



OBSTETRICS AND GYNAECOLOGY
CLINICAL PRACTICE GUIDELINE

Cervical Screening Test

(previously within guideline 'Vaginal Procedures')

Scope (Staff):	WNHS Obstetrics and Gynaecology Directorate staff
Scope (Area):	Obstetrics and Gynaecology Directorate clinical areas at KEMH, OPH and home visiting (e.g. Visiting Midwifery Services, Community Midwifery Program and Midwifery Group Practice)

This document should be read in conjunction with this [Disclaimer](#)

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Aim

Inform staff of cervical screening eligibility criteria, provide guidance on the procedure for collecting a Cervical Screening Test (CST)^a and to advise management of abnormal results.

National Cervical Screening Program (NCSP) recommendations²

The [NCSP National Cervical Screening Policy \(external website\)](#) recommends:

- Cervical screening should be undertaken every five years in asymptomatic women and people with a cervix aged 25-74 years of age, using a primary human papillomavirus (HPV) test with partial genotyping and liquid-based cytology (LBC) triage if high risk HPV detected.
 - People who have ever had sexual contact (digital, oral or penile) should commence cervical screening at 25 years of age.
 - Both HPV vaccinated and unvaccinated people are included in the NCSP.
- Anyone eligible for a CST under the NCSP will be given a choice of HPV testing either through self-collection of a vaginal sample or clinician-collection of a sample from the cervix.
 - Self-collection is not appropriate if the participant requires a co-test or is experiencing **symptoms** (such as abnormal vaginal bleeding, pelvic pain, pain with sexual intercourse, abnormal vaginal discharge).
- Self-collection should be an option any time an HPV test is needed, including for follow-up HPV testing after an intermediate risk result.
- People in whom HPV is detected should be managed in accordance with the [NCSP Guidelines for the management of screen-detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding \(NCSP Clinical Guidelines\)](#) (external website) and the [Cervical screening pathway](#) (external website).

For a full list of recommendations, refer to the [NCSP National Cervical Screening Policy](#) (external website).

Women and people with a cervix of any age who have symptoms suggestive of cervical cancer require diagnostic testing and should be managed in accordance with the [NCSP Clinical Guidelines](#) (external website), regardless of their cervical screening history.

^a CST: Cervical Screening Test- a clinician- collected cervical sample for HPV testing and reflex liquid-based cytology (LBC) when indicated, or a self-collected vaginal sample for HPV testing.

Cervical screening in specific populations

The [NCSP Clinical Guidelines](#) (external website) outline the management of women in specific populations. These groups, and where to access the relevant recommendations, include women and people with a cervix who:

- [Are pregnant](#) (external website)
- [Have undergone a total hysterectomy](#) (external website)
- [Are experiencing abnormal vaginal bleeding](#) (external website)
- [Are immune-deficient](#) (external website)
- [Have been exposed to diethylstilbestrol \(DES\)](#) in utero (external website)
- [Experienced early sexual activity or have been victims of sexual abuse](#) (external website)

Cervical screening information

For further information refer to the WNHS [Cervical Screening: For Health Professionals website](#).

To access your patient's cervical screening history, contact the National Cancer Screening Register (NCSR) on 1800 627 701 or look up via the online [NCSR Healthcare Provider Portal](#) (external website).

Discussing CST options

Providing accurate and clear information about cervical screening can assist patients to make an informed choice. When talking with patients, key information includes:

- The link between persistent HPV infection and cervical cancer, noting
 - HPV infections are usually cleared by the immune system in 1–2 years
 - if HPV infection persists, in rare cases it can lead to development of cervical cancer after about 10–15 years
 - Cervical cells can undergo several changes before cancer develops. Therefore, regular screening can detect these changes early and, if needed, treatment initiated before cervical cancer develops.
- Cervical screening is based on HPV testing, and cells in the sample will only be studied for changes if HPV is detected or the patient is experiencing symptoms.
- Patients have the choice to screen either through self-collection of a vaginal sample using a simple swab (unless a co-test is indicated), or clinician-collection of a sample from the cervix using a speculum.
 - Self-collection is an option any time an HPV test is needed, including for follow-up HPV testing 12 months after an intermediate risk result.
 - The [NCSP Self-collection and the Cervical Screening Test \(external website\)](#) fact sheet can be provided during a consultation to help discuss cervical screening options with patients.
 - [NCSP Your choices explained \(external website\)](#) is a video guide to help people from culturally and linguistically diverse communities understand the importance of cervical screening and the choices available.
- When deciding whether to self-collect a vaginal sample or have a clinician-collected cervical sample, patients must be given clear information about the possibility that HPV may be detected and, if so, what follow-up will be required.
 - A self-collected sample is from the vagina (not the cervix). It can only be tested for HPV and not for cytology (cervical cell abnormalities).
 - To be fully informed, participants should be advised that if HPV is detected on a self-collected vaginal sample, they will need to return for either a clinician-collected cervical sample for LBC analysis or be referred directly for colposcopy. Follow-up care will be determined by the type of HPV detected.
 - Among those attending for routine screening, approximately 2% have HPV 16/18 detected and approximately 6% have HPV (not 16/18) detected, although the latter varies by age.
 - Over 90% of participants who have routine Cervical Screening Tests do not have any HPV detected and therefore are recommended to screen again in 5 years' time, unless symptomatic.
- Routine cervical screening is only indicated once every 5 years for patients who do not have HPV detected.

For more information on discussing cervical screening with patients, refer to [Understanding the NCSP Management Pathway: A Guide for Healthcare Providers](#) (external website).

Pathology tests for cervical and vaginal testing

Clinical information on pathology request forms assists pathology laboratories perform the right tests, match the right clinical recommendations and select the right MBS item(s). Practitioners will need to specify on the pathology request form:

- whether the collection is part of routine screening or is for clinical management or for screening symptomatic people **and**
- the tests required (refer to the [NCSP Pathology test guide for cervical and vaginal testing \(Pathology test guide\)](#) (external website)) **and**
- whether the sample was clinician-collected or self-collected **and**
- other relevant clinical information e.g. screening history, DES exposure **and**
- the patient's Aboriginal and/or Torres Strait Islander status.

The [Pathology test guide](#) (external website) provides guidelines for pathology testing.

Procedure: Clinician-collected cervical sample or self-collected sample

	Procedure	Additional information
1	Preparation	
1.1	Inform the patient of: • The importance of cervical screening and the risks of not participating • Both cervical screening options, including the follow-up required for positive and negative results: ➢ Self-collected vaginal sample OR ➢ Clinician-collected cervical sample	Prior to taking a clinician-collected sample ensure: • The patient has been provided with sufficient and suitable information to make an informed decision³ • The patient has been offered both cervical screening options • Privacy is ensured³ • The patient understands the role and benefits of the NCSR (see below) • Engage an interpreter if needed and consider using pictorial and translated resources with patients to explain the process.
1.2	Confirm patient's identification. Record the patient's name, date of birth and UMRN number on the specimen vial.	See WNHS policy: Patient Identification .
1.3	Ask the patient if they are of Aboriginal and/or Torres Strait Islander origin.	In accordance with the Australia Bureau of Statistics Indigenous Status Standard (external website), Aboriginal and/or

	Procedure	Additional information
		Torres Strait Islander status may influence clinical management (e.g. those patients determined to be at intermediate risk).
1.4	On the pathology request form record the following: • Patient identification (see 1.2 above) • Cervical screening and other relevant medical history (including gynaecological history) • Any visible cervical abnormalities noted during the examination • Aboriginal and/or Torres Strait Islander status • Country of birth; and • Main language other than English spoken at home (if applicable) • Clearly indicate that the sample was either clinician-collected or self-collected	Refer to the NCSP Pathology test guide (external website) for details what information to specify on the pathology request form. To access the patient's screening history contact the NCSR on 1800 627 701 or look up via the online Healthcare Provider Portal (external website). Where the form does not allow for Aboriginal and/or Torres Strait Islander status or culturally and linguistically diverse information to be collected, clearly write the information obtained in an appropriate space on the form.
1.5	In addition to the above: For Clinician-Collected sample: • Obtain verbal consent ³ • All women shall be offered a chaperone. The chaperone must be a NMHS-employed clinician. • Position the patient so they are comfortable. • Explain to the patient how the test will be taken	Refer to, and document (name, profession etc.) as per, NMHS Chaperone policy. A Chaperone Stamp is available in some areas. The NCSP – What happens when my healthcare provider collects my sample (external website) is a visual guide that can be given to patients to help them understand the process.

Role and benefits of the NCSR includes:

- maintaining a national database of cervical screening records
- inviting eligible people to commence cervical screening when they turn 25
- reminding participants when they are due and overdue for cervical screening
- providing participants' cervical screening history to laboratories to inform screening recommendations

- providing a 'safety net' for participants who are at risk and who have not attended further testing by prompting them to have follow-up tests.
- See [NCSR](#) (external website) for more details

Taking a clinician-collected cervical sample

Equipment

- Bi-valve speculum (plastic or metal)
- Cervex-Brush® / Cytobrush®
- Torch or extension light
- SurePath LBC collection vial
- Water based lubricating gel
- Kidney dish
- Sheet
- Examination gloves

Procedure (clinician-collected sample)

	Procedure	Additional information
1	Preparation	
	As per previous section ' Preparation '	
2	Speculum insertion	
2.1	Refer to section in Vaginal Procedures guideline: 'Speculum Examination'.	Provides instruction on performing a speculum examination.
3	Taking the cervical sample	
3.1	1. Insert the speculum. 2. Visually inspect the cervix. Note the appearance of the cervix, whether the cervix appears normal, a variation of normal e.g. ectropion/pin-point os, or abnormal. 3. If familiar with types of transformation zone, please document	Offering the patient self-insertion of the speculum may help reduce feelings of vulnerability and powerlessness. Moisten and warm the speculum with warm water or a small amount of water-soluble and carbomer-free lubricant (taking care to avoid the tip of the speculum) (See WACCPP Use of Lubricants for Cervical Screening). Any abnormality noted on visual inspection of the cervix requires colposcopy referral.
3.2	If unable to locate the cervix: • Ask the patient to lift their buttocks and place a rolled towel under them or they can sit on their fists. • Withdraw the speculum and palpate the position of the cervix. Reinsert the speculum in the direction of the cervix. • Use a different size speculum.	If the lateral vaginal walls are bulging inwards, consider using: • A larger speculum; and/or • A condom over the speculum (cut off the reservoir tip of the condom).

Taking the cervical sample: GYNAECOLOGY	Taking the cervical sample: OBSTETRIC
Take the sample using appropriate implement(s) to suit the type of transformation zone (Cervex-Brush®, Cytobrush®). To capture adequate samples of both endocervical (glandular) and squamous cells), a Cytobrush® should be used in conjunction with the Cervex-Brush® in patients who: • have undergone surgery for a previous cervical abnormality • have previously tested negative for endocervical cells • are Post-menopausal • have a type 3 transformation zone (pin-point os) The Cervex-Brush® is used to collect both endocervical and ectocervical cells and is the preferred implement for most women. An optimal cervical sample has: • Sufficient mature and metaplastic squamous cells to indicate adequate sampling from the transformation zone. • Sufficient endocervical cells, to ensure screening for glandular abnormalities.	1. Inform the woman that cervical screening can be performed safely in pregnancy.¹ 2. Collect the sample using the Cervex-Brush® as described below. Additional information: Do not use the Cytobrush® in pregnancy.¹ Read REC14.11 and REC14.12 on next page. See also WNHS Flowchart for cervical screening in antenatal patients. Note: Cervical sampling should generally be delayed in cases of placenta praevia, vasa praevia and cervical insufficiency. If there is a strong clinical indication to collect in these pregnancies, it should be performed by an experienced clinician.
Using the Cytobrush®	Using the Cervex-Brush®
• Gently insert the Cytobrush® into the cervical os. • Ensure 1 row of bristles remains visible • Gently rotate Cytobrush® one quarter to one half of a turn in one direction. • Snap the head of the brush into the SurePath collection vial.	• Insert the centre of the brush into the endocervical canal. • Rotate the brush five times in a clockwise direction, keeping bristles in contact with the ectocervix. • Use the interior rim of the SurePath collection vial to pull off the head of the

Additional information: • Do not insert Cytobrush® out of vision • To reduce unnecessary bleeding, do not over rotate brush	brush and deposit into the SurePath vial. Additional information: If a large ectropion is present, ensure that a sample of cells is collected from beyond the border of this area as well. REC14.11: Cervical screening in pregnancy (external website) Routine antenatal and postpartum care should include a review of the patient's cervical screening history. Those who are due or overdue for screening should be screened. REC14.12: Cervical screening in pregnancy (external website) A patient can be safely screened at any time during pregnancy, provided that the correct sampling equipment is used. An endocervical brush should not be inserted into the cervical canal because of the risk of associated bleeding, which may be distressing.
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Follow-up
Antenatal patients: Follow-up of results through antenatal team / clinician. See also WNHS Pathway for Cervical Screening in Antenatal Patients. Gynaecology clinics / EC patients: Cytology Nurse manages the CST results. Inform the patient that a letter advising of the result and any follow-up needed will be sent to: • The patient themselves; and • The patient's General Practitioner (GP) Oncology / Colposcopy: Test results for patients attending Oncology and Colposcopy services are reviewed and managed by the attending doctor.

Procedure: Facilitating a self-collected vaginal sample

Self-collection provides a level of control, choice and removes a significant barrier to participation in screening. There are some groups that are less likely to screen, including:

- Aboriginal and/or Torres Strait Islander peoples
- Culturally and linguistically diverse communities
- People who identify as LGBTIQ+
- People with disabilities
- People who have experienced sexual violence
- People who have experienced Female Genital Mutilation/Cutting (FGM/C)
- Post-menopausal people and
- People who have had previous negative cervical screening experiences.

Self-collection may be more acceptable to these groups.

For asymptomatic patients, there is strong evidence that HPV tests on self-collected vaginal samples and clinician-collected cervical samples have equivalent sensitivity when using a PCR-based HPV test.

Eligibility

Currently anyone eligible for a CST under the NCSP has the choice to screen either through self-collection of a vaginal sample using a simple swab (unless a co-test is indicated), or clinician-collected sample from the cervix with the help of a speculum.

Self-collection is not appropriate for patients who require a co-test, in the following situations:

- are symptomatic (e.g. experiencing unusual vaginal bleeding, pain or discharge),
- are undergoing Test of Cure surveillance following treatment of a glandular abnormality, Cotest is required
- These patients only need HPV screening so can probably self-collect, same as treatment for HSIL have been exposed to diethylstilbesterol (DES) in utero.

Self-collection of a vaginal sample needs to be ordered and overseen by a healthcare professional who can also ensure timely clinician-collected testing if required as part of follow-up assessment, and for Medicare reimbursement. However, within that framework, healthcare professionals have flexibility to develop models of screening in collaboration with other healthcare workers, in order to best meet the needs of their patients and communities.

As per the [NCSP Policy](#), self-collection should be offered in-clinic wherever possible.

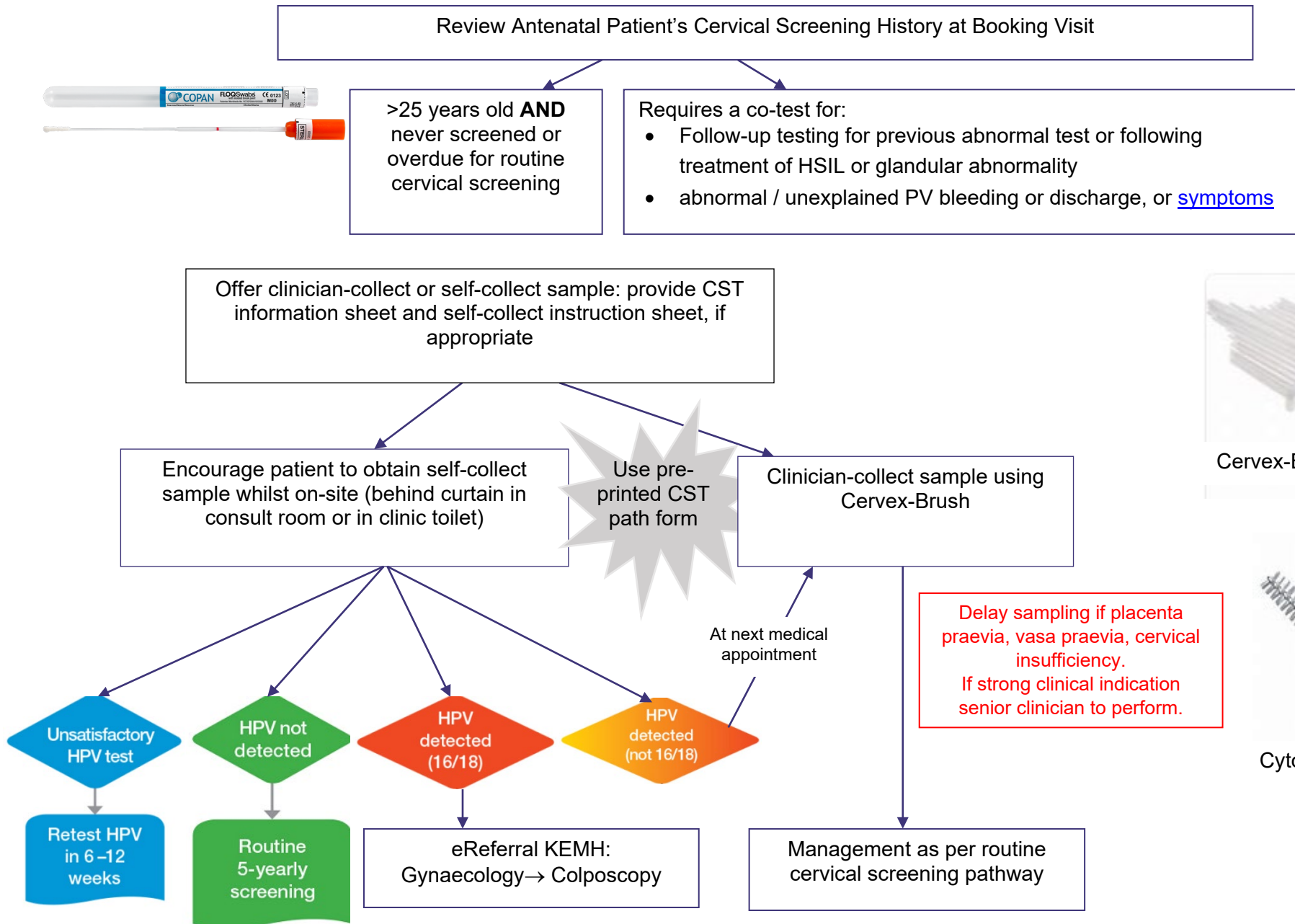
Refer to [A Summary Guide for Healthcare Providers](#) (external website) for key self-collection updates within the NCSP Clinical guidelines.

Procedure (self-collected sample)

	Procedure	Additional information
1	Preparation	
	As per previous section ' Preparation '	
2	Self-collection of a vaginal HPV sample	
2.1	Provide the patient with: - Self-collection instruction sheet and talk through each step - Self-collection information sheet - A swab approved for use in self-collection	The self-collection instructions (external website) and information sheet (external website) can be downloaded, printed and provided to the patient. The self-collection instructions are a visual guide to help people understand how to collect their test. There is a visual guide (external website) to help people from culturally and linguistically diverse communities understand the test. There are also videos which explain how patients can take their own sample: video (external website) video (external website) for Aboriginal and Torres Strait Islander patients. The sample medium for a self-collected HPV test will vary between pathology laboratories, but for PathWest is the COPAN FLOQswab 552c (red top). 
2.2	Provide the patient with a private space to collect their sample (e.g. behind a curtain or in the bathroom).	If patient not comfortable collecting their own vaginal sample, the sample may be collected by the healthcare provider. If this occurs, still request 'HPV test, self-collected sample' on the request form.
2.3	Place the self-collected sample and pathology request form in a specimen bag for transport to the laboratory.	

3	Self-collection: OBSTETRIC	
	Inform the patient that cervical screening can be performed safely in pregnancy Pregnant patients are suitable self-collection	Note: Cervical sampling should generally be delayed in cases of placenta praevia, vasa praevia and cervical insufficiency. If there is a strong clinical indication to collect in these pregnancies, it should be performed by a senior clinician. 7.1 Pregnancy (external website) Routine antenatal and postpartum care should include a review of the patient's cervical screening history. Patients who are due or overdue for screening should be screened. See WNHS Pathway: Cervical Screening in Antenatal Patients REC 7.3 Cervical screening in pregnancy: self-collection sample All patients who are due for cervical screening during pregnancy may be offered the option of self-collection of a vaginal swab for HPV testing.
4	Follow-up	
	As per follow-up processes for clinician collected samples	

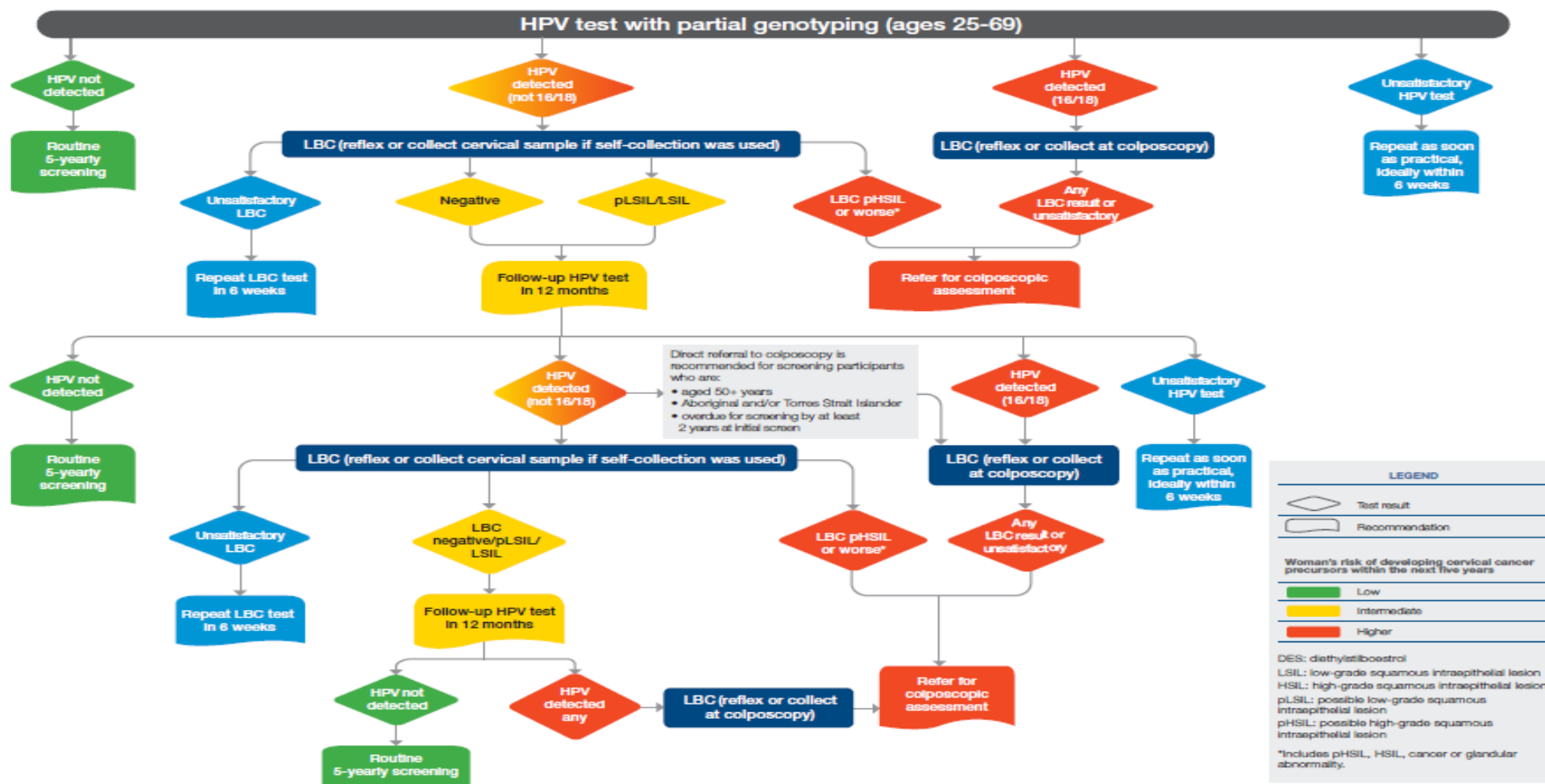
WNHS pathway: Cervical screening in antenatal patients



Interpreting results and management

Cervical screening pathway (clinician-collected or self-collected)

The Cervical Screening Test and pathway is a risk-based approach to the management of patients participating in the NCSP. Patients are managed according to their risk of developing significant cervical abnormalities. For more information about the risk-based approach refer to [Understanding the NCSP Management Pathway: A Guide for Healthcare Providers](#) (external website). The screening pathway (below) and the results matrix (on next page) outline how the risk categories and management strategies are determined based on HPV and LBC (if performed) results.



Acknowledgment: Cancer Council Australia Clinical Guidelines: Cervical Screening: [Cervical Screening Pathway](#) (PDF, 121KB, external website).

Results matrix: Cervical Screening Test results and LBC guidance – clinician-collected and self-collected samples

HPV test result	LBC	LBC result	Risk Level	Recommended management
HPV not detected (anywhere in screening pathway)	Not required	–	Low risk	Return to screening in 5 years
HPV (16/18) detected (anywhere in screening pathway)	Yes. If clinician-collected, laboratory will do reflex LBC. If self-collected, LBC collected at colposcopy, not required prior to referral.	Any result: If reflex LBC is unsatisfactory, it could be repeated at time of colposcopy	Higher risk	Refer to specialist (colposcopy)
HPV (not 16/18) detected: routine screening test in participant aged 25-69 years	Yes. If clinician-collect, laboratory will do reflex LBC. If self-collected, screening participants should return to their healthcare provider as soon as practical, ideally within 6 weeks, to have a cervical sample collected for LBC.	Negative, pLSIL or LSIL	Intermediate risk	Repeat HPV test in 12 months
		pHSIL, HSIL or any glandular	Higher risk	Refer to specialist (colposcopy)
		Unsatisfactory	–	Return for a repeat LBC in 6 weeks.
HPV (not 16/18) detected: 12-month follow-up test in a participant in an exception category	Yes. If clinician-collected, laboratory will do reflex LBC. If self-collected, LBC collected at colposcopy, not required prior to referral.	Any result: If reflex LBC is unsatisfactory, it could be repeated at time of colposcopy	Higher risk	Refer to specialist (colposcopy)
HPV (not 16/18) detected: 12-month follow-up test; not in exception category	Yes. If clinician-collect, laboratory will do reflex LBC. If self-collected, screening participants should return to their healthcare provider as soon as practical, ideally within 6 weeks, to have a cervical sample collected for LBC.	Negative, pLSIL or LSIL	Intermediate risk	Repeat HPV test in 12 months
		pHSIL, HSIL or any glandular	Higher risk	Refer to specialist (colposcopy)
		Unsatisfactory	–	Return for a repeat LBC test in 6 weeks.
HPV (any type) detected: 24-month repeat	Yes. Yes. If clinician-collected, laboratory will do reflex LBC. If self-collected, LBC collected at colposcopy, not required prior to referral.	Any result If reflex LBC is unsatisfactory, it could be repeated at time of colposcopy	Higher risk	Refer to specialist (colposcopy)
Unsatisfactory	–	–	–	Return for a repeat HPV test (self-collected or a clinician-collected sample) as soon as practical, ideally within 6 weeks.

Acknowledgement: [National Cervical Screening Program – Understanding the National Cervical Screening Program Management Pathway \(external website\)](#). See ‘Understanding the risk categories’ (pp14-17) for a full explanation of strategies.

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Risk categories

Low risk

Low-risk result means HPV was not detected. **Patients with a low-risk result should be invited to rescreen in 5 years.**

Intermediate risk

An intermediate-risk result means HPV (not 16/18) was detected and, on LBC, there were either no cell changes, possible LSIL or LSIL.

Patients with an intermediate risk result will be invited to return for a repeat HPV test in 12 months. This is to check if the HPV infection has been cleared by their immune system.

If the sample was self-collected and HPV (not 16/18) was detected the patient should be asked to return for a clinician-collected LBC sample.

12 months after intermediate risk result

The patient should have a follow-up HPV test, and will receive one of the following possible results:

- HPV not detected on follow-up: **The patient can now safely return to 5-yearly screening, if they remain asymptomatic.**
- HPV detected (not 16/18) on follow-up: LBC should be performed. **If the LBC report is negative or pLSIL/LSIL patient should return for a second follow-up HPV test in a further 12 months.**
- **Some groups of people may be at higher risk of a high-grade abnormality (HSIL) and should be referred to colposcopy if HPV (any type) is detected at the 12 month follow-up tests**, regardless of the LBC result. These include people who:
 - were overdue for screening by at least 2 years at the time of their initial CST which detected HPV (not 16/18)
 - identify as Aboriginal and/or Torres Strait Islander
 - are aged 50 years or older.

24 months after intermediate risk result (12 months after follow-up HPV test)

The patient should have a second follow-up HPV test, and will receive one of two possible results:

- HPV not detected: **The patient can now safely return to 5-yearly screening**, if they remain asymptomatic.

HPV detected (any type): This result means that there is a persistent HPV infection (any type). **The patient should be referred for colposcopic assessment.** Refer to Cervical Screening Pathway, referral dependant on LBC result.

Higher risk

Any patient who has received a higher risk result should be referred for colposcopic assessment.

On routine screening:

- HPV detected (16/18): **Patients should be referred directly for colposcopic assessment because they are at higher risk of cervical cancer.** A colposcopy examination will determine if a biopsy is needed and based on the result, a decision will be made regarding treatment. LBC will inform the colposcopic assessment.
 - If the LBC showed invasive cancer the **patient should be referred to a gynaecological oncologist or gynaecological cancer centre for urgent evaluation**, ideally within 2 weeks.
 - If the LBC showed pHSIL/HSIL/invasion or any glandular abnormality, the **patient should be referred for colposcopic assessment at the earliest opportunity**, ideally within 8 weeks.

On second follow-up HPV test after an intermediate risk result:

- HPV detected (not 16/18): If HPV (not 16/18) is detected at the 12 or 24 month repeat HPV test, LBC should be performed.
 - If the LBC showed invasive cancer the **patient should be referred to a gynaecological oncologist or gynaecological cancer centre for urgent evaluation**, ideally within 2 weeks.
 - If the LBC showed pHSIL/HSIL/invasion or any glandular abnormality, the **patient should be referred for colposcopic assessment at the earliest opportunity**, ideally within 8 weeks.

WACCPP Quick Reference Guides

- [Cervical Sampling Card](#)
- [Vaginal Sampling Card](#)
- [Cervical screening during pregnancy card](#)
- [Female Genital Cutting/Mutilation \(FGC/M\) & cervical screening](#)

References

1. Cancer Council Australia. National Cervical Screening Program: Guidelines for the management of screen-detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding. 2025. Available from: https://www.cancer.org.au/clinical-guidelines/cervical-cancer-screening/?title=Guidelines:Cervical_cancer/Screening
2. Australian Government Department of Health and Aged Care. National Cervical Screening Program: National cervical screening policy. 2022. Available from: <https://www.health.gov.au/sites/default/files/documents/2022/09/national-cervical-screening-program-national-cervical-screening-policy.pdf>

3. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists. C-Gyn 30: Gynaecological examinations and procedures. 2024. Available from: <http://ranzcog.edu.au/resources/statements-and-guidelines-directory/>

Related NMHS and WNHS policies, guidelines and procedures

NMHS [Chaperone policy](#)

WNHS Obstetrics and Gynaecology:

- [Vaginal Procedures](#) (including Chaperone and Speculum sections);

Useful resources and related forms

- Department of Health WA: Safety and Quality in Healthcare: [Procedure Specific Information Sheets](#): NMHS: KEMH: Colposcopy and LLETZ OG13 (WA Health employees access through HealthPoint)
- [National Competencies for Cervical Screening Providers \(external site\)](#) – see Appendix F of the [NCSP Quality Framework](#) (external website)
- Sexual Health Quarters (formerly Family Planning WA): [Certificate in Sexual and Reproductive Health \(Nursing\)- Cervical Screening](#) (external website)

Additional resources (external websites)

Australian Government: National Cervical Screening Program:

- Consumer information: [How to collect your own](#) sample and [What happens when my healthcare provider collects my sample](#)
- Healthcare provider information: [A Summary Guide for Healthcare Providers; Understanding the National Cervical Screening Program management pathway](#)
- [General resources](#) and [toolkit](#)

Australian Institute of Health and Welfare. [National Cervical Screening Program monitoring report 2025](#). Cadman L, Waller J, Ashdown-Barr L, Szarewski A. [Barriers to cervical screening in women who have experienced sexual abuse: An exploratory study](#). The Journal of Family and Reproductive Health Care. 2012; 38(4):214-220.

Cancer Council Australia.

- [Cervical Cancer Early Detection Policy](#) Sydney: Cancer Council Australia. 2018.
- [FAQ for Providers: Self-collection updates to the National Cervical Screening Program Clinical Guidelines](#). June 2022.

National Centre for Immunisation Research and Surveillance [NCIRS]

- [Impact evaluation of Australian national human papillomavirus vaccination program Final report, 2021](#).
- The Royal Australian and New Zealand College of Obstetricians and Gynaecologists [RANZCOG]. [Guidelines: Guidelines for HPV vaccine: C-Gyn 18](#). 2024.

E-learning:

- [GPEx National Cervical Screening Program \(NCSP\) Bundle](#)

Keywords:	Cervical Screening Test, CST, cervical screening, cervical screening, cervical cancer, National Cervical Screening Program, NCSP, cervical cancer prevention, prevention screening for cancer, screening in pregnancy, human papillomavirus, HPV, HPV test, HPV vaccine, HPV vaccination, cervical screening in pregnancy, Cervical Screening Test report, cytology screening, colposcopy, Thin-Prep, thin prep, SurePath, liquid-based cytology, self-collect cervical screening, self-collect HPV test, self collection, cervical screening results, cervical screening result management, thin-prep, Pap, Pap smear, cytobrush, cervex brush		
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NSQHS Standards (v2) applicable:	☒  1: Clinical Governance ☒  2: Partnering with Consumers ☒  3: Preventing and Controlling Healthcare Associated Infection ☐  4: Medication Safety	☐  5: Comprehensive Care ☒  6: Communicating for Safety ☐  7: Blood Management ☐  8: Recognising and Responding to Acute Deterioration	
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Version history

Version number	Date	Summary
1	Nov 2022	First version. History: Previously a chapter within the Vaginal Procedures guideline. Prior to 2017, was called ‘Papanicolaou (Pap) Smear’. Contact OGD Guideline Coordinator for archived versions. Changes include: - National cervical screening program changed- Expansion of vaginal HPV sample self-collection option to all women eligible for CST (except if symptomatic, DES in utero, total hysterectomy with HSIL and/or undergoing test of cure). Read self-collection sections. - All CST sections updated and restructured format; New pathway for screening antenatal patients; Updated interpreting results section - Vaginal Procedures guideline separated into two- CST chapter removed to be stand-alone guideline - Inclusive language for women and people with a cervix

2.0	February 2026	• Resource documents and links updated throughout. • Inclusion of WACCPP suite of Quick Reference Guides. • NCSP policy recommendation of reducing 'at home testing'. • Removal of reference to 'transitioning participants to the renewed program'.
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