Medical Council https://www.mcnz.org.nz/our-standards/current-standards/cultural-safety
Nursing Council of New Zealand (2011) Guidelines for Cultural Safety https://www.nursingcouncil.org.nz/Public/Nursing/Standards_and_guidelines/NCNZ/nursing-section/Standards_and_guidelines_for_nurses.aspx

TOPIC	STANDARD	DETAIL	TARGET
Culturally competent and culturally safe practices (continued)		Everyone who provides a cervical screening service should undertake cultural competency training. The learning modules below are recommended. • The Ministry's Foundation Course in Cultural Competency, which focuses on improving Māori health outcomes: learnonline.health.nz • The eCALD online cultural competency learning modules, which focus on improving cultural awareness, sensitivity, knowledge and skills in working with Culturally and Linguistically Diverse[5] groups (CALD)s: ecald.com	Expected best practice.
	3.2.5 Participants are supported to observe their own cultural practices where appropriate.	Cervical sample takers: • work with the participant's cultural beliefs, values and practices when providing cervical screening services • include the participant's whānau/family in their healthcare, when appropriate.	Expected best practice.
Maintaining a culturally safe environment	**3.2.6** Cervical sample takers and cervical screening services maintain a culturally safe and appropriate environment for providing cervical screening.	The sample taker: • understands that a participant's experience with cervical screening must be positive and underpinned by respect from the first contact with the service onwards • considers how the environment can be adapted to ensure cultural safety • actively supports participants by welcoming whānau and support people to be present during the consultation • uses 'language matched' staff or interpreters when required (refer to Appendix 4 on use of interpreters).	Expected best practice.
Providing information on other health services and networks	**3.2.7** Informs participants of other cultural networks and services for their health needs and support	Cervical sample takers provide options and information and support cultural needs by ascertaining preferences for service provider, including 'by Māori for Māori' services where available, type of test or how the service is provided. Cervical sample takers offer, refer to or consult with cultural advisors and cultural service providers when required and when requested by the participant.	Expected best practice.

Priority groups – Manaakitanga

Manaakitanga he aroha whakatō, he aroha ka puta mai.
If kindness is sown, then kindness is received

Purpose: To support priority groups to access cervical screening services.

The NSU has a responsibility to uphold the principles of Te Tiriti o Waitangi, and a key goal is attaining equitable outcomes in cervical screening and elimination of cervical cancer. To achieve these goals, the new programme needs to follow an equity-led design approach and prioritise equity approaches.

Definition: Priority groups are Māori and Pacific people, and under-screened and unscreened participants who are 30 years and over. Within this group the highest priority are Māori and Pacific aged 30 years and over who are unscreened and under screened.

TOPIC	STANDARD	DETAIL	TARGET
Priority-group participants	**3.2.8** Cervical sample takers and cervical screening services actively support access and participation for priority groups in cervical screening.	Sample takers and cervical screening services: • understand that participation in cervical screening for priority-group participants will improve individual health outcomes and contribute to health equity. People who experience barriers and do not participate in cervical screening have a higher risk of developing, and dying from, cervical cancer compared with other groups. • acknowledge that alternative and additional strategies may be required and implement systems and strategies that improve access and participation for priority groups. • confirm participants' ethnicity and update as required including updating the NCSP Register so this is accurately recorded, • as appropriate, provide information to, or offer referral for, priority group participants to services that may be culturally appropriate and services that provide free or low-cost screening if available. Information is available from the NSU website nsu.govt.nz/health-professionals/national-cervical-screening-programme/ncsp-workforce/screening-support-services	80% coverage across all ethnic groups.

Barriers and enablers for cervical screening Tauārai

E hara taku toa I te toa takitahi he toa takitini –
My strength is not as an individual but as a collective

Purpose: Knowledge of the barriers and enablers to cervical screening is used to enhance service provision and participant experience.

Refer also to:

- Appendix 3 for further information about barriers and enablers.

TOPIC	STANDARD	DETAIL	TARGET
Understanding enablers and barriers to cervical screening	**3.2.9** Cervical sample takers and cervical screening services use their knowledge of the enablers and barriers to cervical screening to improve services to participants	To improve inequities in cervical screening it is important that everybody who works in cervical screening is aware of enablers and barriers to cervical screening, and that this information is used to improve service delivery or tailor the delivery of services to participants.	Expected best practice.

The cervical screening environment

Know my face before you know my cervix – Waireti Walters

Purpose: To ensure cervical screening occurs in an appropriate environment.

TOPIC	STANDARD	DETAIL	TARGET
Providing an appropriate environment	**3.2.10** Cervical sample takers and cervical screening services work to support participant's needs and provide services that respect the dignity, privacy, and autonomy of participants in a way that is mana enhancing and empowering.	Cervical screening conversations and procedures should take place in an environment where the participant feels physically and culturally safe. The following should be provided: • Privacy during the history and participant decision-making part of the consultation. • Areas used for self-testing must be private, acceptable to participants, and have hand hygiene facilities and a place for disposal of potentially contaminated items. • Sample taking must be in a space that is warm, feels safe and is private, secure and free from interruption and intrusion. • The cervical sample-taking space should include: – a curtain or screen for privacy when getting changed before and after the procedure – a place for the participant to put their belongings – appropriate covers for modesty during the procedure. **Practice points** • Allow plenty of time so the participant does not feel rushed • Ask the participant about any preferences they have. • Ask the participant if they would like to have a support person or offer a chaperone • Ask the participant if they have a preference for who their sample taker is (this may include a preference for a specific gender, language skills or the profession of the sample taker) • The cervical sample taker should also consider their own requirement for the presence of a chaperone or support person. • A choice for location of testing where practical; in a clinical environment, in the community, at an event or at home. Where clinics are held at events or in mobile units consider: • privacy, (location of mobile unit parking is appropriate) • access into the mobile unit • ventilation, heating/air conditioning, When at a marae, ensure the bed position is facing away from the wharenui and wharekai for cultural sensitivity and respect.	Expected best practice.

TOPIC	STANDARD	DETAIL	TARGET
Ensuring inclusive, mana-enhancing support for all people to participate in the NCSP	**3.2.11** Cervical sample takers and cervical screening services ensure practice that supports diversity and inclusion	Cervical sample takers ensure that every effort is made to include and support people who: • live with a disability • identify as LGBTQIA+ • have had or are having harmful sexual contact • are neurodiverse • belong to other diverse groups who may experience barriers to screening. **Practice points:** Identify ways to empower and provide options to people, ask about preferences including: • preferred pronouns • previous experiences • how you can support them to have a safe and comfortable experience of cervical screening. Where a person with a cervix is male or non-binary, updating this with the NCSP Register so it is accurately recorded. Refer to Appendix 3 for enablers for groups who experience barriers to screening.	Expected best practice.

Notification, invitation and recall

Identifying and inviting eligible people to be screened

E huri tō aroaro ki te rā, tukuna tō ataarangi ki muri I a koe. Turn and face the sun and let the shadow fall behind you.

Purpose: To ensure eligible people are invited to participate in the NCSP.

Refer also to:

- Eligibility Direction Policy https://www.tewhatuora.govt.nz/our-health-system/eligibility-for-publicly-funded-health-services/eligibility-explained

Screening age and interval

- Anyone with a cervix or vagina who has ever been sexually active should be offered an HPV primary screening test from age 25 to age 69.
- If the HPV screening test result is HPV Not detected the next screening test should occur in five years, or in three years for those who are immune deficient.
- All participants should have an HPV Not detected result before exiting screening. Those aged between 70 and 74 years who were unscreened or under-screened prior to age 70 should have a negative HPV test before ceasing screening.

Eligibility Direction Policy

Cervical screening services must follow Te Whatu Ora Eligibility Direction Policy. It is the responsibility of all healthcare providers to check eligibility for publicly funded healthcare services.

Where a referral/request is made to a laboratory or colposcopy service, eligibility for publicly funded health services must be clearly indicated

TOPIC	STANDARD	DETAIL	TARGET
Eligibility for publicly funded services	**3.3.1** Cervical sample takers and cervical screening services must follow the Eligibility Direction Policy.	The sample taker should follow Te Whatu Ora Eligibility Direction Policy, that is, they should advise laboratory and colposcopy services if participants are not eligible for publicly funded services and advise participants of the implications, including costs.	All cervical sample takers follow Te Whatu Ora's Eligibility Direction Policy.

TOPIC	STANDARD	DETAIL	TARGET
Invitation and recall	**3.3.2** Eligible people are invited and recalled in accordance with NCSP Policies and Standards Section 3 and the NCSP Guidelines.	People should be encouraged to participate in the NCSP if they are a woman, or anyone who has a cervix, aged 25 to 69. This includes people who: • have ever had any type of intimate skin-to-skin or sexual contact (even if they haven't been sexually active for a long time) • have only had non-penetrative sex (i.e., oral sex) • are straight, gay or bisexual • are transgender, gender diverse, or non-binary and has a cervix • have only been with one sexual partner • have had the HPV vaccination, or not • are pregnant • have had a baby • have been through menopause. **Invitation and recall systems** From September 2023 the NCSP Register will begin a transition process that: • notifies people when they become eligible or due for cervical screening • reminds when cervical screening is overdue • provides safety net reminders when expected clinical follow-up has not occurred. Until the NCSP Register notification process has completed transition, cervical screening providers should continue to invite and recall people that use their service for cervical screening. After transition, cervical screening providers can continue to invite and recall people who use the service until they are confident in the quality and safety of the centralised notification process.	100% of participants eligible for cervical screening are invited to be screened.

TOPIC	STANDARD	DETAIL	TARGET
Minimising early re-screening	**3.3.2** The cervical sample taker minimises inappropriate early re-screening	Early re-screening is defined as participants who are screened earlier than recommended from their screening or surveillance history test. This definition does not apply to people who require earlier screening due to their clinical history, specialist recommendation or if the laboratory requests that the sample is repeated. **Screening intervals defined** For participants recommended to return at five-year interval: • on-time screening is defined as returning for a cervical screening test within +/- 6 months of their due date • early screening is defined as returning for a cervical screening test less than 4.5 years from their previous test • late screening is defined as returning for acervical screening test more than 5.5 years from their previous test. **Sub-categories for late screening:** • Overdue is defined as returning for a cervical screening test between 66 months (5.5 years) and 84 months (7 years) of their previous test. • Under-screened is defined as returning for a cervical screening test more than 84 months (7 years) of their previous test. For participants recommended to return for 12-month recall: • on-time screening is defined as attending between 9-15 months of their previous test (i.e., within +/- 3 months of their due date) • early screening is defined as attending less than 9 months of their previous test • late screening is defined as attending more than 15 months of their previous test. Note: Investigation of symptoms is not early re-screening. A co-test on an LBC sample from the cervix should be taken when investigating symptoms as a diagnostic test, not a screening test. For additional guidance, refer to the NCSP Guidelines.	Expected best practice.

Recall processes

Purpose: To ensure effective recall processes and follow-up of participants.

Refer also to:
- 3.2: Priority groups

TOPIC	STANDARD	DETAIL	TARGET
Recall systems and processes	**3.3.3** The cervical screening service and the cervical sample takers who work there have an effective recall system in place to ensure participants are appropriately followed up. **3.3.4** The clinician who requested the test or another delegated health practitioner must set the recall date.	**Recall processes** As stated in 3.4.3 following transition to NCSP Register notification process, cervical screening services must continue to maintain an accurate record of screening history and next due date to support opportunistic screening. All cervical screening services must have an effective recall system in place to ensure participants are recalled appropriately and followed up if they have an abnormal result. This includes having systems in place to recall participants at the appropriate time in accordance with NCSP Guidelines. The recall date *must* be set by the cervical sample taker or another delegated health practitioner. The recall method should reflect contact preferences of the participant, e.g. text or email. Providers must undertake all reasonable efforts to contact participants for cervical screening – with the minimum being three attempts. Where possible, up to three different methods of contacting participants should be utilised, for example, letter, text, phone call, email. • If a participant is to be recalled at the normal screening interval, providers should make a minimum of three attempts within six months of the recall date. • If a participant requires recall within or at 12 months, providers should make a minimum of three attempts within three months of the recall date. To avoid inappropriate recall, providers must have a system for identifying participants who do not want to participate in cervical screening.	100% of cervical screening services have recall processes in place.

TOPIC	STANDARD	DETAIL	TARGET
Recall systems and processes (continued)		**Participants who do not respond to recall** Providers should not remove or archive participants from recall lists. They should be recalled regularly even if they have not previously responded. Options for following up any participant who is not responding to recall include: • providing the participant with information on alternative services • placing an alert on the patient management system (PMS) so that opportunistic screening is considered when the participant next presents • referring the participant to an alternative cervical screening or Screening Support Services provider. **Refer also to 3.4.3 Informing people about the NCSP and enrolment and 3.4.4 Declining screening**	No participants that have not responded to recall are archived from further recall.
Independent/ outreach cervical screening services	**3.3.8** Providers of independent or outreach cervical screening services have follow-up processes in place, and participants are advised of recall and follow-up processes.	Independent cervical screening providers and outreach services must have processes in place to: • inform the participant of their results and ensure (where possible) that a copy is sent to their Primary Care Provider with consent • if the result needs to be repeated or clinical follow-up is indicated, ensure that this is arranged • if the result is abnormal and requires referral, the sample taker must refer the participant for specialist assessment or arrange follow up cytology testing as per the NCSP Guidelines. If the participant chooses that the result is not forwarded to their Primary Care Provider or they are not enrolled with a Primary Care Provider they must be advised when their test is next due and given information on alternative cervical screening options and/or the contact details of regional NCSP services that can provide this information.	Expected best practice.

Informed consent and communication

Providing information to participants

Mā roto hoki kia ora ka pai te kōrero – When refreshed, the conversation will be agreeable

Purpose: To ensure participants are adequately informed about cervical screening and the NCSP.

TOPIC	STANDARD	DETAIL	TARGET
Informed consent	**3.4.1** People are supported to make an informed choice to participate in cervical screening and the NCSP.	The cervical sample taker has a key role in ensuring that each participant understands cervical screening, the procedures involved and in communicating information about the NCSP and the NCSP Register. Section 112L of Part 4A of the Health Act 1956 sets out the duties of people taking cervical screening tests, including duties to provide information to participants and the NCSP (Health Act 1956). These duties apply to every person providing a cervical screening service. **Information to be provided at a first test** The following information must be provided to participants at their first cervical screening test: **Information on the NCSP:** • The objectives of the NCSP • Benefits of participating in the NCSP • Enrolment in the NCSP and how to cancel enrolment if this is chosen • Communications from NCSP • How personal information is stored, who can access it and what it is used for	Every participant has the information they need to give informed consent to participate in the programme.

TOPIC	STANDARD	DETAIL	TARGET
Informed consent (continued)		**Cervical screening information** **Information about cervical screening should include the following points:** • HPV and cervical cancer • The HPV screening test options • Who is eligible for cervical screening • How often cervical screening needs to be done • Getting results • What happens if HPV is found • Follow-up tests – what to expect • Accuracy of HPV screening • HPV vaccine • People who have symptoms should see a health practitioner **Key messages for participants are provided in the *Cervical Screening: What You Need To Know* brochure available from the Health Ed website https://healthed.govt.nz** **Information to be provided with subsequent cervical screening:** When subsequent cervical screening tests are undertaken, the cervical sample taker should supply as much information as is 'reasonable in the circumstances' (Section 112L (2) of Part 4A of the Health Act, 1956). **Other information** Information about screening, the NCSP and enrolment in the NCSP must consider different levels of health literacy and be presented in a language and a manner that is culturally appropriate and easy to understand. If participants demonstrate discomfort or difficulties due to language or cultural barriers, the sample taker and/or provider should consider using a qualified interpreter and linking with or referring the participant to services that might be more appropriate to their needs (refer to standard 3.2.6 in Section 2 Best practice service delivery principles). Participants must be informed of the cervical screening service complaints process.	Expected best practice.

TOPIC	STANDARD	DETAIL	TARGET
NCSP resources	**3.4.2** Cervical sample takers and cervical screening services must use NCSP resources or NCSP-approved resources.	NCSP resources are available for providing information to people about the NCSP, cervical screening, cervical screening results and colposcopy services. It is important that participants are fully informed about cervical screening and the NCSP when they are invited to participate in the NCSP for the first time. An NCSP brochure *Cervical Screening: What You Need to Know* is available in a range of languages. NCSP resources can be ordered from: nsu.govt.nz/health-professionals/national-cervical-screening-programme/national-cervical-screening-programme **Practice point:** PDFs of NCSP resources can be sent via text or email message and viewed in mobile friendly format. Providers and sample takers must ensure that any resources provided to participants are either NCSP resources, or resources that have been approved by the NCSP Programme Manager. timetoscreen.nz/cervical-screening	100% of participants are provided with information on cervical screening and the NCSP when they are invited to participate in the NCSP for the first time.
Informing people about the NCSP and enrolment	**3.4.3** Cervical sample takers must provide information to participants about the NCSP and the NCSP Register.	**NCSP Register** The NCSP Register is a population register that holds demographic information for the target population for cervical screening. **Enrolment in the NCSP** Enrolment in the NCSP occurs when a participant's screening result is entered onto the NCSP Register. This occurs when the NCSP receives the first cervical screening test, or histology result. At the time of a first cervical screening test, cervical sample takers must provide participants with information about enrolling in the NCSP. A participant's results and all subsequent results will be recorded on the NCSP Register unless they choose to withdraw from the programme. **Opting out of communications** A participant can choose to opt out of communications from any communication channel, or opt out of all communications from the NCSP Register. People who opt out of communications remain enrolled in the NCSP, eligible for cervical screening, and their results and screening history continue to be kept on the NCSP Register.	100% of participants understand thier enrolment in the NCSP.

TOPIC	STANDARD	DETAIL	TARGET
Informing people about the NCSP and enrolment (continued)		**Withdrawal from the NCSP** Participants can choose to withdraw from the NCSP. Following withdrawal, all electronic records except for background details that identify the participant are deleted from the NCSP Register, and there is no further communication from the NCSP Register except to notify them that their request to withdraw from the programme has been received and processed. Any participant who wishes to withdraw must complete a Withdrawal from the NCSP form, available at: nsu.govt.nz/resources/withdraw-national-cervical-screening-programme-consent-form. A participant who has withdrawn can continue to have cervical screening and can re-enrol at any time. A participant can re-enrol at any time, and their screening history will recommence with the most recent cervical screening test. A *Re-enrol in the Programme* form is available at: nsu.govt.nz/resources/ncsp-re-enrolment-form. Note: Participants need to complete these forms themselves; providers cannot do this.	Expected best practice.
Declining screening	**3.4.4** Cervical sample takers and cervical screening services must notify the NCSP Register about any participants who decline screening.	**Participants who decline further screening** If a participant declines further screening, the NCSP Register should be notified so that preferences can be updated. People who decline will receive a 'no further cervical screening' communication from the NCSP Register.	Expected best practice.

Communication between the NCSP and participants

Te manu kai miro, nōna te ngahere; te manu kai matauranga, nōna te ao. The bird that eats the miro berries, theirs is the forest; the bird that consumes the knowledge, the world is theirs

Purpose: To ensure participants are aware of what communication they may receive from the NCSP.

TOPIC	STANDARD	DETAIL	TARGET
Informing participants about: **Communication from the NCSP** **How they can access their information**	**3.4.5** Cervical sample takers and cervical screening services must be able to explain the communication and information participants can expect to receive from the NCSP and how they can access their information on the NCSP Register.	**Communication from the NCSP** Participants can expect to receive notifications when screening is due or overdue and reminders when follow-up management is indicated. Participants can choose to opt out of communications from NCSP. **Notifications** NCSP will notify people: • when they are eligible for their first cervical screen • when they are due for cervical screening NCSP will remind people: • when they are overdue for screening • when follow-up management such as a follow-up cytology test or a colposcopy visit is indicated. **How participants can access their information** Participants can obtain their personal information including letters, results, cervical screening histories by phoning Consumer information number 0800 729 729.	100% of participants know how to access their information and are aware of NCSP communications.

Cervical screening and follow-up responsibilities

Taking the cervical screening sample

He tangata takahe manuhiri, he marae puehu.
When a guest is disrespected the marae suffers

Purpose: to support best practice in obtaining samples for cervical screening.

Refer also to:

- NCSP Guidelines
- NCSP Policies and Standards Section 5

This section includes information on:

- key actions for taking a cervical screening sample
- obtaining an optimal cervical cytology sample
- obtaining an optimal clinician–taken vaginal swab for HPV testing
- supporting participants to collect an optimal vaginal swab for HPV testing
- factors related to an inadequate/unsatisfactory cytology sample.

TOPIC	STANDARD	DETAIL	TARGET
Cervical screening practices	**3.5.1** Cervical sample takers practise under their own HPI number.	Cervical sample takers are 'Responsible Clinicians' with clinical responsibility for all samples (including participant-taken samples) taken as part of the services they provide, including follow-up of test results and taking appropriate follow-up action.	100% of cervical sample takers practise under own HPI number.

TOPIC	STANDARD	DETAIL	TARGET
Self-testing at home or offsite	**3.5.2** Participants are provided with clear guidelines for the collection and return of the specimen when offered option of self-testing when the responsible clinician is not present.	Home testing and routine mail out is not delivered by the NCSP, cervical screening providers who choose to provide these options must do so in accordance with this standard. Responsible clinicians and cervical screening services must liaise with their local laboratory to ensure that the laboratory is aware and that swab storage and return requirements are met. Responsible clinicians are required to ensure that where participants are provided with the option of at home testing or testing where the responsible clinician is not present: • they are provided with a prelabelled swab for self-testing • a check is undertaken to ensure that the prelabelled swab and laboratory request are for the same person • they are provided with a laboratory request form that includes a field for date sample was taken • they have a copy of NCSP how to take your HPV self-test instructions • they have a copy of NCSP Cervical Screening –what you need to know • they know who to contact if they have questions • they are aware they need to complete the date the sample was taken on the laboratory request • they know where to return the sample to • they know the date the specimen must be returned by • they know how to appropriately store the sample and timeframe for return after the sample has been taken • they have a process in place to follow up with the participant to remind them to return the sample for testing Cervical screening services and responsible clinicians must ensure that a record is made of the date the kit was provided and that it is clear that the self-test has not yet been undertaken. **Practice point** Set task or reminder to check for a result.	
Sample taking	**3.5.3** The process of taking cervical screening samples follows best-practice techniques.	Further information is provided below.	Expected best practice.

Key actions for taking a cervical screening sample

STAGES	ACTION
1	• Provide information about the NCSP and cervical screening in accordance with section 112L of Part 4A of the Health Act 1956 (see 3.4: Informed consent and communication). This includes NCSP key messages for cervical screening. • Obtain a screening history from the NCSP Register. If participant is under surveillance (follow-up) due to screening history a cervical sample may be recommended. In some situations a co-test may be indicated. • Offer participant options to choose a cervical screening test that is right for them and ensure that they are clear that if a self-test or swab is chosen, a follow-up cytology test will be recommended if HPV is detected: Options for cervical screening: • A self-taken swab test for HPV • A swab for HPV taken by a clinician • A sample taken from the cervix
2	• Obtain previous screening notes if possible • Take a history*, which should include: – date and result of last cervical screening test including previous HPV test results – preferences for cervical screening tests, such as clinician collected, self-test or cervical screening position (dorsal, left lateral) or information about previous experience. **For LBC cervical samples, the following clinical information is required:** • Contraception, use of IUCD is relevant for laboratory analysis • Post-natal history – if postpartum and/or breastfeeding • Post-menopausal • Use of hormone replacement therapy (HRT) • Last menstrual period (LMP)

STAGES	ACTION
2	**For all samples the following clinical information is required:** • Immune deficiency • Hysterectomy total/subtotal • Any symptoms of concern to the participant, including: – bleeding or spotting between periods – bleeding after periods have stopped (after menopause) – pain during sex, or bleeding or spotting after sex – persistent pelvic pain – unusual or persistent discharge from the vagina. These symptoms can happen for many reasons and are rarely caused by cervical cancer. They require a co-test for investigation. Where symptoms of concern are reported or where screening history indicates a co-test is required, the participant must be referred to a clinician who is qualified/accredited to take a cervical cytology sample from the cervix. A sample should be taken even if the participant is bleeding, and a co-test (HPV and cytology) requested. Symptoms should be investigated in line with local and regional health pathways and the NCSP Guidelines. Clinical information including gynaecological history must be included on the laboratory request. *parity and obstetric history are not required as part of a gynaecologic history for cervical screening.
3	• Document history and assessment in the participant's clinical notes
4	• Explain the procedure that is chosen by the participant, equipment to be used and what the participant might expect during the procedure. • Ensure the cervical screening environment is private, and the participant feels culturally and physically safe.
5	• Ensure all the equipment is clean and that contamination is avoided throughout the process.

STAGES	ACTION
6	**Taking the cervical screening sample** **Self-taken sample** Ensure participant has access to instructions for self-testing and has had an opportunity to ask questions. • The swab must be labelled prior to taking the sample, and the laboratory form completed. • The label must not cover the barcode present on the swab. • Check tube is sealed against leakage. • Provide kit for self-testing and arrange for the return of sample. • For participants who choose to self-test in a clinic bathroom, ensure that there is a clean environment free from contamination. A place to dispose of self-test packaging must be available to prevent contamination. • Note some participants will not be comfortable to complete their self-test in a clinic bathroom, ensure an alternative option is available. • Discuss with the participant how they will receive their results and the follow-up management plan if HPV is detected. • Ensure contact details are up to date to provide the result and arrange follow-up if necessary. **Clinician-collected vaginal swab:** • Insert the swab 4-5 cm (thumb's length) into the vagina, rotate the swab for 20 seconds replace in the swab container. • Ensure sample is correctly labelled, that the label does not cover the barcode on the swab, and that the laboratory form is completed. • Check the tube is sealed to avoid leakage if appropriate. • Discuss with the participant how they will receive their results and the follow-up management plan. • Ensure contact details are up to date to provide the result and arrange follow-up if necessary. • Document the history and any observations in the participant's clinical record.
7	**Cervical LBC Sample** • Insert the speculum and visualise the cervix taking care to do so gently – see practice points for exposing the cervix below. • Assess the surrounding skin, groin, vulva, lower genital tract and note any clinical findings (e.g., two cervices). • Use an appropriate sampling device. The cervibroom is the recommended sampling device for cervical screening as it can collect sufficient cells for both cytology and HPV testing, and effectively sample the endocervical/transformation zone. It is normally the only sampling device necessary to collect samples in both SurePath™ and ThinPrep® liquid-based cytology (LBC) samples. • The cervibroom is also appropriate for vaginal vault samples and cytology in pregnancy. • Clinical judgement can be used in considering use of a cytobrush in addition to a cervibroom, particularly in post-menopausal participants where the squamocolumnar junction may be high in the endocervical canal. • The absence of an endocervical / transformation zone component does not indicate a limited or less-than-satisfactory sample, and does not warrant use of an additional sampling device or early recall (refer below to 'Obtaining an optimal cervical cytology sample' and 'Adequate sampling including endocervical cells'). • If an ectropion is present, the sample must include the ectropion and the border of the ectropion.

STAGES	ACTION
7	**Practice Points** Tips for exposing the cervix: • Offer participant to insert speculum. • Encourage deep breaths or cough if appropriate, this can assist with fully visualising the cervix. • Remove and re-insert speculum using a different angle. • Sometimes a different speculum size is required. • Ask participant to tilt their pelvis by placing their hands or an appropriate item such as a rolled towel/sheet under their hips/bottom. • Change position for screening. If the cervix cannot be located when participant is in the dorsal position, the left lateral position is indicated.
8	Transfer the sample into the LBC vial according to instructions from the manufacturer and laboratory
9	Remove the speculum, examining the vaginal walls as the speculum is withdrawn.
10	Provide the participant with any items for their comfort such as tissue or pad and ensure privacy as they get dressed.
11	Discuss with the participant how they will receive their results and the follow-up management plan. Ensure contact details are up to date to provide the result and arrange follow-up if necessary.
12	Document the history and clinical examination details in the participant's clinical record.
13	Complete the required details on the sample and laboratory referral form. See 3.5: Information required by the laboratory.

TOPIC	STANDARD	DETAIL	TARGET
Visible abnormalities or abnormal bleeding	**3.5.4** Participants with symptoms or abnormal examination findings suggestive of genital tract cancer are investigated according to local health pathways regardless of the HPV result or cytological finding and referred where appropriate.	Any person who presents with symptoms suggestive of cervical cancer (eg, post coital or intermenstrual bleeding, pelvic pain, or a persistent vaginal discharge) should be investigated as per local health pathways or referred to an appropriate practitioner for investigation. Any cervical abnormalities that are visualised must be documented on the laboratory request form. A normal or unsatisfactory cervical screening test can occur in the presence of an invasive carcinoma of the cervix. Clinical suspicion of cancer overrules any normal cervical screening test result, and the participant should be urgently referred for further investigation.	Expected best practice.

Obtaining an optimal cervical cytology sample

HOW TO OBTAIN AN OPTIMAL CERVICAL CYTOLOGY SAMPLE	
Adequate sampling: including endocervical cells	Most cervical lesions occur in the cervical transformation zone, and an optimal cervical screening sample contains sufficient endocervical or metaplastic squamous cells to indicate that the transformation zone has been sampled. A satisfactory cervical screening sample is determined as containing sufficient well-preserved and well-visualised squamous cells. Although the presence of an endocervical / transformation zone component is optimal and indicates that the transformation zone has been sampled, an absence of these cells will be commented on in the cytology report but will not make the sample unsatisfactory. If a cytology test is reported as 'satisfactory' (even if no endocervical / transformation zone component is present) it does not need to be repeated. The sample taker should follow the recommended recall provided in the laboratory report. When the laboratory reports that endocervical cells are absent, the sample taker should consider the clinical situation that may have affected the cell content at the time of taking the sample, and if indicated review their sample taking technique. Factors that can make it difficult for a sample taker to obtain endocervical cells include: • pregnant or post-menopausal participants (when the endocervical cells are located high in the endocervical canal, so the sampling device cannot sample the area) • very heavy mucus or inflammation obscuring the transformation zone • cervical stenosis.

HOW TO OBTAIN AN OPTIMAL CERVICAL CYTOLOGY SAMPLE	
An optimal sample	Sample takers can help to ensure endocervical cells are sampled by: • undertaking four to five full rotations with the broom as per the manufacturer's recommendations (due to the fine cutting-edge design of the cervibroom bristles, it is only effective when sufficiently rotated in a clockwise direction) • for SurePath™ samples – placing and retaining the head of the sampling device in the LBC vial • for ThinPrep® – being reasonably vigorous when swirling and agitating the head of the sampling device in the LBC vial. Do not retain the head in the ThinPrep® vial. It should not be necessary to wipe the cervix before taking the sample. Gentle removal of excessive mucus or inflammatory exudate is acceptable. Heavy wiping is not acceptable under any circumstance as this may remove surface epithelial cells. Note: The use of LBC means that the processing of the sample in the laboratory removes excessive mucus, blood and leucocytes when the cytology slide is prepared. Refer also to 'Cervix covered in inflammatory exudate due to infection' under Factors related to an inadequate/ unsatisfactory cytology sample (below).
Cervical ectropion	A cervical ectropion appears as a well-demarcated red velvety area on the ectocervix, extending into the endocervical canal. Almost every pre-menopausal participant has a cervical ectropion. It is normal and represents an area of normal columnar cells on the ectocervix. It is less common in post-menopausal participants. It is important to sample around the edge of the ectropion, not just the inner os.
Order of procedure where an STI swab is also taken	Where testing for sexually transmitted infections (STI) is indicated at the time of cervical screening, vaginal swabs should be collected before speculum insertion. Wipe the swab around the vaginal entrance, then insert the swab 4 cm (thumb's length) into the vagina, count slowly to 5 and replace in the swab container The cervical LBC sample can be collected after STI swab collection as above. Sexual Health Check | NZ STI Guidelines https://sti.guidelines.org.nz/sexual-health-check
If the participant has two cervices	If the participant has two cervices, the sample taker needs to take two individual samples, which are placed in separate LBC vials. The samples must be carefully labelled and clear information provided on the laboratory form so the laboratory understands that the samples are from two cervices for the one participant.

Factors related to HPV tests that are Invalid or unsuitable for analysis

Invalid HPV tests

HPV tests can be invalid due to:

- the effects of inhibitory substances such as presence of infection
- insufficient cellular material present (the test has an internal control to check it has been used).

If this occurs, then the test will be reported as invalid with a recommendation for a repeat sample.

If the HPV test is invalid on an LBC sample, cytology will be reported where possible.

A repeat HPV test should be arranged. The repeat HPV test can be a self- or clinician-taken swab, as repeat cytology will not be required.

A repeat HPV should be arranged as soon as practicable, there is no time delay required for repeat HPV tests.

Unsuitable for analysis HPV tests

LBC vials and HPV collection tubes that have leaked on receipt in the laboratory are not processed and the test is reported as unsuitable for analysis.

Unsuitable for analysis HPV tests may be repeated without any time delay and should be repeated as soon as practicable.

Factors related to an inadequate/unsatisfactory cytology sample

An LBC preparation can be unsatisfactory for evaluation for a range of reasons, only some of which are a result of sampling technique.

If the sample is unsatisfactory, the laboratory will report the reason why, and recommend a repeat sample.

A repeat LBC sample for cytology should be taken 6-12 weeks after the first sample.

Use of LBC overcomes most reasons for an unsatisfactory cytology sample; however, the table below lists some of these factors.

POSSIBLE CAUSATIVE FACTOR FOR AN INADEQUATE SAMPLE	SUGGESTED IMPROVEMENT MEASURE
Insufficient squamous cells	Revise the technique to ensure that the sampling device samples the cervix appropriately – refer above to 'Adequate sampling including endocervical cells' and 'An optimal sample'. Use the appropriate technique with the LBC sampling instrument and vial. • If ThinPrep® is used ensure the proper technique is used to rinse the sampling device. • If SurePath™ is used ensure the head of the sampling device is retained in the vial.
Cervix covered in inflammatory exudate due to infection	Where appropriate, it is recommended the test is postponed until the infection has been treated, as the presence of infection may adversely affect the adequacy of the sample. The participant should be asked to return two to four weeks after treatment. **If the participant is unlikely to return for a follow-up test, it is important to take the sample anyway.** Refer also to how to obtain an optimal cervical cytology sample (above) and the importance of not wiping away exudate unless necessary.

POSSIBLE CAUSATIVE FACTOR FOR AN INADEQUATE SAMPLE	SUGGESTED IMPROVEMENT MEASURE
Contamination with lubricant	Excess lubricant applied to the speculum increases the risk of obscuring the cellular sample. It is recommended that minimal lubricant (less than 0.4 mL) is used to lubricate the speculum. It should be applied sparingly on the outer portion of the speculum, avoiding the tip.
Contamination with spermicide or vaginal cream	Creams can have a profound effect on cytology as they can mask the cells, rendering the sample unsatisfactory or possibly masking abnormal cells. It is preferable to postpone the test for two days, as wiping the cream off before sampling could remove the surface cells.
Timing of the cervical screening test	Whilst a sample can be taken at any time using an LBC medium, menstrual cell changes can cause confusion in interpreting the sample. Therefore, unless there is a risk of the participant not attending, it is preferable to avoid sample collection during menses.
Timing of a repeat test	If a repeat LBC test is required, to avoid the potential of a higher false-negative rate this should be repeated 6-12 weeks after the first sample
Difficulty in obtaining an endocervical / transformation zone component in participants who are post-menopausal, using Depo Provera, breastfeeding, on testosterone therapy, or who have had treatment for a cervical abnormality	Consider arranging a course of topical oestrogen therapy before the next test. Recommended course: apply vaginal oestrogen every day for three weeks, stop two days prior to cytology testing. Participants should be tested within two weeks of discontinuing oestrogen treatment.
Leaked LBC sample	Ensure the lid is closed tightly on the vial following the sampling procedure.

Cervical screening during pregnancy and post-partum

Hapū māmā

Purpose: To ensure pregnant participants are offered options for cervical screening and that they receive appropriate follow up.

Refer also to:

- Clinical Practice Guidelines
- NCSP Policies and Standards Section 6

TOPIC	STANDARD	DETAIL	TARGET
Cervical screening during pregnancy and post-partum	**3.5.4** Screening samples taken during pregnancy and post-partum follow best-practice guidelines.	Participants can be safely screened at any time during pregnancy. Routine antenatal care should include a review of the participant's cervical screening history. Participants who are due or overdue for screening can be offered all of the cervical screening options. If the participant chooses a clinician-taken sample from the cervix, a cervibroom is recommended. If colposcopy referral is indicated during pregnancy this should not be delayed. If a follow-up assessment cytology, HPV test and/or colposcopy is required postpartum, it should be performed at least six weeks following birth. This interval is optimal to educe the risk of cytology interpretation difficulties due to oestrogen deficiency or unsatisfactory cytology.	Expected best practice.

Information required by the laboratory

Purpose: To ensure the laboratory receives complete information to accurately process the specimen and assign recall.

Refer also to:

- NCSP Policies and Standards: Section 5: Providing a Laboratory Service

TOPIC	STANDARD	DETAIL	TARGET
Information required by the laboratory	**3.5.5** LBC samples and samples for HPV testing are labelled in accordance with laboratory policy. Laboratory request forms provide relevant clinical information.	The provision of sufficient and accurate specimen labelling and sufficient information on the laboratory request form is essential. All samples must be clearly and unambiguously identified with permanent marking to ensure accurate matching with the laboratory request form. Laboratory requests must contain all of the required, demographic, test, clinical and requestor information. Refer to Section 5: Providing a Laboratory Service. Standard 514: LBC samples, samples for HPV testing only and laboratory request form labelling policy.	100% of samples are labelled in accordance with laboratory policy.
Ethnicity data collection	**3.5.6** All participants self-identify their ethnicity.	The NCSP requires accurate ethnicity data to monitor outcomes for different ethnic groups. Documentation of ethnicity must follow Te Whatu Ora Ethnicity Data protocols[17] • The participant must identify their own ethnicity. • The standard ethnicity question for the health and disability sector must be used, that is the Stats NZ 2018 Census ethnicity question. • The sample taker must not guess ethnicity on behalf of the respondent or limit the number of ethnicities given.	100% of participants self-identify ethnicity.

17. HISO 10001:2017 Ethnicity Data Protocols [Internet]. Ministry of Health. Wellington: Ministry of Health; 2017. Available from: http://moh.govt.nz/notebook/nbbooks.nsf/0/569DDB6A56F7E726CC2581FC00665BEB/$file/hiso-10001-2017-ethnicity-data-protocols.pdf

Infection control Whakahaere tikanga a pokenga

Purpose: To ensure optimal infection control processes are in place to minimise spread of potentially infectious materials or contamination of the sample.

TOPIC	STANDARD	DETAIL	TARGET
Infection control processes	**3.5.7** Cervical sample takers and cervical screening services follow best practice standards for infection control	**Standard precautions** Standard infection control processes must be followed to prevent potentially infectious materials including HPV contaminating the participant, the specimens or other people. For cervical screening, infection control procedures include: • ensuring that participants who choose to self-test can do so in a location where they have access to hand hygiene and can easily dispose of self-sampling packaging in an environment free from contamination • washing hands before and after contact with each person and after activities that are likely to cause contamination of cervical screening equipment or clinic surfaces • clinicians use gloves during specimen collection (not required for participant self-taken swab) • immediately transferring the sample into the container without contacting other surfaces or causing the material to become airborne • ensuring the lid of the specimen container is tightly closed and placed in an individual leak-proof bag for transport to avoid contamination of the environment or other specimens.	Expected best practice.

Follow-up responsibilities after taking a cervical screening sample

Ka whāia te wāhie mo takurua ka mahia te kai mō te tau. If you look for firewood in the winter, you will have plenty of food all year round

Purpose: To ensure effective recall processes and follow-up of participants.

TOPIC	STANDARD	DETAIL	TARGET
Ensuring cervical screening results have been received	**3.5.8** Cervical sample takers and cervical screening services have processes in place to ensure that results are obtained from the laboratory in a timely manner.	Sample takers must have processes in place to ensure that results are obtained from the laboratory in a timely manner. The target for laboratories is that 100% of cervical screening reports are provided within 10 working days. If cervical screening results are not received, the requestor must contact the laboratory to ensure that the laboratory received the cervical screening sample and that a report will be forthcoming.	Expected best practice.
Filing of results	**3.5.9** Cervical screening results are viewed and acted on by the cervical sample taker before filing.	The cervical sample taker who requests the test must sight all laboratory results and initiate appropriate follow-up before the results are filed. If the Responsible Clinician is unable to check the results for whatever reason, they or the provider must have processes in place to ensure that participants' results are received and acted upon in a timely manner. The Responsible Clinician must check the laboratory recommendation against the screening history. Any discrepancy or questions regarding the recommendation should be referred to the laboratory.	100% of cervical screening test results are reviewed, and the necessary follow-up is undertaken.

TOPIC	STANDARD	DETAIL	TARGET
Providing participants with the result of their test and future follow-up	**3.5.10** Participants are informed about their results and any future follow-up in the manner agreed upon with the cervical sample taker	The cervical sample taker who requested the cervical screening test is responsible for ensuring the following: • Participants receive their results in the manner agreed upon. • Participants are clear about their test result and next due date for cervical screening. • Participants are aware of necessary follow-up; e.g., a follow-up cytology test or referral to colposcopy. • All results including normal results are provided to participants. Participants must be provided with their cervical screening test result within 15 working days of the result being received.	100% of participants who have HPV 16/18 detected are referred to colposcopy within 10 days. 90% of participants who have HPV Other detected have appropriate follow-up and referral within 3 months. 100% of participants are provided with their result within 15 working days.
Transfer of participants if a sample taker ceases to perform cervical screening	**3.5.11** If a cervical sample taker ceases to perform cervical screening services, they must inform participants about future follow-up.	If a cervical sample taker ceases to provide services, participants should be advised about future screening options. Where possible, participants should be transferred to another provider. The sample taker must also inform the NCSP Register that they have ceased to provide cervical screening services.	Expected best practice.

Referral and follow-up of participants for further investigation

Purpose: To ensure appropriate referral for further investigation.

Refer also to:

- Appendix 6 for a sample referral form to colposcopy services
- *National Cervical Screening Programme Policies and Standards: Section 6 – Providing a Colposcopy Service* (Te Whatu Ora 2023).

TOPIC	STANDARD	DETAIL	TARGET
Referral and/or follow-up of participants for further investigation	**3.5.12** Cervical sample takers and cervical screening services have processes in place to ensure the appropriate referral and/or follow-up of participants with a 'detected' HPV test, an abnormal cervical screening test or histology result, or other clinical signs and symptoms suggestive of cervical cancer.	The pathway for referral to colposcopy is outlined in the NCSP Guidelines. The cervical sample taker who requests the cervical screening test must ensure appropriate referral to colposcopy for participants with an abnormal test result that meets the criteria for referral. In addition, participants presenting with symptoms suggestive of cervical cancer – for example, post-coital or intermenstrual bleeding, pelvic pain or a persistent vaginal discharge – must be referred promptly for gynaecologic or colposcopic examination, with all the relevant clinical information provided in accordance with the NCSP Guidelines. If a participant has a cervical screening test result that is 'suspicious of cancer or cancer', they must be referred urgently for colposcopic assessment. The urgency of the referral must be highlighted. Contact with the colposcopy clinic to expect an urgent referral is recommended. Note: Cervical sample takers should consider clinical history, signs and symptoms presented (irrespective of the laboratory result and recommendations made) to inform a decision on recall, investigation or where appropriate referral for gynaecologic assessment. Where return for an LBC cervical sample is indicated, at the time the result is provided, if eligible the participant should be provided with options for other cervical screening services including referral to Screening Support Services if available Where a referral to colposcopy is indicated, at the the time the result is provided the participant must be provided with reasonable information about what to expect at colposcopy and, if eligible, offered referral to Screening Support Services where available Colposcopy referrals must be made by the Responsible Clinician who requested the test.	Expected best practice.

TOPIC	STANDARD	DETAIL	TARGET
Referral and/ or follow-up of participants for further investigation (continued)		**Practice points** Ask participants if they have any preferences for their colposcopy referral such as need for interpreter, appointment in school hours or preferred gender of colposcopist. Include name of participant's GP or healthcare provider if relevant. NCSP information about colposcopy and cervical screening results can be sent as a PDF via text or email in mobile-friendly format – consider offering this information after notifying result.	Expected best practice.

Appendices

Appendix 1
Peer Assessment for Cervical Screening

This peer assessment measures sample taker performance against relevant cervical screening standards.

Competency measures:

- **Standard met (M) –** standard met
- **Standard not met (NM) –** standard not met (clinical support or supervision required to meet standard)

Application	**Frequency:**
• Cervical Sample-takers	• Every two years

		Competency Measure: M or NM
Name and role of sample taker:		
Name and role of peer reviewer:		
Date:		
Standard 3.1. Training, performance review and professional development	Has completed training appropriate to scope of practice	
	Has attended a cervical screening update within last two years	
	Practices under own HPI number	
	Has taken at least 10 LBC samples	
	No more than 3 cervical samples are reported as unsatisfactory* *Sample takers with persistent high rates of 'unsatisfactory' cytology samples over one year (i.e., >3) must undertake a peer review to address the cause or enlist the support of a clinical supervisor.	

Standard 3.2 Best practice service delivery	Can demonstrate or describe how they provide culturally safe cervical screening **Comment:**	
	Can give examples of using knowledge of the barriers and enablers for cervical screening to improve access **Comment:**	
	Can demonstrate or describe how they support participant to observe own cultural practice **Comment:**	
	Provides a culturally and physically safe environment for cervical screening	
	Can demonstrate or describe how to ensure practice supports diversity and inclusion **Provide example:** **Comment:**	
Standard 3.3 Notification, invitation and recall	Can demonstrate how to apply appropriate recall timeframes **Comment:**	
Standard 3.4 Informed consent and communication	Provides appropriate information about cervical screening and the NCSP so people can make an informed choice to participate.	
	Ensures participants are aware of all of the options for cervical screening	
	Ensures participants who choose an HPV self-test are aware they will need to return for a cytology test or will be referred to a specialist if HPV is detected.	

Standard 3.5 Cervical screening and follow-up responsibilities	Checks screening history and assesses participant for symptoms. Recommends co-test where indicated	
	Takes cervical screening samples, using best practice techniques	
	Supports participants to complete an HPV self-test using best practice techniques	
	Provides required information on specimen and laboratory form.	
	Completes appropriate and accurate documentation	
	Reviews and actions laboratory result	
	Ensures participant is provided with result	
	Can access Clinical Practice Guidelines for Cervical Screening in Aotearoa New Zealand for information. Uses the Guidelines to support clinical decision making	
	Can access NCSP Policies and Standards for information	
	Ensures that referrals to specialist care are made in a timely manner	
Standard 3.6 Infection control	Uses best-practice infection control practices and procedures.	
	Participant is supported to self- test in a clean environment, with hand hygiene facilities and adequate disposal to avoid sample contamination	

Comments:	
Competency standards met:	
Recommendations if not met:	
Signature of Sample-taker:	Date:
Signature of Peer reviewer:	Date:

Appendix 2
Enrolled Nurse Delegation

Notes

- As per the Nursing Council of New Zealand requirements, enrolled nurses work under the direction and delegation of a registered nurse or nurse practitioner. For cervical screening, this also includes under the direction and delegation of a medical practitioner.
- If enrolled nurses practise cervical screening independently in community settings, it is best practice that this delegation is formally documented.
- Enrolled nurses do not need direct supervision when taking cervical screening samples.
- The enrolled nurse must inform and seek guidance from the health practitioner when they encounter situations or aspects of care that are beyond their educational preparation and competency. They must transfer care to a relevant health practitioner when the client's needs are beyond their scope of practice.
- The health practitioner(s) supervising the enrolled nurse must be available to provide timely advice.

Name of enrolled nurse:	
Role/job title of Enrolled Nurse:	
Nursing Council of New Zealand number:	
NZNC Number:	HPI Number:

Training record

Date achieved NZQA Unit Standard 29566:	
Date completed NCSP HPV Primary Screening modules:	
Peer Assessment date:	Date of 2 yearly NCSP update:
Name of Responsible Clinician:	
Role/Job title of Responsible Clinician:	
Employer:	
NZNC/NZMC Number:	HPI Number:

Delegation record

Date of delegation:	
Duration of delegation:	
Delegation review date:	
Signature of Enrolled Nurse:	Signature of Responsible Clinician:

Appendix 3
Barriers and enablers for cervical screening

Barriers to cervical screening are well documented in local and international literature[18], In Aotearoa New Zealand there are longstanding ethnic and socioeconomic inequities in cervical cancer incidence and mortality, with cancers concentrated in unscreened and under-screened groups, in particular Māori and Pacific people and other people living in higher deprivation.[19]

HPV Primary Screening introduces new options for cervical screening that could potentially have a positive impact on the cervical screening barriers that people experience.[20] An option to self-test alone is not enough to address the systemic barriers without everybody who provides cervical screening services working to ensure people have:

- Access to acceptable, affordable and appropriate cervical screening services
- An empowering, culturally and physically safe experience of cervical screening
- Appropriate follow up, diagnosis and treatment.

18. Aotearoa New Zealand Deaf women's perspectives on breast and cervical cancer screening. Deborah A Payne 1, Agnes Terraschke 2, Karen Yoshida 3, Victoria A Osasah 4.
Human Papillomavirus (HPV) Self-Sampling among Never-and Under-Screened Indigenous Māori, Pacific and Asian Women in Aotearoa New Zealand: A Feasibility Study - PMC https://pubmed.ncbi.nlm.nih.gov/34639352.
Adcock, A., Cram, F., Lawton, B., Geller, S., Hibma, M., Sykes, P., MacDonald, E.J., Dallas-Katoa, W., Rendle, B., Cornell, T., Mataki, T., Rangiwhetu, T., Gifkins, N. and Hart, S. (2019), Acceptability of self-taken vaginal HPV sample for cervical screening among an under-screened Indigenous population. Aust N Z J Obstet Gynaecol, 59: 301-307. https://doi.org/10.1111/ajo.12933.
Kirubarajan, A., Leung, S., Li, X. et al. Barriers and facilitators for cervical cancer screening among adolescents and young people: a systematic review. BMC Women's Health 21, 122 (2021). https://doi.org/10.1186/s12905-021-01264-x.
Sherman, SM, Brewer, N, Bartholomew, K, et al. Human papillomavirus self-testing among unscreened and under-screened Māori, Pasifika and Asian women in Aotearoa New Zealand: a preference survey among responders and interviews with clinical-trial nonresponders. Health Expect. 2022; 25: 2914- 2923. doi:10.1111/hex.13599
19. Recommendations for implementing HPV self-testing in Aotearoa (nzma.org.nz) 22 June 2023 at 11:48 am Jane Grant
Review of Cervical Cancer Occurrences in relation to Screening History in New Zealand for the years 2013-2017 (nsu.govt.nz)
20. Hamers, Françoise F.a; Poullié, Anne-Isabelleb; Arbyn, Marcc. Updated evidence-based recommendations for cervical cancer screening in France. European Journal of Cancer Prevention 31(3):p 279-286, May 2022. | DOI: 10.1097/CEJ.0000000000000701

Barriers	Enablers
Access barriers: • Being busy, making time for an appointment • No evening or weekend appointments • GP Clinics in area have closed books • Cost • Having an outstanding account • Living a long way from services • Culturally appropriate services are not available	**Access enablers:** • Offer opportunistic screening • Use dashboards and alerts • Run after hours clinics • Collaborate with other services to offer after hours clinics • Make the most of funding for priority groups • Refer to Screening Support Services where available
Personal barriers: • Previous negative experience • Fear/distrust of process • Perception that harms of screening outweigh benefits[21] • Triggers distress discomfort and trauma • Association with sexual violence • Lack of privacy • Lack of bodily autonomy and control • Feeling pressured by providers • Lack of trust in health services, caused by systemically racist systems and colonial legacy • Services that are unaware of communication needs related to disability or other factors	**Personal enablers:** • Providers that utilise trauma informed practice principles • Acknowledge the power imbalance and take steps to address it • Allow time • Create certainty, let people know exactly what is involved with procedure • Give people space in the room • Offer for whānau and/or support people to be present • Let people know they are in control, let them be in control • Option to take own sample in own space where possible • Consider communication preferences including interpreters, preferred pronouns • Use visual aids and resources to support health literacy.

21. Butler TL, Lee N, Anderson K, Brotherton JML, Cunningham J, Condon JR, et al. (2022) Under-screened Aboriginal and Torres Strait Islander women's perspectives on cervical screening. PLoS ONE 17(8): e0271658. https://doi.org/10.1371/journal.pone.0271658

Appendix 4
Working with interpreters

1. For effective communication, it is essential that health providers assess the participant's proficiency in English, both conversation and reading. When assessing language proficiency always use open ended questions to avoid 'Yes' or 'No answers,
2. Service users generally prefer to speak with health professionals who speak the user's first language. The best approach is to provide a 'language-matched' health professional for any work with non-English speaking clients. The next best approach is to use skilled professional interpreters to address the communication barrier between participant's and health providers (Lim and Mortensen 2014).
3. If an interpreter is used it is recommended that the appointment be extended because consecutive interpreting will require double the length of time for a consultation session.
4. For some cultures it is inappropriate to discuss sensitive health issues in the presence of people of a different sex or gender Where practical, offer options to the participant in selecting an interpreter. The provider could use telehealth (video or phone) interpreting if face-to-face interpreting services are not available.
5. Some migrant or refugee communities are small and close-knit, and this can compromise confidentiality if the interpreter knows the participant or their family personally. To overcome this, the provider could use phone or video interpreting services that access interpreters from outside the local community.
6. The health provider needs to be careful when considering a participant's request to have a family member interpret. The family member may not be fluent in English, may not translate everything that the participant says, may normalise the information provided, or unconsciously make decisions for the participant. The health provider may need to negotiate the situation respectfully and explain to the participant that the use of a skilled interpreter is essential to ensure effective communication and that interpreters are bound by confidentiality.
7. It is essential that health providers know how to work with interpreters when participants are being screened. This can be achieved by attending eCALD Working with Interpreters training:
    - Interpreting and Translation Providers – ecald.com/resources/migrant-and-refugee-services/?keywords=Interpreting#filter
    - eCALD® Resources: CALD Working with Interpreters – seeecald.com/programmes/cultural-competency-training-for-the-general-health-workforce/cald-4-working-with-interpreters

Regional Coordinators can provide advice on how to access local interpreter services.

Microsoft Word - Handout 2 Final Guidelines for Working with Interpreters RFT 27Sep20.docx (ecald.com)

Appendix 5
Referral form for Screening Support Services

Information about Screening Support Services can be found at: Screening Support Services | National Screening Unit (nsu.govt.nz)

Referred by

Date of referral:		◯ Urgent ◯ Semi-urgent ◯ Routine	
Name of Health Facility:			
Name of referrer:		Position:	
Phone:	EDI:		Fax:
Email:			

Participant details

NHI:	Date of birth:		Ethnicities:
First Names:		Surname:	
Residential Address:			
Daytime phone:	Evening phone:		Cell:
Email:			
Alternative contact person:			
Preferred contact method:			
GP:		Clinic:	

Referral details

Type of referral:	
◯ **BSA** (Māori and Pacific participants or other participants unscreened or under-screened)	◯ **NCSP** (Māori and Pacificparticipants or other participants unscreened or under-screened)
◯ Support to mammography	◯ Support to cervical screening
◯ Support to assessment or first specialist treatment appointment	◯ Support to colposcopy (assessment/treatment)
◯ Other support required (eg, transport, childcare, interpreter) – please state	◯ Other support required (eg, transport, childcare, interpreter) – please state

Reason for referral:		
◯ Support to Screening	◯ Support to follow-up (cervical cytology test)	◯ Support to assessment or treatment
Further details: include appointment type, provider and location (if known)		
Time of appointment if known:		

Important information:		
Is the participant aware of the referral?	◯ Yes	◯ No
Please provide follow up actions you have taken to contact the person:		
Relevant medical history:		
Access barriers:		
Is the persons home accessible?		
Are there dogs on the property?		
Other relevant information:		
Signature:		

Appendix 6
Referral form for Colposcopy

Referred by

Date of referral:	◯ Urgent ◯ Semi-urgent ◯ Routine
Name of Health Facility:	
Name of referrer:	Position:
Phone:	EDI:
Email:	

Participant details

NHI:	Date of birth:		Ethnicities:
First Names:		Surname:	
Residential Address:			
Daytime phone:	Evening phone:		Cell:
Email:			
Alternative contact person:			
Preferred contact method:			
GP:		Clinic:	

Referral details

Type of referral:

First assessment (new): ◯ Yes ◯ No

Subsequent assessment (follow-up): ◯ 1st ◯ 2nd ◯ 3rd ◯ 4th

Reason for referral (tick all that apply):

Abnormal Cytology

◯ HSIL/ASC-H (high grade squamous intraepithelial lesion)

◯ LSIL/ASC-US (low grade squamous intraepithelial lesion)

◯ Suspicious of invasive cancer (squamous/adenocarcinoma)

◯ Glandular abnormality (AIS/AGC)

HPV Detected

◯ HPV 16/18 type detected

◯ HPV other type detected

◯ HPV 16/18 and HPV other type detected

◯ Invalid HPV test

◯ HPV not detected

◯ Abnormal appearance of cervix
Please describe. Symptoms indicative of risk for cervical cancer:

◯ Post-coital bleeding

◯ Post-menopausal bleeding

◯ Abnormal vaginal bleeding

◯ Unusual or persistent discharge from the vagina

◯ Persistent pelvic pain

◯ Dyspareunia (pain during sex)

◯ Other reason eg, vulval (specify):

Relevant clinical history:

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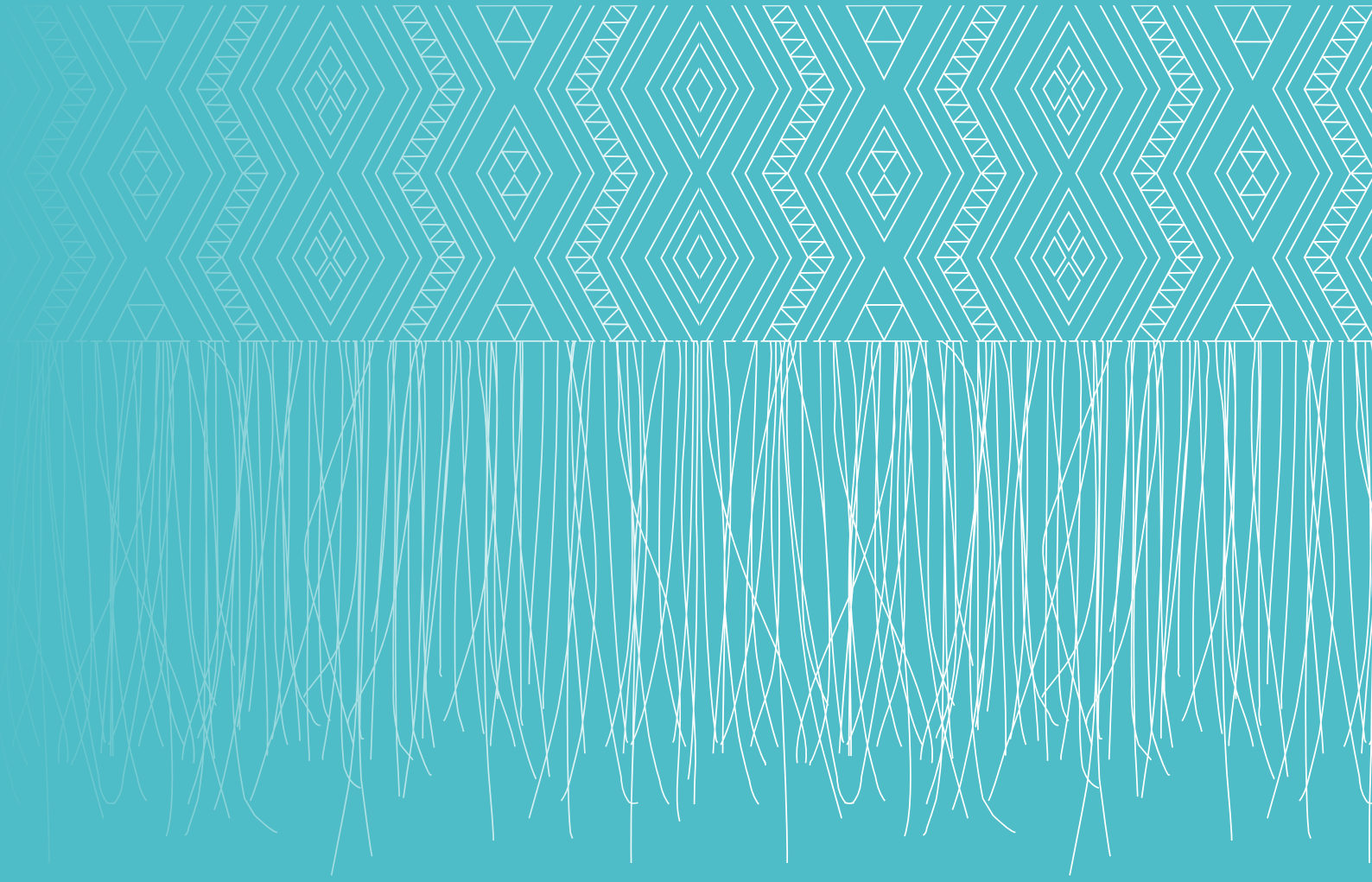

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