



**MEDICAL AND
HEALTH SCIENCES**
SCHOOL OF MEDICINE

*G*ynaecology *T*eaching *A*ssociates

INFORMATION BOOKLET

for

MEDICAL STUDENTS

HELEN ROBERTS, MB, MPH
Associate Professor in Women's Health
School of Medicine
University of Auckland

CONTENTS

1	Introduction	Page 3
2	GTA teaching model	Page 4
3	Student protocol for sensitive examination	Page 4
4	Female anatomy	Page 5
5	GTA gynaecological examination	Page 7
6	Taking a cervical smear	Page 11
7	Obtaining the ideal smear	Page 13
8	Taking vaginal swabs	Page 14
9	Performing a bimanual vaginal examination	Page 15
10	Examination in left lateral position	Page 17
	Appendix 1: Technique for vaginal self-swabs	Page 18

Acknowledgements to Fay Adams, who created all the diagrams in this book

GYNAECOLOGY TEACHING ASSOCIATES (GTAs)

Training of Medical Students



Dr Helen Roberts, MB, MPH
Associate Professor in Women's Health

1 INTRODUCTION

GTAs are women who are surrogate patients and educators at the same time and who have a commitment to women's health. In many American and Canadian medical schools students are taught pelvic examinations by GTAs. Teaching medical students in a supportive and non-threatening environment is an important part of the programme.

This course was introduced to the Auckland Medical School in 1993 and is designed to give medical students the skills and confidence to become competent in taking cervical smears, vaginal swabs, and in carrying out bimanual/speculum examination. Consideration of informed consent, appropriate communication and attitudinal skills will be emphasised.

The GTA teaching evenings are from 6pm–9pm. The initial hour will involve video and pelvic model demonstration. The remainder of the teaching is the GTA session where students, in groups of 2, receive individual teaching from a doctor and GTA. The focus of teaching is about normal genital and pelvic examination.

2 GTA TEACHING MODEL

The GTA model is:

- to focus on appropriate interpersonal skills and methods of patient education and relaxation to reduce patient anxiety
- to teach the technical skills in a supportive and non-threatening environment with the opportunity for repeated practice and positive reinforcement.

GTAs participating in the program are women:

- with an interest in improving medical education and supportive of both male and female medical students
- with an interest in improving the health care women receive
- with effective teaching skills

3 STUDENT PROTOCOL FOR SENSITIVE EXAMINATIONS

Sensitive examinations include vaginal (PV), breast and rectal (PR) examinations as well as those of male external genitalia. There are certain steps to be taken BEFORE any sensitive examinations are performed by a medical student. These steps are:

1. You have received specific teaching on the examination technique by a University of Auckland teacher.
2. Apart from scheduled supervised teaching with full patient consent (e.g. GTA teaching in 5th year, examination under anaesthesia), there is a well-defined clinical indication to perform the examination.
3. If you believe that there is such an indication for a sensitive examination, you will first discuss the performance of this with the medical staff (or a midwife, in the case of obstetrics) responsible for that patient.
4. The examination is carried out with a doctor or senior nurse or midwife (in the case of obstetrics) present. The senior staff member should ask the patient initially (without the student being present) if they agree to the examination by a student. As a student you should confirm that consent has been given and document in the patient's chart.
5. Female patients must be offered the choice of a chaperone (it's their right under the HDC Code of Rights) and the offer should be made without the student present.
6. Gloves should be worn for all sensitive examinations except examination of the breast.

Your training requires the goodwill of patients, health professionals (both university and non-university), and health authorities, with the maintenance of a high level of collaboration and trust among all parties. Maintaining this trust requires all parties to:

- Protect patients from inappropriate or unnecessary examinations
- Ensure that patients are not unduly alarmed by incorrect interpretation of physical findings.
- Protect you, your teachers, and the health authorities from the situation where a complaint may be laid.

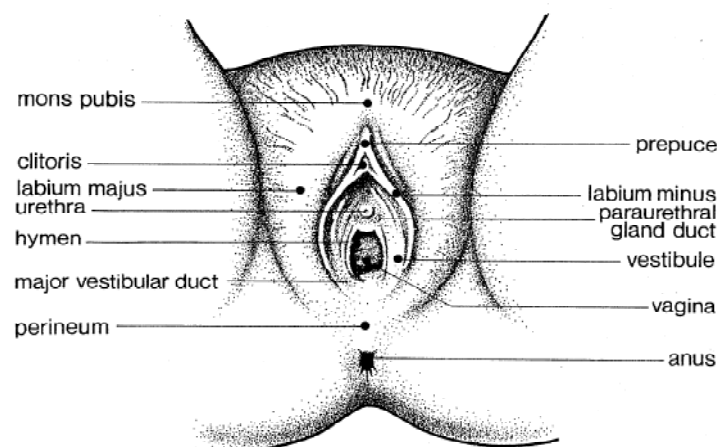
Policy pertaining to those who contravene these steps

Any student who contravenes this protocol for sensitive examinations risks suspension from the medical programme while the situation is fully investigated. Depending on the outcome of this investigation, it is possible that the student may not be readmitted to the undergraduate medical programme following the initial suspension.

4 FEMALE ANATOMY

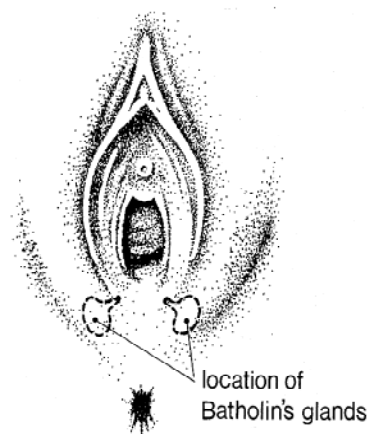
The anatomy of the external female genitalia, or vulva, include the mons pubis, a hair covered fat pad overlying the symphysis pubis; the labia majora, rounded folds of adipose tissue; the labia minora, thinner pinkish red folds that extend anteriorly to form the prepuce; and the clitoris (*Figure 1*). The vestibule is the boat-shaped fossa between the labia minora. In its posterior portion lies the vaginal opening or introitus, which in virgins may be hidden by the hymen. The term perineum, as commonly used clinically, refers to the tissue between the introitus and anus.

Figure 1: Anatomy of external female genitalia



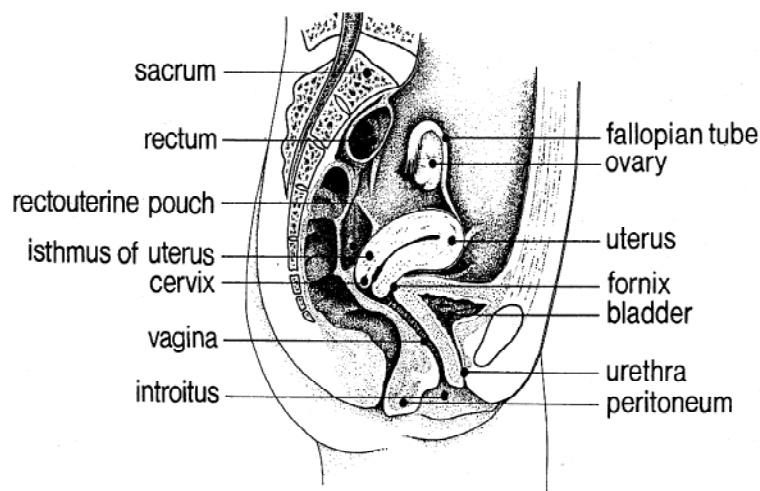
The urethral orifice (urethral meatus) opens into the vestibule between the clitoris and vagina. Just posterior to it on either side can sometimes be discerned the openings of the paraurethral or Skene's glands. The ducts of Bartholin's glands are located posteriorly on either side of the vaginal opening, but are not usually visible. Bartholin's glands themselves are situated more deeply, posterior and lateral to each side of the vestibule (*Figure 2*).

Figure 2: Location of Bartholin's glands



The vagina is a tubular structure which extends upwards and backwards from the perineum to the cervix, passing between the courses of the urethra anteriorly and the rectum posteriorly (*Figure 3*). The cervix protrudes into the upper end of the vagina, dividing the cup shaped vaginal fornix into anterior, posterior, and lateral fornices. The external cervical os, visualised as a depression in the cervix on vaginal speculum examination, marks the opening of the endocervical canal into the uterine cavity. The external os is a small round opening in nulliparous women but a wider slit like opening in multiparous women. Above the cervix is the body of the uterus, a flattened, pear-shaped, fibromuscular structure. The convex upper surface of the uterine body is called the fundus, which may be palpated on abdominal or bimanual vaginal examination, forming an important external anatomical landmark in the clinical assessment of uterine size. The orientation of the cervix to the uterus varies. Most commonly, the uterine body tilts anteriorly from the cervix, which is termed the anteverted uterine position. However, the uterine body may be orientated in the same longitudinal plane as the cervix (mid-position) or may tilt backwards from the cervix (retroverted uterine position).

Figure 3: Cross section of female pelvis, side view



Within the abdominal cavity, a fallopian tube extends from each side of the fundus. Each fallopian tube has a fringed, funnel-shaped end which curves toward the ovary. However, the fallopian tube and ovary on each side are not connected. An ovary is an almond-shaped structure that varies considerably in size from puberty through menopause, but averages about 3.5 x 2 x 1.5 cm in size. The ovaries may be palpable on pelvic examination in slim pre-menopausal women, but normal tubes cannot be felt. The term adnexa refers collectively to the ovary, tube and supporting tissues on one side of the pelvis. An adnexal mass felt on bimanual examination may represent an abnormality within the ovary or tube.

The ovaries have two primary functions; the production of gametes (ova) and the secretion of hormones, including oestrogen, progesterone, and testosterone. Increased hormonal secretions during puberty stimulate the growth of the uterus and its endometrial lining. They enlarge the vagina and thicken its epithelium. They also stimulate the development of secondary sex characteristics, including the breasts and pubic hair.

Parietal peritoneum extends downward behind the uterus to create the lowermost extension of the peritoneal cavity, called the pouch of Douglas (or rectouterine pouch, which lies between the uterus and the rectum. This anatomical area may be involved in various gynaecological conditions and can be palpated vaginally in the posterior fornix.

5 GTA GYNAECOLOGICAL EXAMINATION

The focus of GTA teaching is how to perform a normal gynaecological examination - specific gynaecology pathology will be covered in other part of the O&G curriculum.

Introduction

- Introduce yourself
- Ask your patient if she would like to be addressed by her surname or first name
- Ask if there are any questions/concerns that she would like to discuss before the examination, when she will be most able to communicate these
- Ensure verbal consent for a vaginal examination
- Women may bring along a support person but always offer a chaperone

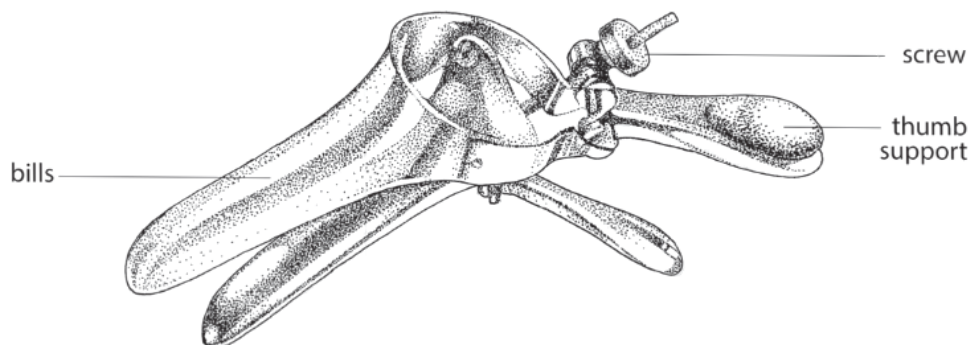
History

Talk with the woman when she is fully clothed in the consultation room. The patient's history needs to address these issues:

- abnormal bleeding
- post coital bleeding
- abnormal vaginal discharge
- possibility of pregnancy
- past cervical smear history

Asking the woman if she has had a pelvic/speculum examination before and, if so, what it was like, gives her an opportunity to express her feelings about the examination and helps alert you to potential problems and provide clues to making this one better. If she has not had a previous pelvic examination, show and explain use of closed speculum (*Figure 4*), which may also need to include a description of bimanual pelvic examination if this is also planned.

Figure 4: Bivalve (Cusco's) Speculum



Communication with women is of the utmost importance. Tell the woman what you are doing and name the structures you are touching using straightforward medical terms as a way of teaching her about her body. Keep in mind as you examine that you can communicate non-verbally as well as verbally.

Table 1: Communication points during the examination
<ul style="list-style-type: none"> • describe procedures as you perform them • encourage the woman to indicate any discomfort • encourage the woman to ask questions • maintain eye contact with the woman if appropriate for her • indicate when an individual procedure is complete • reassure that the anatomy is normal if this is so

Choice of words will help to reduce any associated anxiety about the examination:

Recommended

bills of the speculum
examine, palpate
examining table
foot supports/rests
collection of cells
relax or move knees apart
insert
discomfort, hurt
mass
slide down until you touch my hand

Not recommended

blades
feel
bed
stirrups
scraping sample (for smear)
spread your legs
stick
pain
tumour
move your bottom down

Cultural awareness: This is essential when undertaking vaginal examinations. For example, many women from central Africa have had female genital cutting or mutilation performed; for Maori women the genital organs are considered tapu, literally meaning sacrosanct, which is reflected by many Maori needing a trustful connection with the person performing the examination.

Preparation

- Offer the woman an opportunity to empty her bladder – pelvic examination is more comfortable with an empty bladder
- Ask her to get undressed, explaining exactly what clothing needs to be removed and providing a sheet/blanket for cover
- Pull the screen closed, or leave the room, to allow her to undress in private
- Give her sufficient time to get undressed, onto the bed and covered
- Ask if she is ready before re-entering the room or screened off area
- Introduce chaperone
- Assure her you will explain the procedure as you go along
- Agree with the woman that if she experiences discomfort physically or emotionally at any time during the examination, she is to ask you to stop.
- Discuss positioning in either dorsal lithotomy position or left lateral position. If there are no clinical requirements, the women may choose the position.
- Talk with her about the importance of relaxing the pelvic floor, which is assisted by slow deep breathing, to avoid discomfort during the examination
- Checking all equipment required is available before starting examination

Table 2: Equipment required to perform a gynaecology examination

- ✓ screened area or separate examination room for privacy
- ✓ access to a sink for hand washing and to warm metal speculum
- ✓ examination couch
- ✓ suitable light source
- ✓ sheet/blanket for cover during the examination
- ✓ variety of sizes and types of speculum (bivalve or Sim's)
- ✓ gloves (clean, sterile not required)
- ✓ lubrication gel
- ✓ sponge forceps/cotton wool swabs
- ✓ sanitary pads or liners (in case of bleeding)
- ✓ tissues for women to wipe away gel after examination
- ✓ clinical disposal bin

If performing smear and/or swabs:

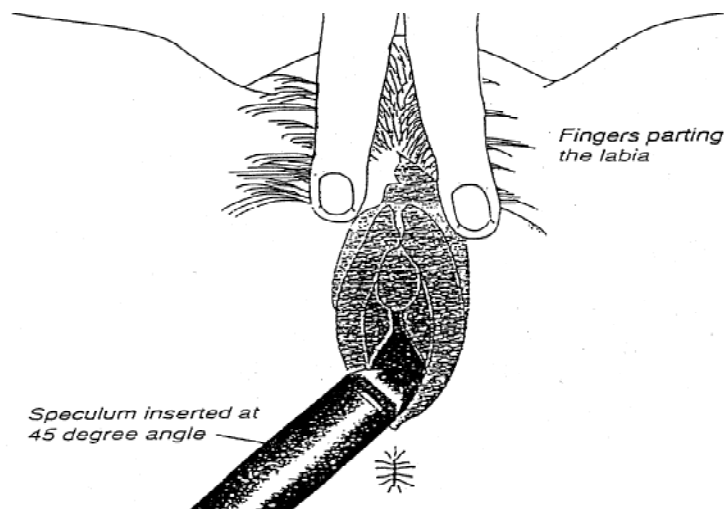
- ✓ spatula/cytobrush/cervibroom sampling device
- ✓ liquid based cytology container (Surepath or Thinprep)
- ✓ appropriate swabs

Do not continue with a pelvic examination that appears to be uncomfortable the patient. Ascertain any source of fear and reassure. Ask for assistance, or have someone more senior person perform the examination, if clinically essential at this visit. Otherwise, defer the examination.

Technique for Speculum Examination

- Complete hand washing
- Use clean gloves on both hands (sterile surgical gloves not required)
- Check that the patient is correctly and comfortably positioned - most women feel comfortable lying on their back and being asked to bend their knees, keep their heels together and allow their knees to relax to the sides
- Explain when the examination is beginning so that the woman is prepared for the first contact
- Inspect external genitalia – this may involve touching the labia to examine all the skin folds of the vulva
- Most speculums are now plastic and disposable- but if using a metal speculum, warm with tepid tap water
- Select an appropriately sized speculum (most clinical areas stock small, medium, long) -avoid verbalising this as this may cause unintentional offense to patient
- Most women require lubrication for speculum insertion - apply to the bills of speculum but away from the tip as may interfere with LBC smear sample.
- Before speculum introduction, part the labia using your left hand to visualise the introitus and ensure the labia are not pulled inwards
- Insert the closed speculum slowly and gently with your right hand, using a light downward and backward pressure to follow the contour of the vagina
- The orientation of the speculum during insertion is important to avoid contact with the urethra or clitoris (highly sensitive structures) (*Figure 5*)
- On insertion in the introitus, the speculum should be orientated obliquely at a 45 degree angle to avoid the urethra, then slowly rotate back to an almost horizontal position with full insertion to ensure the speculum is not pressing the clitoris
- Open the speculum bills slowly to locate the cervix
- Ensure the cervix is well visualised, then tighten speculum screw to secure position of speculum
- Inspect the cervix and undertake vaginal swabs or cervical smear as indicated
- Release speculum screw and withdraw the speculum a little to clear the cervix before releasing the bills and closing the speculum (you will need to keep your thumb on the thumb support to achieve this).
- Although it is difficult to examine the entire vagina, you may visualise the upper vaginal walls as you initially withdraw the speculum
- Remove the speculum with the bills completely closed in the oblique position to avoid contact with the urethra - if the bills stick, assist them to close
- Inform woman when the examination is completed, leave her to dress privately and offer tissues to wipe away excess lubricant
- When the woman is fully dressed, discuss the findings of the examination, whether normal or otherwise, and how the test results will be communicated
- Dispose of plastic speculum (or send any used metal speculum for sterilisation)

Figure 5: Insertion of the speculum



Tips for locating the cervix

- If the uterus is in a retroverted position, the cervix is located anteriorly. If you have difficulty finding such a cervix, withdraw the speculum slightly and angle further upwards.
- If cervix still cannot be viewed, remove the speculum and obtain cervical position by gentle vaginal examination (inform the women that you are going to do this).
- The left lateral position may enable better visualisation of the cervix, particularly if the woman is overweight or has vaginal prolapse.

6. TAKING A CERVICAL SMEAR

The cervical screening recommendations in New Zealand are well documented in 'Guidelines for Cervical Screening in New Zealand'. This is available from Canvas or can be downloading from: <https://www.nsu.govt.nz/health-professionals/national-cervical-screening-programme/cervical-screening-guidelines>

Although the efficiency of the cervical smear has never been tested in a prospective blinded study, there is ample evidence that it can contribute to the reduction of invasive cervix cancer in countries with an organised cervical screening programme. Health care providers can contribute to the effectiveness of such a programme by ensuring that:

- women are given the information about the need and frequency of a cervical smear
- the experience is comfortable and inclusive for the woman so that she feels positive about ongoing screening
- the sample is adequate
- the woman is aware of the results of her smear and when the next one is due

A smear may be taken during menstruation now that the National Screening Programme uses liquid based cytology (LBC) rather than slides. However, a women may wish to defer the test, especially if the bleeding is heavy or there is associated pelvic pain.

Technique (See *Table 3* and *Figure 6* for details of sampling devices):

- Complete speculum examination as described in section 5 (GTA Gynaecological Examination)
- If there is mucus covering the external os, use a cotton wool ball mounted on a sponge forceps holder to gently clean this away before smear taking
- If the transformation zone (TZ) is seen on inspection of the cervix, using either a cervibroom or plastic spatula will usually ensure adequate sampling.
- The cervibroom needs to be rotated *clockwise* several times in the external os
- The plastic spatula should be rotated one full 360° around the external os
- If the TZ is not seen, a cervibrush is ALSO required (see *Figure 7*)
- Place sampling device immediately in the LBC liquid and agitate the device to release the sampled cells
- There are two types of LBCs. If using Surepath LBC then it is **appropriate** to break off the head of the sampling device into liquid- Remember “Surepath = snap it off”
- If using Thinprep LBC then do **not** break off the heads of the sampling device into liquid.
- If there has been contact bleeding from the cervix with taking the smear sample, inform the women and offer her a sanitary pad/liner
- Discuss how she will be informed of her smear result and when her next smear is due

Table 3: Smear sampling devices and types of LBC liquid

<i>Cervibroom</i>	Most commonly used sampling device Rotate a few times around clockwise in the endocervix Can be used to take smear when transformation zone (TZ) seen or not seen
<i>Plastic Spatula</i> (do not use wooden for LBC)	Rotate 360° in cervix. Do not allow to sit in the liquid as cells can get fixed to spatula Can be used alone if TZ seen. If TZ not seen, also need to use cytobrush
<i>Cytobrush</i>	Use in conjunction with spatula if TZ not seen (do spatula first) Rotate once in cervix and deposit sample in same LBC liquid. Do not use if women is pregnant
<i>Type of LBC</i> (Thinprep and Surepath)	There are two types of LBC used in New Zealand. If using Surepath LBC then break off the head of the sampling device into liquid- remember <u>“Surepath = snap it off”</u> . If using Thinprep LBC do not break off head of sampling devices into liquid

Figure 6: Sampling Devices

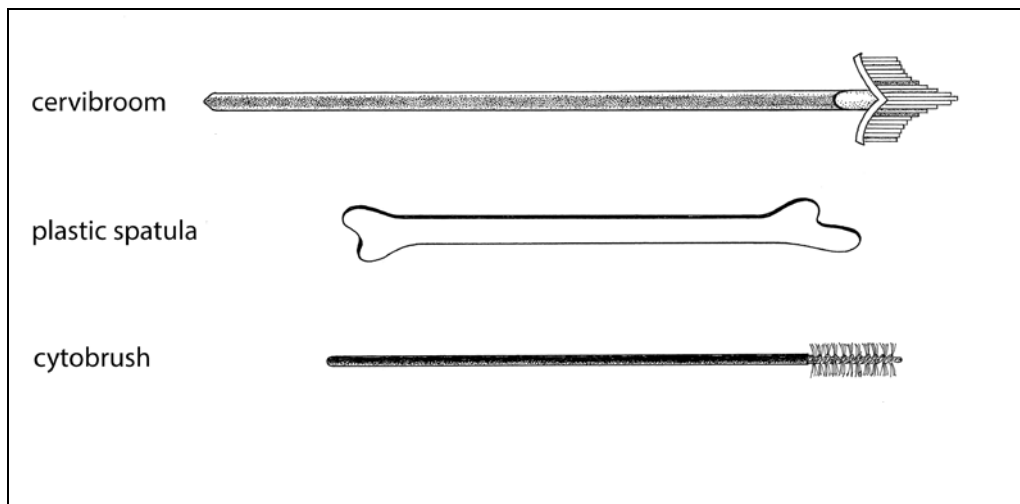
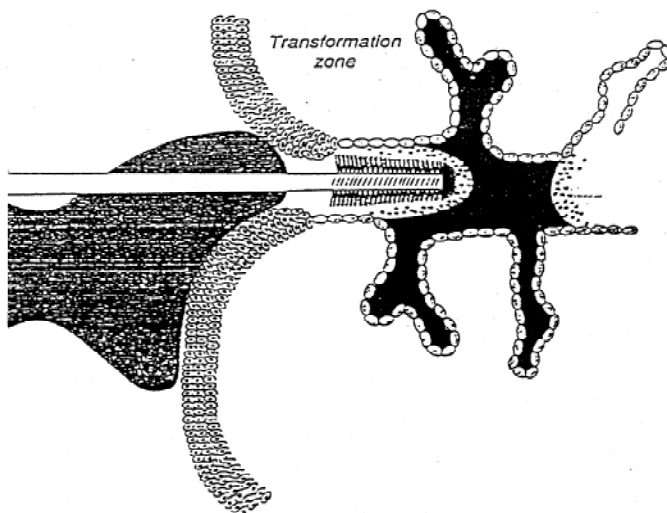


Figure 7: Diagram to show the regions from which cells are taken



- The cervibroom should be rotated a full 360° inside the cervical canal.

7. OBTAINING THE IDEAL SMEAR

For a smear to have maximum diagnostic value it must contain cervical epithelial cells sampled from the transformation zone (TZ) where most cervical cancers develop. The presence of endocervical cells may indicate a well taken smear, but should not be used as the sole criterion of a satisfactory sample. An adequate smear is one containing sufficient numbers of well-preserved epithelial cells, appropriate for the women's age and hormonal status.

Transformation zone

Prior to puberty the ectocervix, which protrudes into, and is continuous with the vagina, is covered by stratified squamous epithelium. The cervical canal, or endocervix, is covered by columnar epithelium. The squamocolumnar junction (SCJ) is the point where the two epithelial types coincide, with the original SCJ location at the external cervical os. During puberty the cervix enlarges, causing eversion of the glandular epithelium from the cervical canal onto the ectocervix. Due to the lower pH of the vagina, the exposed endocervical cells undergo metaplastic change to squamous epithelium, producing a transformation zone at the new SCJ. On speculum examination, the protuberant endocervical mucosa surrounding the external os appears granular, as there are many fine papillae present, and red because the columnar epithelium is one cell thick with prominent blood vessels. This appearance of the everted endocervical mucosa is termed 'ectropion'.

Liquid Based Cytology

The National Screening programme changed in 2009 to Liquid Based Cytology (LBC). This was because LBC results in less inadequate smears than traditional glass slides.

However, inadequate smears may still occur due to the following:

- Cellular degeneration and/or sparsity– this can be seen in women using Depot contraception (low oestrogen effect) or in postmenopausal women. A repeat smear should be performed within 5 days of finishing a short course of vaginal oestrogen.
- If there is a significant vaginal infection, the inflammatory cells and exudate may obscure the epithelial cells. A repeat smear after treatment of the infection may be required.

The accuracy of a cervical smear

The cervical smear is not an absolutely accurate diagnostic test it is essential that regular tests are performed. Furthermore, the clinical appearance of the cervix should be taken into account when deciding on a smear result. If an invasive lesion is suspected or the cervix is clinically abnormal it is essential to seek a specialist opinion.

The cervical screening register

The smear taker needs to inform the woman that unless she signs an 'opt out' form, her name will automatically be entered on the register when her smear is sent to the laboratory. The register will inform both the woman and her smear taker of results of her smear and the due date for her next smear.

8. TAKING VAGINAL SWABS

A summary of the recommended sexual health check for symptomatic and asymptomatic women is available from: <http://www.nzshs.org/docman/guidelines/principles-of-sexual-health-care/146-sexual-health-check/file>

Be really clear about the site from which swabs need to be taken (*Table 4*). When in doubt, check with your local laboratory as different DHBs may have different types and colours of swabs. A vulvo-vaginal swab (VVS) is more sensitive than an endocervical swab for a

chlamydia/gonorrhoea NATT test. If the woman needs a speculum examination a VVS is more easily done before speculum insertion which allows swab sampling from the vulva and periurethral areas.

Table 4: Types of vaginal swabs

<i>High Vaginal Swab</i>	Taken from posterior fornix in mid vagina. Tests for candida and bacterial vaginosis (BV). The community lab will only test for BV if woman is symptomatic or pre TOP. If no speculum is required, this can be a self-taken swab by the patient (<i>see Appendix 1</i>)
<i>Endocervical swab for gonorrhoea (GC) culture</i>	No longer routine for asymptomatic women. May be requested if there are clinical signs of gonorrhoea or if sexual contact with positive gonorrhoea case
Vulvo vaginal swabs (VVS) for Nucleic acid amplification test (NAAT)	<i>Tests for chlamydia, gonorrhoea and trichomonas vaginalis (TV). The community lab will only routinely test for TV when requested and for those with positive gonorrhoea.</i> VVS can be done by the doctor or self-taken (<i>see Appendix 1</i>).

9. PERFORMING A BIMANUAL VAGINAL EXAMINATION

If a smear or swabs are required, a bimanual examination should be performed after these are taken.

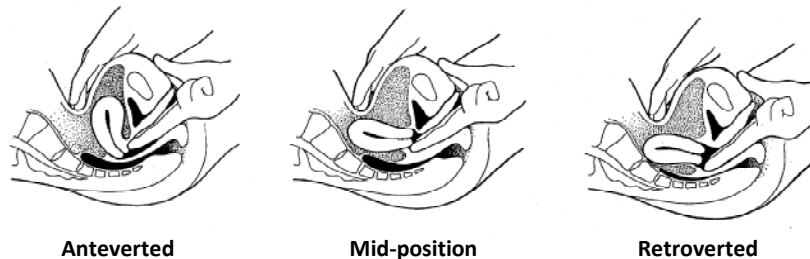
- Use clean gloves on both hands (sterile surgical gloves not required)
- Check that the patient is correctly and comfortably positioned
- Explain when the examination is beginning so that the woman is prepared for the first contact
- Inspect external genitalia
- Lubricate first two fingers of gloved hand that will be internally examining (a one finger examination may be required if small introitus or postmenopausal)
- Part labia with the other hand (inform woman that you are going to do this)
- Gently insert fingers obliquely into vagina, following the downwards and backwards direction of the vagina
- Palpate surface of cervix for any focal lesions or irregularities
- Palpate vaginal walls for masses
- Place your fingers in the posterior vaginal fornix and move the cervix gently whilst watching the woman's face for signs of discomfort
- Movement of the cervix is an uncomfortable sensation, but if pain is elicited, this is termed cervical excitation and is a sign of pelvic inflammatory disease or ectopic pregnancy
- With the internal fingers in the posterior fornix (or if not possible, place fingers against the posterior portion of the cervix), palpate the uterus bimanually between your internal fingers and your external hand on woman's lower abdominal wall

- Use the bimanual technique with gentle pressure to assess the uterus for size, shape, mobility and position (*Figure 8*)
- Assessment of uterus size relies on palpation of the uterine fundus, measured as centimetres above the pelvic rim (as with pregnancy)
- Palpate each adnexal regions for masses and/or tenderness by moving internal fingers into the lateral vaginal fornix and sweeping external hand on the lower abdomen down toward vaginal fingers, keeping gentle pressure directed towards perineum
- Inform woman when the examination is completed, leave her to dress privately and offer tissues to wipe away excess lubricant
- When the woman is fully dressed, discuss the findings of the examination, whether normal or otherwise

Tips for assessing uterine position

- A normal anteverted uterus may not be palpable in an obese women or if there is a poor relaxation of the abdominal wall
- If you cannot feel the uterus, the uterine body may be tilted backwards with the cervix (retroverted) or the uterine body may be angled backwards with the cervix in the usual position (retroflexed)- slide your internal fingers into the posterior fornix and feel for the uterus butting against your fingertips

Figure 8: Position of the uterus



Retroversion of the uterus is a common variant occurring in about 1 in 5 women. Early clues on pelvic examination are a cervix that faces upwards and forward and a uterine body that cannot be felt by the abdominal hand. A retroverted uterus is usually mobile and asymptomatic. A retroverted uterus that is fixed and immobile is due to scarring from conditions such as endometriosis or pelvic inflammatory disease.

10. EXAMINATION IN LEFT LATERAL POSITION

The left lateral position (*Figure 9*) is commonly used for assessing vaginal prolapse using a Sim's speculum (*Figure 10*). However, it may also be used with the bivalve speculum as per the patient's preference or if there is difficulty locating the cervix in a dorsal position

Technique:

- The patient needs to lie on their left side
- Ask patient to slide their lower back to the edge of the examination couch whilst keeping their head on the pillow and allowing their left arm to drop back
- Roll their right shoulder away - this allows abdominal contents to fall away from the area of examination
- The patient is now positioned obliquely at a 45° angle across the examination couch
- The uppermost leg is flexed more than the lower leg, and may need to be lifted by patient/chaperone to allow vaginal examination

Figure 9: Left Lateral Position



Figure 10: Sim's Speculum



APPENDIX 1- Technique for vaginal self- swabs

How to do your vaginal swab

1. Getting ready:

- Wash and dry your hands first.
- The swab is in a plastic tube with your details on it.

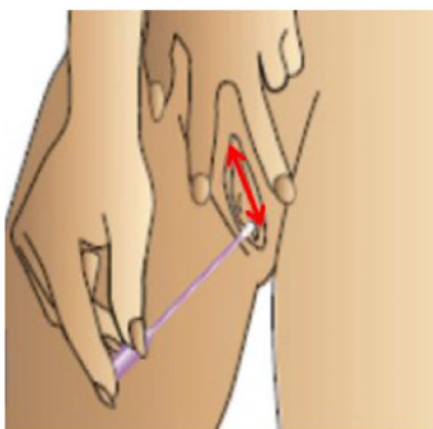
2. How to hold the swab:

- Hold the purple top of the swab & take it out of the tube.
- Only touch the purple top of the tube. Ask for a new swab if you touch any other part of the swab or drop the swab.



3. Taking the sample:

- Gently rub the swab around the upper part of the entrance to the vagina a couple of times. See red arrow in the diagram below.
- Then insert the swab a thumbs length (4 to 5cm) into the vagina.
- Rotate the swab inside the vagina, making sure it touches the vaginal wall for 5 seconds (count to 5 slowly).
- Carefully pull the swab out.



4. To finish off:

- Put the swab back in the tube.
- Wash and dry your hands.
- Return the swab to the clinician.



Adapted with permission from Leeds Centre for Sexual Health
by Auckland Sexual Health Service www.ashs.org.nz