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# HPV Self-Collection: A Screening Test Is Not a Screening Program

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## Abstract

In April 2026, the American College of Obstetricians and Gynecologists (ACOG) issued a new Committee Statement replacing its 2021 cervical cancer screening guidance. The update identifies primary high-risk human papillomavirus (hrHPV) testing every 5 years as the preferred screening strategy for average-risk individuals aged 30–65 years and, when appropriate infrastructure and follow-up mechanisms are in place, introduces patient-collected sampling for hrHPV testing every 3 years as an additional option.

## Keywords

HPV Self-Collection; Cervical cancer; Human papillomavirus.

## Introduction

In April 2026, the American College of Obstetricians and Gynecologists (ACOG) issued a new Committee Statement replacing its 2021 cervical cancer screening guidance. The update identifies primary high-risk human papillomavirus (hrHPV) testing every 5 years as the preferred screening strategy for average-risk individuals aged 30–65 years and, when appropriate infrastructure and follow-up mechanisms are in place, introduces patient-collected sampling for hrHPV testing every 3 years as an additional option [1]. By reducing barriers such as the need for a clinical visit and speculum examination, self-collection has the potential to reach populations with historically low participation in cervical cancer screening. However, this approach represents more than a change in how a sample is obtained: a screening test is not, by itself, a screening program. The clinical value of a self-collected sample ultimately depends on whether its result is accurately communicated, appropriately evaluated, and, when indicated, linked to timely diagnostic assessment and treatment.

The principal promise of HPV self-collection is not merely convenience; it is the potential to re-engage populations that are difficult to reach through conventional screening pathways. A systematic review published in 2025 found that HPV self-collection increased screening participation compared with clinician-collected sampling, with direct mailing of self-sampling kits achieving particularly high uptake among low socioeconomic groups, ethnic minority populations, and women who had previously not participated in screening [2]. Real-world evidence further supports this potential. In an organized cervical cancer screening programme in Italy involving 19,327 women who had never or irregularly participated in screening, self-collection more than doubled participation compared with clinician-collected sampling, while adherence to subsequent follow-up exceeded 90% [3].

The distinction matters because a screening programme must extend beyond the test itself. ACOG explicitly recommends offering self-collected HPV testing only when the necessary clinical infrastructure is in place to ensure appropriate result notification, documentation, and follow-up or referral when indicated [1]. The rationale is straightforward: the goal of screening is not merely to detect HPV infection, but to prevent cervical cancer by linking clinically meaningful findings to appropriate evaluation and management at the right time. ACOG further cautions that implementing self-collection without adequately structured processes for result communication and follow-up may contribute to missed diagnoses or failures in care, particularly because a negative result may mean that the next routine screening opportunity will not occur for another three years [1].

Türkiye's experience illustrates clearly that a screening test alone is not sufficient. Türkiye initiated a population-based cervical cancer screening programme using cytology in 2004, but limited coverage and logistical challenges led to the transition, in 2014, to an HPV-based, centralized, and traceable screening programme. This transition established an integrated system in which women aged 30–65 years were invited for screening every 5 years, samples were processed in centralized HPV laboratories, and individual screening status could be monitored through a national call-and-recall system [4].

Türkiye's existing screening infrastructure provides an important foundation for implementing self-collection; however, integrating this new approach into the programme would involve more than simply changing how samples are obtained. In the current system, sample collection, laboratory processing, result reporting, and referral for further evaluation are embedded within a defined clinical and administrative framework [5]. Self-collection moves the first step of this pathway outside the healthcare facility, raising a different question: the issue is no longer who collects the sample, but who-and how-activates the system once the sample has been collected. Accordingly, the safe expansion of self-collection may require more than simply adding a "kit distribution" model to the existing infrastructure; it may require strengthening the mechanisms that ensure results are documented, communicated to patients, and, when positive, linked to the appropriate level of clinical care.

One of the greatest strengths of self-collection is its potential to reach populations that are less likely to participate in conventional screening programmes. Studies have shown that offering self-collection can increase screening participation among groups with lower socioeconomic status, ethnic minority populations, and individuals who have not previously participated in screening, with implementation

strategies such as direct mailing of self-sampling kits appearing particularly effective in some of these populations [2]. However, increasing access is not the same as completing the screening pathway. Real-world evidence from an organized screening programme demonstrates that self-collection can successfully engage previously underscreened women, but that its clinical value depends on effective result assessment and completion of appropriate follow-up [3]. Self-collection should therefore be evaluated not simply by how many more women it reaches, but by how effectively those women can be carried through the entire pathway of care.

Accordingly, the key determinant of the clinical success of self-collection may lie less in how the sample is obtained than in how its result is managed. A negative result provides reassurance only within the context of continued screening at the recommended interval, whereas a positive result requires risk-based triage, colposcopic evaluation when indicated, and timely access to appropriate treatment. In Türkiye's existing programme, HPV-positive women are referred for colposcopy on the basis of HPV genotype and cytology, demonstrating that this follow-up pathway is not merely theoretical but already embedded in routine practice [5]. The key question in expanding self-collection, therefore, should be not only "How can we make it easier for women to get screened?" but also "How can we ensure that no woman is lost to follow-up after a positive result?"

HPV self-collection represents an important, evidence-based opportunity to expand access to cervical cancer screening; rather than avoiding this innovation, the focus should be on defining the conditions under which it can be implemented safely and effectively. The 2026 ACOG update explicitly links this option to appropriate clinical infrastructure and follow-up mechanisms [1]. Türkiye, meanwhile, already has a population-based HPV screening programme supported by centralized laboratory infrastructure and individual-level traceability [4]. The next step, therefore, should not be to replace this infrastructure with self-collection, but to integrate self-collection in a way that strengthens it. Ultimately, the success of cervical cancer screening should be measured not by how many more samples we collect, but by how many more women reach the right care at the right time.

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