The National Association of NURSE PRACTITIONERS in WOMEN'S HEALTH

POSITION STATEMENT

Cervical Cancer Screening and Risk-Based Management of Abnormal Tests

The National Association of Nurse Practitioners in Women's Health (NPWH) supports a concerted effort to continue improving cervical cancer screening (CCS) rates and ensuring timely, appropriate follow-up and treatment when screening results are abnormal. NPWH urges women's health nurse practitioners (WHNPs) and other advanced practice registered nurses (APRNs) who provide women's and gender-related healthcare to lead the implementation of evidence-based screening and follow-up guidelines, ensuring that innovation translates into equitable access and improved outcomes across diverse populations. The goal is to reduce cervical cancer incidence, morbidity, and mortality.

NPWH recognizes the disproportionate burden of cervical cancer incidence, morbidity, and mortality and the urgency to alleviate disparities. The causes for inequities in access to CCS, timely follow-up, and treatment are multifactorial and often intersecting. Social determinants of health-mediated inequality, structural racism, and cultural factors must be addressed through changes in healthcare systems and public health measures. NPWH supports policies at the local, state, and federal levels that ensure access to CCS services, follow-up, and treatment.

Furthermore, NPWH emphasizes that cervical cancer research must prioritize innovations that reduce disparities and improve outcomes. Advances in understanding the natural history and cervical carcinogenesis of human papillomavirus (HPV), alongside innovations in screening technologies and evidence-based, risk-informed management of abnormal results, offer substantial potential to strengthen cervical cancer prevention and early detection. These advances will have the greatest impact when they are implemented in ways that address persistent structural and social barriers to care.

BACKGROUND

Cervical cancer was once one of the leading causes of cancer-related death among women in the United States. However, over the past five decades, widespread implementation of CCS, primarily through the Papanicolaou (Pap) test and later high-risk human papillomavirus (hrHPV) testing, has dramatically reduced both incidence

and mortality. Despite substantial declines in incidence and mortality in the US since the 1970s, cervical cancer continues to pose a public health burden. In 2026, an estimated 13,490 new cases of invasive cervical cancer and 4,200 deaths are expected, underscoring continuing gaps in prevention and screening despite significant advances in hrHPV testing and vaccination.[1]

Persistent infection with hrHPV is the cause of nearly all cervical cancers.[2,3] HPV infection is prevalent and typically transient, with more than 90% of infections clearing to levels that are no longer detected by 24 months.[4,5] However, persistent infections can lead to cervical intraepithelial neoplasia (CIN), particularly CIN2 and CIN3. These high-grade lesions carry a significantly elevated risk of progression to invasive cervical cancer. Although many low-grade abnormalities regress naturally, CIN3 lesions may progress to cancer over a period of 10 to 15 years if left untreated.[3] This long latency period provides an opportunity for routine screening to detect and treat precancerous lesions before they progress into invasive cancer.[2,4,5] Of important note, HPV infections that were previously cleared to levels that are no longer detected can reactivate and be detected again.[6] For this reason, routine screening guidelines for the general population do not change based on sexual history. It is important to counsel patients that a positive HPV test does not necessarily indicate a new exposure to the virus.

The specific HPV genotype and duration of persistence are key determinants of progression risk. As the prevalence of HPV 16 and 18 declines in vaccinated populations, emerging data indicate a growing proportion of CIN2+ and cervical cancers are attributable to other high-risk genotypes, including HPV 31, 33, 45, 52, and 58.[3,4] In risk-based management of abnormal screening tests, there is clinical value in knowing which HPV genotype is present. Extended genotyping can refine triage strategies and optimize patient outcomes in the context of shifting epidemiology.[7]

In the US, CCS has been guided primarily by recommendations from the United States Preventive Services Task Force (USPSTF) and the American Cancer Society (ACS). These recommendations apply to individuals at average risk for cervical cancer (See Box).[8] Excluded from these recommendations and thus requiring more intensive follow-up are those with immunocompromising conditions (including HIV), in utero exposure to diethylstilbestrol, or a history of cervical intraepithelial neoplasia grade 2 or higher (CIN 2+).

BOX. CRITERIA FOR AVERAGE RISK[8]

- Asymptomatic – no abnormal bleeding or other symptoms concerning cervical cancer
- Screening for the first time or history of all normal CCS in the past or remote history of abnormal results in which the individual now fulfills criteria to resume routine screening based on recommendations from the ASCCP Risk-Based Management Consensus Guidelines

Note: Must meet both criteria.

ASCCP, American Society for Colposcopy and Cervical Pathology; CCS, cervical cancer screening.

The ACS updated its CCS guidelines in December 2025.[9] The update of the 2018 USPSTF screening recommendation has yet to be finalized. A draft published in January 2025 remains under review, resulting in a prolonged gap in federal guidance.[10] In January 2026, the Health Resources and Services Administration (HRSA) published updated CCS guidelines to address this gap and reflect advances in scientific evidence, technology, and implementation. The HRSA guidelines include new requirements for most insurance plans to cover all testing necessary to complete the screening process for malignancies, with mandatory coverage beginning January 1, 2027.[11] Details on current screening guidelines are provided in the Table.

TABLE. CERVICAL CANCER SCREENING GUIDELINES FOR INDIVIDUALS AT AVERAGE RISK[9-11]

ORGANIZATION	START AGE	PREFERRED SCREENING METHOD	ALTERNATIVES	DISCONTINUATION
ACS (Dec 2025)	25	Primary hrHPV every 5 years for ages 25–65 (clinician-collected preferred or self-collected acceptable*)	hrHPV/Pap co-testing every 5 years or Pap every 3 years	Negative primary hrHPV tests or negative hrHPV/Pap co-tests at age 60 & 65 **or** 3 consecutive negative Pap tests at recommended intervals, with the last at age 65
USPSTF (Dec 2024) DRAFT	21	Pap only for ages 21–29 Primary hrHPV preferred for ages 30–65 (clinician-collected or self-collected*)	hrHPV/Pap co-testing every 5 years or Pap every 3 years	Screening can stop after age 65 if there is adequate prior screening (3 consecutive negative Pap tests or 2 negative hrHPV or hrHPV/Pap co-tests within the past 10 years, most recent within 3–5 years) and no history of high-risk conditions or precancerous lesions.
HRSA (Jan 2026)	21	Pap only for ages 21–29 Primary hrHPV preferred for ages 30–65 (clinician-collected or self-collected*)	hrHPV/Pap co-testing every 5 years or Pap every 3 years	Age 65

**Patient-collected vaginal samples are recommended every 3 years, and clinician-collected cervical samples are recommended every 5 years.*

ACS, American Cancer Society; hrHPV, high-risk human papillomavirus; HRSA, Health Resources and Services Administration; USPSTF, United States Preventive Services Task Force.

In 2025, the ACS updated its CCS guidelines for average-risk individuals to include self-collection of vaginal specimens for primary hrHPV testing using tests FDA approved for this purpose and endorsing the 2025 Enduring Consensus Cervical Cancer Screening and Management Guidelines Committee recommendation.[9,12] The Enduring Guidelines Committee is a standing committee of the American Society for Colposcopy and Cervical Pathology (ASCCP) with the primary purpose of assessing newly approved technologies for CCS and management and issuing recommendations for use.[13,14] ASCCP guidelines aim to integrate emerging technologies and risk-based approaches to enhance cancer prevention while reducing unnecessary procedures among those at lower risk. These guidelines are designed to be both enduring and adaptable, evolving with innovation while upholding clinical safety and effectiveness.[13,14]

The updated HRSA guideline designates hrHPV testing using either clinician-collected or patient self-collected samples as the preferred screening modality for average-risk individuals age 30 to 65 years, while retaining cervical cytology for individuals age 21 to 29 years.[11] Aligned with the revised screening recommendations of ACS, this update represents a meaningful advance in cervical cancer prevention by expanding access, reducing structural and psychosocial barriers, and improving screening uptake. The inclusion of self-collection as a primary hrHPV screening option offers a reliable, less invasive alternative that can increase participation among individuals who are under screened due to discomfort with pelvic exams, stigma, or limited access to healthcare

without compromising test accuracy. Patients must be counseled that any positive hrHPV result from a self-collected sample requires timely follow-up with a clinician, either for a speculum-based cervical sample or direct referral to colposcopy, to ensure appropriate diagnostic evaluation and management.[9–12] Treatment and management are guided by the current ASCCP Risk-Based Management Consensus Guidelines.[12,14] Importantly, when self-collection is used there must be a system in place to ensure follow-up and referrals for positive results. ASCCP currently recommends a 3-year rather than a 5-year follow-up for negative results with self-collected specimens until long-term data accrue.[12]

Clinician-collected cervical specimens remain the preferred method because they allow laboratories to perform testing for hrHPV as primary screening and cytology (Pap test) or dual stain for reflex testing on the same sample.[12] Both the Pap test and dual stain are performed on cervical cells fixed on a slide to identify high-grade abnormalities when an hrHPV test is positive. Conversely, self-collected sampling obtains a vaginal specimen and does not directly obtain cervical cells.

Clinicians should verify whether the HPV test they are using is approved for primary hrHPV screening, extended genotyping, and/or self-collection, as these capabilities vary by assay.[12,14] FDA-approved self-collection options are now available for use in both healthcare settings and at home, depending on the specific assay.[9,12] Not all FDA-approved hrHPV tests are authorized for every screening indication or method.

In 2025, the ACS also updated its recommendation for qualifications for average-risk individuals to exit CCS.[9] Approximately 1 in 4 cervical cancers occurs in individuals older than age 65 years. Cervical cancer cases in individuals age 65 years and older are primarily due to under screening. The mortality rate for these individuals is twice that of younger individuals.[9,10] The new recommendation is for average-risk individuals to have negative primary hrHPV tests (preferred) or negative cotesting with hrHPV tests and cytology (acceptable) at ages 60 and 65 years.[9] The USPSTF did not make any changes in recommendations for exiting CCS in its 2024 update draft.[10]

Inadequate screening and follow-up persist, and cervical cancer incidence and mortality remain higher among underserved and marginalized populations. Populations with lower CCS rates include individuals with low socioeconomic status, individuals who are uninsured or underinsured, rural residents, and Native American and Alaska Native people.[15–18] Individuals with physical or intellectual disabilities have lower CCS rates.[19,20] Disparities in CCS exist for LGBTQ+ individuals, including transgender men.[21–23]

Cervical cancer incidence is higher in Native American and Alaska Native people, Hispanic people, and Non-Hispanic Black people than in Non-Hispanic White people. There are higher cervical cancer incidence rates among rural people. Individuals living in rural and low-income counties in the US are more likely to be diagnosed with distant-stage cervical cancer.[16–18] Non-Hispanic Black individuals bear a disproportionate burden of mortality from cervical cancer, despite having similar screening rates to non-Hispanic White individuals.[16–18]

Strategies to increase screening and follow-up include offering self-collected vaginal specimens for HPV testing and a variety of outreach interventions. Patient navigation systems, which use trained patient navigators, have been associated with improved outcomes in addressing individual barriers to follow-up and treatment for abnormal CCS results. Patient navigation services are often multicomponent, including community-based education, screening reminders, assistance with appointment scheduling, transportation, and childcare support, language translation services, and financial aid.[23–26]

IMPLICATIONS FOR WOMEN'S AND GENDER-RELATED HEALTHCARE AND NP PRACTICE

NPWH calls on WHNPs and other APRNs providing women's and gender-related healthcare to identify populations in their own communities facing obstacles to CCS as an essential first step. NPs can:

- Implement and evaluate outcomes of evidence-based strategies to reduce barriers and facilitate preventive healthcare for these populations.
- Participate in community-based approaches to reach marginalized populations with culturally aware education focused on addressing misperceptions and lack of knowledge about screening and cervical cancer.
- Create healthcare environments that are welcoming and nonjudgmental, fostering a comfortable, affirming CCS experience.

Individuals may be uncertain about the appropriate screening frequency and test type for their age group, as recommendations vary. If they have received the HPV vaccination, they may have the misconception

that they can forgo regular CCS. It is crucial to provide individuals with evidence-based information in a way that is meaningful to them. This facilitates person-centered care and shared decision making, promoting health and preventing disease.

Effective reminder and follow-up systems are crucial. It is essential that NPs are innovative in designing and implementing reminder systems that reach all patients and engage them to return for both routine screening and any additional follow-up needed. Improving CCS rates and HPV vaccination rates go hand in hand to reduce the incidence of cervical cancer. Take steps in your clinical practice to identify patients who need HPV vaccination, strongly recommend it, administer it on the same day the need is determined, and use reminder systems to ensure patients return to the office to complete the vaccination series.

Share your CCS and follow-up quality improvement initiatives and outcomes through presentations, journal articles, and social media. Lead research to identify ways we can reduce disparities and inequities in access to CCS. Use reputable resources such as ACS, USPSTF, ASCCP, and HRSA for guidance on evidence-based practice.

NPWH LEADERSHIP

NPWH will provide leadership to ensure that:

- Continuing education programs and other learning resources are available to help NPs stay up to date on evidence-based guidelines for CCS and the management of abnormal test results.
- NPs have the resources to develop and/or implement strategies to reduce disparities and improve CCS and follow-up among marginalized populations.
- Research moves forward in all aspects of cervical cancer prevention, screening, and treatment to improve healthcare outcomes and reduce disparities.
- Policies support equitable access to CCS, appropriate follow-up, and treatment when needed.

REFERENCES

1. Siegel RL, Kratzer TB, Wagle NS, Sung H, Jemal A. Cancer statistics, 2026. *CA Cancer J Clin*. 2026;76(1):e70043. doi:10.3322/caac.700432
2. Melnikow J, Henderson JT, Burda BU, et al. Screening for Cervical Cancer with High-Risk Human Papillomavirus Testing: A Systematic Evidence Review for the U.S. Preventive Services Task Force: Evidence Synthesis No. 158. Rockville, MD: Agency for Healthcare Research and Quality. 2018. Publication No. 17-05231-EF-1.3.
3. Moscicki AB, Schiffman M, Burchell A, et al. Updating the natural history of human papillomavirus and anogenital cancers. *Vaccine.* 2012;30(suppl 5):F24-F33. doi:10.1016/j.vaccine.2012.05.089
4. Insinga RP, Dasbach EJ, Elbasha EH, et al. Incidence and duration of cervical human papillomavirus 6, 11, 16, and 18 infections in young women: an evaluation from multiple analytic perspectives. *Cancer Epidemiol Biomarkers Prev*. 2007;16(4):709-715. doi:10.1158/1055-9965.EPI-06-0846
5. Plummer M, Schiffman M, Castle PE, et al. A 2-year prospective study of human papillomavirus persistence among women with a cytological diagnosis of atypical squamous cells of undetermined significance or low-grade squamous intraepithelial lesion. *J Infect Dis*. 2007;195(11):1582-1589. doi:10.1086/516784
6. Lycke KD, Steben M, Garland SM, et al; IPVS policy committee. An updated understanding of the natural history of cervical human papillomavirus infection-clinical implications. *Am J Obstet Gynecol.* 2025;232(5):453-460. doi:10.1016/j.ajog.2025.02.029
7. Bonde JH, Sandri MT, Gary DS, Andrews JC. Clinical utility of human papillomavirus genotyping in cervical cancer screening: a systematic review. *J Low Genit Tract Dis*. 2020;24(1):1-13. doi:10.1097/LGT.0000000000000494
8. Fontham ETH, Wolf AMD, Church TR. Cervical cancer screening for individuals at average risk: 2020 guideline update from the American Cancer Society. *CA Cancer J Clin*. 2020;70(5):321-346. doi:10.3322/caac.21628
9. Perkins RB, Wolf AMD, Church TR, et al. Self-collected vaginal specimens for human papilloma testing and guidance on screening exit: an update to the American Cancer Society cervical cancer screening guideline. *Ca Cancer J Clin*. 2026;76(1):e70041. doi:10.3322/caac.70041
10. United States Preventive Services Task Force (USPSTF). Draft Recommendation Statement. Screening for Cervical Cancer. USPSTF; 2024. Accessed January 15, 2026. https://www.uspreventiveservicestaskforce.org/uspstf/draft-recommendation/cervical-cancer-screening-adults-adolescents

11. Christine B, Bush M, Thurakal A, Sheehy AM. New cervical cancer screening guidelines from the US Department of Health and Human Services: strengthening women's preventive health. *JAMA.* Published online January 5, 2026. doi:10.1001/jama.2025.26456
12. Wentzensen N, Massad LS, Clarke MA, et al. Self-collected vaginal specimens for HPV testing: recommendations from the Enduring Consensus Cervical Cancer Screening and Management Guidelines Committee. *J Low Genit Tract Dis*. 2025;29(2):144-152. doi:10.1097/LGT.0000000000000885
13. Wentzensen N, Garia F, Clarke MA, et al. Enduring Consensus guidelines for cervical cancer screening and management: introduction to the scope and process. *J Low Genit Tract Dis*. 2024;28(2):117-123. doi:10.1097/LGT.0000000000000804
14. Perkins RB, Guido RS, Castle PE, et al. 2019 ASCCP risk-based management consensus guidelines for abnormal cervical cancer screening tests and cancer precursors. *J Low Genit Tract Dis*. 2020;24(2):102-131. doi:10.1097/LGT.0000000000000525
15. Sokale IO, Montealegre JR, Oluyomi AO, Thrift AP. Trends and racial/ethnic differences in predictors of cervical cancer screening among US women ages 30-64 years. *Cancer Epidemiol Biomarkers Prev*. 2023;32(1):82-90. doi:10.1158/1055-9965.Epi-22-0970
16. Schaefer A, Rockson A, Islam JY, et al. Structural racism in cervical cancer care and survival outcomes: a systematic review of inequities and barriers. *Curr Epidemiol Rep.* 2025;12(1):7. doi:10.1007/s40471-025-00360-y
17. Perkins R, Mitchell E. Cervical cancer disparities. *J Natl Med Assoc.* 2023;115(2S). Suppl S19-S25. doi:10.1016/j.jnma.2023.02.006
18. Buskwofie A, David-West G, Clare CA. A review of cervical cancer: incidence and disparities. *J Natl Med Assoc*. 2020;112(2):229-232. doi:10.1016/j.jnma.2020.03.002
19. Vinson AH, Norrid C, Haro EK. Cervical cancer screening in women with physical disabilities. *JAMA Netw Open*. 2025;8(1):e2457290. doi:10.1001/jamanetworkopen.2024.57290
20. Tuschick E, Barker J, Giles EL, et al. Barriers and facilitators for people with severe mental illness accessing cancer screening: a systematic review. *Psychooncology*. 2024;33(1):e6274. doi:10.1002/pon.6274
21. Domogauer J, Cantor T, Quinn G, Stasenko M. Disparities in cancer screenings for sexual and gender minorities. *Curr Probl Cancer*. 2022;46(5):100858. doi:10.1016/j.currproblcancer.2022.100858
22. Bauman K, Matzke H, Peterson CE, et al. Sexual orientation and cervical cancer screening among cisgender women. *JAMA Netw Open.* 2024;7(5):e248886. doi:10.1001/jamanetworkopen.2024.8886
23. American Cancer Society. Cancer facts and figures 2024. Special section: cancer in people who identify as lesbian, gay, bisexual, transgender, queer, or gender-nonconforming. Accessed January 16, 2025. https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2024/special-section-facts-and-figures-2024.pdf
24. Nelson HD, Cantor A, Wagner J, et al. Achieving health equity in preventive services: a systematic review for a National Institutes of Health pathways to prevention workshop. *Ann Intern Med*. 2020;172(4)258-271. doi:10.7326/M19-3199
25. Nelson HD, Cantor AG, Pappas M, et al. Patient navigation services for breast and cervical cancer screening and follow-up: a meta-analysis. *JAMA Intern Med.* 2025;185;(8):976-985. doi:10.1001/jamainternmed.2025.1590
26. Community Preventive Services Task Force. Cancer Screening: Patient Navigation Services to Increase Breast, Cervical, and Colorectal Cancer Screenings and Advance Health Equity. The Community Guide. 2022. The Community Preventive Services Task Force, Atlanta, Georgia. doi.10.15620/cdc/164181

NPWH gratefully acknowledges Danielle Clement, M.Ed., MSN, WHNP, AGNP (lead writer); Nancy R Berman MSN, ANP-BC, MSCP; Kim Choma, DNP, WHNP-BC; Aimee Holland, DNP, WHNP-BC, FNP-C; and Beth Kelsey EdD, APRN, WHNP-BC for their contributions as writing group members of this position statement.

Approved by NPWH Board of Directors: February 19, 2026