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Supplementary Material

Primary care experiences in the 'Let's test for HPV' study: a qualitative analysis

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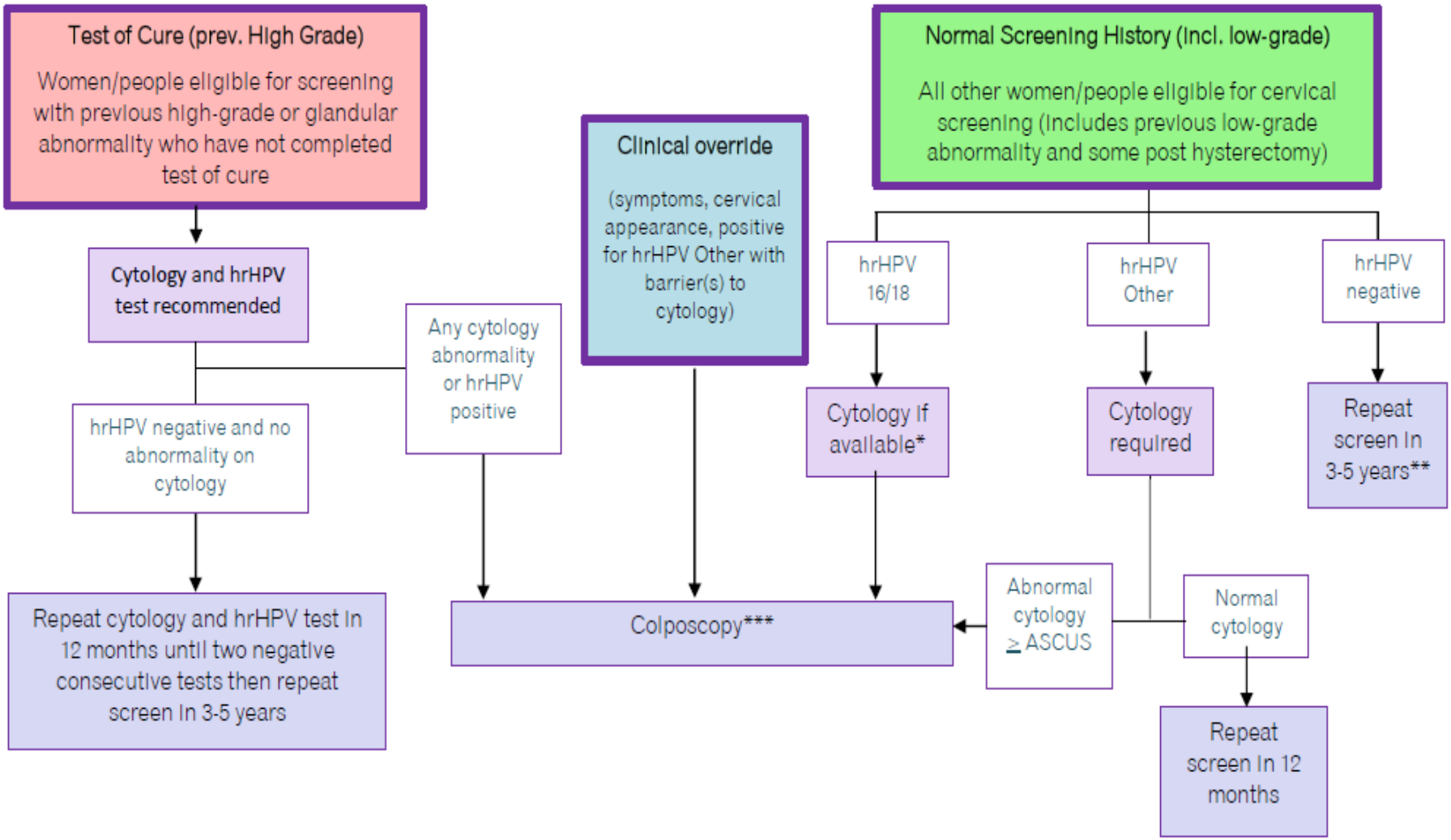
Supplemental Material – Flowchart for management of hrHPV results (15)



*****Note if a vaginal self-test is taken and the result is positive a cervical cytology specimen is indicated to stratify risk, however in some circumstances it will not change so is not required. (i.e. HPV16/18 positive) If a cervical test has been taken this will be performed on the same specimen by the laboratory. It is advised that this test is performed within 2 weeks.

******With the new five yearly screening interval, those coming in for their next screening test (after previous cytology screening) any time in the last five years before age 69, i.e. 65 – 69 years of age (inclusive), can exit the programme if their hrHPV test result is negative. This includes those with normal screening histories, with no screening history and those with previous abnormalities who have already been returned to regular interval (three yearly) screening. Exceptions are:

1. Participants who are still in active surveillance following previous abnormalities need to complete their follow-up. So if a test of cure is indicated and hasn't been successfully completed then they need a test of cure – one negative HPV test is not sufficient in this circumstance.
2. Immune deficient participants with a negative hrHPV test need to return in three years for a repeat hrHPV screen, if this falls before 69 years of age
3. Women who have had a recent hysterectomy will need a test of cure if there is high-grade histology in the hysterectomy specimen, which may or may not have been preceded by high-grade cytology.

Those who would normally exit the NCSP under the current NCSP exit requirements i.e. have had two normal screening cytology samples between ages 62 and 69 years of age, can exit at 69 years of age without HPV testing (providing not immune deficient or requiring further follow-up because of abnormal results).

*******Urgency of referrals to Colposcopy are as follows;

- **Very Urgent** – Suspicion of Malignancy (10 working days)
- **Urgent** – High-grade cytology and/or HPV 16 or 18 positive (20 working days)
- **Semi-Urgent** – other high-risk HPV and low-grade/ASCUS cytology (3 months)
- Colposcopy can be referred as a clinical override e.g. hrHPV other and patient declining cytology triage.

ASCUS: Atypical Squamous Cells of Undetermined Significance hrHPV: high risk human papillomavirus NCSP: National Cervical Screening Programme

Supplementary Material - Interview Schedule

First, I'd like to ask some general questions about the program and your role within it:

1. Is there anything you would like to tell me right off the bat about the whole process of using the HPV screening pathway?
2. What role do you have regarding the screening program?
3. How do you manage with this role?
   Prompts: Did you find the extra work from this role was manageable? Do you think the amount of work given to you was fair and reasonable?
4. Do you think there have been any additional costs to your practice (e.g. staff time) in using the new pathway? Have patients had any extra costs, above what they would usually have for a cervical screening test?
   Prompt: Do you think your Practice was adequately compensated?

Now I'd like to move on to some questions about how you found the experience:

5. Overall, how has your experience been with carrying out the screening process?
   Prompt: How have you found dealing with inviting and consenting Women to have a test? ***(interviewer note: not consenting Women to participate in the study)?***
   Prompts: How did you find the recall list supplied to your practice, *Do you think patients understand the new pathway? Would you like to see some more advertising or outreach*, *How did you find the sample collection process? How have you found dealing with the results (both positive and negative results) in terms of both the recall/referral process and breaking the news to the patients?*
6. Did you feel you had enough training or preparation to use the new screening pathway? (**interviewer note: not the research process part)**
   Prompt: Were there gaps in the training or information provided that you'd like to see filled?
7. What has been working well with the new pathway?
   Prompt: Why do you think this worked well?
8. What challenges have you encountered using the new pathway?
   Prompt: What would make the process easier for you?
9. What would you like to see changed or added from a primary care perspective about this program before it is implemented? Why?

My last few questions relate to how you think patients have found the screening program in this trial

10. How do you think patients have found this new pathway?
   Prompts: What do you think patients have found went well? What do you think patients have not liked? Can you think of any ways in which these issues could be fixed? Was there any part of the process which you did not think was meeting the patients' needs? Was the information supplied to you to give to patients good/sufficient
11. We are particularly interested in the impact the new screening pathway has had on Māori, Pasifika, Rural and Asian Women. Do you think this new program has influenced how Women from these groups participate in Cervical cancer screening?
   Prompts: Why do you think this improved/did not improve/did not impact uptake of screening? What do you think the biggest barriers to participation were for women of these backgrounds? What changes do you think could be made to improve uptake for these groups?
12. Were there any groups which were particularly difficult to engage in this program?
   Prompt: How have you found engaging transgender individuals?
13. And lastly is there anything else you would like us to know?