



Australian Government

**Australian Institute of
Health and Welfare**

National Cervical Screening Program Data Dictionary

Version 1.0

**National Cervical
Screening Program**

A joint Australian, State and Territory Government initiative

CANCER SERIES NO. 103



Australian Government

**Australian Institute of
Health and Welfare**

*Authoritative information and statistics
to promote better health and wellbeing*

CANCER SERIES

Number 103

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Australian Institute of Health and Welfare
Canberra

Cat. no. CAN 102

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This publication is part of the Australian Institute of Health and Welfare's Cancer series. A complete list of the Institute's publications is available from the Institute's website www.aihw.gov.au.

ISSN 2205-4855 (PDF)

ISBN 978-1-76054-085-2 (PDF)

Suggested citation

Australian Institute of Health and Welfare 2017. National Cervical Screening Program data dictionary: Version 1.0. Cancer series no. 103. Cat. no. CAN 102. Canberra: AIHW.

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Published by the Australian Institute of Health and Welfare

This publication is printed in accordance with ISO 14001 (Environmental Management Systems) and ISO 9001 (Quality Management Systems). The paper is sourced from sustainably managed certified forests.



Please note that there is the potential for minor revisions of data in this report. Please check the online version at www.aihw.gov.au for any amendments.

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Acknowledgments

The *National Cervical Screening Program Data Dictionary version 1.0* was prepared by Alison Budd, Biljana Tanevska and Natasha Bartlett of the Australian Institute of Health and Welfare (AIHW), with assistance from state and territory cervical screening programs, the National Cervical Screening Program data dictionary working group, and from cervical screening experts on behalf of the National Cervical Screening Program (NCSP).

The National Cervical Screening Program data dictionary working group was comprised of state and territory cervical screening program representatives Nerida Steel, Peter Couvee, Hansen Sun, Chehani Alles, Flora Ding, Scott Marshall, Stacey-Mae Prokopyszyn, Robert Henderson, Duane Pearce, Jacek Gonsalves, and Chrissy Fletcher; Commonwealth Department of Health representatives Alison Lang and Siobhan Mealing; and AIHW representatives Alison Budd and Biljana Tanevska.

Additional input into specific elements of the data dictionary was provided by the NCSP Quality and Safety Monitoring Committee, the Colposcopy Working Group convened to progress the collection and reporting of colposcopy data in the new NCSP, and cervical screening experts Professor Ian Hammond, Associate Professor Marion Saville, Dr Julia Brotherton, Professor David Roder and Professor Dorota Gertig.

Thanks are extended to all these individuals for their assistance.

The financial support and professional assistance of the Screening Policy Section, Cancer and Palliative Care Branch, Population Health and Sport Division of the Australian Government Department of Health is also gratefully acknowledged.

Version

The current data dictionary is Version 1.0, endorsed by the Standing Committee on Screening in February 2017 and released by the AIHW on 25 May 2017.

Abbreviations

ABS	Australian Bureau of Statistics
ACD	Australian Cancer Database
AIHW	Australian Institute of Health and Welfare
AIS	adenocarcinoma in situ
CIN	cervical intraepithelial lesion
HPV	human papillomavirus
HSIL	high-grade squamous intraepithelial lesion
LSIL	low-grade squamous intraepithelial lesion
NCSP	National Cervical Screening Program
NHMRC	National Health and Medical Research Council

1 Introduction

1.1 A new National Cervical Screening Program

In 2014 the Medical Services Advisory Committee (MSAC) recommended that the National Cervical Screening Program (NCSP) adopt human papillomavirus (HPV)-based screening at 5-yearly intervals. This heralded a major change to cervical screening in Australia, since women have been screened for cervical abnormalities and cancer using the Pap test – whether on an ad hoc basis prior to the introduction of the NCSP, or every 2 years as has been recommended by the NCSP since it commenced in 1991.

Behind this change are many developments over the past two decades that mean that the environment in which the NCSP operates is very different from what existed in 1991. The main driver has been a greater understanding of the natural history of cervical cancer and the role HPV infection plays in this disease, as this has led to an examination of the optimal screening age range and interval internationally; the development of methods to test for the presence of HPV, and subsequently, a vaccine against HPV and the introduction of the National HPV Vaccination Program in 2007. By protecting vaccinated women from infection with the high-risk HPV types 16 and 18, the vaccination program is expected to reduce the number of cervical abnormalities and eventually the incidence of cervical cancer, which will affect both the effectiveness and cost-effectiveness of the current NCSP. Thus it was recognised that the NCSP would need to change to adapt to this different environment while continuing to operate according to current evidence and best practice.

In light of this, in 2011 the former Australian Population Health Development Principal Committee of the Australian Health Ministers' Advisory Council (AHMAC) endorsed a plan to renew the NCSP ('the Renewal'), which commenced in 2011, undertaken by the Standing Committee on Screening and supported by the Department of Health. The aim of the Renewal is to ensure that all Australian women, HPV-vaccinated and unvaccinated, have access to a cervical screening program that is safe, acceptable, effective, efficient and based on current evidence (MSAC 2014).

On 28 April 2014 the Medical Services Advisory Committee (MSAC) announced its recommendations for a new NCSP. These recommendations include 5-yearly cervical screening of HPV-vaccinated and unvaccinated women aged 25–69, using a primary HPV test with partial HPV genotyping and reflex liquid-based cytology (LBC) triage, followed by exit testing of women aged 70–74 (MSAC 2014). This is a major change from the current program, which recommends 2-yearly cervical screening using Pap tests for HPV-vaccinated and unvaccinated women from 18 to 20 years (or 1 or 2 years after first having sexual intercourse, whichever is later) to 69 years.

These recommendations were accepted by the Australian Government in May 2015, with the new NCSP currently scheduled to commence on 1 December 2017.

1.2 Role of the National Cervical Screening Program data dictionary

These major changes to the NCSP require that all documents and procedures that support the NCSP, including methods of monitoring the performance, quality and safety of the NCSP, are updated to reflect the new screening and management pathway.

This new data dictionary is a key document that has been developed to support monitoring and reporting for the new NCSP, although it has been recognised that this document will support the new NCSP and its operation more broadly.

The data dictionary also plays a major role in ensuring consistency in data collection for the NCSP. Previously, cervical screening data were collected and held in state and territory cervical screening registers. Under the new NCSP, data will have either been retained in a state or territory cervical screening register, or migrated to a new National Cancer Screening Register (NCSR) that also includes the National Bowel Cancer Screening Program Register. It is therefore important to ensure that national data continue to be reported consistently.

As the primary purpose of this data dictionary is to support monitoring and reporting by the Australian Institute of Health and Welfare for the new NCSP, only key data items required for this purpose, along with selected others considered important to support the new NCSP more broadly are included in this data dictionary. Many more data items exist on jurisdictional cervical screening registers and the NCSR such as operational data items required for the day-to-day running of a register that are not included in this data dictionary.

1.3 Development and endorsement of the National Cervical Screening Program data dictionary

The National Cervical Screening Program data dictionary was developed by the AIHW with the assistance of state and territory cervical screening programs, and the National Cervical Screening data dictionary working group, convened specifically for this purpose.

This working group was comprised of state and territory cervical screening program representatives Nerida Steel, Peter Couvee, Hansen Sun, Chehani Alles, Flora Ding, Scott Marshall, Stacey-Mae Prokopyszyn, Robert Henderson, Duane Pearce, Jacek Gonsalves, and Chrissy Fletcher; Commonwealth Department of Health representatives Alison Lang and Siobhan Mealing; and AIHW representatives Alison Budd and Biljana Tanevska.

Additional input into specific elements of the data dictionary was provided by the NCSP Quality and Safety Monitoring Committee, the Colposcopy Working Group convened to progress the collection and reporting of colposcopy data in the new NCSP, and cervical screening experts Professor Ian Hammond, Associate Professor Marion Saville, Dr Julia Brotherton, Professor David Roder and Professor Dorota Gertig.

Following a lengthy development process alongside other key documents including the clinical management guidelines, quality framework, a form for the collection of colposcopy data, and NPAAC standards for pathology laboratories reporting cervical screening tests, the data dictionary was endorsed by the Standing Committee on Screening in February 2017.

2 Technical aspects

2.1 Data item specifications

The data items in the National Cervical Screening Program data dictionary are described and defined using a standard metadata format that is designed to ensure that each data item is clear, concise, unambiguous, comprehensive and provides sufficient information to ensure all those who collect, provide, analyse and use the data understand its meaning.

The format is consistent with that of AIHW's Metadata Online Registry (METeOR), which would allow these items to be imported into METeOR in the future.

Identifying and definitional attributes

Identifying and definitional attributes include the name and definition of the data item, as well as its collection status within the NCSP. Collection status reflects the importance of the data item to the collection, and can be Essential, Desirable or Aspirational. There are also Conditional data items, whose inclusion depends on criteria for this data item being met.

Value domain attributes

Representation class refers to the form of the data item, such as identifier, text, date or code. The data type refers to the type of symbol, character or other designation used to represent the data item (for example, string, date/time, number, text), and the format and character length describe how the value should appear for that data item.

Formats can be alphabetic character (denoted by the letter A), numeric (denoted by the letter N) alphanumeric (denoted by the letter X), or specific to dates (D for day, M for month, Y for year). Characters that are not in brackets denote a value that must be represented. Round brackets are used to indicate the number of repeats if a character is repeated more than 6 times in succession (X(9) indicates 9 alphanumeric characters). Square brackets are used to indicate that characters are optional in any ordered combination ([XXX] indicates 0, 1, 2 or 3 alphanumeric characters). Curly brackets are used to indicate that characters are entirely optional (X{XX} indicates 1 or 3 alphanumeric characters).

Value domain format examples

- X(10) – No square/curly brackets, therefore exactly 10 alphanumeric characters must be entered.
- {X(10)} – Curly brackets, therefore optional with fixed length. Either 0 or exactly 10 alphanumeric characters must be entered.
- [X(10)] – Square brackets, therefore optional with variable length – either 0 or between 1 to 10 alphanumeric characters entered.
- X[X(39)] – At least 1 alphanumeric character is required (an X is outside any square/curly brackets) and optionally supports an additional 0 to 39 alphanumeric characters, which means the maximum total length is 40 alphanumeric characters.
- {N(10)[N]} – Curly brackets, therefore optional with fixed length. Either 0 or 10 numeric characters with a further optional single numeric character entered. This allows for 0, 10 or a maximum of 11 numeric characters.
- {AAX[XXX]} – Curly brackets, therefore optional with fixed length. Either 0 or 2 alphabetic characters followed by a single alphanumeric character with a further

optional 0 to 3 alphanumeric characters allowed. This allows for 0, 3, 4, 5 or a maximum of 6 characters (2 alphabetic, and 4 alphanumeric). If only 3 characters are entered, then they must be 2 alphabetic followed by 1 alphanumeric.

See tables 2.1 and 2.2 for further examples of the use of codes and brackets.

Collection and usage attributes may be included to ensure that data are captured correctly and to aid in the correct interpretation of permissible values.

Data item attributes

This section of the data item may also include a guide for use, which takes the form of additional comments or advice on interpretation or application, and collection methods, which are comments and advice concerning the capture of data for a particular data item.

Additional information relates to source, reference documents, as well as an indication of whether this is a new data item, or whether it supersedes a data item in the previous National Cervical Cancer Prevention data dictionary version 1 (AIHW 2014).

Table 2.1: Data item format – codes

Code	Definition	Description	Example
A	Alphabetic	Supports letter characters (including punctuation) only (that is, no numbers)	AAA = ABC not A1C
N	Numeric	Supports numeric digits only (that is, no alphabetic characters)	NNN = 123 not 1B3
X	Alphanumeric	Supports both alphabetic characters (including punctuation) and numeric digits	XXX = ABC or 123 or A1C or 1B3
D	Day	Date specific: day number within a month. Represented as DD in DDMMYYYY date format	23rd day of August 2013 <u>23</u> 082013
M	Month	Date specific: month number within a year. Represented as MM in DDMMYYYY date format	8th month of 2013 23 <u>08</u> 2013
Y	Year	Date specific: year number. Represented as YYYY in DDMMYYYY date format.	2013th year 2308 <u>2013</u>

Table 2.2: Data item format – use of brackets

Bracket type	Description	Example	Notes
No square or curly brackets	Characters must be entered in the format presented. <i>Note:</i> number in round brackets () represents characters repeated 7 or more times in succession.	AAA	Exactly 3 alphabetic characters
		NN	Exactly 2 numeric characters
		X(8)	Exactly 8 alphanumeric characters
Curly brackets /braces { }	Characters are optional, but if entered, they are fixed in length and must match exactly the format presented.	{AAA}	0 or exactly 3 alphabetic characters
		{NN}	0 or exactly 2 numeric characters
		{X(8)}	0 or exactly 8 alphanumeric characters
Square brackets []	Characters are optional, but if entered are variable in length up to the maximum length designated	[AAA]	Either 0, 1, 2 or 3 alphabetic characters
		[NN]	Either 0, 1 or 2 numeric characters
		[N(8)]	Either 0, 1, 2, 3, 4, 5, 6, 7 or 8 numeric characters

2.2 Terminology

The change in primary screening test for the NCSP from a Pap test to an HPV test with partial genotyping and reflex LBC has led to the introduction of new terminology and new concepts. Here, the more important terms and concepts have been defined.

Cervical screening: This term describes the process of screening for the prevention of cervical cancer. The term 'HPV screening' should not be used.

Cervical Screening Test (CST): The agreed term to describe the screening test of the NCSP, which is an HPV test.

Follow-up episode: Is a term that encompasses a **follow-up HPV test** (repeat HPV test after negative or pLSIL/LSIL reflex LBC) and an LBC if this is required.

HPV: This term is used to indicate oncogenic HPV (otherwise known as high-risk HPV), which are the types of HPV associated with cervical cancer.

HPV types: HPV types should be referred to as **oncogenic** or **non-oncogenic** and not high risk and low risk. This is to avoid confusion with the risk of significant cervical abnormality.

HPV test: Performed as part of the screening round to test for the presence of oncogenic HPV types; this is defined as either a **screening HPV test** when it is part of the screening episode, or a **follow-up HPV test** if it is performed 12 months after the screening episode (this is also sometimes referred to as a repeat HPV test).

HPV test result: An HPV test result will be reported as **detected** or **not detected** in line with molecular testing terminology (where detection levels are based on a set threshold) rather than HPV positive or HPV negative. The HPV test result groupings are:

- HPV 16/18 detected
- Oncogenic HPV (not 16/18) detected
- Oncogenic HPV not detected
- Unsatisfactory (test cannot be performed due to technical reasons).

Reflex test: LBC test following an HPV test that detected oncogenic HPV.

Risk of significant cervical abnormality: There are three risk classifications:

- women who are classified at **low risk** will be invited to re-screen in five years
- women who are classified at **intermediate risk** will be invited to have another HPV test in 12 months. This is to check that the HPV infection has cleared. This second HPV test is a **follow-up test**, not a screening test because women at intermediate risk are not at average population risk
- women classified at **higher risk** will be referred directly to colposcopy for further investigation.

Screening episode: Is a term that encompasses a primary screening HPV test and an LBC if this is required.

Screening round: Covers the entire screening pathway for a woman from her primary HPV test through to a final screening outcome; a screening round is only completed when a woman returns to routine 5 yearly screening or has a diagnosis of a cervical abnormality that requires treatment or cervical cancer.

Self-collected sample: A vaginal sample taken by a woman, under supervision of her healthcare professional.

3 Data items

3.1 Structure of data items

The following table provides an overview of the data items in this version of the National Cervical Screening Program data dictionary. It also maps current data items to their previous number, where data items have been retained across the versions.

Data items are arranged into two main groups – Client data items which either do not change or do not change very often, and screening pathway data items that will be added to a woman’s record each time she screens. This is illustrated in Table 3.1.

Table 3.1: Data item structure

	<i>Associated groups</i>
<i>Client</i>	Group A: Client identifier data items Group B: Client data items Group C: Client status data items Group D: Client vaccination status data items Group E: Client demographic data items
<i>Screening pathway</i>	Group F: Contact data items Group G: Test type data item Group H: HPV test data items Group I: Cytology test data items Group J: Screening episode data items Group K: Colposcopy data items Group L: Histology test data items Group M: Treatment data items Group N: Provider data items Group O: Pathology laboratory data items Group P: Screening history data items

3.2 Summary of data items

The following table provides a summary of the data items in the data dictionary. To aid in transition from the previous version of the data dictionary to this version, the number of each data item is shown alongside the number in the previous data dictionary. Where there is no number shown for 'previous', this indicates that the data item is new.

Table 3.2: Summary of data items

Client			
Group A	Client Identifier data items	Current	Previous
	Client identifier	A1	A1
	Previous client identifier	A2	..
	Medicare card number	A3	A2
	Individual healthcare identifier	A4	A3
Group B	Client data items		
	Family name	B1	A4
	Given name	B2	A5
	Other given names	B3	..
	Date of birth	B4	A7
	Sex	B5	..
	Indigenous status	B7	A8
	Country of birth	B8	A10
	Main language other than English spoken at home	B9	A9
	CALD status	B10	..
Group C	Client status data items		
	Active status	C1	A23
	Reason for temporary inactivation	C2	..
	Date of temporary inactivation	C3	..
	Date of reactivation	C4	..
	Withdrawn date	C5	..
	Withdrawn rescinded date	C6	..
	Hysterectomy flag	C7	A21
	Date of hysterectomy	C8	A22
	Death flag	C9	A24
	Date of death	C10	A25
Group D	Client vaccination status data items		
	HPV vaccination status	D1	V2
	HPV vaccination completion date	D2	V3
	HPV vaccination episode date	D3	V4
	HPV vaccine dose number	D4	V5
	HPV vaccine type	D5	V1

Group E Client demographic data items			
Residential address	E1	A11	
Residential suburb/town/locality	E2	A12	
Residential alternative or other names for suburb/town/locality	E3	A13	
Residential Australian state/territory	E4	A14	
Residential Australian postcode	E5	A15	
Residential geocode—latitude	E6	..	
Residential geocode—longitude	E7	..	
Residential geocode—quality	E8	..	
Residential SA1	E9	..	
Mailing geocode—latitude	E10	..	
Mailing geocode—longitude	E11	..	
Mailing geocode—quality	E12	..	
Mailing SA1	E13	..	
Screening pathway			
Group F Contact data items			
Type of contact	F1	..	
Date of contact	F2	..	
Method of contact	F3	..	
Contact failure flag	F4	..	
Contact failure date	F5	..	
Contact failure type	F6	..	
Group G Test type data item			
Type of test	G1	T1	
Group H HPV test data items			
HPV test date	H1	D2	
HPV test collection method	H2	..	
HPV test specimen site	H3	..	
Reason for HPV test	H4	..	
HPV test result—oncogenic HPV	H5	D5	
Secondary HPV test result—HPV 16/18 detected	H6	..	
Secondary HPV test result—oncogenic HPV (not 16/18) detected	H7	..	
HPV test type	H8	D6	
HPV test sample	H9	..	
HPV test batch information—Control kit lot number	H10	..	
HPV test batch information—Control kit expiry date	H11	..	
HPV test batch information—Cellular (LBC) extraction kit lot number	H12	..	
HPV test batch information—Cellular (LBC) extraction kit expiry date	H13	..	
HPV test batch information—Nucleic acid extraction kit lot number	H14	..	
HPV test batch information—Nucleic acid extraction kit expiry date	H15	..	

	HPV test batch information—Amplification kit lot number	H16	..
	HPV test batch information—Amplification kit expiry date	H17	..
	HPV test batch information—Detection kit lot number	H18	..
	HPV test batch information—Detection kit expiry date	H19	..
	HPV test batch information—Wash buffer lot number	H20	..
	HPV test batch information—Wash buffer expiry date	H21	..
Group I	Cytology test data items		
	Cytology test date	I1	C2
	Cytology test specimen type	I2	C4
	Cytology test specimen site	I3	C3
	Reason for cytology test	I4	..
	Cytology test squamous cytology cell analysis	I5	C5
	Cytology test endocervical (glandular) cytology cell analysis	I6	C6
	Cytology test other/non-cervical cytology cell analysis	I7	C7
	Cytology test result	I8	C9
Group J	Screening episode data items		
	Primary screening episode commencement date	J1	..
	Primary screening episode completion date	J2	..
	Primary screening episode result	J3	..
	Primary screening episode risk of significant cervical abnormality	J4	..
	Primary screening episode recommendation	J5	..
	Follow-up episode commencement date	J6	..
	Follow-up episode completion date	J7	..
	Follow-up episode result	J8	..
	Follow-up episode risk of significant cervical abnormality	J9	..
	Follow-up episode recommendation	J10	..
Group K	Colposcopy data items		
	Colposcopy episode identifier	K1	..
	Date of colposcopy episode	K2	..
	Indication for colposcopy	K3	..
	Indication for colposcopy—other indication free text	K4	..
	General colposcopic assessment—adequacy	K5	..
	General colposcopic assessment—transformation zone visibility	K6	..
	Colposcopic impression—primary diagnosis	K7	..
	Colposcopy impression—other finding free text	K8	..
	Biopsy this episode	K9	..
	Pregnancy flag	K10	..
Group L	Histology test data items		
	Histology test date	L1	H2
	Histology test specimen site	L2	H3

	Procedure used for obtaining specimen for histological analysis	L3	H4
	Squamous histology cell analysis	L4	H5
	Endocervical (glandular) histology cell analysis	L5	H6
	Other/non-cervical histology cell analysis	L6	..
	Histology test result	L7	H9
	Histology stain	L8	..
	Histology stain result	L9	..
Group M	Treatment data items		
	Treatment this episode	M1	..
	Treatment date	M2	..
	Excision performed this episode	M3	..
	Modality/method used for excision	M4	..
	Ablation performed this episode	M5	..
	Hysterectomy	M6	..
	Treatment anaesthetic type	M7	..
	Location of service	M8	
	Eligible for test of cure flag	M9	..
	Eligible for test of cure date	M10	..
	Test of cure completion flag	M11	..
	Test of cure completion date	M12	..
Group N	Provider data items		
	Medicare provider number	N1	B1
	Healthcare provider identifier—organisation (HPI-O)	N2	B3
	Healthcare provider identifier—individual (HPI-I)	N3	B2
	Provider type	N4	..
	Provider Australian state/territory	N5	B10
	Provider Australian postcode	N6	B11
	Identifier of a provider collecting specimen	N7	B13
	Healthcare provider identifier—organisation (HPI-O) of a provider collecting specimen	N8	B15
	Healthcare provider identifier—individual (HPI-I) of a provider collecting specimen	N9	B14
	Type of provider collecting specimen	N10	B12
Group O	Pathology laboratory data items		
	Pathology laboratory identifier	O1	L1
	Pathology laboratory name	O2	..
	Pathology laboratory accession number/identifier	O3	C1
Group P	Screening history data items		
	Previously screened flag	P1	..
	Date of last screening test	P2	..
	Last screening test type	P3	..
	Number of days since last screening test	P4	..

3.3 Data items

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- A4 Individual healthcare identifier20
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Group A: Client identifier data items

- A1 Client identifier
- A2 Previous client identifier
- A3 Medicare card number
- A4 Individual healthcare identifier

A1 Client identifier

Identifying and definitional attributes

<i>Data item name</i>	Client identifier
<i>Definition</i>	Client identifier unique within the state and territory cervical screening register or the National Cancer Screening Register.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Identifier
<i>Data type</i>	String
<i>Format</i>	X[X(19)]
<i>Maximum character length</i>	20

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	This data item is used to uniquely identify women who participate in cervical screening within a screening register; either a state or territory cervical screening register or the National Cancer Screening Register.
<i>Collection methods</i>	Assigned by the state or territory cervical screening register or the National Cancer Screening Register.

Relational attributes

<i>Related metadata reference</i>	Supersedes National cervical cancer prevention data dictionary Version 1, Data element A1 Woman—client identifier, identifier X[X(19)]
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A2 Previous client identifier

Identifying and definitional attributes

<i>Data item name</i>	Previous client identifier
<i>Definition</i>	Client identifier unique within the state or territory cervical screening register from which the record has been transferred.
<i>Collection status</i>	Conditional

Value domain attributes

<i>Representation class</i>	Identifier
<i>Data type</i>	String
<i>Format</i>	[X(20)]
<i>Maximum character length</i>	20

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	<p>This data item only applies to clients who have been migrated from a state or territory cervical screening register to the National Cancer Screening Register.</p> <p>Therefore, it only applies to 'legacy clients' within the National Cancer Screening Register, and not to new clients within the National Cervical Screening Register, or to state and territory cervical screening registers.</p>
<i>Collection methods</i>	<p>When the National Cancer Screening Register migrates women from a state or territory cervical screening register, it is important that the client identifier as it appeared on that register is also migrated.</p> <p>There needs to be the capacity to collect more than one A2 for an individual in the National Cancer Screening Register, as there will be women who appear on more than one state or territory cervical screening register that will be migrated to a single entry in the National Cancer Screening Register, either because a single record was sent by pathology laboratories to more than one state or territory cervical screening register, or because these women have resided in more than one jurisdiction over their screening history.</p> <p>This means that each individual on the National Cancer Screening Register will have zero, one, or many A2 fields, and all these possibilities need to be able to be captured by the National Cancer Screening Register.</p>
<i>Comments</i>	<p>To prevent a situation whereby clients from different registers have the same identifier, and to avoid losing information about the state or territory from which the client was migrated, the identifier and state or territory both need to be recorded. To do this, the number that corresponds to the source state or territory of the record (which is not necessarily the state or territory in which the client resides) should be used as a prefix to the previous client identifier.</p> <p>For example, a client identifier of 123456789 that was migrated from</p>

a New South Wales register would become 1-123456789.
(New South Wales = 1; Victoria = 2; Queensland = 3; Western
Australia = 4; South Australia = 5; Tasmania = 6; Australian Capital
Territory = 7; Northern Territory = 8).

Relational attributes

<i>Related metadata reference</i>	New data item
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A3 Medicare card number

Identifying and definitional attributes

<i>Data item name</i>	Medicare card number
<i>Definition</i>	A numeric number on a medical card allocated by Medicare Australia for the purpose of identifying those people eligible for specific services.
<i>Collection status</i>	Desirable

Value domain attributes

<i>Representation class</i>	Identifier
<i>Data type</i>	Number
<i>Format</i>	{N(10)[N]}
<i>Maximum character length</i>	11

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	Format allows the collection of full Medicare number for an individual (that is, family number plus person (individual reference) number), or truncated Medicare number.
<i>Comments</i>	<p>The Medicare card number is printed on a Medicare card and is used to access Medicare records for an eligible person.</p> <p>Up to 9 persons can be included under the one Medicare card number with up to five persons appearing on one physical card.</p> <p>Persons grouped under one Medicare card number are often a family, however, there is no requirement for persons under the same Medicare card number to be related.</p> <p>A person may be shown under separate Medicare card numbers where, for example, a child needs to be included on separate Medicare cards held by their parents. As a person can be identified on more than one Medicare card this is not a unique identifier for a person.</p>

Relational attributes

<i>Related metadata references</i>	<p>Supersedes <i>National cervical cancer prevention data dictionary Version 1</i>, Data element A2 Woman—Medicare card number, identifier {N(10)[N]}</p> <p>Supersedes <i>Standardised cervical screening data dictionary Cytology (first) sub-set data element 9 Person—government funding identifier</i>, Medicare card number identifier N(11)</p>
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A4 Individual healthcare identifier

Identifying and definitional attributes

<i>Data item name</i>	Individual healthcare identifier
<i>Definition</i>	An individual healthcare identifier (IHI) is a unique 16 digit number allocated to each Australian resident and others seeking healthcare in Australia.
<i>Collection status</i>	Desirable

Value domain attributes

<i>Representation class</i>	Identifier
<i>Data type</i>	Number
<i>Format</i>	{N(16)}
<i>Maximum character length</i>	16

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	An individual healthcare identifier (IHI) is allocated to all individuals enrolled in the Medicare program or those who are issued with a Department of Veterans' Affairs (DVA) treatment card, and others who seek healthcare in Australia.
<i>Comment</i>	As not all clients will have an IHI or be matched, this does not replace A1 Client identifier.

Source and reference attributes

<i>Origin</i>	National E-Health Transition Authority (NEHTA)
<i>Reference documents</i>	

Relational attributes

<i>Related metadata reference</i>	Supersedes <i>National cervical cancer prevention data dictionary Version 1</i> , A3 Woman—individual healthcare identifier, identifier {N(16)}
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Group B: Client data items

- B1 Family name
- B2 Given name
- B3 Other given names
- B4 Date of birth
- B5 Sex
- B6 Indigenous status
- B7 Country of birth
- B8 Main language other than English spoken at home
- B9 CALD status

B1 Family name

Identifying and definitional attributes

<i>Data item name</i>	Family name
<i>Definition</i>	The text that represents the part of a name a woman usually has in common with some other members of her family, as distinguished from her given names
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Text
<i>Data type</i>	String
<i>Format</i>	X[X(39)]
<i>Maximum character length</i>	40

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	This should be recorded for all clients. A full history of names should be retained.
<i>Collection methods</i>	Where a person uses multiple names, these should all be recorded to increase data linkage, and a preferred name flag be used to ensure the preferred name is used in correspondence.
<i>Comments</i>	Often people use a variety of names, including legal names, married/maiden names, nicknames, assumed names, traditional names, and so forth. Even small differences in recording — such as the difference between MacIntosh and McIntosh — can make record linkage impossible.

Relational attributes

<i>Related metadata references</i>	Supersedes <i>National cervical cancer prevention data dictionary Version 1, A4 Woman—family name, text X[X(39)]</i> Supersedes <i>Standardised cervical screening data dictionary Cytology (first) sub-set data element 1 Person—family name, text X[X(39)]</i>
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B2 Given name

Identifying and definitional attributes

<i>Data item name</i>	Given name
<i>Definition</i>	The woman's identifying name within the family group or by which the woman is socially identified.
<i>Collection status</i>	Desirable

Value domain attributes

<i>Representation class</i>	Text
<i>Data type</i>	String
<i>Format</i>	[X(40)]
<i>Maximum character length</i>	40

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	This should be recorded for all clients. A full history of names should be retained.
<i>Collection methods</i>	Where a woman uses multiple names, these should all be recorded to increase data linkage, and a preferred name flag be used to ensure the preferred name is used in correspondence.
<i>Comments</i>	Often people use a variety of names, including legal names, married/maiden names, nicknames, assumed names, traditional names, and so forth. Even small differences in recording — such as the difference between MacIntosh and McIntosh — can make record linkage impossible.

Relational attributes

<i>Related metadata references</i>	Supersedes <i>National cervical cancer prevention data dictionary Version 1, A5 Woman—given names, text X[X(39)]</i> Supersedes <i>Standardised cervical screening data dictionary Cytology (first) sub-set data element 2 Person—given names, text X[X(40)]</i>
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B3 Other given names

Identifying and definitional attributes

<i>Data item name</i>	Other given names
<i>Definition</i>	The woman's other identifying name(s) within the family group or by which the woman is socially identified.
<i>Collection status</i>	Desirable

Value domain attributes

<i>Representation class</i>	Text
<i>Data type</i>	String
<i>Format</i>	[X(40)]
<i>Maximum character length</i>	40

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	This should be recorded for all clients. A full history of names should be retained.
<i>Collection methods</i>	Where a person uses multiple names, these should all be recorded to increase data linkage, and a preferred name flag be used to ensure the preferred name is used in correspondence.
<i>Comments</i>	Often people use a variety of names, including legal names, married/maiden names, nicknames, assumed names, traditional names, and so forth. Even small differences in recording — such as the difference between MacIntosh and McIntosh — can make record linkage impossible.

Relational attributes

<i>Related metadata references</i>	New data item
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B4 Date of birth

Identifying and definitional attributes

<i>Data item name</i>	Date of birth
<i>Definition</i>	The date on which a woman was born.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Date
<i>Data type</i>	Date/Time
<i>Format</i>	DDMMYYYY
<i>Maximum character length</i>	8

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	If date of birth is not known or cannot be obtained, provision should be made to collect or estimate age. If only the year and month is known, date of birth should be set to 01MMYYYY; if only the year is known, date of birth should be set to 0107YYYY.
<i>Collection methods</i>	Date of birth should be in the preferred representational layout DDMMYYYY.
<i>Comments</i>	If there is more than one date of birth, all should be recorded.

Relational attributes

<i>Related metadata references</i>	Supersedes <i>National cervical cancer prevention data dictionary Version 1</i> , A7 Woman—date of birth, date DDMMYYYY Supersedes <i>Standardised cervical screening data dictionary Cytology (first) sub-set data element 10</i> Person—date of birth, date DDMMYYYY
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B5 Sex

Identifying and definitional attributes

<i>Data item name</i>	Sex
<i>Definition</i>	The distinction between male, female, and others who do not have biological characteristics typically associated with either the male or female sex.
<i>Collection status</i>	Desirable

Value domain attributes

<i>Representation class</i>	Code								
<i>Data type</i>	String								
<i>Format</i>	X								
<i>Maximum character length</i>	1								
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Male</td></tr><tr><td>2</td><td>Female</td></tr><tr><td>3</td><td>Other</td></tr></tbody></table>	Value	Meaning	1	Male	2	Female	3	Other
Value	Meaning								
1	Male								
2	Female								
3	Other								
<i>Supplementary values</i>	9 Not stated/Inadequately described								

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	<p>The term 'sex' refers to a person's biological characteristics. A person's sex is usually described as being either male or female; some people may have both male and female characteristics, or neither male nor female characteristics, or other sexual characteristics.</p> <p>Sex is assigned at birth and is relatively fixed. However, a person's sex may change during their lifetime as a result of procedures commonly referred to as sex change, gender reassignment, gender affirmation, transsexual surgery, transgender reassignment or sexual reassignment. Throughout this process, which may be over a considerable period of time, sex may be recorded as either male, female or other.</p> <p>Collection of sex excludes gender information, which is interrelated but conceptually distinct. The concept of sex is based on the physical or biological aspects of a person's body while the concept of gender relates to the way a person feels, presents and is recognised within the general community and may refer to outward social markers such as their name, outward appearance, mannerisms and dress. Sexual orientation is a separate concept to sex and gender, involving a person's emotional or sexual attraction to another person, and is not covered in the collection of sex information.</p> <p>In general, both sex and gender should not be collected in a single collection instrument. The Australian Government Guidelines on the</p>
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Recognition of Sex and Gender recommends the preferred Australian Government approach of collecting and using gender information, with sex only being collected where there is a legitimate need to know the biological characteristics of the target population. It should be recognised that in some cases an individual may choose to report their gender when sex is being requested. Organisations should ensure when they collect sex and/or gender information they use the correct terminology for the information they are seeking. Male and female are predominantly associated with the set of biological attributes that define the different types of sexes, while masculine and feminine characteristics are predominantly associated with the set of factors that make up gender. However, it should be recognised that male/female and masculine/feminine are sometimes used interchangeably to refer to sex and/or gender.

Collection methods

For statistical purposes, the following category codes, labels and definitions are preferred:

CODE 1 Male

Persons who have male or predominantly masculine biological characteristics, or male sex assigned at birth.

CODE 2 Female

Persons who have female or predominantly feminine biological characteristics, or female sex assigned at birth.

CODE 3 Other

Persons who have mixed or non-binary biological characteristics (if known), or a non-binary sex assigned at birth.

The value meaning of 'Other' has been assigned to Code 3 for this value domain. Terms such as 'indeterminate', 'intersex', 'non-binary', and 'unspecified' are variously used to describe the 'Other' category of sex. The label 'Other' is used because a more descriptive term has not been widely agreed within the general community.

Sex refers to the chromosomal, gonadal and anatomical characteristics associated with biological sex. Where there is an inconsistency between anatomical and chromosomal characteristics, sex is based on anatomical characteristics.

Standard Question Module

For the collection of sex, the following standard tick box question module could be used:

What is your sex? Please [tick/mark/select] one box.

Male

Female

Other, please specify _____

Mandatory elements

The following elements should be included:

- the word 'sex' in the question to clearly articulate the concept

being collected;

- label the response options 'Male', 'Female' and 'Other'; and
- a note that only one response is permitted.

Optional elements

The following elements may be included:

- the response option for 'Other' is labelled 'Other, please specify'; and
- a write-in facility is available when the 'Other' response option is selected.

The inclusion of the write-in facility for 'Other' allows respondents the opportunity to describe their sex using a term they are comfortable with, whilst also maximising the potential for analysis of the responses provided.

Allowable variations

Minor variations to the question wording are allowed. For example:

Which of the following describes your sex? Please [tick/mark/select] one box

or

Sex, please [tick/mark/select] one box.

Optional inclusions

Organisations should refrain from making assumptions about a person's sex based on indicators such as their name, voice or appearance. Respondents should be presented with all response options for sex. The Australian Bureau of Statistics (ABS) Standard for Sex and Gender Variables recommends a standard script explaining the importance of the question. Refer to the ABS standard for explanatory information that can be included in self-completed questionnaires (e.g., web forms and paper forms), or read in face-to-face and telephone interviews. The inclusion of explanatory material is optional and at the discretion of those undertaking the collection.

Supplementary values

CODE 9 Not stated/inadequately described

This supplementary value is used to code inadequately described responses and non-responses for sex. It is not to be used on primary collection forms. It is primarily for use in administrative collections when transferring data from data sets where the item has not been collected.

Comments

This data item collects an individual's sex. Individuals participating in cervical screening will almost be exclusively female, as the presence of a cervix puts an individual at risk of cervical cancer; however, as the National Cancer Screening Register will include the National Bowel Cancer Screening Register which includes both

males and females, sex becomes an important field to collect.

Source and reference attributes

Origin

Adapted from METeOR candidate Data Element 635126.

Reference documents

Australian Bureau of Statistics 2016. Standard for Sex and Gender Variables (Cat. no. 1200.0.55.012).

Attorney-General's Department 2015. Australian Government Guidelines on the Recognition of Sex and Gender.

Relational attributes

Related metadata reference

New data item

B6 Indigenous status

Identifying and definitional attributes

<i>Data item name</i>	Indigenous status
<i>Definition</i>	Whether a woman identifies as being of Aboriginal or Torres Strait Islander descent.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Code												
<i>Data type</i>	Number												
<i>Format</i>	N												
<i>Maximum character length</i>	1												
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Aboriginal but not Torres Strait Islander origin</td></tr><tr><td>2</td><td>Torres Strait Islander but not Aboriginal origin</td></tr><tr><td>3</td><td>Both Aboriginal and Torres Strait Islander origin</td></tr><tr><td>4</td><td>Neither Aboriginal nor Torres Strait Islander origin</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Aboriginal but not Torres Strait Islander origin	2	Torres Strait Islander but not Aboriginal origin	3	Both Aboriginal and Torres Strait Islander origin	4	Neither Aboriginal nor Torres Strait Islander origin	9	Not stated/inadequately described
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9	Not stated/inadequately described												
<i>Supplementary values</i>	9												

Data item attributes

Collection and usage attributes

Guide for use The classification for Indigenous status has a hierarchical structure comprising two levels. There are four categories at the detailed level of the classification which are grouped into two categories at the broad level. There is one supplementary category for 'Not stated/inadequately described' responses. The classification is as follows:

Indigenous Australians:

- Aboriginal but not Torres Strait Islander origin.
- Torres Strait Islander but not Aboriginal origin.
- Both Aboriginal and Torres Strait Islander origin.

Non-Indigenous Australians:

- Neither Aboriginal nor Torres Strait Islander origin.

Not stated/inadequately described:

This category is not to be available as a valid answer to the questions but is intended for use:

- Primarily when importing data from other data collections that do not contain mappable data.
- Where the answer cannot be determined without clarification from the respondent (for example, 'No' and 'Yes, Aboriginal' are both selected).
- Where an answer was declined.
- Where the question was not able to be asked because the client

was unable to communicate or a person who knows the client was not available.

The Indigenous status question allows for more than one response. The procedure for coding multiple responses is as follows:

- If the respondent answers 'Yes, Aboriginal' and 'Yes, Torres Strait Islander', then their response should be coded to 'Yes, both Aboriginal and Torres Strait Islander origin'.
- If the respondent answers 'No' and one or more of the following:
 - 'Yes, Aboriginal'
 - 'Yes, Torres Strait Islander'
 - 'Yes, both Aboriginal and Torres Strait Islander'

then the response should be coded to 'Not stated/inadequately described' if the response cannot be clarified with the respondent.

Collection methods

The following information provides advice on the recommended way to ask the Indigenous status question.

Self-enumerated collections

For self-enumerated collections (for example, self-completed questionnaires or forms), the following question is recommended:

Q1. [Are you] [Is the person] [Is (name)] of Aboriginal or Torres Strait Islander origin?

- No
- Yes, Aboriginal
- Yes, Torres Strait Islander

If [you] [the person] [(name)] are of both Aboriginal and Torres Strait Islander origin, answer using both 'Yes' options.

This approach may be problematic in some data collections, for example when data are collected using screen based data capture systems. An additional response category of 'Yes, both Aboriginal and Torres Strait Islander' may be included if this better suits the data collection practices of the agency or establishment concerned.

If the Indigenous status question has not been completed on a returned form, this should be followed up and confirmed with the person.

Interviewer-conducted collections

For interviewer-conducted collections in which the Indigenous status of one person is collected, the following question set is recommended:

Q1. Are you of Aboriginal or Torres Strait Islander origin?

- Yes
- No (no more questions)

Q2. Are you of Aboriginal origin, Torres Strait Islander origin, or both?

- Aboriginal
- Torres Strait Islander
- Both Aboriginal and Torres Strait Islander

The first question is used to sequence out non-Indigenous Australians. The second question is used to determine the specific

Aboriginal and/or Torres Strait Islander origin of the person. A benefit of this approach is that the interviewer is not required to prompt the respondent with response categories. The 'Both Aboriginal and Torres Strait Islander' response category can be included or excluded in interviewer conducted collections depending on which option best suits the data collection practices of the agency concerned. Including the additional response category ensures that respondents are aware of the option to identify as being of both Aboriginal and Torres Strait Islander origin.

Various articulations of the standard question are recommended to address the following circumstances:

Person is present and answers

This question wording is recommended where it is known that the person being interviewed is the subject:

Q1. Are you of Aboriginal or Torres Strait Islander origin?

Q2. Are you of Aboriginal origin, Torres Strait Islander origin, or both?

Person is not present and someone else who knows the person well answers

The following question wording is recommended when another member of the household answers for the person. Examples of such incidents include: parents answering for children, or relatives answering in hospital situations.

Q1. Is [the person] [(name)] of Aboriginal or Torres Strait Islander origin?

Q2. Is [the person] [(name)] of Aboriginal origin, Torres Strait Islander origin, or both?

Person is deceased and someone else answers on their behalf (for example, death information form)

In these circumstances a close relative or friend should answer. Only if a relative or friend is unavailable should the undertaker or other such person answer. The suggested question wording follows:

Q1. Was [the person] [(name)] of Aboriginal or Torres Strait Islander origin?

Q2. Was [the person] [(name)] of Aboriginal origin, Torres Strait Islander origin, or both?

Person is an infant and parents answer (e.g. perinatal information form)

In this circumstance it is recommended that parents are asked:

Q1. Is [the baby's] [(name)'s] mother of Aboriginal or Torres Strait Islander origin?

Q2. Is [the baby's] [(name)'s] mother of Aboriginal origin, Torres Strait Islander origin, or both?

and

Q1. Is [the baby's] [(name)'s] father of Aboriginal or Torres Strait Islander origin?

Q2. Is [the baby's] [(name)'s] father of Aboriginal origin, Torres Strait Islander origin, or both?

For interview conducted collections in which the Indigenous Status of

more than one person is collected from a household representative, the following question set is recommended:

Q1. Is anyone who (usually lives here) (or) (is visiting here) of Aboriginal or Torres Strait Islander origin?

- Yes
- No

Q2. Who are they?

Question 3 is asked of each person identified as being of Aboriginal or Torres Strait Islander origin.

Q3. [Are you] [Is (name)] of Aboriginal origin, Torres Strait Islander origin, or both?

- Aboriginal
- Torres Strait Islander
- Both Aboriginal and Torres Strait Islander

The first question is used to sequence out households in which no Aboriginal and/or Torres Strait Islander people usually live (or are visiting). The second question is used to identify those usual residents (and visitors) of Aboriginal or Torres Strait Islander origin. This approach eliminates the need to repeatedly ask the Indigenous status question of each individual in a household when data are collected on a single household form. It is particularly advantageous when collecting from areas with a large proportion of households with non-Indigenous Australians.

For both self-enumerated collections and interviewer-conducted collections

The Indigenous status question can be used in circumstances where a close relative, friend, or another member of the household is answering on behalf of the subject. It is strongly recommended that the question be asked directly wherever possible.

When the subject person is not present, the person answering for them should be in a position to do so, that is, this person must know the person about whom the question is being asked well and feel confident to provide accurate information about them.

The Indigenous status question must always be asked regardless of data collectors' perceptions based on appearance or other factors.

The Indigenous status question may only be left unanswered in the following circumstances:

- Where the person declined to answer
- Where the question was not able to be asked because the client was unable to communicate or a person who knows the client was not available.

Comments

The following definition, commonly known as 'The Commonwealth Definition', was given in a High Court judgement in the case of *Commonwealth v Tasmania* (1983) 46 ALR 625.

'An Aboriginal or Torres Strait Islander is a person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by the community in which he or she lives'.

There are three components to the Commonwealth definition:

- descent;
- self-identification; and
- community acceptance.

In practice, it is not feasible to collect information on the community acceptance part of this definition in general purpose statistical and administrative collections and therefore standard questions on Indigenous status relate to descent and self-identification only.

Source and reference attributes

<i>Origin</i>	Adapted from METeOR Data Element 602543.
<i>Reference documents</i>	Australian Bureau of Statistics 2014. Indigenous Status Standard Version 1.5, Canberra. (Cat. no. 1200.0.55.008). Australian Institute of Health and Welfare 2010. National best practice guidelines for collecting Indigenous status in health data sets. Cat. no. AIHW 29. Canberra: AIHW.

Relational attributes

<i>Related metadata references</i>	Supersedes <i>National cervical cancer prevention data dictionary Version 1</i> , A8 Woman—Indigenous status, code N Supersedes <i>Standardised cervical screening data dictionary Cytology (first) sub-set data element 11 Person—Indigenous status</i> , code N
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B7 Country of birth

Identifying and definitional attributes

<i>Data item name</i>	Country of birth
<i>Definition</i>	The country in which the person was born.
<i>Collection status</i>	Desirable

Value domain attributes

<i>Representation class</i>	Code
<i>Data type</i>	Number
<i>Format</i>	{NNNN}
<i>Maximum character length</i>	4

Data item attributes

Collection and usage attributes

Guide for use The Standard Australian Classification of Countries 2016 is a four-digit, three-level hierarchical structure specifying major group, minor group and country.

A country, even if it comprises other discrete political entities such as states, is treated as a single unit for all data domain purposes. Parts of a political entity are not included in different groups. Thus, Hawaii is included in Northern America (as part of the identified country United States of America), despite being geographically close to and having similar social and cultural characteristics as the units classified to Polynesia.

Collection methods Some data collections ask respondents to specify their country of birth. In others, a pre-determined set of countries is specified as part of the question, usually accompanied by an 'other (please specify)' category.

Recommended questions are:

In which country were you/was the person/was (name) born?

Australia

Other (please specify) ...

or

In which country were you/was the person/was (name) born?

Australia

England

New Zealand

India

Italy

Vietnam

Philippines

South Africa

Scotland

Malaysia

Other (please specify) ...

The option list for this question includes countries according to their statistical frequency in Australia, according to data from the Census of Population and Housing. Exceptions are made for countries such as 'United Kingdom' and 'China', as they are likely to reduce the level of detail that is possible to be coded to the Standard Australian Classification of Countries.

Source and reference attributes

Origin

Adapted from METeOR Data Element 659454.

Relational attributes

Related metadata reference

Supersedes *National cervical cancer prevention data dictionary Version 1*, A10 Woman—country of birth, code (SACC 2011) {NNNN}

B8 Main language other than English spoken at home

Identifying and definitional attributes

<i>Data item name</i>	Main language other than English spoken at home
<i>Definition</i>	The language reported by a person as the main language other than English spoken by that person in his/her home (or most recent private residential setting occupied by the person) to communicate with other residents of the home or setting and regular visitors.
<i>Collection status</i>	Desirable

Value domain attributes

<i>Representation class</i>	Code
<i>Data type</i>	Number
<i>Format</i>	{N{NNN}}
<i>Maximum character length</i>	4

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	<p>The Australian Standard Classification of Languages (ASCL) has a three-level hierarchical structure. The most detailed level of the classification consists of languages which are represented by four-digit codes. The second level of the classification comprises narrow groups of languages (the Narrow group level), identified by two-digit and three-digit codes. The most general level of the classification consists of broad groups of languages (the Broad group level) and is identified by one-digit codes. The classification includes Australian Indigenous languages and sign languages.</p> <p>For example, the Lithuanian language has a code of 3102. In this case 3 denotes that it is an Eastern European language, while 31 denotes that it is a Baltic language. The Pintupi Aboriginal language is coded as 8713. In this case 8 denotes that it is an Australian Indigenous language and 87 denotes that the language is a Western Desert language.</p> <p>Language data may be output at the Broad group level, Narrow group level or the language level of the classification. Also, significant languages within a Narrow group can be presented separately with the remaining languages of the Narrow group aggregated. The same principle can be adopted to highlight significant Narrow groups within a Broad group</p>
<i>Collection methods</i>	<p>Where extensive data on main language other than English spoken at home is needed, one of the two questions below may be used:</p> <p>Alternative 1</p> <p><i>Do you/Does the person/Does (name)/ Will (name of child under two years) speak a language other than English at home? (If more than one language, indicate the language that is spoken most often.)</i></p> <p><i>No, (English only) []</i></p>

Yes, Mandarin

Yes, Italian

Yes, Arabic

Yes, Cantonese

Yes, Greek

Yes, Vietnamese

Yes, Spanish

Yes, Hindi

Yes, Tagalog

Yes, Other (please specify) _____

The above list includes languages based on their statistical frequency in Australia, based on data from the Census of Population and Housing.

Alternative 2

Do you/Does the person/Does (name)/ Will (name of child under two years) speak a language other than English at home?

No, English only

Yes, Other - please specify _____

Where there is no requirement for detailed language data, the following question may be suitable:

Do you/Does the person/Does (name)/ Will (name of child under two years) speak a language other than English at home?

No, English only

Yes, Other

Comments

This data element is important in identifying those people most likely to suffer disadvantage in terms of their ability to access services due to language and/or cultural difficulties. In conjunction with Indigenous status, Proficiency in spoken English and Country of birth this data element forms the minimum core set of cultural and language indicators recommended by the ABS.

Data on main language other than English spoken at home are regarded as an indicator of 'active' ethnicity and also as useful for the study of inter-generational language retention. The availability of such data may help providers of health and community services to effectively target the geographic areas or population groups that need those services. It may be used for the investigation and development of language services such as interpreter/ translation services.

Source and reference attributes

Origin

Adapted from METeOR Data Element 659402.

Reference documents

Australian Bureau of Statistics 2016a. Australian Standard Classification of Languages (ASCL) 2016. ABS cat. no.1267.0. Canberra: ABS.

Australian Bureau of Statistics 2016b. Language Standards 2016. ABS cat. no.1200.0.55.005. Canberra: ABS.

Relational attributes

Related metadata reference Supersedes *National cervical cancer prevention data dictionary Version 1*, A9 Woman—main language other than English spoken at home, code (ASCL 2011) {NN{NN}}

B9 CALD status

Identifying and definitional attributes

<i>Data item name</i>	CALD status
<i>Definition</i>	An overall indication of CALD status.
<i>Collection status</i>	Desirable

Value domain attributes

<i>Representation class</i>	Code								
<i>Data type</i>	Number								
<i>Format</i>	N								
<i>Maximum character length</i>	1								
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>CALD</td></tr><tr><td>2</td><td>Not CALD</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	CALD	2	Not CALD	9	Not stated/inadequately described
Value	Meaning								
1	CALD								
2	Not CALD								
9	Not stated/inadequately described								

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	<p>CALD status is derived from the two data items B7 'Country of birth' and B8 'Main language other than English spoken at home'.</p> <p>CALD is defined as:</p> <ul style="list-style-type: none">• people born overseas in countries where English is not the main language spoken (that is, people whose country of birth is not Australia and its external territories, New Zealand, the United Kingdom, Ireland, the United States of America, Canada or South Africa. This selection of countries is based on the main countries from which Australia receives overseas settlers who are likely to speak English); or• people born in Australia whose main language other than English spoken at home is not English (excluding Aboriginal languages).
<i>Collection methods</i>	CALD status is derived from the two data items B7 'Country of birth' and B8 'Main language other than English spoken at home'.

Relational attributes

<i>Related metadata reference</i>	New data item
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Group C: Client status data items

- C1 Active status
- C2 Reason for temporary inactivation
- C3 Date of temporary inactivation
- C4 Date of reactivation
- C5 Withdrawn date
- C6 Withdrawn rescinded date
- C7 Hysterectomy flag
- C8 Date of hysterectomy
- C9 Death flag
- C10 Date of death

C1 Active status

Identifying and definitional attributes

<i>Data item name</i>	Active status
<i>Definition</i>	An indication as to whether a woman's record is currently active.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Code												
<i>Data type</i>	Number												
<i>Format</i>	N												
<i>Maximum character length</i>	1												
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Active</td></tr><tr><td>2</td><td>Inactive — temporary</td></tr><tr><td>3</td><td>Inactive — permanent</td></tr><tr><td>4</td><td>Withdrawn — client identifier data items removed; test data items retained</td></tr><tr><td>5</td><td>Withdrawn — client identifier data items retained; test data items removed</td></tr></tbody></table>	Value	Meaning	1	Active	2	Inactive — temporary	3	Inactive — permanent	4	Withdrawn — client identifier data items removed; test data items retained	5	Withdrawn — client identifier data items retained; test data items removed
Value	Meaning												
1	Active												
2	Inactive — temporary												
3	Inactive — permanent												
4	Withdrawn — client identifier data items removed; test data items retained												
5	Withdrawn — client identifier data items retained; test data items removed												

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	<p>Active status indicates whether a woman is currently able to be invited to screen or rescreen, or whether this activity has been suspended — either temporarily or permanently.</p> <p>'Active' indicates that a woman's record on a register is currently active, which means that invitations to screen or rescreen function as per recommendations.</p> <p>'Inactive (temporary)' indicates that the woman's record on a register is currently inactive. Refer to C2 'Reason for temporary inactivation' and 'C3 Date of temporary inactivation' to determine when the record was set to inactive and why.</p> <p>'Inactive (permanent)' indicates that the woman's record on a register is permanently inactive. This may be because she has died, or it may be because she has had a total hysterectomy with the cervix removed AND has been deemed as requiring no further follow up according to the <i>National Cervical Screening Program: Guidelines for the management of screen-detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding</i> (see Flowchart 13.1 Vaginal screening after total hysterectomy). (Cancer Council Australia and Cervical Cancer Screening Guidelines Working Party 2016).</p> <p>Refer to C7 'Hysterectomy flag', C8 'Date of hysterectomy', C9 'Death flag' and C10 'Date of death' to determine the reason and</p>
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date if this is required.

'Withdrawn' indicates that the woman has opted off a register and two possible outcomes in terms of data retention and removal. Refer to C5 'Withdrawn date' to determine the date if this is required.

Comments

This data item indicates a woman's current active status on a register. Other data items in this section can be used to determine a woman's historic active status if this is required.

Note that a woman's record may be active but with no correspondence permitted. The status of 'active' in this data item does not distinguish between those who allow correspondence and those who do not. This information is stored within data items specific to contact with the client.

Source and reference attributes

Reference documents

Cancer Council Australia and Cervical Cancer Screening Guidelines Working Party 2016. National Cervical Screening Program: Guidelines for the management of screen-detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding. Cancer Council Australia: Sydney.
(See Flowchart 13.1 Vaginal screening after total hysterectomy.)

Relational attributes

Related metadata references

Supersedes *National cervical cancer prevention data dictionary Version 1*, A23 Woman—active status, code A
Supersedes *Standardised cervical screening data dictionary Cytology (first) sub-set data element 35* Person—registry contact suspension flag, code N

C2 Reason for temporary inactivation

Identifying and definitional attributes

<i>Data item name</i>	Reason for temporary inactivation
<i>Definition</i>	The reason for a woman's record on a register being set to temporarily inactive.
<i>Collection status</i>	Conditional

Value domain attributes

<i>Representation class</i>	Code										
<i>Data type</i>	Number										
<i>Format</i>	N										
<i>Maximum character length</i>	1										
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Suspension requested by client</td></tr><tr><td>2</td><td>Lost to follow-up</td></tr><tr><td>3</td><td>Exited</td></tr><tr><td>4</td><td>Other</td></tr></tbody></table>	Value	Meaning	1	Suspension requested by client	2	Lost to follow-up	3	Exited	4	Other
Value	Meaning										
1	Suspension requested by client										
2	Lost to follow-up										
3	Exited										
4	Other										

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	<p>'Suspension requested by client' indicates that a client has requested a temporary suspension of her record on a register. This may be due to a request from the client for no correspondence to be sent, or could be due to pregnancy or an overseas holiday, for example.</p> <p>'Lost to follow-up' indicates that there is contact failure for all contact information on a register. If the record is lost to follow-up, D14 'Contact failure flag' = 1.</p> <p>'Exited' indicates that a woman aged 70–74 received a screening result of 'oncogenic HPV not detected' and therefore exited the program. Her record is set to temporarily inactive rather than permanently inactive to accommodate any screening that may occur after her exiting the program.</p> <p>'Other' can be used for any circumstances for temporary inactivation that do not fall within the parameters described above.</p>
<i>Rules for use</i>	If C1 'Active status' = 2, C2 'Reason for temporary inactivation' should not be null.

Relational attributes

<i>Related metadata reference</i>	New data item
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C3 Date of temporary inactivation

Identifying and definitional attributes

<i>Data item name</i>	Date of temporary inactivation
<i>Definition</i>	The date a woman's record became temporarily inactive.
<i>Collection status</i>	Conditional

Value domain attributes

<i>Representation class</i>	Date
<i>Data type</i>	Date/Time
<i>Format</i>	{DDMMYYYY}
<i>Maximum character length</i>	8

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	<p>The collection of data for this data item is conditional on a woman's record having been made temporarily inactive.</p> <p>While it is preferable that this be an accurate date of temporary inactivation, part of the date may need to be estimated. If this date needs to be estimated, the following guide should be used; if only the year and month is known, date should be set to 01MMYYYY; if only the year is known, date should be set to 0107YYYY.</p>
<i>Rules for use</i>	<p>If C1 'Active status' = 2, C3 'Temporary inactivation suspension date' should not be null.</p>
<i>Collection methods</i>	<p>This data item should always be recorded as an 8-digit valid date comprising day, month and year. Year should always be recorded in its full 4 digit format. For days and months with a numeric value of less than 10, zeros should be used to ensure that the date contains the required 8 digits. For example, a date of 1 July 2015 should be recorded as 01072015 as specified in the representational layout.</p>
<i>Comment</i>	<p>This data item can be used to determine current and historic active status if this is required.</p>

Relational attributes

<i>Related metadata reference</i>	New data item
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C4 Date of reactivation

Identifying and definitional attributes

<i>Data item name</i>	Date of reactivation
<i>Definition</i>	The date a woman's record is reactivated after being temporarily inactive.
<i>Collection status</i>	Conditional

Value domain attributes

<i>Representation class</i>	Date
<i>Data type</i>	Date/Time
<i>Format</i>	{DDMMYYYY}
<i>Maximum character length</i>	8

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	<p>The collection of data for this data item is conditional on a woman's record becoming temporarily inactive and then being reactivated. While it is preferable that this be an accurate date of reactivation, part of the date may need to be estimated. If this date needs to be estimated, the following guide should be used; if only the year and month is known, date should be set to 01MMYYYY; if only the year is known, date should be set to 0107YYYY.</p>
<i>Comment</i>	This data item can be used to determine current and historic active status if this is required.

Relational attributes

<i>Related metadata reference</i>	New data item
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C5 Withdrawn date

Identifying and definitional attributes

<i>Data item name</i>	Withdrawn date
<i>Definition</i>	The date a woman's record on a register is withdrawn (that is, the date a woman opted off)
<i>Collection status</i>	Conditional

Value domain attributes

<i>Representation class</i>	Date
<i>Data type</i>	Date/Time
<i>Format</i>	{DDMMYYYY}
<i>Maximum character length</i>	8

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	While it is preferable that this be an accurate date the client opts off a register, part of the date may need to be estimated. If this date needs to be estimated, the following guide should be used; if only the year and month is known, date should be set to 01MMYYYY; if only the year is known, date should be set to 0107YYYY.
<i>Rules for use</i>	If C1 'Active status' = 4 or 5, C5 'Withdrawn date' should not be null.
<i>Collection methods</i>	This data item should always be recorded as an 8-digit valid date comprising day, month and year. Year should always be recorded in its full 4 digit format. For days and months with a numeric value of less than 10, zeros should be used to ensure that the date contains the required 8 digits. For example, a date of 1 July 2015 should be recorded as 01072015 as specified in the representational layout.

Relational attributes

<i>Related metadata reference</i>	New data item
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C6 Withdrawn rescinded date

Identifying and definitional attributes

<i>Data item name</i>	Withdrawn rescinded date
<i>Definition</i>	The date a woman reverses her decision to opt off a register.
<i>Collection status</i>	Conditional

Value domain attributes

<i>Representation class</i>	Date
<i>Data type</i>	Date/Time
<i>Format</i>	{DDMMYYYY}
<i>Maximum character length</i>	8

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	While it is preferable that this be an accurate date, part of the date may need to be estimated. If this date needs to be estimated, the following guide should be used; if only the year and month is known, date should be set to 01MMYYYY; if only the year is known, date should be set to 0107YYYY.
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Relational attributes

<i>Related metadata reference</i>	New data item
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C7 Hysterectomy flag

Identifying and definitional attributes

<i>Data item name</i>	Hysterectomy flag
<i>Definition</i>	An indication as to whether a woman has had a total hysterectomy (removal of uterus and cervix).
<i>Collection status</i>	Conditional

Value domain attributes

<i>Representation class</i>	Code				
<i>Data type</i>	Number				
<i>Format</i>	[N]				
<i>Maximum character length</i>	1				
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Total hysterectomy</td></tr></tbody></table>	Value	Meaning	1	Total hysterectomy
Value	Meaning				
1	Total hysterectomy				

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	Hysterectomy flag should be raised at such time as it is known that a woman has had a hysterectomy.
<i>Rules for use</i>	If C8 'Date of hysterectomy' is not null, C7 'Hysterectomy flag should be = 1.
<i>Collection methods</i>	While this can be communicated by the practitioner, hysterectomy flag is triggered by the presence of a procedure code for total hysterectomy on a register.
<i>Comments</i>	Whether or not a woman who had had a hysterectomy will require further follow-up within the NCSP should be according to clinical recommendations in the <i>National Cervical Screening Program: Guidelines for the management of screen-detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding</i> (as per 'Flowchart 13.1 Vaginal screening after total hysterectomy') (Cancer Council Australia and Cervical Cancer Screening Guidelines Working Party 2016).

Relational attributes

<i>Related metadata references</i>	Supersedes <i>National cervical cancer prevention data dictionary Version 1</i> , A21 Woman—hysterectomy status, code N Supersedes <i>Standardised cervical screening data dictionary Cytology (first) sub-set data element 13 Person—Hysterectomy status, code N</i>
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C8 Date of hysterectomy

Identifying and definitional attributes

<i>Data item name</i>	Date of hysterectomy
<i>Definition</i>	The date a woman underwent a total hysterectomy (removal of uterus and cervix).
<i>Collection status</i>	Conditional

Value domain attributes

<i>Representation class</i>	Date
<i>Data type</i>	Date/Time
<i>Format</i>	{DDMMYYYY}
<i>Maximum character length</i>	8

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	<p>The collection of data for this data item is conditional on a woman having had a total hysterectomy.</p> <p>While it is preferable that this be an accurate date of a reported hysterectomy, part of the date may need to be estimated. If this date needs to be estimated, the following guide should be used; if only the year and month is known, date should be set to 01MMYYYY; if only the year is known, date should be set to 0107YYYY.</p>
<i>Rules for use</i>	<p>If C7 'Hysterectomy status' = 1, C8 'Date of hysterectomy' should not be null.</p> <p>If C7 'Hysterectomy status' = 2, C8 'Date of hysterectomy' should be null.</p>
<i>Collection methods</i>	<p>This data item should always be recorded as an 8-digit valid date comprising day, month and year. Year should always be recorded in its full 4 digit format. For days and months with a numeric value of less than 10, zeros should be used to ensure that the date contains the required 8 digits. For example, a date of 1 July 2015 should be recorded as 01072015 as specified in the representational layout.</p>

Relational attributes

<i>Related metadata references</i>	<p>Supersedes <i>National cervical cancer prevention data dictionary Version 1, A22 Woman—date of hysterectomy, date {DDMMYYYY}</i></p> <p>Supersedes <i>Standardised cervical screening data dictionary Cytology (first) sub-set data element 14 Person—date of hysterectomy, date DDMMYYYY</i></p>
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C9 Death flag

Identifying and definitional attributes

<i>Data item name</i>	Death flag
<i>Definition</i>	An indication as to whether a woman is deceased.
<i>Context</i>	These data are essential to ensure that correspondence is not sent to deceased people to avoid potential distress for the woman's family or friends.
<i>Collection status</i>	Conditional

Value domain attributes

<i>Representation class</i>	Code				
<i>Data type</i>	Number				
<i>Format</i>	[N]				
<i>Maximum character length</i>	1				
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Deceased</td></tr></tbody></table>	Value	Meaning	1	Deceased
Value	Meaning				
1	Deceased				

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	
<i>Rules for use</i>	If C10 'Date of death' is not null, C9 'Death flag' should be = 1.
<i>Collection methods</i>	Frequent linking to the National Death Index or similar source of identified deaths data.

Relational attributes

<i>Related metadata references</i>	Supersedes <i>National cervical cancer prevention data dictionary Version 1</i> , A24 Woman—vital status, code [N] Supersedes <i>Standardised cervical screening data dictionary</i> Cytology (first) sub-set data element 36 Person—vital status, code N
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C10 Date of death

Identifying and definitional attributes

<i>Data item name</i>	Date of death
<i>Definition</i>	The date of death of the woman.
<i>Context</i>	Required to prevent screening reminder letters or other correspondence being sent to deceased people.
<i>Collection status</i>	Conditional

Value domain attributes

<i>Representation class</i>	Date
<i>Data type</i>	Date/Time
<i>Format</i>	{DDMMYYYY}
<i>Maximum character length</i>	8

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	While it is preferable that this be an accurate date of death, part of the date may need to be estimated. If this date needs to be estimated, the following guide should be used; if only the year and month is known, date should be set to 01MMYYYY; if only the year is known, date should be set to 0107YYYY.
<i>Rules for use</i>	If C9 'Death flag = 1, C10 'Date of death' should not be null.
<i>Collection methods</i>	This data item should always be recorded as an 8-digit valid date comprising day, month and year. Year should always be recorded in its full 4 digit format. For days and months with a numeric value of less than 10, zeros should be used to ensure that the date contains the required 8 digits. For example, a date of 1 July 2015 should be recorded as 01072015 as specified in the representational layout.
<i>Comments</i>	Depending on how this information is collected, day or even month may not be known. The death flag should be used as soon as it is known that a woman has died, as it is important individuals who are deceased are not sent correspondence (this is more important than recording the day and month of death).

Relational attributes

<i>Related metadata references</i>	Supersedes <i>National cervical cancer prevention data dictionary Version 1, A25 Woman—date of death, date {DDMMYYYY}</i> Supersedes <i>Standardised cervical screening data dictionary Cytology (first) sub-set data element 37 Woman—date of death, DDMMYYYY</i>
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Group D: Client vaccination status data items

- D1 HPV vaccination status
- D2 HPV vaccination completion date
- D3 HPV vaccination episode date
- D4 HPV vaccine dose number
- D5 HPV vaccine type

D1 HPV vaccination status

Identifying and definitional attributes

<i>Data item name</i>	HPV vaccination status
<i>Definition</i>	An indication as to whether a woman is vaccinated against HPV.
<i>Collection status</i>	Desirable

Value domain attributes

<i>Representation class</i>	Code												
<i>Data type</i>	Number												
<i>Format</i>	N												
<i>Maximum character length</i>	1												
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>0</td><td>Unvaccinated</td></tr><tr><td>1</td><td>Vaccinated – complete</td></tr><tr><td>2</td><td>Vaccinated – incomplete</td></tr><tr><td>3</td><td>Vaccinated – too close</td></tr><tr><td>4</td><td>Vaccinated – no valid status</td></tr></tbody></table>	Value	Meaning	0	Unvaccinated	1	Vaccinated – complete	2	Vaccinated – incomplete	3	Vaccinated – too close	4	Vaccinated – no valid status
Value	Meaning												
0	Unvaccinated												
1	Vaccinated – complete												
2	Vaccinated – incomplete												
3	Vaccinated – too close												
4	Vaccinated – no valid status												

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	<p>Vaccination status is according to clinical completion status, which is determined by the National HPV Vaccination Program Register (NHVPR), based on an algorithm that considers number of doses and length of time between doses.</p> <p>‘Unvaccinated’ refers to individuals who have never received a dose of HPV vaccine, and as such, will not appear on the NHVPR.</p> <p>‘Complete’ refers to girls or women who received a full course of HPV vaccine at adequate intervals.</p> <p>‘Incomplete’ refers to girls or women who received only one or two doses of HPV vaccine rather than the currently recommended three doses.</p> <p>‘Too close’ refers to girls or women who received their HPV vaccine doses too close together, and as such their clinical status is uncertain.</p> <p>Definitions of ‘complete’, ‘incomplete’ and ‘too close’ are subject to change based on future research findings.</p> <p>‘No valid status’ is to be used for girls or women who are on the NHVPR but do not have a valid clinical completion status. These girls or women should not be interpreted as ‘unvaccinated’, which is to be reserved for girls or women who have never received a dose of HPV vaccine, and therefore do not appear on the NHVPR.</p>
<i>Comments</i>	The default status is ‘Unvaccinated’.

Source and reference attributes

Origin National HPV Vaccination Program Register

Relational attributes

Related metadata reference Supersedes *National cervical cancer prevention data dictionary Version 1, V2 Vaccination—HPV vaccination status, code N*

D2 HPV vaccination completion date

Identifying and definitional attributes

<i>Data item name</i>	HPV vaccination completion date
<i>Definition</i>	The date on which a woman is considered completely vaccinated with HPV vaccine.
<i>Collection status</i>	Conditional

Value domain attributes

<i>Representation class</i>	Date
<i>Data type</i>	Date/Time
<i>Format</i>	{DDMMYYYY}
<i>Maximum character length</i>	8

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	<p>Record the date that a girl or woman received an HPV vaccine dose that changed her status to 'complete', according to her clinical completion status, as shown in F1 'HPV vaccination status'.</p> <p>This data item should always be recorded as an 8-digit valid date comprising day, month and year. Year should always be recorded in its full 4 digit format. For days and months with a numeric value of less than 10, zeros should be used to ensure that the date contains the required 8 digits. For example, 1 July 2007 should be recorded as 01072007 as specified in the representational layout.</p>
<i>Business rule</i>	If F1 'HPV vaccination status' = 1 ('Complete'), F2 'HPV vaccination completion date' must be populated.

Source and reference attributes

<i>Origin</i>	National HPV Vaccination Program Register
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Relational attributes

<i>Related metadata reference</i>	Supersedes <i>National cervical cancer prevention data dictionary Version 1, V3 Vaccination—HPV vaccination completion date, date {DDMMYYYY}</i>
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D3 HPV vaccination episode date

Identifying and definitional attributes

<i>Data item name</i>	HPV vaccination episode date
<i>Definition</i>	The date on which a woman receives an HPV vaccine dose.
<i>Collection status</i>	Desirable

Value domain attributes

<i>Representation class</i>	Date
<i>Data type</i>	Date/Time
<i>Format</i>	DDMMYYYY
<i>Maximum character length</i>	8

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	<p>Record the date of a woman's vaccination episode. A separate episode date should be recorded for each dose a girl or woman receives. This can be any number — one to many.</p> <p>This data item should always be recorded as an 8-digit valid date comprising day, month and year. Year should always be recorded in its full 4 digit format. For days and months with a numeric value of less than 10, zeros should be used to ensure that the date contains the required 8 digits. For example, 1 July 2007 should be recorded as 01072007 as specified in the representational layout.</p>
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Source and reference attributes

<i>Origin</i>	National HPV Vaccination Program Register
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Relational attributes

<i>Related metadata reference</i>	Supersedes <i>National cervical cancer prevention data dictionary Version 1, V4 Vaccination—HPV vaccination episode date, date {DDMMYYYY}</i>
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D4 HPV vaccine dose number

Identifying and definitional attributes

<i>Data item name</i>	HPV vaccine dose number
<i>Definition</i>	The dose of HPV vaccine.
<i>Collection status</i>	Desirable

Value domain attributes

<i>Representation class</i>	Code
<i>Data type</i>	Number
<i>Format</i>	[NN]
<i>Maximum character length</i>	2

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	Most girls and women receive either 1, 2 or 3 doses, but there can be more doses given under particular circumstances, and it is not yet known whether booster doses will need to be administered.
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Source and reference attributes

<i>Origin</i>	National HPV Vaccination Program Register
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Relational attributes

<i>Related metadata reference</i>	Supersedes <i>National cervical cancer prevention data dictionary Version 1, V5 Vaccination—HPV vaccine dose number, code [NN]</i>
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D5 HPV vaccine type

Identifying and definitional attributes

<i>Data item name</i>	HPV vaccine type
<i>Definition</i>	The specific HPV vaccine used.
<i>Collection status</i>	Desirable

Value domain attributes

<i>Representation class</i>	Code								
<i>Data type</i>	Number								
<i>Format</i>	N[N]								
<i>Maximum character length</i>	2								
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Gardasil</td></tr><tr><td>2</td><td>Cervarix</td></tr><tr><td>99</td><td>Unknown</td></tr></tbody></table>	Value	Meaning	1	Gardasil	2	Cervarix	99	Unknown
Value	Meaning								
1	Gardasil								
2	Cervarix								
99	Unknown								

Data item attributes

Collection and usage attributes

<i>Comments</i>	While at the time of development of this data dictionary there were only two types of HPV vaccine used by the National HPV Vaccination Program, it is expected that this number will grow; the data dictionary will be updated with these additional types of HPV vaccine as these start to be used by the National HPV Vaccination Program.
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Source and reference attributes

<i>Origin</i>	National HPV Vaccination Program Register
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Relational attributes

<i>Related metadata reference</i>	Supersedes <i>National cervical cancer prevention data dictionary Version 1, V1 Vaccination—HPV vaccine type, code N</i>
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Group E: Client demographic data items

While it is preferable that demographic analyses are performed on place of residence, this may not be known, in which case demographic analyses are performed on the mailing address.

- E1 Residential address
- E2 Residential suburb/town/locality name
- E3 Residential alternative or other names for suburb/town/locality
- E4 Residential Australian state/territory
- E5 Residential Australian postcode
- E6 Residential geocode—latitude
- E7 Residential geocode—longitude
- E8 Residential geocode—quality
- E9 Residential SA1
- E10 Mailing geocode—latitude
- E11 Mailing geocode—longitude
- E12 Mailing geocode—quality
- E13 Mailing SA1

E1 Residential address

Identifying and definitional attributes

<i>Data item name</i>	Residential address
<i>Definition</i>	The address where a woman usually resides.
<i>Collection status</i>	Desirable

Value domain attributes

<i>Representation class</i>	Text
<i>Data type</i>	String
<i>Format</i>	[X(180)]
<i>Maximum character length</i>	180

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	<p>Address is a composite of one or more standard address components that describes a low level of geographical/physical description of a location. Used in conjunction with the other high-level address components, that is, Suburb/town/locality, Postcode — Australian, Australian state/territory, and Country, forms a complete geographical/physical address of a woman.</p> <p>Residential or a postal (mailing) address should be provided for a woman.</p>
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Relational attributes

<i>Related metadata references</i>	<p>Supersedes <i>National cervical cancer prevention data dictionary Version 1</i>, A11 Woman—residential address, text [X(180)]</p> <p>Supersedes <i>Standardised cervical screening data dictionary Cytology (first) sub-set data element 4 Person (address)—address line</i>, text X[X(180)]</p>
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E2 Residential suburb/town/locality name

Identifying and definitional attributes

<i>Data item name</i>	Residential suburb/town/locality name
<i>Definition</i>	The suburb/town/locality where a woman usually resides.
<i>Collection status</i>	Desirable

Value domain attributes

<i>Representation class</i>	Text
<i>Data type</i>	String
<i>Format</i>	[A(50)]
<i>Maximum character length</i>	50

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	<p>Suburb/town/locality is the text that represents the full name of the locality contained within the specific address of a woman.</p> <p>The suburb/town/locality name, may be a town, city, suburb or commonly used location name such as a large agricultural property or Aboriginal community. The Australian Bureau of Statistics has suggested that a maximum field length of 50 characters should be sufficient to record the vast majority of locality names. This metadata item may be used to describe the location of woman, organisation or event. It can be a component of a street or postal address.</p> <p>If there is no data for this item please refer to E3 'Residential alternative or other names for suburb/town/locality' as this may contain an alternative name the locality can be known by.</p> <p>Residential or a postal (mailing) address should be provided for a woman.</p>
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Relational attributes

<i>Related metadata references</i>	<p>Supersedes <i>National cervical cancer prevention data dictionary Version 1</i>, A12 Woman—residential suburb/town/locality name, text [A(50)]</p> <p>Supersedes <i>Standardised cervical screening data dictionary Cytology (first) sub-set data element 5 Person (address)</i>—suburb/town/locality name, text [A(50)]</p>
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E3 Residential alternative or other names for suburb/town/locality

Identifying and definitional attributes

<i>Data item name</i>	Residential alternative or other names for suburb/town/locality
<i>Definition</i>	The alternative name or other name of the suburb/town/locality (for example, an Indigenous name or a colloquial name for a locality that is different to the official or commonly used name) where a woman usually resides.
<i>Collection status</i>	Desirable

Value domain attributes

<i>Representation class</i>	Text
<i>Data type</i>	String
<i>Format</i>	[A(50)]
<i>Maximum character length</i>	50

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	<p>The alternative name or other name of the suburb/town/locality is, for example, an Indigenous name or a colloquial name for a locality that is different to the official or commonly used name, that is contained within the specific address of a woman.</p> <p>The alternative or other name for a suburb/town/locality may be used instead of, or in addition to, the official or commonly used name of the locality.</p>
<i>Collection methods</i>	If there is not an alternative or other name for a locality other than the official or commonly used name, then do not enter any data for this item.

Relational attributes

<i>Related metadata references</i>	<p>Supersedes <i>National cervical cancer prevention data dictionary Version 1</i>, A13 Woman—residential alternative or other names for suburb/town/locality, text [A(50)]</p> <p>Supersedes <i>Standardised cervical screening data dictionary Cytology (first) sub-set data element 6 Person</i>—alternative or other names for suburb/town/locality, text [A(50)]</p>
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E4 Residential Australian state/territory

Identifying and definitional attributes

<i>Data item name</i>	Residential Australian state/territory
<i>Definition</i>	The Australian state or territory in which a woman usually resides.
<i>Collection status</i>	Desirable

Value domain attributes

<i>Representation class</i>	Code																		
<i>Data type</i>	Text																		
<i>Format</i>	{AA[A]}																		
<i>Maximum character length</i>	3																		
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>NSW</td><td>New South Wales</td></tr><tr><td>VIC</td><td>Victoria</td></tr><tr><td>QLD</td><td>Queensland</td></tr><tr><td>WA</td><td>Western Australia</td></tr><tr><td>SA</td><td>South Australia</td></tr><tr><td>TAS</td><td>Tasmania</td></tr><tr><td>ACT</td><td>Australian Capital Territory</td></tr><tr><td>NT</td><td>Northern Territory</td></tr></tbody></table>	Value	Meaning	NSW	New South Wales	VIC	Victoria	QLD	Queensland	WA	Western Australia	SA	South Australia	TAS	Tasmania	ACT	Australian Capital Territory	NT	Northern Territory
Value	Meaning																		
NSW	New South Wales																		
VIC	Victoria																		
QLD	Queensland																		
WA	Western Australia																		
SA	South Australia																		
TAS	Tasmania																		
ACT	Australian Capital Territory																		
NT	Northern Territory																		

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	<p>This data item is important for national reporting by the Australian Institute of Health and Welfare.</p> <p>The order presented here is the standard for the Australian Institute of Health and Welfare, and reflects the current order of states and territories in order of most populated to least populated.</p> <p>Residential or a postal (mailing) address should be provided for a woman.</p>
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Relational attributes

<i>Related metadata reference</i>	Supersedes <i>National cervical cancer prevention data dictionary Version 1</i> , A14 Woman—residential Australian state/territory name, code {AA[A]}
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E5 Residential Australian postcode

Identifying and definitional attributes

<i>Data item name</i>	Residential Australian postcode
<i>Definition</i>	The code that represents a postal delivery area, aligned with locality, suburb or place for the address where a woman usually resides.
<i>Collection status</i>	Desirable

Value domain attributes

<i>Representation class</i>	Code
<i>Data type</i>	Number
<i>Format</i>	{NNNN}
<i>Maximum character length</i>	4

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	When used to supply data to the AIHW, it is preferable for the residential postcode to be 'at the time of test'.
<i>Comments</i>	Must accept zero as the leading digit to accommodate all Australian postcodes. Australian Postcode may be used in the analysis of data on a geographical basis, which involves a conversion from postcodes to the Australian Bureau of Statistics (ABS) postal areas. This conversion results in some inaccuracy of information. However, in some data sets postcode is the only geographic identifier, therefore the use of other more accurate indicators is not always possible.

Relational attributes

<i>Related metadata references</i>	Supersedes <i>National cervical cancer prevention data dictionary Version 1</i> , A15 Woman—residential Australian postcode, {NNNN} Supersedes <i>Standardised cervical screening data dictionary Cytology (first) sub-set data element 8 Person (address)—Australian postcode</i> , {NNNN}
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E6 Residential geocode—latitude

Identifying and definitional attributes

<i>Data item name</i>	Residential geocode—latitude
<i>Definition</i>	Latitude of place of residence.
<i>Collection status</i>	Desirable

Value domain attributes

<i>Representation class</i>	Identifier
<i>Data type</i>	Geospatial
<i>Format</i>	XN[N][.N(9)]
<i>Maximum character length</i>	13

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	<p>While it is preferable to conduct geospatial analyses based on place of residence, if this is not recorded for a client, then the mailing address can be used instead.</p> <p>The 'X' in the latitude format symbolises the designator symbol '+' or '-' and should be placed prior to the first number. Latitudes north of the equator are positive and shall be designated by use of the plus sign (+), latitudes south of the equator are negative and shall be designated by use of the minus sign (-). The equator shall be designated by use of the plus sign (+).</p> <p>The format XN[N][.N(9)] allows for 1 or 2 digit latitudes (that is, degree values) with the option of 0 to 9 decimal places (that is, decimal degree values).</p> <p>Usage examples:</p> <ul style="list-style-type: none">• +14.091360569• +2• -50.321
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Source and reference attributes

<i>Origin</i>	Standards Australia 2006. AS 4590—2006 Interchange of client information. Sydney: Standards Australia.
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Reference documents

Relational attributes

<i>Related metadata reference</i>	New data item
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E7 Residential geocode—longitude

Identifying and definitional attributes

<i>Data item name</i>	Residential geocode—longitude
<i>Definition</i>	Longitude of place of residence.
<i>Collection status</i>	Desirable

Value domain attributes

<i>Representation class</i>	Identifier
<i>Data type</i>	Geospatial
<i>Format</i>	XN[N][.N(9)]
<i>Maximum character length</i>	13

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	<p>The 'X' in the longitude format symbolises the designator symbol '+' or '-' and should be placed prior to the first number.</p> <p>The designator symbol for longitudes east of Greenwich are positive and shall be designated by use of the plus sign (+), while longitudes west of Greenwich are negative and shall be designated by use of the minus sign (-). The Prime Meridian shall be designated by use of the plus sign (+). The 180th meridian shall be designated by use of the minus sign (-).</p> <p>The format XN[N][.N(9)] allows for 1, 2 and 3 digit longitudes (that is, degrees) with the option of 0 to 9 decimal places (that is, decimal degrees).</p> <p>Usage examples:</p> <ul style="list-style-type: none">• +149.091360569• +2• -50.321
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Relational attributes

<i>Related metadata reference</i>	New data item
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E8 Residential geocode—quality

Identifying and definitional attributes

<i>Data item name</i>	Residential geocode—quality
<i>Definition</i>	A measure of the quality of geocode for place of residence.
<i>Collection status</i>	Desirable

Value domain attributes

<i>Representation class</i>	Code
<i>Data type</i>	Number
<i>Format</i>	N
<i>Maximum character length</i>	1

Data item attributes

Relational attributes

<i>Related metadata reference</i>	New data item
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E9 Residential SA1

Identifying and definitional attributes

<i>Data item name</i>	Residential SA1
<i>Definition</i>	SA1 of place of residence.
<i>Collection status</i>	Desirable

Value domain attributes

<i>Representation class</i>	Code
<i>Data type</i>	String
<i>Format</i>	N(11)
<i>Maximum character length</i>	11

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	SA1 coding structure: SA1s are identified by an 11-digit fully hierarchical code. The SA1 identifier is a 2-digit code, assigned within an SA2. An SA1 code is only unique within a state/territory when it is preceded by the state/territory identifier.
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For example:

State/territory	SA4	SA3	SA2	SA1
N	NN	NN	NNNN	NN

<i>Comments</i>	There are approximately 55,000 SA1s. In aggregate, they cover the whole of Australia without gaps or overlaps. SA1 can be used in geospatial analyses to assign individuals to any geography that is larger than this, such as SA2, SA3, SA4, or to geographies of interest such as Primary Health Network (PHN).
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Source and reference attributes

<i>Origin</i>	1270.0.55.001 — Australian Statistical Geography Standard (ASGS): Volume 1 — Main Structure and Greater Capital City Statistical Areas
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Reference documents

Relational attributes

<i>Related metadata reference</i>	New data item
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E10 Mailing geocode—latitude

Identifying and definitional attributes

<i>Data item name</i>	Mailing geocode—latitude
<i>Definition</i>	Latitude of mailing address.
<i>Collection status</i>	Desirable

Value domain attributes

<i>Representation class</i>	Identifier
<i>Data type</i>	Geospatial
<i>Format</i>	XN[N][.N(9)]
<i>Maximum character length</i>	13

Data item attributes

Collection and usage attributes

Guide for use While it is preferable to conduct geospatial analyses based on place of residence, if this is not recorded for a client, then the mailing address can be used instead.

The 'X' in the latitude format symbolises the designator symbol '+' or '-' and should be placed prior to the first number. Latitudes north of the equator are positive and shall be designated by use of the plus sign (+), latitudes south of the equator are negative and shall be designated by use of the minus sign (-). The equator shall be designated by use of the plus sign (+).

The format XN[N][.N(9)] allows for 1 or 2 digit latitudes (that is, degree values) with the option of 0 to 9 decimal places (that is, decimal degree values).

Usage examples:

- +14.091360569
- +2
- -50.321

Source and reference attributes

Origin Standards Australia 2006. AS 4590—2006 Interchange of client information. Sydney: Standards Australia.

Reference documents

Relational attributes

Related metadata reference New data item

E11 Mailing geocode—longitude

Identifying and definitional attributes

<i>Data item name</i>	Mailing geocode —longitude
<i>Definition</i>	Longitude of mailing address.
<i>Collection status</i>	Desirable

Value domain attributes

<i>Representation class</i>	Identifier
<i>Data type</i>	Geospatial
<i>Format</i>	XN[N][.N(9)]
<i>Maximum character length</i>	13

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	<p>While it is preferable to conduct geospatial analyses based on place of residence, if this is not recorded for a client, then the mailing address can be used instead.</p> <p>The 'X' in the longitude format symbolises the designator symbol '+' or '-' and should be placed prior to the first number.</p> <p>The designator symbol for longitudes east of Greenwich are positive and shall be designated by use of the plus sign (+), while longitudes west of Greenwich are negative and shall be designated by use of the minus sign (-). The Prime Meridian shall be designated by use of the plus sign (+). The 180th meridian shall be designated by use of the minus sign (-).</p> <p>The format XN[N][.N(9)] allows for 1, 2 and 3 digit longitudes (that is, degrees) with the option of 0 to 9 decimal places (that is, decimal degrees).</p> <p>Usage examples:</p> <ul style="list-style-type: none">• +149.091360569• +2• -50.321
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Relational attributes

<i>Related metadata reference</i>	New data item
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E12 Mailing geocode—quality

Identifying and definitional attributes

<i>Data item name</i>	Mailing geocode—quality
<i>Definition</i>	A measure of the quality of geocode for mailing address.
<i>Collection status</i>	Desirable

Value domain attributes

<i>Representation class</i>	Code
<i>Data type</i>	Number
<i>Format</i>	[N]
<i>Maximum character length</i>	1

Data item attributes

Relational attributes

<i>Related metadata reference</i>	New data item
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E13 Mailing SA1

Identifying and definitional attributes

<i>Data item name</i>	Mailing SA1
<i>Definition</i>	SA1 of mailing address.
<i>Collection status</i>	Desirable

Value domain attributes

<i>Representation class</i>	Code
<i>Data type</i>	String
<i>Format</i>	{N(11)}
<i>Maximum character length</i>	11

Data item attributes

Collection and usage attributes

Guide for use While it is preferable to conduct geospatial analyses based on place of residence, if this is not recorded for a client, then the mailing address can be used instead.
SA1 coding structure:

SA1s are identified by an 11-digit fully hierarchical code. The SA1 identifier is a 2-digit code, assigned within an SA2. An SA1 code is only unique within a state/territory when it is preceded by the state/territory identifier.

For example:

State/territory	SA4	SA3	SA2	SA1
N	NN	NN	NNNN	NN

Comments There are approximately 55,000 SA1s. In aggregate, they cover the whole of Australia without gaps or overlaps.
SA1 can be used in geospatial analyses to assign individuals to any geography that is larger than this, such as SA2, SA3, SA4, or to geographies of interest such as Primary Health Network (PHN).

Source and reference attributes

Origin 1270.0.55.001— Australian Statistical Geography Standard (ASGS): Volume 1 — Main Structure and Greater Capital City Statistical Areas

Reference documents

Relational attributes

Related metadata reference New data item

Group F: Contact data items

- F1 Type of contact
- F2 Date of contact
- F3 Method of contact
- F4 Contact failure flag
- F5 Contact failure date
- F6 Contact failure type

F1 Type of contact

Identifying and definitional attributes

<i>Data item name</i>	Type of contact
<i>Definition</i>	An indication of the type of contact made by a register with the client.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Code																								
<i>Data type</i>	Number																								
<i>Format</i>	AN																								
<i>Maximum character length</i>	2																								
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>A1</td><td>Screening invitation</td></tr><tr><td>A2</td><td>Screening reminder</td></tr><tr><td>B1</td><td>Screening invitation—self collection eligible</td></tr><tr><td>B2</td><td>Screening reminder—self collection eligible</td></tr><tr><td>C1</td><td>Rescreening invitation</td></tr><tr><td>C2</td><td>Rescreening reminder</td></tr><tr><td>D1</td><td>Rescreening invitation—self collection eligible</td></tr><tr><td>D2</td><td>Rescreening reminder—self collection eligible</td></tr><tr><td>E1</td><td>Exit letter</td></tr><tr><td>F0</td><td>Follow-up</td></tr><tr><td>G0</td><td>Other</td></tr></tbody></table>	Value	Meaning	A1	Screening invitation	A2	Screening reminder	B1	Screening invitation—self collection eligible	B2	Screening reminder—self collection eligible	C1	Rescreening invitation	C2	Rescreening reminder	D1	Rescreening invitation—self collection eligible	D2	Rescreening reminder—self collection eligible	E1	Exit letter	F0	Follow-up	G0	Other
Value	Meaning																								
A1	Screening invitation																								
A2	Screening reminder																								
B1	Screening invitation—self collection eligible																								
B2	Screening reminder—self collection eligible																								
C1	Rescreening invitation																								
C2	Rescreening reminder																								
D1	Rescreening invitation—self collection eligible																								
D2	Rescreening reminder—self collection eligible																								
E1	Exit letter																								
F0	Follow-up																								
G0	Other																								

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	<p>Screening refers to a woman's first screen in the program; rescreening refers to any screen that is not her first.</p> <p>A1 & A2 applies to:</p> <ul style="list-style-type: none">• women turning 25 who have never screened before; or• women aged between 25 and <30 who have been newly identified from Medicare enrolment data but have not been sent an invitation previously; or• women aged between 25 and <30 who have a screening history and are not eligible for self collection. <p>B1 & B2 applies to:</p> <ul style="list-style-type: none">• women aged ≥ 30 and <75 who have been newly identified from Medicare enrolment data. <p>C1 & C2 applies to:</p> <ul style="list-style-type: none">• women aged between ≥ 30 to <75 years of age who have a
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screening history and are less than two years overdue for their next screening test.

D1 & D2 applies to:

- women aged between 30 and <75 years of age who have screening history and are more than 2 years overdue for their next screening test.

E1 refers to a letter that is sent to women aged 70–74 who are invited to have an HPV test and oncogenic HPV is not detected in their HPV test, as they will no longer be invited to rescreen.

F0 refers to any follow-up contact with a woman.

G0 refers to other correspondence sent to a woman such as a welcome letter or a letter to acknowledge opt-out.

Comments

This data item relates only to contact with a client by a register.

Relational attributes

Related metadata reference

New data item

F2 Date of contact

Identifying and definitional attributes

<i>Data item name</i>	Date of contact
<i>Definition</i>	The date on which a register attempted to contact a client.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Date
<i>Data type</i>	Date/Time
<i>Format</i>	DDMMYYYY
<i>Maximum character length</i>	8

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	The date of contact is the date that an attempt was made by a register. This may not be the same date that the client received the correspondence, as there can be a delay between the date a letter, email or SMS is sent by a register and the date a client receives the correspondence.
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<i>Comments</i>	This data item relates only to contact with a client by a register.
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Relational attributes

<i>Related metadata reference</i>	New data item
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F3 Method of contact

Identifying and definitional attributes

<i>Data item name</i>	Method of contact
<i>Definition</i>	The method by which contact with a client by a register was attempted.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Code										
<i>Data type</i>	Number										
<i>Format</i>	N										
<i>Maximum character length</i>	1										
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Mail</td></tr><tr><td>2</td><td>Telephone</td></tr><tr><td>3</td><td>SMS</td></tr><tr><td>4</td><td>Email</td></tr></tbody></table>	Value	Meaning	1	Mail	2	Telephone	3	SMS	4	Email
Value	Meaning										
1	Mail										
2	Telephone										
3	SMS										
4	Email										

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	Method of contact is likely to differ depending on the type of contact as specified in F1 'Type of contact'.
<i>Comments</i>	This data item relates only to contact with a client by a register.

Relational attributes

<i>Related metadata reference</i>	New data item
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F4 Contact failure flag

Identifying and definitional attributes

<i>Data item name</i>	Contact failure flag
<i>Definition</i>	An indication that a client's contact details are not valid.
<i>Collection status</i>	Optional

Value domain attributes

<i>Representation class</i>	Code				
<i>Data type</i>	Number				
<i>Format</i>	{N}				
<i>Maximum character length</i>	1				
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Contact failure</td></tr></tbody></table>	Value	Meaning	1	Contact failure
Value	Meaning				
1	Contact failure				

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	<p>'Contact failure' flag is to be used in any instance where a client's contact details are found to be invalid. This may take the form of a letter marked 'return to sender', an email address that 'bounces', or verbal communication via telephone that the client no longer resides or works at the designated telephone number.</p> <p>This flag can be used several times for one client, if more than one method of contact is determined to be invalid.</p> <p>A client may only have one method of contact (usually a mailing address). If there are no other contact details recorded for a client, they will be lost to follow-up until such time as new contact information is received.</p>
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Relational attributes

<i>Related metadata reference</i>	New data item
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F5 Contact failure date

Identifying and definitional attributes

<i>Data item name</i>	Contact failure date
<i>Definition</i>	Date on which contact failure notification was received by the NCSR.
<i>Collection status</i>	Desirable

Value domain attributes

<i>Representation class</i>	Date
<i>Data type</i>	Date/Time
<i>Format</i>	{DDMMYYYY}
<i>Maximum character length</i>	8

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	This would be the date a letter marked 'return to sender' was received, or the date of an email or verbal indication of invalid contact details.
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Relational attributes

<i>Related metadata reference</i>	New data item
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F6 Contact failure type

Identifying and definitional attributes

<i>Data item name</i>	Contact failure type
<i>Definition</i>	The type of contact details found to be invalid
<i>Collection status</i>	Desirable

Value domain attributes

<i>Representation class</i>	Code												
<i>Data type</i>	Number												
<i>Format</i>	{N}												
<i>Maximum character length</i>	1												
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Mailing address</td></tr><tr><td>2</td><td>Telephone number—home</td></tr><tr><td>3</td><td>Telephone number—work</td></tr><tr><td>4</td><td>Telephone number—mobile</td></tr><tr><td>5</td><td>Email address</td></tr></tbody></table>	Value	Meaning	1	Mailing address	2	Telephone number—home	3	Telephone number—work	4	Telephone number—mobile	5	Email address
Value	Meaning												
1	Mailing address												
2	Telephone number—home												
3	Telephone number—work												
4	Telephone number—mobile												
5	Email address												

Data item attributes

Relational attributes

<i>Related metadata reference</i>	New data item
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Group G: Test type data item

G1 Type of test

G1 Type of test

Identifying and definitional attributes

<i>Data item name</i>	Type of test
<i>Definition</i>	Whether the test of interest is an HPV test, a cytology test (either LBC or conventional Pap test), colposcopy, or histology test.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Code										
<i>Data type</i>	String										
<i>Format</i>	A										
<i>Maximum character length</i>	1										
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>V</td><td>HPV test</td></tr><tr><td>C</td><td>Cytology test</td></tr><tr><td>P</td><td>Colposcopy</td></tr><tr><td>H</td><td>Histology test</td></tr></tbody></table>	Value	Meaning	V	HPV test	C	Cytology test	P	Colposcopy	H	Histology test
Value	Meaning										
V	HPV test										
C	Cytology test										
P	Colposcopy										
H	Histology test										

Data item attributes

Relational attributes

<i>Related metadata references</i>	Supersedes <i>National cervical cancer prevention data dictionary Version 1</i> , T1 Type of test—code A Supersedes <i>Standardised cervical screening data dictionary Cytology (first) sub-set data element 26 Pathology laboratory—test type</i> , code AN
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Group H: HPV test data items

H1	HPV test date
H2	HPV test collection method
H3	HPV test specimen site
H4	Reason for HPV test
H5	HPV test result—oncogenic HPV
H6	Secondary HPV test result—HPV 16/18 detected
H7	Secondary HPV test result—oncogenic HPV (not 16/18) detected
H8	HPV test type
H9	HPV test sample
H10	HPV test batch information—Control kit lot number
H11	HPV test batch information—Control kit expiry date
H12	HPV test batch information—Cellular (LBC) extraction kit lot number
H13	HPV test batch information—Cellular (LBC) extraction kit expiry date
H14	HPV test batch information—Nucleic acid extraction kit lot number
H15	HPV test batch information—Nucleic acid extraction kit expiry date
H16	HPV test batch information—Amplification kit lot number
H17	HPV test batch information—Amplification kit expiry date
H18	HPV test batch information—Detection kit lot number
H19	HPV test batch information—Detection kit expiry date
H20	HPV test batch information—Wash buffer lot number
H21	HPV test batch information—Wash buffer expiry date

H1 HPV test date

Identifying and definitional attributes

<i>Data item name</i>	HPV test date
<i>Definition</i>	The date specimen for HPV test was collected.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Date
<i>Data type</i>	Date/Time
<i>Format</i>	DDMMYYYY
<i>Maximum character length</i>	8

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	This is an important date, as it is used to determine other features of interest that occur 'at time of test', such as age at test, remoteness area and socioeconomic area of residence at time of test, HPV vaccination status at time of test, etcetera.
<i>Collection methods</i>	<p>For a single cervical test, there can be a test request date, a test collection date, a laboratory receipt date, a laboratory report date and a laboratory transmission date.</p> <p>The date of interest for reporting is the test collection date, as this is the date on which the specimen was collected from the woman.</p> <p>If test collection date is unknown, another date can be used instead, and will be treated as the test date. This should be receipt date, followed by report date, followed by transmission date.</p>
<i>Comments</i>	Registers need to collect all dates to ensure timely progression of a specimen, for instance by determining the time between the laboratory receipt date, the laboratory report date, and the laboratory transmission date.

Relational attributes

<i>Related metadata reference</i>	Supersedes <i>National cervical cancer prevention data dictionary Version 1</i> , D2 HPV DNA test—date of HPV DNA test, date DDMMYYYY
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H2 HPV test collection method

Identifying and definitional attributes

<i>Data item name</i>	HPV test collection method
<i>Definition</i>	An indication of whether an HPV test sample is collected by a practitioner or self-collected.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Code						
<i>Data type</i>	Number						
<i>Format</i>	N						
<i>Maximum character length</i>	1						
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Practitioner-collected sample</td></tr><tr><td>2</td><td>Self-collected sample</td></tr></tbody></table>	Value	Meaning	1	Practitioner-collected sample	2	Self-collected sample
Value	Meaning						
1	Practitioner-collected sample						
2	Self-collected sample						

Data item attributes

Relational attributes

<i>Related metadata reference</i>	New data item
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H3 HPV test specimen site

Identifying and definitional attributes

<i>Data item name</i>	HPV test specimen site
<i>Definition</i>	An indication as to the site from which the specimen was collected.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Code	
<i>Data type</i>	Number	
<i>Format</i>	N	
<i>Maximum character length</i>	1	
<i>Permissible values</i>	Value	Meaning
	0	Not stated
	1	Cervical
	2	Vaginal
	3	Other gynaecological site

Data item attributes

Relational attributes

<i>Related metadata reference</i>	New data item
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H4 Reason for HPV test

Identifying and definitional attributes

<i>Data item name</i>	Reason for HPV test
<i>Definition</i>	The reason why an HPV test is performed.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Code														
<i>Data type</i>	Number														
<i>Format</i>	N{XXX}														
<i>Maximum character length</i>	4														
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Primary screening HPV test</td></tr><tr><td>2</td><td>Follow-up HPV test (Repeat HPV test after intermediate risk result or unsatisfactory test)</td></tr><tr><td>3i</td><td>Co-test— test of cure</td></tr><tr><td>3ii</td><td>Co-test— investigation of signs or symptoms</td></tr><tr><td>3iii</td><td>Co-test— other, as recommended in guidelines</td></tr><tr><td>4</td><td>Other</td></tr></tbody></table>	Value	Meaning	1	Primary screening HPV test	2	Follow-up HPV test (Repeat HPV test after intermediate risk result or unsatisfactory test)	3i	Co-test— test of cure	3ii	Co-test— investigation of signs or symptoms	3iii	Co-test— other, as recommended in guidelines	4	Other
Value	Meaning														
1	Primary screening HPV test														
2	Follow-up HPV test (Repeat HPV test after intermediate risk result or unsatisfactory test)														
3i	Co-test— test of cure														
3ii	Co-test— investigation of signs or symptoms														
3iii	Co-test— other, as recommended in guidelines														
4	Other														

Data item attributes

Relational attributes

<i>Related metadata reference</i>	New data item
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H5 HPV test result—oncogenic HPV

Identifying and definitional attributes

<i>Data item name</i>	HPV test result—oncogenic HPV
<i>Definition</i>	The result of an HPV test for oncogenic HPV types.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Code										
<i>Data type</i>	String										
<i>Format</i>	X										
<i>Maximum character length</i>	1										
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>U</td><td>Unsatisfactory</td></tr><tr><td>0</td><td>Oncogenic HPV not detected</td></tr><tr><td>1</td><td>HPV 16/18 detected</td></tr><tr><td>2</td><td>Oncogenic HPV (not 16/18) detected</td></tr></tbody></table>	Value	Meaning	U	Unsatisfactory	0	Oncogenic HPV not detected	1	HPV 16/18 detected	2	Oncogenic HPV (not 16/18) detected
Value	Meaning										
U	Unsatisfactory										
0	Oncogenic HPV not detected										
1	HPV 16/18 detected										
2	Oncogenic HPV (not 16/18) detected										

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	<p>'U Unsatisfactory' indicates that the HPV test was unsatisfactory.</p> <p>'0 Oncogenic HPV not detected' indicates that none of the 14 oncogenic HPV types were detected.</p> <p>'1 HPV 16/18 detected' indicates that one or more of the oncogenic HPV types 16 or 18 were detected. Data item H6 'Secondary HPV test result—HPV 16/18 detected' provides further information as to which of these HPV types were detected.</p> <p>'2 Oncogenic HPV (not 16/18) detected' indicates that one or more of the oncogenic HPV types 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 66, or 68 were detected. Data item H7 'Secondary HPV test result—oncogenic HPV (not 16/18) detected' provides further information as to which of these HPV types were detected.</p>
<i>Collection methods</i>	A register will be able to store more than one HPV test outcome for each HPV test. A register will then use an algorithm to determine the most serious HPV type recorded which will be used, along with the reflex LBC (where this is required) to assign a woman with an overall risk for cervical cancer precursors.

Relational attributes

<i>Related metadata reference</i>	Supersedes <i>National cervical cancer prevention data dictionary Version 1</i> , D6 HPV DNA test—High-risk HPV DNA result, code AX
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H6 Secondary HPV test result—HPV 16/18 detected

Identifying and definitional attributes

<i>Data item name</i>	Secondary HPV test result—HPV 16/18 detected
<i>Definition</i>	The secondary HPV test result where the primary HPV test result was 'HPV 16/18 detected' providing additional information about oncogenic test types detected.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Code								
<i>Data type</i>	Number								
<i>Format</i>	N								
<i>Maximum character length</i>	1								
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Type 16 detected</td></tr><tr><td>2</td><td>Type 18 detected</td></tr><tr><td>3</td><td>Type 18/45 detected</td></tr></tbody></table>	Value	Meaning	1	Type 16 detected	2	Type 18 detected	3	Type 18/45 detected
Value	Meaning								
1	Type 16 detected								
2	Type 18 detected								
3	Type 18/45 detected								

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	This data item is used to provide secondary HPV test result information when H5 'HPV test result—oncogenic HPV' = 1 HPV 16/18 detected.
<i>Rules for use</i>	If H5 'HPV test result—oncogenic HPV' = 1 then H6 'Secondary HPV test result—HPV 16/18 detected' should be populated.
<i>Collection methods</i>	A register will be able to store more than one HPV test outcome for each HPV test. A register will then use an algorithm to determine the most serious HPV type recorded which will be used, along with the reflex LBC (where this is required) to assign a woman with an overall risk for cervical cancer precursors.

Relational attributes

<i>Related metadata reference</i>	New data item
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H7 Secondary HPV test result—oncogenic HPV (not 16/18) detected

Identifying and definitional attributes

<i>Data item name</i>	Secondary HPV test result—oncogenic HPV (not 16/18) detected
<i>Definition</i>	The secondary HPV test result where the primary HPV test result was 'Oncogenic HPV (not 16/18) detected' providing additional information about oncogenic HPV types detected.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Code						
<i>Data type</i>	Number						
<i>Format</i>	N						
<i>Maximum character length</i>	1						
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>One or more of the following types detected: 31, 33, 45, 52, or 58</td></tr><tr><td>2</td><td>One or more of the following types detected: 35, 39, 51, 56, 59, 66, or 68</td></tr></tbody></table>	Value	Meaning	1	One or more of the following types detected: 31, 33, 45, 52, or 58	2	One or more of the following types detected: 35, 39, 51, 56, 59, 66, or 68
Value	Meaning						
1	One or more of the following types detected: 31, 33, 45, 52, or 58						
2	One or more of the following types detected: 35, 39, 51, 56, 59, 66, or 68						

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	This data item is used to provide secondary HPV test result information when H5 'HPV test result—oncogenic HPV' = 2 Oncogenic HPV (not 16/18) detected.
<i>Rules for use</i>	If H5 'HPV test result—oncogenic HPV' = 2 then H7 'Secondary HPV test result—oncogenic HPV (not 16/18) detected' should be populated.
<i>Collection methods</i>	A register will be able to store more than one HPV test outcome for each HPV test. A register will then use an algorithm to determine the most serious HPV type recorded which will be used, along with the reflex LBC (where this is required) to assign a woman with an overall risk for cervical cancer precursors.
<i>Comments</i>	<p>Oncogenic HPV (not 16/18) has been broken into two groups to align with the HPV types that are included in the 9-valent HPV vaccine, as it is recognised that it would be valuable in future to be able to assess an HPV test result in the context of vaccination history.</p> <p>The HPV types included in the 9-valent HPV vaccine are (in addition to 6, 11, 16 and 18) 31, 33, 45, 52, and 58 (as detailed in value 1).</p>

Relational attributes

<i>Related metadata reference</i>	New data item
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H8 HPV test type

Identifying and definitional attributes

<i>Data item name</i>	HPV test type
<i>Definition</i>	The type of test used to determine the oncogenic HPV test result.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Code
<i>Data type</i>	Number
<i>Format</i>	N{XXX}
<i>Maximum character length</i>	3

<i>Permissible values</i>	Value	Meaning
	0	Not stated
	1i	Qiagen—Hybrid capture II
	2i	Roche—cobas 4800
	2ii	Roche—cobas 6800
	2iii	Roche—cobas 8800
	3i	Abbott—m2000
	3ii	Abbott—Alinity m
	4i	Becton Dickinson—Onclarity
	5i	Cepheid—Xpert
	6i	Hologic—Cervista
	6ii	Hologic—Aptima
	7i	Seegene—Anyplex
	8i	Genera—PapType
	9i	Euroimmun—Euroarray
	999	Other

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	HPV test types have been grouped according to manufacture, with the specific platforms listed. This will provide detailed information about HPV test type for quality monitoring of this screening test, as well as enabling additional HPV test types to be added in the future.
<i>Collection methods</i>	Registers will be able to store more than one HPV test outcome for each HPV test, with the field for this duplicated as many times as is required to store all outcomes transmitted. Registers will then use an algorithm to determine the most serious HPV type recorded which will be used, along with the reflex LBC (where this is required) to assign a woman with an overall risk of significant cervical abnormality (low, intermediate or higher).

Comments

The HPV test types listed here will be tests that are registered on the ARTG for HPV testing of cervical samples. It is not an indication of which tests are suitable for use in the NCSP. Only those HPV tests that meet the requirements set out in the NPAAC Standards and Performance Measures for cervical screening should be used in the NCSP. Tests that do not meet the requirements now may meet them in future and therefore all tests listed on the ARTG will be coded. The HPV tests currently listed are tests which were known to be registered on the ARTG at the time of developing the data dictionary. There may be others that are on the ARTG and were not identified at the time of development or will be added in future. Any tests that are listed on the ARTG will be added to the data dictionary if the NCSP is informed.

Relational attributes

Related metadata references

Supersedes *National cervical cancer prevention data dictionary Version 1*, D5 HPV DNA test—HPV DNA test type, code ANN
Supersedes Cytology (first) sub-set data element 28 Person—HPV DNA test type, code AAN

H9 HPV test sample

Identifying and definitional attributes

<i>Data item name</i>	HPV test sample
<i>Definition</i>	Information about the sample collected for an HPV test
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Code														
<i>Data type</i>	Number														
<i>Format</i>	N{N}														
<i>Maximum character length</i>	2														
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>0</td><td>Not stated</td></tr><tr><td>1</td><td>PreservCyt Solution</td></tr><tr><td>2</td><td>SurePath medium</td></tr><tr><td>97</td><td>Other commercial self-collection device</td></tr><tr><td>98</td><td>Specimen transport medium</td></tr><tr><td>99</td><td>Flocked or cotton swab</td></tr></tbody></table>	Value	Meaning	0	Not stated	1	PreservCyt Solution	2	SurePath medium	97	Other commercial self-collection device	98	Specimen transport medium	99	Flocked or cotton swab
Value	Meaning														
0	Not stated														
1	PreservCyt Solution														
2	SurePath medium														
97	Other commercial self-collection device														
98	Specimen transport medium														
99	Flocked or cotton swab														

Data item attributes

Collection and usage attributes

Guide for use	<p>This data item is intended to provide information about the sample that is provided, and whether it is suitable for HPV testing and reflex LBC testing, or whether it is suitable only for HPV testing, with a second sample required for reflex LBC testing (if indicated).</p> <p>Values ≥ 90 will be suitable for HPV testing only, either due the sample being self-collected, or due to an inappropriate sampling device or sampling media being used.</p>
Collection methods	<p>If the head of a swab is received by the laboratory in sampling media such as PreservCyt or SurePath, then it must be coded as '99 Flocked or cotton swab'.</p>

Relational attributes

<i>Related metadata reference</i>	New data item
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H10 HPV test batch information—Control kit lot number

Identifying and definitional attributes

<i>Data item name</i>	HPV test batch information—Control kit lot number
<i>Definition</i>	Lot number from the control kit
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Identifier
<i>Data type</i>	String
<i>Format</i>	X[X(19)]
<i>Maximum character length</i>	20

Data item attributes

Collection and usage attributes

<i>Collection methods</i>	For each of these codes one or more Lot numbers and associated expiry dates need to be reported. The fields need to be able to accept both letters and numbers as well as N/A (in the case of LBC extraction on a self-collected sample). Where a 'kit' includes reagents for multiple testing steps the Lot numbers and expiry dates should be repeated for each of the codes.
<i>Comments</i>	Collected by pathology laboratories

Relational attributes

<i>Related metadata reference</i>	New data item
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H11 HPV test batch information—Control kit expiry date

Identifying and definitional attributes

<i>Data item name</i>	HPV test batch information—Control kit expiry date
<i>Definition</i>	The expiry date of the control kit.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Date
<i>Data type</i>	Date/Time
<i>Format</i>	DDMMYYYY
<i>Maximum character length</i>	8

Data item attributes

Collection and usage attributes

<i>Collection methods</i>	For each of these codes one or more Lot numbers and associated expiry dates need to be reported. The fields need to be able to accept both letters and numbers as well as N/A (in the case of LBC extraction on a self-collected sample). Where a 'kit' includes reagents for multiple testing steps the Lot numbers and expiry dates should be repeated for each of the codes.
<i>Comments</i>	Collected by pathology laboratories

Relational attributes

<i>Related metadata reference</i>	New data item
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H12 HPV test batch information—Cellular (LBC) extraction kit lot number

Identifying and definitional attributes

<i>Data item name</i>	HPV test batch information—Cellular (LBC) extraction kit lot number
<i>Definition</i>	Lot number from the cellular (LBC) extraction kit.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Identifier
<i>Data type</i>	String
<i>Format</i>	X[X(19)]
<i>Maximum character length</i>	20

Data item attributes

Collection and usage attributes

<i>Collection methods</i>	For each of these codes one or more Lot numbers and associated expiry dates need to be reported. The fields need to be able to accept both letters and numbers as well as N/A (in the case of LBC extraction on a self-collected sample). Where a 'kit' includes reagents for multiple testing steps the Lot numbers and expiry dates should be repeated for each of the codes.
<i>Comments</i>	Collected by pathology laboratories

Relational attributes

<i>Related metadata reference</i>	New data item
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H13 HPV test batch information—Cellular (LBC) extraction kit expiry date

Identifying and definitional attributes

<i>Data item name</i>	HPV test batch information—Cellular (LBC) extraction kit expiry date
<i>Definition</i>	The expiry date of the cellular (LBC) extraction kit.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Date
<i>Data type</i>	Date/Time
<i>Format</i>	DDMMYYYY
<i>Maximum character length</i>	8

Data item attributes

Collection and usage attributes

<i>Collection methods</i>	For each of these codes one or more Lot numbers and associated expiry dates need to be reported. The fields need to be able to accept both letters and numbers as well as N/A (in the case of LBC extraction on a self-collected sample). Where a 'kit' includes reagents for multiple testing steps the Lot numbers and expiry dates should be repeated for each of the codes.
<i>Comments</i>	Collected by pathology laboratories

Relational attributes

<i>Related metadata reference</i>	New data item
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H14 HPV test batch information—Nucleic acid extraction kit lot number

Identifying and definitional attributes

<i>Data item name</i>	HPV test batch information—Nucleic acid extraction kit lot number
<i>Definition</i>	Lot number from the nucleic acid extraction kit.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Identifier
<i>Data type</i>	String
<i>Format</i>	X[X(19)]
<i>Maximum character length</i>	20

Data item attributes

Collection and usage attributes

<i>Collection methods</i>	For each of these codes one or more Lot numbers and associated expiry dates need to be reported. The fields need to be able to accept both letters and numbers as well as N/A (in the case of LBC extraction on a self-collected sample). Where a 'kit' includes reagents for multiple testing steps the Lot numbers and expiry dates should be repeated for each of the codes.
<i>Comments</i>	Collected by pathology laboratories

Relational attributes

<i>Related metadata reference</i>	New data item
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H15 HPV test batch information—Nucleic acid extraction kit expiry date

Identifying and definitional attributes

<i>Data item name</i>	HPV test batch information—Nucleic acid extraction kit expiry date
<i>Definition</i>	The expiry date of the nucleic acid extraction kit.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Date
<i>Data type</i>	Date/Time
<i>Format</i>	DDMMYYYY
<i>Maximum character length</i>	8

Data item attributes

Collection and usage attributes

<i>Collection methods</i>	For each of these codes one or more Lot numbers and associated expiry dates need to be reported. The fields need to be able to accept both letters and numbers as well as N/A (in the case of LBC extraction on a self-collected sample). Where a 'kit' includes reagents for multiple testing steps the Lot numbers and expiry dates should be repeated for each of the codes.
<i>Comments</i>	Collected by pathology laboratories

Relational attributes

<i>Related metadata reference</i>	New data item
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H16 HPV test batch information—Amplification kit lot number

Identifying and definitional attributes

<i>Data item name</i>	HPV test batch information—Amplification kit lot number
<i>Definition</i>	Lot number from the amplification kit.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Identifier
<i>Data type</i>	String
<i>Format</i>	X[X(19)]
<i>Maximum character length</i>	20

Data item attributes

Collection and usage attributes

<i>Collection methods</i>	For each of these codes one or more Lot numbers and associated expiry dates need to be reported. The fields need to be able to accept both letters and numbers as well as N/A (in the case of LBC extraction on a self-collected sample). Where a 'kit' includes reagents for multiple testing steps the Lot numbers and expiry dates should be repeated for each of the codes.
<i>Comments</i>	Collected by pathology laboratories

Relational attributes

<i>Related metadata reference</i>	New data item
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H17 HPV test batch information—Amplification kit expiry date

Identifying and definitional attributes

<i>Data item name</i>	HPV test batch information—Amplification kit expiry date
<i>Definition</i>	The expiry date of the amplification kit.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Date
<i>Data type</i>	Date/Time
<i>Format</i>	DDMMYYYY
<i>Maximum character length</i>	8

Data item attributes

Collection and usage attributes

<i>Collection methods</i>	For each of these codes one or more Lot numbers and associated expiry dates need to be reported. The fields need to be able to accept both letters and numbers as well as N/A (in the case of LBC extraction on a self-collected sample). Where a 'kit' includes reagents for multiple testing steps the Lot numbers and expiry dates should be repeated for each of the codes.
<i>Comments</i>	Collected by pathology laboratories

Relational attributes

<i>Related metadata reference</i>	New data item
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H18 HPV test batch information—Detection kit lot number

Identifying and definitional attributes

<i>Data item name</i>	HPV test batch information—Detection kit lot number
<i>Definition</i>	Lot number from the detection kit.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Identifier
<i>Data type</i>	String
<i>Format</i>	X[X(19)]
<i>Maximum character length</i>	20

Data item attributes

Collection and usage attributes

<i>Collection methods</i>	For each of these codes one or more Lot numbers and associated expiry dates need to be reported. The fields need to be able to accept both letters and numbers as well as N/A (in the case of LBC extraction on a self-collected sample). Where a 'kit' includes reagents for multiple testing steps the Lot numbers and expiry dates should be repeated for each of the codes.
<i>Comments</i>	Collected by pathology laboratories

Relational attributes

<i>Related metadata reference</i>	New data item
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H19 HPV test batch information—Detection kit expiry date

Identifying and definitional attributes

<i>Data item name</i>	HPV test batch information—Detection kit expiry date
<i>Definition</i>	The expiry date of the detection kit.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Date
<i>Data type</i>	Date/Time
<i>Format</i>	DDMMYYYY
<i>Maximum character length</i>	8

Data item attributes

Collection and usage attributes

<i>Collection methods</i>	For each of these codes one or more Lot numbers and associated expiry dates need to be reported. The fields need to be able to accept both letters and numbers as well as N/A (in the case of LBC extraction on a self-collected sample). Where a 'kit' includes reagents for multiple testing steps the Lot numbers and expiry dates should be repeated for each of the codes.
<i>Comments</i>	Collected by pathology laboratories

Relational attributes

<i>Related metadata reference</i>	New data item
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H20 HPV test batch information—Wash buffer lot number

Identifying and definitional attributes

<i>Data item name</i>	HPV test batch information—Wash buffer lot number
<i>Definition</i>	Lot number from the wash buffer.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Identifier
<i>Data type</i>	String
<i>Format</i>	X[X(19)]
<i>Maximum character length</i>	20

Data item attributes

Collection and usage attributes

<i>Collection methods</i>	For each of these codes one or more Lot numbers and associated expiry dates need to be reported. The fields need to be able to accept both letters and numbers as well as N/A (in the case of LBC extraction on a self-collected sample). Where a 'kit' includes reagents for multiple testing steps the Lot numbers and expiry dates should be repeated for each of the codes.
<i>Comments</i>	Collected by pathology laboratories

Relational attributes

<i>Related metadata reference</i>	New data item
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H21 HPV test batch information—Wash buffer expiry date

Identifying and definitional attributes

<i>Data item name</i>	HPV test batch information—Wash buffer expiry date
<i>Definition</i>	The expiry date of the wash buffer.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Date
<i>Data type</i>	Date/Time
<i>Format</i>	DDMMYYYY
<i>Maximum character length</i>	8

Data item attributes

Collection and usage attributes

<i>Collection methods</i>	For each of these codes one or more Lot numbers and associated expiry dates need to be reported. The fields need to be able to accept both letters and numbers as well as N/A (in the case of LBC extraction on a self-collected sample). Where a 'kit' includes reagents for multiple testing steps the Lot numbers and expiry dates should be repeated for each of the codes.
<i>Comments</i>	Collected by pathology laboratories

Relational attributes

<i>Related metadata reference</i>	New data item
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Group I: Cytology test data items

- I1 Cytology test date
- I2 Cytology test specimen type
- I3 Cytology test specimen site
- I4 Reason for cytology test
- I5 Cytology test squamous cytology cell analysis
- I6 Cytology test endocervical (glandular) cytology cell analysis
- I7 Cytology test other/non-cervical cytology cell analysis
- I8 Cytology test result

I1 Cytology test date

Identifying and definitional attributes

<i>Data item name</i>	Cytology test date
<i>Definition</i>	The date when a specimen for a cytology test was collected.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Date
<i>Data type</i>	Date/Time
<i>Format</i>	DDMMYYYY
<i>Maximum character length</i>	8

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	This is an important date, as it is used to determine other features of interest that occur 'at time of test', such as age at test, remoteness area and socioeconomic area of residence at time of test, HPV vaccination status at time of test, etcetera.
<i>Collection methods</i>	<p>For a single cervical test, there can be a test request date, a test collection date, a laboratory receipt date, a laboratory report date and a laboratory transmission date.</p> <p>The date of interest for reporting is the test collection date, as this is the date on which the specimen was collected from the woman.</p> <p>If test collection date is unknown, another date can be used instead, and will be treated as the test date. This should be receipt date, followed by report date, followed by transmission date.</p> <p>The National Cancer Screening Register needs to collect all dates associated with a specimen so that analyses can be performed to ensure timely progression of a specimen, for instance by determining the time between the laboratory receipt date, the laboratory report date, and the laboratory transmission date.</p>
<i>Comments</i>	Collected by pathology laboratories

Relational attributes

<i>Related metadata references</i>	<p>Supersedes <i>National cervical cancer prevention data dictionary Version 1</i>, C2 Cytology test—date of cytology test, date DDMMYYYY</p> <p>Supersedes <i>Standardised cervical screening data dictionary</i> Cytology (first) sub-set data element 12 Person—date of cervical cytology screening specimen, date DDMMYYYY</p>
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I2 Cytology test specimen type

Identifying and definitional attributes

<i>Data item name</i>	Cytology test specimen type
<i>Definition</i>	An indication as to whether the cytology specimen is liquid-based cytology (LBC) or a conventional Pap test.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Code										
<i>Data type</i>	String										
<i>Format</i>	AN										
<i>Maximum character length</i>	2										
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>A0</td><td>Not stated</td></tr><tr><td>A1</td><td>Conventional smear</td></tr><tr><td>A2</td><td>Liquid-based specimen</td></tr><tr><td>A3</td><td>Conventional smear and liquid-based</td></tr></tbody></table>	Value	Meaning	A0	Not stated	A1	Conventional smear	A2	Liquid-based specimen	A3	Conventional smear and liquid-based
Value	Meaning										
A0	Not stated										
A1	Conventional smear										
A2	Liquid-based specimen										
A3	Conventional smear and liquid-based										

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	While the renewed NCSP will use reflex LBC as part of the screening test rather than a conventional Pap test, it is likely that some women will have a conventional Pap test after the renewed NCSP commences, and it is important that a register can record details of these tests.
<i>Comments</i>	Collected by pathology laboratories

Relational attributes

<i>Related metadata references</i>	Supersedes National cervical cancer prevention data dictionary Version 1, C4 Cytology test—cytology specimen type, code AN Supersedes Standardised cervical screening data dictionary Cytology (first) sub-set data element 29 Person—cervical cytology specimen type, cervical cytology screening code AN
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I3 Cytology test specimen site

Identifying and definitional attributes

<i>Data item name</i>	Cytology test specimen site
<i>Definition</i>	An indication as to the site from which the sample was collected.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Code										
<i>Data type</i>	String										
<i>Format</i>	AN										
<i>Maximum character length</i>	2										
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>B0</td><td>Not stated</td></tr><tr><td>B1</td><td>Cervical</td></tr><tr><td>B2</td><td>Vaginal</td></tr><tr><td>B3</td><td>Other gynaecological site</td></tr></tbody></table>	Value	Meaning	B0	Not stated	B1	Cervical	B2	Vaginal	B3	Other gynaecological site
Value	Meaning										
B0	Not stated										
B1	Cervical										
B2	Vaginal										
B3	Other gynaecological site										

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	While the renewed NCSP will use reflex LBC as part of the screening test rather than a conventional Pap test, it is likely that some women will have a conventional Pap test after the renewed NCSP commences, and it is important that a register can record details of these tests.
<i>Comments</i>	Collected by pathology laboratories

Relational attributes

<i>Related metadata references</i>	Supersedes National cervical cancer prevention data dictionary Version 1, C3 Cytology test—cytology specimen site, code AN Supersedes Standardised cervical screening data dictionary Cytology (first) sub-set data element 30 Person—cervical cytology specimen site, cervical cytology screening code AN
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I4 Reason for cytology test

Identifying and definitional attributes

<i>Data item name</i>	Reason for cytology test
<i>Definition</i>	The reason why a cytology test is performed.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Code																				
<i>Data type</i>	String																				
<i>Format</i>	X{XXX}																				
<i>Maximum character length</i>	4																				
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Reflex LBC cytology after detection of oncogenic HPV in primary screening HPV test</td></tr><tr><td>2</td><td>Cytology after detection of oncogenic HPV in self-collected sample</td></tr><tr><td>3</td><td>Reflex LBC after detection of oncogenic HPV in Follow-up HPV test</td></tr><tr><td>4</td><td>Cytology at colposcopy</td></tr><tr><td>5i</td><td>Co-test—test of cure</td></tr><tr><td>5ii</td><td>Co-test—investigation of signs or symptoms</td></tr><tr><td>5iii</td><td>Co-test—other, as recommended in guidelines</td></tr><tr><td>6</td><td>Other</td></tr><tr><td>P</td><td>Conventional Pap test to screen for cervical cancer precursors</td></tr></tbody></table>	Value	Meaning	1	Reflex LBC cytology after detection of oncogenic HPV in primary screening HPV test	2	Cytology after detection of oncogenic HPV in self-collected sample	3	Reflex LBC after detection of oncogenic HPV in Follow-up HPV test	4	Cytology at colposcopy	5i	Co-test—test of cure	5ii	Co-test—investigation of signs or symptoms	5iii	Co-test—other, as recommended in guidelines	6	Other	P	Conventional Pap test to screen for cervical cancer precursors
Value	Meaning																				
1	Reflex LBC cytology after detection of oncogenic HPV in primary screening HPV test																				
2	Cytology after detection of oncogenic HPV in self-collected sample																				
3	Reflex LBC after detection of oncogenic HPV in Follow-up HPV test																				
4	Cytology at colposcopy																				
5i	Co-test—test of cure																				
5ii	Co-test—investigation of signs or symptoms																				
5iii	Co-test—other, as recommended in guidelines																				
6	Other																				
P	Conventional Pap test to screen for cervical cancer precursors																				

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	'Conventional Pap test to screen for cervical cancer precursors' has been allocated to a code of P, as it is anticipated that, in time, this code may no longer be required, and will be subsequently dropped.
<i>Comments</i>	Collected by pathology laboratories

Relational attributes

<i>Related metadata reference</i>	New data item
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I5 Cytology test squamous cytology cell analysis

Identifying and definitional attributes

<i>Data item name</i>	Cytology test squamous cytology cell analysis
<i>Definition</i>	The squamous result of the cytology analysis.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Code																		
<i>Data type</i>	String																		
<i>Format</i>	AX																		
<i>Maximum character length</i>	2																		
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>S1</td><td>Cell numbers and preservation satisfactory. No abnormality or only reactive changes</td></tr><tr><td>S2</td><td>Possible low-grade squamous intraepithelial lesion (LSIL)</td></tr><tr><td>S3</td><td>Low-grade squamous intraepithelial lesion (LSIL) (HPV and/or CIN 1)</td></tr><tr><td>S4</td><td>Possible high-grade squamous intraepithelial lesion (HSIL)</td></tr><tr><td>S5</td><td>High-grade squamous intraepithelial lesion (HSIL) (CIN 2/CIN 3)</td></tr><tr><td>S6</td><td>High-grade squamous intraepithelial lesion (HSIL) with possible microinvasion/ invasion</td></tr><tr><td>S7</td><td>Squamous carcinoma</td></tr><tr><td>SU</td><td>Unsatisfactory for evaluation</td></tr></tbody></table>	Value	Meaning	S1	Cell numbers and preservation satisfactory. No abnormality or only reactive changes	S2	Possible low-grade squamous intraepithelial lesion (LSIL)	S3	Low-grade squamous intraepithelial lesion (LSIL) (HPV and/or CIN 1)	S4	Possible high-grade squamous intraepithelial lesion (HSIL)	S5	High-grade squamous intraepithelial lesion (HSIL) (CIN 2/CIN 3)	S6	High-grade squamous intraepithelial lesion (HSIL) with possible microinvasion/ invasion	S7	Squamous carcinoma	SU	Unsatisfactory for evaluation
Value	Meaning																		
S1	Cell numbers and preservation satisfactory. No abnormality or only reactive changes																		
S2	Possible low-grade squamous intraepithelial lesion (LSIL)																		
S3	Low-grade squamous intraepithelial lesion (LSIL) (HPV and/or CIN 1)																		
S4	Possible high-grade squamous intraepithelial lesion (HSIL)																		
S5	High-grade squamous intraepithelial lesion (HSIL) (CIN 2/CIN 3)																		
S6	High-grade squamous intraepithelial lesion (HSIL) with possible microinvasion/ invasion																		
S7	Squamous carcinoma																		
SU	Unsatisfactory for evaluation																		

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	<p>S1 Cell numbers and preservation satisfactory. No abnormality or only reactive changes</p> <p>Record this code where there is no abnormality detected and cell numbers and preservation is satisfactory.</p> <p>S2 Possible low-grade squamous intraepithelial lesion (LSIL)</p> <p>This code encompasses changes in squamous cells where the reporting cytologist/pathologist believes the changes may represent a low grade squamous intraepithelial lesion but no definitive changes are present.</p> <p>S3 Low grade squamous intraepithelial lesion (LSIL) (HPV and/or CIN 1)</p> <p>Record this code where the cytologist/pathologist observes changes which would have been described as HPV effect or CIN 1 (that is, incorporates HPV effect and/or CIN 1).</p>
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S4 Possible high grade squamous intraepithelial lesion (HSIL)

Record this code when the presence of a high grade squamous abnormality such as CIN 2, CIN 3 or SCC is suspected but the changes are insufficient to justify a confident cytological prediction of a high grade lesion.

S5 High grade squamous intraepithelial lesion (HSIL)
(CIN 2/CIN 3)

Record this code where the changes observed would have previously been described as CIN 2 or CIN 3 (that is, code S5 incorporates CIN 2 and CIN 3.)

S6 High grade squamous intraepithelial lesion (HSIL) with possible microinvasion/invasion

Record this code when a definite HSIL is present, but the possibility of invasion cannot be excluded.

S7 Squamous carcinoma

Record this when squamous carcinoma is present.

SU Unsatisfactory for evaluation

Record this code if the specimen is unable to be assessed due to poor cellularity, poor preservation, cell detail obscured by inflammation/blood/degenerate cells.

Comments

Collected by pathology laboratories

Relational attributes

Related metadata reference

Supersedes *National cervical cancer prevention data dictionary Version 1*, C5 Cytology test—squamous cytology cell analysis, code AX

I6 Cytology test endocervical (glandular) cytology cell analysis

Identifying and definitional attributes

<i>Data item name</i>	Cytology test endocervical (glandular) cytology cell analysis
<i>Definition</i>	The endocervical result of the cytology analysis.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Code																				
<i>Data type</i>	String																				
<i>Format</i>	AX																				
<i>Maximum character length</i>	2																				
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>E0</td><td>No endocervical component</td></tr><tr><td>E-</td><td>Not applicable: vault smear/previous hysterectomy</td></tr><tr><td>E1</td><td>Endocervical component present. No abnormality or only reactive changes</td></tr><tr><td>E2</td><td>Atypical endocervical cells of uncertain significance</td></tr><tr><td>E3</td><td>Possible high-grade endocervical glandular lesion</td></tr><tr><td>E4</td><td>Endocervical adenocarcinoma-in-situ</td></tr><tr><td>E5</td><td>Endocervical adenocarcinoma-in-situ with possible microinvasion/invasion</td></tr><tr><td>E6</td><td>Endocervical adenocarcinoma</td></tr><tr><td>EU</td><td>Due to unsatisfactory nature of the specimen, no assessment has been made</td></tr></tbody></table>	Value	Meaning	E0	No endocervical component	E-	Not applicable: vault smear/previous hysterectomy	E1	Endocervical component present. No abnormality or only reactive changes	E2	Atypical endocervical cells of uncertain significance	E3	Possible high-grade endocervical glandular lesion	E4	Endocervical adenocarcinoma-in-situ	E5	Endocervical adenocarcinoma-in-situ with possible microinvasion/invasion	E6	Endocervical adenocarcinoma	EU	Due to unsatisfactory nature of the specimen, no assessment has been made
Value	Meaning																				
E0	No endocervical component																				
E-	Not applicable: vault smear/previous hysterectomy																				
E1	Endocervical component present. No abnormality or only reactive changes																				
E2	Atypical endocervical cells of uncertain significance																				
E3	Possible high-grade endocervical glandular lesion																				
E4	Endocervical adenocarcinoma-in-situ																				
E5	Endocervical adenocarcinoma-in-situ with possible microinvasion/invasion																				
E6	Endocervical adenocarcinoma																				
EU	Due to unsatisfactory nature of the specimen, no assessment has been made																				

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	<p>E0 No endocervical component</p> <p>Record this when there is no endocervical component.</p> <p>E- Not applicable: vault smear/previous hysterectomy</p> <p>Record this when it is a vault smear or there has been a previous total hysterectomy.</p> <p>E1 Endocervical component present. No abnormality or only reactive changes</p> <p>Record if no abnormality is detected and cell numbers and preservation is satisfactory.</p> <p>E2 Atypical endocervical cells of uncertain significance</p> <p>Record where abnormal glandular cells are identified in a cervical cytology sample, but where the degree of abnormality is not sufficient</p>
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for a diagnosis of adenocarcinoma in situ to be made.

E3 Possible high grade endocervical glandular lesion

Record if adenocarcinoma in situ is suspected but a confident prediction is not possible.

E4 Endocervical adenocarcinoma in situ

Record when the reporting cytologist/pathologist is confident of the presence of an adenocarcinoma in situ.

E5 Endocervical adenocarcinoma in situ with possible microinvasion /invasion

Record this when a definite adenocarcinoma in situ is present, but the possibility of invasion cannot be excluded.

E6 Endocervical adenocarcinoma

Record this when a definite adenocarcinoma is present.

EU Due to the unsatisfactory nature of the smear, no assessment has been made.

Unable to be assessed due to poor cellularity, poor preservation, cell detail obscured by blood/inflammation/degenerate cells. If a smear is sub optimal but atypical/abnormal cells are detected, the abnormality overrides the unsatisfactory coding and should be coded to reflect the abnormality detected.

Comments

Collected by pathology laboratories

Relational attributes

Related metadata reference

Supersedes *National cervical cancer prevention data dictionary Version 1*, C6 Cytology test— endocervical (glandular) cytology cell analysis, code AX

I7 Cytology test other/non-cervical cytology cell analysis

Identifying and definitional attributes

<i>Data item name</i>	Cytology test other/non-cervical cytology cell analysis
<i>Definition</i>	The other/non-cervical result from the cytology analysis.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Code																						
<i>Data type</i>	String																						
<i>Format</i>	AX																						
<i>Maximum character length</i>	2																						
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>O1</td><td>No other abnormal cells.</td></tr><tr><td>O2</td><td>Atypical endometrial cells of uncertain significance</td></tr><tr><td>O3</td><td>Atypical glandular cells of uncertain significance—site unknown</td></tr><tr><td>O4</td><td>Possible endometrial adenocarcinoma</td></tr><tr><td>O5</td><td>Possible high-grade lesion—non-cervical</td></tr><tr><td>O6</td><td>Malignant cells—uterine body</td></tr><tr><td>O7</td><td>Malignant cells—vagina</td></tr><tr><td>O8</td><td>Malignant cells—ovary</td></tr><tr><td>O9</td><td>Malignant cells—other</td></tr><tr><td>OU</td><td>Due to the unsatisfactory nature of the specimen, no assessment has been made</td></tr></tbody></table>	Value	Meaning	O1	No other abnormal cells.	O2	Atypical endometrial cells of uncertain significance	O3	Atypical glandular cells of uncertain significance—site unknown	O4	Possible endometrial adenocarcinoma	O5	Possible high-grade lesion—non-cervical	O6	Malignant cells—uterine body	O7	Malignant cells—vagina	O8	Malignant cells—ovary	O9	Malignant cells—other	OU	Due to the unsatisfactory nature of the specimen, no assessment has been made
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Data element attributes

Collection and usage attributes

<i>Guide for use</i>	<p>O1 No other abnormal cells</p> <p>Record this where there is no abnormality detected and cell numbers and preservation is satisfactory.</p> <p>O2 Atypical endometrial cells of uncertain significance</p> <p>Record this where there are changes in endometrial cells, but insufficient to raise the possibility of an endometrial carcinoma.</p> <p>O3 Atypical glandular cells of uncertain significance—site unknown</p> <p>Record this where there is uncertainty about whether the abnormal cells were endocervical or endometrial in origin. Use where changes are insufficient to raise the possibility of a neoplasm but are beyond a reactive process.</p> <p>O4 Possible endometrial adenocarcinoma</p> <p>Record this if endometrial adenocarcinoma is suspected, but a</p>
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confident prediction is not possible.

O5 Possible high grade lesion—non cervical

Record if abnormal cells are present but do not appear to be cervical in origin.

O6 Malignant cells—uterine body

Record when malignant endometrial cells are present.

O7 Malignant cells—vagina

Record if malignant cells are present in a vaginal or vault smear.

O8 Malignant cells—ovary

Record if malignant ovarian cells are present.

O9 Malignant cells—other

Record if malignant cells are present which belong to none of the above categories.

OU Due to the unsatisfactory nature of the smear, no assessment has been made

Record this code when specimen is unable to be assessed due to poor cellularity, poor preservation, cell detail obscured by blood/inflammation/degenerate cells. If a specimen is sub optimal but atypical/abnormal cells are detected, the abnormality overrides the unsatisfactory coding and should be coded to reflect the abnormality detected.

Comments

Collected by pathology laboratories

Relational attributes

Related metadata reference

Supersedes *National cervical cancer prevention data dictionary Version 1*, C7 Cytology test— other/non-cervical cytology cell analysis, code AX

I8 Cytology test result

Identifying and definitional attributes

<i>Data item name</i>	Cytology test result
<i>Definition</i>	The overall cytology result assigned to a cytology test.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Code												
<i>Data type</i>	Number												
<i>Format</i>	N												
<i>Maximum character length</i>	1												
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>0</td><td>Unsatisfactory</td></tr><tr><td>1</td><td>Negative</td></tr><tr><td>2</td><td>pLSIL/LSIL</td></tr><tr><td>3</td><td>pHSIL/HSIL+</td></tr><tr><td>4</td><td>Any glandular abnormality</td></tr></tbody></table>	Value	Meaning	0	Unsatisfactory	1	Negative	2	pLSIL/LSIL	3	pHSIL/HSIL+	4	Any glandular abnormality
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Data item attributes

Collection and usage attributes

<i>Guide for use</i>	<p>When cytology takes the form of a reflex LBC to be combined with an HPV test to assign a screening episode result, cytology test results are summarised into:</p> <ul style="list-style-type: none">• Unsatisfactory: I5 = SU and I6 = (EU or E- or E0 or E1)• Negative: I5 = S1 and I6 = (E- or E0 or E1)• pLSIL/LSIL: I5 = S2 or S3 and I6 < E2• pHSIL/HSIL+: I5 = S4 or S5 or S6 or S7 and I6 < E2• Any glandular abnormality: I6 = E2 or E3 or E4 or E5 or E6 <p>This is different to the way that cytology tests are summarised for reporting and monitoring purposes; however these results can be determined from the S, E and O codes in I5, I6 and I7.</p>
<i>Comments</i>	Collected by pathology laboratories

Relational attributes

<i>Related metadata reference</i>	Supersedes <i>National cervical cancer prevention data dictionary Version 1</i> , C9 Cytology test— cytology result, code {AA}
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Group J: Screening episode data items

- J1 Primary screening episode commencement date
- J2 Primary screening episode completion date
- J3 Primary screening episode result
- J4 Primary screening episode risk of significant cervical abnormality
- J5 Primary screening episode recommendation
- J6 Follow-up episode commencement date
- J7 Follow-up episode completion date
- J8 Follow-up episode result
- J9 Follow-up episode risk of significant cervical abnormality
- J10 Follow-up episode recommendation

J1 Primary screening episode commencement date

Identifying and definitional attributes

<i>Data item name</i>	Primary screening episode commencement date
<i>Definition</i>	The date the primary screening episode commenced.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Date
<i>Data type</i>	Date/Time
<i>Format</i>	DDMMYYYY
<i>Maximum character length</i>	8

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	The primary screening episode date is the date on which the sample was collected for the primary screening HPV test. Where the HPV test is on a self-collected sample and a second sample for LBC collected by a healthcare provider, the primary screening episode date should be the date of the HPV test and not the LBC test.
<i>Collection methods</i>	This date can be derived by H1 HPV test date where H4 Reason for HPV test = 1

Relational attributes

<i>Related metadata reference</i>	New data item
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J2 Primary screening episode completion date

Identifying and definitional attributes

<i>Data item name</i>	Primary screening episode completion date
<i>Definition</i>	The date the primary screening episode was completed.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Date
<i>Data type</i>	Date/Time
<i>Format</i>	DDMMYYYY
<i>Maximum character length</i>	8

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	<p>The primary screening episode completion date is the date on which there was a valid HPV test and a valid LBC test (where this is required) to allow a risk rating to be assigned.</p> <p>For most women the primary screening episode completion date will be identical to the primary screening episode commencement date. Where a second sample for LBC needs to be collected by a healthcare provider, either because of an unsatisfactory LBC test or because the HPV test was on a self-collected sample, there can be some time between the primary screening episode commencement date and the primary screening episode completion date.</p>
<i>Collection methods</i>	This is a derived date.
<i>Comments</i>	This data item should be used when determining time between primary screening episode and follow-up events.

Relational attributes

<i>Related metadata reference</i>	New data item
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J3 Primary screening episode result

Identifying and definitional attributes

<i>Data item name</i>	Primary screening episode result
<i>Definition</i>	The overall primary screening episode result that is a combination of an HPV test and an LBC test (where this is required).
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Code																														
<i>Data type</i>	String																														
<i>Format</i>	X[XX]																														
<i>Maximum character length</i>	3																														
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Data item attributes

Collection and usage attributes

<i>Guide for use</i>	<p>An HPV test is the primary screening test of the renewed NCSP. However, this is used in conjunction with partial genotyping of the HPV test to distinguish between HPV 16/18 and oncogenic HPV (not 16/18), as well as triage of all oncogenic HPV results (16/18 and not 16/18) with reflex liquid-based cytology (LBC). This means that the overall screening episode result is a combination of the primary screening HPV test result and the LBC result (where performed). It also means that it is possible for a woman to have an incomplete screening episode (and therefore no overall result or risk rating can be assigned). This can be either due to an unsatisfactory HPV test or LBC test (in which case this can be rectified by a repeat test), or due</p>
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to a woman with a self-collected sample test positive for HPV who then did not have a sample collected for the reflex LBC test.

Complete primary screening episode results are comprised of an HPV test result and (unless the result was 'oncogenic HPV not detected') a reflex LBC test result.

Collection methods

Primary screening HPV test results and LBC test results are derived from the HPV test and cytology test sections.

Comments

Categories that include 'not performed' or 'unsatisfactory' can change as tests that are required are performed.

This means that more than one primary screening episode result will need to be able to be collected within each screening round.

The primary screening episode is not complete until receipt of a valid test, or after a specified period of time if no test result is received

Relational attributes

Related metadata reference

New data item

J4 Primary screening episode risk of significant cervical abnormality

Identifying and definitional attributes

<i>Data item name</i>	Primary screening episode risk of significant cervical abnormality
<i>Definition</i>	A woman's risk of significant cervical abnormality determined from her primary screening episode result, comprised of a primary HPV test with partial genotyping and triage with reflex LBC (where this is required).
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Code										
<i>Data type</i>	String										
<i>Format</i>	X										
<i>Maximum character length</i>	1										
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>0</td><td>Unsatisfactory</td></tr><tr><td>1</td><td>Low risk</td></tr><tr><td>2</td><td>Intermediate risk</td></tr><tr><td>3</td><td>Higher risk</td></tr></tbody></table>	Value	Meaning	0	Unsatisfactory	1	Low risk	2	Intermediate risk	3	Higher risk
Value	Meaning										
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Data item attributes

Collection and usage attributes

<i>Guide for use</i>	This primary screening episode result is used to assign a risk of significant cervical abnormality. This risk level is used to determine the appropriate management.
<i>Collection methods</i>	Risk is allocated as follows: 0 Unsatisfactory: J3 Primary screening episode result = 0 or 2.0 1 Low risk: J3 Primary screening episode result = 1 2 Intermediate risk: J3 primary screening episode result = 2.1 or 2.2 3 Higher risk: J3 screening episode result = 2.3, 2.4, 3.X, 3.0, 3.1, 3.2, 3.3, or 3.4.
<i>Comments</i>	Risk and management for 2.X is to be determined. It may be sensible to have a risk category of 'incomplete' or 'pending' that can be attributed to a primary screening episode while waiting for a retest following an unsatisfactory test, or while waiting for a woman with a self-collected sample to have an LBC test.

Relational attributes

<i>Related metadata reference</i>	New data item
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J5 Primary screening episode recommendation

Identifying and definitional attributes

<i>Data item name</i>	Primary screening episode recommendation
<i>Definition</i>	The appropriate management based on the risk level of the primary screening episode result.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Code																										
<i>Data type</i>	String																										
<i>Format</i>	X																										
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Data item attributes

Collection and usage attributes

<i>Collection methods</i>	Determined by registers as per clinical management guidelines.
<i>Comments</i>	Full list of possible recommendations is included for consistency.

Relational attributes

<i>Related metadata reference</i>	New data item
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J6 Follow-up episode commencement date

Identifying and definitional attributes

<i>Data item name</i>	Follow-up episode commencement date
<i>Definition</i>	The date the follow-up episode commenced.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Date
<i>Data type</i>	Date/Time
<i>Format</i>	DDMMYYYY
<i>Maximum character length</i>	8

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	The follow-up episode date is the date on which the sample was collected for the follow-up HPV test.
<i>Collection methods</i>	This date can be derived by H1 'HPV test date' where H4 'Reason HPV test' = 2.

Relational attributes

<i>Related metadata reference</i>	New data item
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J7 Follow-up episode completion date

Identifying and definitional attributes

<i>Data item name</i>	Follow-up episode completion date
<i>Definition</i>	The date the follow-up episode was completed.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Date
<i>Data type</i>	Date/Time
<i>Format</i>	DDMMYYYY
<i>Maximum character length</i>	8

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	<p>The follow-up episode completion date is the date on which there was a valid HPV test and a valid LBC test (where this is required) to allow a risk rating to be assigned.</p> <p>For most women the follow-up episode completion date will be identical to or similar to the follow-up episode commencement date. Where a second sample for LBC needs to be collected by a healthcare provider, either because of an unsatisfactory LBC test or because the HPV test was on a self-collected sample, there can be sometime between the follow-up episode commencement date and the follow-up episode completion date.</p>
<i>Collection methods</i>	This is a derived date.

Relational attributes

<i>Related metadata reference</i>	New data item
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J8 Follow-up episode result

Identifying and definitional attributes

<i>Data item name</i>	Follow-up episode result
<i>Definition</i>	The follow-up episode result is a combination of an HPV test and an LBC test (where this is performed) where the HPV test is a repeat HPV test performed 12 months after the screening episode.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Code																														
<i>Data type</i>	String																														
<i>Format</i>	X[XX]																														
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Data item attributes

Collection and usage attributes

<i>Guide for use</i>	An HPV test is the primary screening test of the renewed NCSP. However, this is used in conjunction with partial genotyping of the HPV test to distinguish between HPV 16/18 and oncogenic HPV (not 16/18), as well as triage of all oncogenic HPV results (16/18 and not 16/18) with reflex liquid-based cytology (LBC). This means that the overall follow-up episode result is a combination of the primary screening HPV test result and the LBC result (where performed).
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Relational attributes

<i>Related metadata reference</i>	New data item
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J9 Follow-up episode risk of significant cervical abnormality

Identifying and definitional attributes

<i>Data item name</i>	Follow-up episode risk of significant cervical abnormality
<i>Definition</i>	A woman's risk of significant cervical abnormality determined from her follow-up episode result, comprised of a primary HPV test with partial genotyping and triage with reflex LBC.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Code								
<i>Data type</i>	String								
<i>Format</i>	X								
<i>Maximum character length</i>	1								
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Data item attributes

Collection and usage attributes

<i>Guide for use</i>	<p>An HPV test is the primary screening test of the renewed NCSP. However, this is used in conjunction with partial genotyping of the HPV test to distinguish between HPV 16/18 and oncogenic HPV (not 16/18), as well as triage of all oncogenic HPV test results with reflex liquid-based cytology (LBC). This means that the overall final screening episode result is a combination of the primary screening HPV test result and the LBC result (where performed). This combined screening episode result is used to assign a risk of significant cervical abnormality. This risk level is used to determine the appropriate management.</p>
<i>Collection methods</i>	<p>Risk should be allocated as:</p> <p>0 Unsatisfactory: J8 follow-up episode result = 0</p> <p>1 Low risk: J8 follow-up episode result = 1</p> <p>3 Higher risk: J8 follow-up episode result = any value greater than 1.</p>
<i>Comments</i>	<p>Permissible value '2' has been purposely omitted from this list so the risks align with those for the primary screening episode for consistency and ease of use.</p>

Relational attributes

<i>Related metadata reference</i>	New data item
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J10 Follow-up episode recommendation

Identifying and definitional attributes

<i>Data item name</i>	Follow-up episode recommendation
<i>Definition</i>	The appropriate management based on the risk level of the follow-up episode result.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Code																										
<i>Data type</i>	String																										
<i>Format</i>	X																										
<i>Maximum character length</i>	1																										
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>0</td><td>No recommendation</td></tr><tr><td>1</td><td>Rescreen in 5 years</td></tr><tr><td>2</td><td>Rescreen in 3 years</td></tr><tr><td>3</td><td>Repeat HPV test in 12 months</td></tr><tr><td>4</td><td>Co-test in 12 months</td></tr><tr><td>5</td><td>Retest in 6 weeks</td></tr><tr><td>6</td><td>Refer for colposcopic assessment</td></tr><tr><td>7</td><td>Test taken at time of colposcopy, no recommendation</td></tr><tr><td>8</td><td>Discharge from program</td></tr><tr><td>9</td><td>Other management recommendation</td></tr><tr><td>S</td><td>Symptomatic—clinical management required</td></tr><tr><td>P</td><td>Rescreen in 2 years</td></tr></tbody></table>	Value	Meaning	0	No recommendation	1	Rescreen in 5 years	2	Rescreen in 3 years	3	Repeat HPV test in 12 months	4	Co-test in 12 months	5	Retest in 6 weeks	6	Refer for colposcopic assessment	7	Test taken at time of colposcopy, no recommendation	8	Discharge from program	9	Other management recommendation	S	Symptomatic—clinical management required	P	Rescreen in 2 years
Value	Meaning																										
0	No recommendation																										
1	Rescreen in 5 years																										
2	Rescreen in 3 years																										
3	Repeat HPV test in 12 months																										
4	Co-test in 12 months																										
5	Retest in 6 weeks																										
6	Refer for colposcopic assessment																										
7	Test taken at time of colposcopy, no recommendation																										
8	Discharge from program																										
9	Other management recommendation																										
S	Symptomatic—clinical management required																										
P	Rescreen in 2 years																										

Data item attributes

Collection and usage attributes

<i>Collection methods</i>	Determined by registers as per clinical management guidelines.
<i>Comments</i>	Full list of possible recommendations is included for consistency.

Relational attributes

<i>Related metadata reference</i>	New data item
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Group K: Colposcopy data items

- K1 Colposcopy episode identifier
- K2 Date of colposcopy episode
- K3 Indication for colposcopy
- K4 Indication for colposcopy—other indication free text
- K5 General colposcopic assessment—adequacy
- K6 General colposcopic assessment—transformation zone visibility
- K7 Colposcopic impression—primary diagnosis
- K8 Colposcopy impression—other finding free text
- K9 Biopsy this episode
- K10 Pregnancy flag

K1 Colposcopy episode identifier

Identifying and definitional attributes

<i>Data item name</i>	Colposcopy episode identifier
<i>Definition</i>	A unique identifier allocated to a colposcopy episode to distinguish it from all other colposcopy episodes.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Identifier
<i>Data type</i>	String
<i>Format</i>	[X(20)]
<i>Maximum character length</i>	20

Data item attributes

Relational attributes

<i>Related metadata reference</i>	New data item
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K2 Date of colposcopy episode

Identifying and definitional attributes

<i>Data item name</i>	Date of colposcopy episode
<i>Definition</i>	The date when a colposcopy or treatment was performed.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Date
<i>Data type</i>	Date/Time
<i>Format</i>	DDMMYYYY
<i>Maximum character length</i>	8

Data item attributes

Collection and usage attributes

<i>Collection method</i>	Colposcopy Data Collection Form
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Relational attributes

<i>Related metadata reference</i>	New data item
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K3 Indication for colposcopy

Identifying and definitional attributes

<i>Data item name</i>	Indication for colposcopy
<i>Definition</i>	Clinical indication as to why colposcopy was performed.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Code																
<i>Data type</i>	Number																
<i>Format</i>	N																
<i>Maximum character length</i>	1																
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>0</td><td>Not performed</td></tr><tr><td>1</td><td>New patient with abnormal cervical screening result</td></tr><tr><td>2</td><td>Follow-up of patient with previous abnormal cervical screening result</td></tr><tr><td>3</td><td>Symptomatic</td></tr><tr><td>4</td><td>Abnormal appearance of cervix</td></tr><tr><td>5</td><td>At time of treatment</td></tr><tr><td>6</td><td>Other</td></tr></tbody></table>	Value	Meaning	0	Not performed	1	New patient with abnormal cervical screening result	2	Follow-up of patient with previous abnormal cervical screening result	3	Symptomatic	4	Abnormal appearance of cervix	5	At time of treatment	6	Other
Value	Meaning																
0	Not performed																
1	New patient with abnormal cervical screening result																
2	Follow-up of patient with previous abnormal cervical screening result																
3	Symptomatic																
4	Abnormal appearance of cervix																
5	At time of treatment																
6	Other																

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	This item refers to the reason for undertaking the current colposcopy.
<i>Collection methods</i>	Colposcopy Data Collection Form

Relational attributes

<i>Related metadata reference</i>	New data item
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K4 Indication for colposcopy—other indication free text

Identifying and definitional attributes

<i>Data item name</i>	Indication for colposcopy—other indication free text
<i>Definition</i>	Clinical indication as to why colposcopy was performed if not one of the coded options in 'Indication for colposcopy'.
<i>Collection status</i>	Conditional

Value domain attributes

<i>Representation class</i>	Text
<i>Data type</i>	String
<i>Format</i>	[X(250)]
<i>Maximum character length</i>	250

Data item attributes

Collection and usage attributes

<i>Rules for use</i>	If K3 'Indication for colposcopy' = 6 ('Other'), then K4 'Indication for colposcopy—other indication free text' should not be null.
<i>Collection methods</i>	Colposcopy Data Collection Form

Relational attributes

<i>Related metadata reference</i>	New data item
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K5 General colposcopic assessment—adequacy

Identifying and definitional attributes

<i>Data item name</i>	General colposcopic assessment—adequacy
<i>Definition</i>	An indication as to whether the colposcopy was adequate or inadequate.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Code						
<i>Data type</i>	Number						
<i>Format</i>	N						
<i>Maximum character length</i>	1						
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>0</td><td>Inadequate</td></tr><tr><td>1</td><td>Adequate</td></tr></tbody></table>	Value	Meaning	0	Inadequate	1	Adequate
Value	Meaning						
0	Inadequate						
1	Adequate						

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	<p>'Adequate' indicates that the view of the cervix is not obscured.</p> <p>'Inadequate' indicates that the cervix cannot be adequately visualised, for example due to inflammation, bleeding, atrophy or scar tissue.</p>
<i>Collection methods</i>	Colposcopy Data Collection Form
<i>Comments</i>	<p>The terms 'satisfactory' and 'unsatisfactory' for describing a colposcopy have been replaced with a two tiered system.</p> <p>The first tier relates to the visibility of the cervix, either adequate for the reason or inadequate if it is obscured, such as by blood, inflammation or scarring, and is the colposcopic assessment captured in this data item.</p> <p>The second tier relates to the visibility of the transformation zone. A Type 1 transformation zone is completely visible and the squamocolumnar junction is completely seen. A Type 2 transformation zone is also completely visible and the squamocolumnar junction is in the endocervical canal but can be seen. A Type 3 transformation zone is not completely visible and the squamocolumnar junction cannot be seen.</p>

Relational attributes

<i>Related metadata reference</i>	New data item
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K6 General colposcopic assessment—transformation zone visibility

Identifying and definitional attributes

<i>Data item name</i>	General colposcopic assessment—transformation zone visibility
<i>Definition</i>	An indication as to whether the transformation zone and/or squamocolumnar junction is visible.
<i>Collection status</i>	Essential (if colposcopy is adequate)

Value domain attributes

<i>Representation class</i>	Code								
<i>Data type</i>	String								
<i>Format</i>	N								
<i>Maximum character length</i>	1								
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Type 1 transformation zone</td></tr><tr><td>2</td><td>Type 2 transformation zone</td></tr><tr><td>3</td><td>Type 3 transformation zone</td></tr></tbody></table>	Value	Meaning	1	Type 1 transformation zone	2	Type 2 transformation zone	3	Type 3 transformation zone
Value	Meaning								
1	Type 1 transformation zone								
2	Type 2 transformation zone								
3	Type 3 transformation zone								

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	<p>'Type 1 transformation zone' indicates that the transformation zone is entirely visible and the squamocolumnar junction is seen.</p> <p>'Type 2 transformation zone' indicates that the transformation zone extends into the endocervical canal but the squamocolumnar junction is seen.</p> <p>'Type 3 transformation zone' indicates that the transformation zone extends into the endocervical canal and either the entire squamocolumnar junction is not seen or the upper limit of the squamocolumnar junction is not seen.</p> <p>A transformation zone type should only be indicated if the colposcopy is considered adequate.</p>
<i>Rules for use</i>	<p>(i) If K5 'General Colposcopic Assessment—Adequacy' = 2 ('Inadequate') then K6 'General Colposcopic Assessment—Transformation Zone Visibility' should be null.</p> <p>(ii) If K5 'General Colposcopic Assessment—Adequacy' = 1 ('Adequate') then K6 'General Colposcopic Assessment—Transformation Zone Visibility' should not be null.</p>
<i>Collection methods</i>	Colposcopy Data Collection Form
<i>Comments</i>	<p>The terms 'satisfactory' and 'unsatisfactory' for describing a colposcopy have been replaced with a two tiered system.</p> <p>The first tier relates to the visibility of the cervix, either adequate for the reason or inadequate if it is obscured, such as by blood, inflammation or scarring.</p> <p>The second tier relates to the visibility of the transformation zone,</p>

and is the colposcopic assessment captured in this data item. A Type 1 transformation zone is completely visible and the squamocolumnar junction is completely seen. A Type 2 transformation zone is also completely visible and the squamocolumnar junction is in the endocervical canal but can be seen. A Type 3 transformation zone is not completely visible and the squamocolumnar junction cannot be seen.

Relational attributes

<i>Related metadata reference</i>	New data item
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K7 Colposcopic impression—primary diagnosis

Identifying and definitional attributes

<i>Data item name</i>	Colposcopic impression—primary diagnosis
<i>Definition</i>	The clinical diagnosis or impression formed at time of colposcopy.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Code																
<i>Data type</i>	String																
<i>Format</i>	N[N]																
<i>Maximum character length</i>	2																
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Normal</td></tr><tr><td>2</td><td>No visible lesion</td></tr><tr><td>3</td><td>LSIL</td></tr><tr><td>4</td><td>HSIL</td></tr><tr><td>5</td><td>Glandular abnormality (adenocarcinoma in situ)</td></tr><tr><td>6</td><td>Cancer</td></tr><tr><td>7</td><td>Other</td></tr></tbody></table>	Value	Meaning	1	Normal	2	No visible lesion	3	LSIL	4	HSIL	5	Glandular abnormality (adenocarcinoma in situ)	6	Cancer	7	Other
Value	Meaning																
1	Normal																
2	No visible lesion																
3	LSIL																
4	HSIL																
5	Glandular abnormality (adenocarcinoma in situ)																
6	Cancer																
7	Other																

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	<p>It is usual for a colposcopist to make a clinical diagnosis/impression and record this impression as the 'result' or diagnosis. This 'diagnosis' is usually made in the terms related to the likely histological outcome or biopsy result.</p> <p>The correlation between the colposcopic diagnosis and the final histological diagnosis is one of the standards for assessment of the colposcopist's diagnostic skill and is used for quality improvement programs.</p> <p>Colposcopists will have the capacity to choose 2–3 impressions as well as the 'Other' category. A register will use rules to determine which impression is recorded (usually the 'worse' finding).</p>
<i>Rules for use</i>	<p>Required if General Colposcopic Assessment is adequate AND transformation zone is type 1 or 2.</p> <p>(i) If K5 'General Colposcopic Assessment—Adequacy' = 2 ('Inadequate') then M7 'Colposcopic impression—primary diagnosis' should be null.</p> <p>(ii) If K5 'General Colposcopic Assessment—Adequacy' = 1 ('Adequate') AND K6 'General Colposcopic Assessment—Transformation Zone Visibility' = 1 or 2 (Type 1 or Type 2 transformation zone) then K7 'Colposcopic impression—primary diagnosis' should not be null.</p> <p>(iii) If K5 'General Colposcopic Assessment—Adequacy' = 1</p>

(‘Adequate’) AND K6 ‘General Colposcopic Assessment—Transformation Zone Visibility’ = 3 (‘Type 3’) then K7 ‘Colposcopic impression—primary diagnosis’ cannot = 1 (‘Normal’).

Collection methods

Colposcopy Data Collection Form

Relational attributes

Related metadata reference

New data item

K8 Colposcopic impression—other finding free text

Identifying and definitional attributes

<i>Data item name</i>	Colposcopic impression—other finding free text
<i>Definition</i>	Clinical diagnosis or impression formed at time of colposcopy if not one of the coded options in ‘Colposcopic impression—primary diagnosis’.
<i>Collection status</i>	Conditional

Value domain attributes

<i>Representation class</i>	Text
<i>Data type</i>	String
<i>Format</i>	[A(250)]
<i>Maximum character length</i>	250

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	<p>It is usual for a colposcopist to make a clinical diagnosis/impression and record this impression as the ‘result’ or diagnosis. This ‘diagnosis’ is usually made in the terms related to the likely histological outcome or biopsy result.</p> <p>This data item is available for a colposcopist to record a colposcopic impression other than those coded in K7 ‘Colposcopic impression—primary diagnosis’ using free text.</p> <p>Colposcopists will have the capacity to choose 2–3 impressions as well as the ‘Other’ category. A register will use rules to determine which impression is recorded (usually the ‘worse’ finding).</p>
<i>Rules for use</i>	If K7 ‘Colposcopic impression—primary diagnosis’ = 7 (‘Other’), then K8 ‘Colposcopic impression— other finding free text’ should not be null.
<i>Collection methods</i>	Colposcopy Data Collection Form

Relational attributes

<i>Related metadata reference</i>	New data item
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K9 Biopsy this episode

Identifying and definitional attributes

<i>Data item name</i>	Biopsy this episode
<i>Definition</i>	An indication as to whether a biopsy was performed as part of the colposcopy episode.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Code						
<i>Data type</i>	Number						
<i>Format</i>	N						
<i>Maximum character length</i>	1						
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes—biopsy performed</td></tr><tr><td>2</td><td>No—biopsy not performed</td></tr></tbody></table>	Value	Meaning	1	Yes—biopsy performed	2	No—biopsy not performed
Value	Meaning						
1	Yes—biopsy performed						
2	No—biopsy not performed						

Data item attributes

Collection and usage attributes

<i>Collection methods</i>	Colposcopy Data Collection Form
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Relational attributes

<i>Related metadata reference</i>	New data item
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K10 Pregnancy flag

Identifying and definitional attributes

<i>Data item name</i>	Pregnancy flag
<i>Definition</i>	An indication as to whether the woman was pregnant at the time of the colposcopy.
<i>Collection status</i>	Conditional

Value domain attributes

<i>Representation class</i>	Code				
<i>Data type</i>	Number				
<i>Format</i>	N				
<i>Maximum character length</i>	1				
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Pregnant</td></tr></tbody></table>	Value	Meaning	1	Pregnant
Value	Meaning				
1	Pregnant				

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	A woman should be recorded as pregnant either as a result of a blood or urine test or if she indicates to the colposcopist verbally or in writing that she is pregnant.
<i>Comment</i>	While it is considered safe to have a colposcopy, there may be some procedures that are not performed, either at the woman's request, or at the discretion of the colposcopist.
<i>Collection methods</i>	Colposcopy Data Collection Form

Relational attributes

<i>Related metadata reference</i>	New data item
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Group L: Histology test data items

- L1 Histology test date
- L2 Histology test specimen site
- L3 Procedure used for obtaining specimen for histological analysis
- L4 Squamous histology cell analysis
- L5 Endocervical (glandular) histology cell analysis
- L6 Other/non-cervical histology cell analysis
- L7 Histology test result
- L8 Histology stain
- L9 Histology stain result

L1 Histology test date

Identifying and definitional attributes

<i>Data item name</i>	Histology test date
<i>Definition</i>	The date when a histology specimen was collected.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Date
<i>Data type</i>	Date/Time
<i>Format</i>	DDMMYYYY
<i>Maximum character length</i>	8

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	<p>This is an important date, as it is used to determine other features of interest that occur 'at time of test', such as age at test.</p> <p>For a single cervical test, there can be a test request date, a test collection date, a laboratory receipt date, a laboratory report date and a laboratory transmission date.</p> <p>The date of interest for reporting is the test collection date, as this is the date on which the specimen was collected from the woman.</p> <p>If test collection date is unknown, another date can be used instead, and will be treated as the test date. This should be receipt date, followed by report date, followed by transmission date.</p>
<i>Comments</i>	<p>Registers need to collect all dates to ensure timely progression of a specimen, for instance by determining the time between the laboratory receipt date, the laboratory report date, and the laboratory transmission date.</p>
<i>Collection methods</i>	Pathology laboratories

Relational attributes

<i>Related metadata reference</i>	Supersedes <i>National cervical cancer prevention data dictionary Version 1</i> , H2 Histology test—date of histology test, date DDMMYYYY
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L2 Histology test specimen site

Identifying and definitional attributes

<i>Data item name</i>	Histology test specimen site
<i>Definition</i>	The site from where a histology specimen has been collected.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Code	
<i>Data type</i>	Number	
<i>Format</i>	N	
<i>Maximum character length</i>	1	
<i>Permissible values</i>	Value	Meaning
	0	Not stated
	1	Cervical
	2	Vaginal
	3	Other gynaecological site

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	Cervical specimen includes all cervical histology including cervical polyps and cervical samples obtained during hysterectomies for benign conditions.
<i>Collection methods</i>	Pathology laboratories

Relational attributes

<i>Related metadata reference</i>	Supersedes <i>National cervical cancer prevention data dictionary Version 1</i> , H3 Histology test—histology specimen site, code AN
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L3 Procedure used for obtaining specimen for histological analysis

Identifying and definitional attributes

<i>Data item name</i>	Procedure used for obtaining specimen for histological analysis
<i>Definition</i>	The type of procedure used to collect a gynaecological specimen for histological analysis for the purpose of assessment of cancer or pre-cancerous changes.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Code																				
<i>Data type</i>	Number																				
<i>Format</i>	N																				
<i>Maximum character length</i>	1																				
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Biopsy (includes directed punch and random punch)</td></tr><tr><td>2</td><td>Endocervical curettage (includes endocervical tissue obtained during D&C)</td></tr><tr><td>3</td><td>LLETZ/LEEP loop biopsy</td></tr><tr><td>4</td><td>Cone biopsy</td></tr><tr><td>5</td><td>Polypectomy</td></tr><tr><td>6</td><td>Subtotal hysterectomy</td></tr><tr><td>7</td><td>Hysterectomy</td></tr><tr><td>8</td><td>Amputated cervix</td></tr><tr><td>9</td><td>Other gynaecological site</td></tr></tbody></table>	Value	Meaning	1	Biopsy (includes directed punch and random punch)	2	Endocervical curettage (includes endocervical tissue obtained during D&C)	3	LLETZ/LEEP loop biopsy	4	Cone biopsy	5	Polypectomy	6	Subtotal hysterectomy	7	Hysterectomy	8	Amputated cervix	9	Other gynaecological site
Value	Meaning																				
1	Biopsy (includes directed punch and random punch)																				
2	Endocervical curettage (includes endocervical tissue obtained during D&C)																				
3	LLETZ/LEEP loop biopsy																				
4	Cone biopsy																				
5	Polypectomy																				
6	Subtotal hysterectomy																				
7	Hysterectomy																				
8	Amputated cervix																				
9	Other gynaecological site																				

Data item attributes

Collection and usage attributes

<i>Collection methods</i>	Pathology laboratories
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Relational attributes

<i>Related metadata reference</i>	Supersedes <i>National cervical cancer prevention data dictionary Version 1</i> , H4 Histology—procedure used for obtaining specimen for histological analysis, code AANN
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L4 Squamous histology cell analysis

Identifying and definitional attributes

<i>Data item name</i>	Squamous histology cell analysis
<i>Definition</i>	The histological analysis of a cervical specimen (squamous cells of the ectocervix) for the purpose of assessment of cancer or pre-cancerous changes.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Code																				
<i>Data type</i>	String																				
<i>Format</i>	AX[XX]																				
<i>Maximum character length</i>	4																				
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>S1</td><td>Negative</td></tr><tr><td>S2</td><td>Low-grade intraepithelial lesion (LSIL)</td></tr><tr><td>S3.1</td><td>High-grade intraepithelial lesion (HSIL) (CIN NOS)</td></tr><tr><td>S3.2</td><td>HSIL (CIN 2)</td></tr><tr><td>S3.3</td><td>HSIL (CIN 3)</td></tr><tr><td>S4.1</td><td>Superficially invasive squamous cell carcinoma (SISCCA)</td></tr><tr><td>S4.2</td><td>Squamous cell carcinoma (SCC)</td></tr><tr><td>SU</td><td>Unsatisfactory</td></tr><tr><td>SN</td><td>Not applicable</td></tr></tbody></table>	Value	Meaning	S1	Negative	S2	Low-grade intraepithelial lesion (LSIL)	S3.1	High-grade intraepithelial lesion (HSIL) (CIN NOS)	S3.2	HSIL (CIN 2)	S3.3	HSIL (CIN 3)	S4.1	Superficially invasive squamous cell carcinoma (SISCCA)	S4.2	Squamous cell carcinoma (SCC)	SU	Unsatisfactory	SN	Not applicable
Value	Meaning																				
S1	Negative																				
S2	Low-grade intraepithelial lesion (LSIL)																				
S3.1	High-grade intraepithelial lesion (HSIL) (CIN NOS)																				
S3.2	HSIL (CIN 2)																				
S3.3	HSIL (CIN 3)																				
S4.1	Superficially invasive squamous cell carcinoma (SISCCA)																				
S4.2	Squamous cell carcinoma (SCC)																				
SU	Unsatisfactory																				
SN	Not applicable																				

Data item attributes

Collection and usage attributes

<i>Comments</i>	<p>Histology nomenclature was revised in the <i>National Cervical Screening Program: Guidelines for the management of screen-detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding</i> (Cancer Council Australia and Cervical Cancer Screening Guidelines Working Party 2016).</p> <p>A two-tiered nomenclature system has been accepted for non-invasive HPV associated squamous proliferations of the cervix. The two groups are LSIL and HSIL, which may be further characterised by the applicable cervical intraepithelial neoplasia (CIN) subcategory.</p> <p>LSIL is the morphologic expression of acute HPV infection. LSIL encompasses changes previously called 'HPV effect' and 'CIN1'.</p> <p>HSIL is the morphologic expression of persistent HPV infection that has the potential to progress to invasive carcinoma. HSIL encompasses lesions previously called 'CIN2' and 'CIN3'.</p> <p>The subcategories HSIL (CIN2) and HSIL (CIN3) should continue to</p>
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be used.

Where a pathologist is considering a diagnosis of CIN2, p16 staining should be performed. If the p16 stain is negative, the lesion is either LSIL or a mimic of HSIL and should not be diagnosed as HSIL. If the p16 stain is positive, the lesion should be diagnosed as HSIL (CIN2).

The term 'microinvasive carcinoma' is no longer recommended, and the term 'superficially invasive squamous cell carcinoma' (SISCCA) should be used instead.

Collection methods

Pathology laboratories

Relational attributes

Related metadata references

Supersedes *National cervical cancer prevention data dictionary Version 1*, H5 Histology—squamous histology cell analysis, code AAX[XXX]

Supersedes *Standardised cervical screening data dictionary Histology (second) sub-set data element 2 Person—cervical (squamous) specimen analysis*, histology code AANN

L5 Endocervical (glandular) histology cell analysis

Identifying and definitional attributes

<i>Data item name</i>	Endocervical (glandular) histology cell analysis
<i>Definition</i>	The histological analysis of an endocervical specimen (glandular/columnar cells of the endocervix) for the purpose of assessment of cancer or pre-cancerous changes.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Code																								
<i>Data type</i>	String																								
<i>Format</i>	AX[XX]																								
<i>Maximum character length</i>	4																								
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>E1</td><td>Negative</td></tr><tr><td>E2</td><td>Endocervical atypia</td></tr><tr><td>E3.1</td><td>Endocervical dysplasia</td></tr><tr><td>E3.2</td><td>Adenocarcinoma in situ</td></tr><tr><td>E3.3</td><td>Mixed carcinoma in situ/ adenocarcinoma in situ</td></tr><tr><td>E4.1</td><td>Endocervical adenocarcinoma, microinvasive</td></tr><tr><td>E4.2</td><td>Invasive adenocarcinoma of cervix</td></tr><tr><td>E4.3</td><td>Adenosquamous carcinoma</td></tr><tr><td>E4.4</td><td>Carcinoma of the cervix (other)</td></tr><tr><td>EU</td><td>Unsatisfactory</td></tr><tr><td>EN</td><td>Not applicable</td></tr></tbody></table>	Value	Meaning	E1	Negative	E2	Endocervical atypia	E3.1	Endocervical dysplasia	E3.2	Adenocarcinoma in situ	E3.3	Mixed carcinoma in situ/ adenocarcinoma in situ	E4.1	Endocervical adenocarcinoma, microinvasive	E4.2	Invasive adenocarcinoma of cervix	E4.3	Adenosquamous carcinoma	E4.4	Carcinoma of the cervix (other)	EU	Unsatisfactory	EN	Not applicable
Value	Meaning																								
E1	Negative																								
E2	Endocervical atypia																								
E3.1	Endocervical dysplasia																								
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E4.2	Invasive adenocarcinoma of cervix																								
E4.3	Adenosquamous carcinoma																								
E4.4	Carcinoma of the cervix (other)																								
EU	Unsatisfactory																								
EN	Not applicable																								

Data item attributes

Collection and usage attributes

<i>Comments</i>	<p>Histology nomenclature was revised in the <i>National Cervical Screening Program: Guidelines for the management of screen-detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding</i> (Cancer Council Australia and Cervical Cancer Screening Guidelines Working Party 2016).</p> <p>However, while this states that 'Adenocarcinoma in situ' (AIS) is the only currently recommended term in Australasia for glandular mucosal preinvasive lesions, other categories are included to allow the collection of these findings.</p>
<i>Collection methods</i>	Pathology laboratories

Relational attributes

<i>Related metadata references</i>	Supersedes <i>National cervical cancer prevention data dictionary Version 1</i> , H6 Histology test—endocervical (glandular) histology cell
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analysis, code AAX[XXX]

Supersedes *Standardised cervical screening data dictionary*

Histology (second) sub-set data element 3 Person—endocervical
(glandular) specimen analysis, histology code AANN

L6 Other/non-cervical histology cell analysis

Identifying and definitional attributes

<i>Data item name</i>	Other/non-cervical histology cell analysis
<i>Definition</i>	The histological analysis of a non-cervical sample.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Code																
<i>Data type</i>	String																
<i>Format</i>	AX[XX]																
<i>Maximum character length</i>	4																
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>O1</td><td>Negative/no abnormalities reported or benign changes only</td></tr><tr><td>O2</td><td>Low grade neoplasia/hyperplasia NOS</td></tr><tr><td>O3.1</td><td>High grade neoplasia/hyperplasia</td></tr><tr><td>O3.2</td><td>Carcinoma in situ</td></tr><tr><td>O4.1</td><td>Carcinoma, microinvasive</td></tr><tr><td>O4.2</td><td>Invasive carcinoma</td></tr><tr><td>ON</td><td>Not applicable</td></tr></tbody></table>	Value	Meaning	O1	Negative/no abnormalities reported or benign changes only	O2	Low grade neoplasia/hyperplasia NOS	O3.1	High grade neoplasia/hyperplasia	O3.2	Carcinoma in situ	O4.1	Carcinoma, microinvasive	O4.2	Invasive carcinoma	ON	Not applicable
Value	Meaning																
O1	Negative/no abnormalities reported or benign changes only																
O2	Low grade neoplasia/hyperplasia NOS																
O3.1	High grade neoplasia/hyperplasia																
O3.2	Carcinoma in situ																
O4.1	Carcinoma, microinvasive																
O4.2	Invasive carcinoma																
ON	Not applicable																

Data item attributes

Collection and usage attributes

<i>Collection methods</i>	Pathology laboratories
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Relational attributes

<i>Related metadata reference</i>	New data item
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L7 Histology test result

Identifying and definitional attributes

<i>Data item name</i>	Histology test result
<i>Definition</i>	Cervical histology result based on S and E codes as defined by the Australian Institute of Health and Welfare for national reporting purposes.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Code												
<i>Data type</i>	Number												
<i>Format</i>	N												
<i>Maximum character length</i>	1												
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>0</td><td>Unsatisfactory</td></tr><tr><td>1</td><td>Negative</td></tr><tr><td>2</td><td>Low-grade</td></tr><tr><td>3</td><td>High-grade</td></tr><tr><td>4</td><td>Cervical cancer</td></tr></tbody></table>	Value	Meaning	0	Unsatisfactory	1	Negative	2	Low-grade	3	High-grade	4	Cervical cancer
Value	Meaning												
0	Unsatisfactory												
1	Negative												
2	Low-grade												
3	High-grade												
4	Cervical cancer												

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	<p>Note that for the purposes of national reporting of cervical histology by the Australian Institute of Health and Welfare, categories are based only on S and E codes.</p> <p>An unsatisfactory histology result is defined as specified in each state or territory, since the entire pathology result is required to make an evaluation. For instance, the overall findings may be unsatisfactory, even if there are valid squamous and endocervical codes allocated, since a pathologist may code what can be observed, even in the case of an unsatisfactory sample. Hence it is not appropriate to define unsatisfactory histology using S and E codes.</p> <p>Note, however, that if high-grade or malignant cells are seen in an otherwise unsatisfactory specimen, the histology result category should reflect the high-grade or malignant finding, rather than the unsatisfactory nature of the sample.</p> <p>A negative histology result is defined as any histology test that is not unsatisfactory and where there is no evidence of HPV infection, intraepithelial pre-neoplasia, or intraepithelial neoplasia.</p> <p>Note that there is no requirement for both squamous and endocervical components to be sampled and to be negative; a histology result that only samples the squamous component and the squamous component is negative, or a histology result that only samples the endocervical component and the endocervical</p>
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component is negative, are both counted as negative histology tests.

A negative histology result can therefore be represented as (L4 = S1 and L5 = E1) or (L4 = S1 and L5 = EN) or (L4 = SN and L5 = E1), although this may not reflect how negative histology is coded by cervical screening registers.

A low-grade histology result is defined as L4 = S2 or L5 = E2 (L4 cannot be >S2 and L5 cannot be >E2).

A high-grade histology result is defined as L4 = S3 or L5 = E3 (L4 cannot be >S3 and L5 cannot be >E3).

A cervical cancer histology result is defined as L4 = S4 or L5 = E4.

Comments

This is the way that histology results are used for reporting and monitoring purposes.

Collection methods

Pathology laboratories

Relational attributes

Related metadata reference

Supersedes *National cervical cancer prevention data dictionary Version 1*, H9 Histology test—histology result, code {AA}

L8 Histology stain

Identifying and definitional attributes

<i>Data item name</i>	Histology stain
<i>Definition</i>	An indication as to what staining was performed on the histology specimen.
<i>Collection status</i>	Aspirational

Value domain attributes

<i>Representation class</i>	Code						
<i>Data type</i>	Number						
<i>Format</i>	N[N]						
<i>Maximum character length</i>	2						
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>0</td><td>No stain</td></tr><tr><td>1</td><td>p16</td></tr></tbody></table>	Value	Meaning	0	No stain	1	p16
Value	Meaning						
0	No stain						
1	p16						

Data item attributes

Collection and usage attributes

<i>Comments</i>	This data item will be expanded as more stains are used on cervical histology specimens to aid in the identification of high-grade cervical abnormalities.
<i>Collection methods</i>	Pathology laboratories

Relational attributes

<i>Related metadata reference</i>	New data item
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L9 Histology stain result

Identifying and definitional attributes

<i>Data item name</i>	Histology stain result
<i>Definition</i>	Result of the histology staining performed.
<i>Collection status</i>	Aspirational

Value domain attributes

<i>Representation class</i>	Code	
<i>Data type</i>	Number	
<i>Format</i>	N	
<i>Maximum character length</i>	1	
<i>Permissible values</i>	Value	Meaning
	0	Not done
	1	Staining
	2	No staining
	3	Equivocal staining

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	The results refer to each of the staining options in L8 'Histology stain', so if L8 = 1 'p16', then the results in L9 are the staining results for p16.
<i>Collection methods</i>	Pathology laboratories

Relational attributes

<i>Related metadata reference</i>	New data item
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Group M: Treatment data items

M1	Treatment this episode
M2	Treatment date
M3	Excision performed this episode
M4	Modality/method used for excision
M5	Ablation performed this episode
M6	Hysterectomy
M7	Treatment anaesthetic type
M8	Location of service
M9	Eligible for test of cure flag
M10	Eligible for test of cure date
M11	Test of cure completion flag
M12	Test of cure completion date

M1 Treatment this episode

Identifying and definitional attributes

<i>Data item name</i>	Treatment this episode
<i>Definition</i>	An indication as to whether treatment was performed as part of the colposcopy episode.
<i>Collection status</i>	Desirable

Value domain attributes

<i>Representation class</i>	Code
<i>Data type</i>	Number
<i>Format</i>	N
<i>Maximum character length</i>	1
<i>Permissible values</i>	Value Meaning
	1 Yes—treatment performed
	2 No—treatment not performed

Data item attributes

Collection and usage attributes

<i>Collection methods</i>	Colposcopy Data Collection Form
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Relational attributes

<i>Related metadata reference</i>	New data item
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M2 Treatment date

Identifying and definitional attributes

<i>Data item name</i>	Treatment date
<i>Definition</i>	An indication as to the date of treatment.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Date
<i>Data type</i>	Date/Time
<i>Format</i>	{DDMMYYYY}
<i>Maximum character length</i>	8

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	This is a derived field, to be populated with K2 'Date of colposcopy episode' when M1 'Treatment this episode' is equal to 1, indicating that treatment was performed during this colposcopy episode.
<i>Collection methods</i>	Derived.

Relational attributes

<i>Related metadata reference</i>	New data item
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M3 Excision performed this episode

Identifying and definitional attributes

<i>Data item name</i>	Excision performed this episode
<i>Definition</i>	Whether or not excision was performed this episode, and if yes, the intended excision type.
<i>Collection status</i>	Desirable

Value domain attributes

<i>Representation class</i>	Code										
<i>Data type</i>	String										
<i>Format</i>	N{A}										
<i>Maximum character length</i>	2										
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>0</td><td>No</td></tr><tr><td>1a</td><td>Yes—Type 1 excision (<10 mm)</td></tr><tr><td>1b</td><td>Yes—Type 2 excision (>10 and <15 mm)</td></tr><tr><td>1c</td><td>Yes—Type 3 excision (>15 mm)</td></tr></tbody></table>	Value	Meaning	0	No	1a	Yes—Type 1 excision (<10 mm)	1b	Yes—Type 2 excision (>10 and <15 mm)	1c	Yes—Type 3 excision (>15 mm)
Value	Meaning										
0	No										
1a	Yes—Type 1 excision (<10 mm)										
1b	Yes—Type 2 excision (>10 and <15 mm)										
1c	Yes—Type 3 excision (>15 mm)										

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	<p>Excisions are stratified as Types 1, 2 or 3, according to the length of cervical tissue excised. Treatment types are defined below (modified from the terminology recommended by the International Federation for Cervical Pathology and Colposcopy in 2011.</p> <ul style="list-style-type: none">• ‘Type 1 excision’ (for Type1 transformation zone): Usually to 8 mm and not more than 10 mm length of cervical tissue excised.• ‘Type 2 excision’ (for Type 2 transformation zone): Not more than 15mm length of tissue excised.• ‘Type 3 excisions’ (for Type 3 transformation zones): Equivalent to ‘cone biopsy’ and >15 mm length. Should be used for women with:<ul style="list-style-type: none">– suspected invasive disease– proven or suspected glandular disease– Type 3 transformation zones with proven or suspected high-grade disease.
<i>Collection methods</i>	Colposcopy Data Collection Form

Relational attributes

<i>Related metadata reference</i>	New data item
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M4 Modality/method used for excision

Identifying and definitional attributes

<i>Data item name</i>	Modality/method used for excision
<i>Definition</i>	The modality or method used for excision, where this was performed.
<i>Collection status</i>	Conditional

Value domain attributes

<i>Representation class</i>	Code												
<i>Data type</i>	String												
<i>Format</i>	{N{A}}												
<i>Maximum character length</i>	2												
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>0</td><td>Excision not performed</td></tr><tr><td>1a</td><td>Loop Diathermy</td></tr><tr><td>1b</td><td>Scalpel (Cold Kinfe)</td></tr><tr><td>1c</td><td>Laser</td></tr><tr><td>1d</td><td>Other</td></tr></tbody></table>	Value	Meaning	0	Excision not performed	1a	Loop Diathermy	1b	Scalpel (Cold Kinfe)	1c	Laser	1d	Other
Value	Meaning												
0	Excision not performed												
1a	Loop Diathermy												
1b	Scalpel (Cold Kinfe)												
1c	Laser												
1d	Other												

Data item attributes

Collection and usage attributes

<i>Rules for use</i>	If M3 Excision performed this episode = 0, then M4 Modality/method used for excision should be 0.
<i>Collection methods</i>	Colposcopy Data Collection Form

Relational attributes

<i>Related metadata reference</i>	New data item
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M5 Ablation performed this episode

Identifying and definitional attributes

<i>Data item name</i>	Ablation performed this episode
<i>Definition</i>	Whether or not ablation was performed this episode, and if yes, the ablation type.
<i>Collection status</i>	Desirable

Value domain attributes

<i>Representation class</i>	Code										
<i>Data type</i>	String										
<i>Format</i>	N{A}										
<i>Maximum character length</i>	2										
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>0</td><td>No</td></tr><tr><td>1a</td><td>Yes—Laser</td></tr><tr><td>1b</td><td>Yes—Thermal Coagulation (Semm)</td></tr><tr><td>1c</td><td>Yes—Diathermy</td></tr></tbody></table>	Value	Meaning	0	No	1a	Yes—Laser	1b	Yes—Thermal Coagulation (Semm)	1c	Yes—Diathermy
Value	Meaning										
0	No										
1a	Yes—Laser										
1b	Yes—Thermal Coagulation (Semm)										
1c	Yes—Diathermy										

Data item attributes

Collection and usage attributes

<i>Collection methods</i>	Colposcopy Data Collection Form
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Relational attributes

<i>Related metadata reference</i>	New data item
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M6 Hysterectomy

Identifying and definitional attributes

<i>Data item name</i>	Hysterectomy
<i>Definition</i>	An indication as to whether hysterectomy was performed
<i>Collection status</i>	Desirable

Value domain attributes

<i>Representation class</i>	Code						
<i>Data type</i>	Number						
<i>Format</i>	N						
<i>Maximum character length</i>	1						
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes—hysterectomy performed</td></tr><tr><td>2</td><td>No—hysterectomy not performed</td></tr></tbody></table>	Value	Meaning	1	Yes—hysterectomy performed	2	No—hysterectomy not performed
Value	Meaning						
1	Yes—hysterectomy performed						
2	No—hysterectomy not performed						

Data item attributes

Collection and usage attributes

<i>Collection methods</i>	Colposcopy Data Collection Form
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Relational attributes

<i>Related metadata reference</i>	New data item
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M7 Treatment anaesthetic type

Identifying and definitional attributes

<i>Data item name</i>	Treatment anaesthetic type
<i>Definition</i>	An indication as to whether the anaesthetic used was local or general.
<i>Collection status</i>	Desirable

Value domain attributes

<i>Representation class</i>	Code	
<i>Data type</i>	Number	
<i>Format</i>	{N}	
<i>Maximum character length</i>	1	
<i>Permissible values</i>	Value	Meaning
	1	Local
	2	Regional
	3	General

Data item attributes

Collection and usage attributes

<i>Collection methods</i>	Colposcopy Data Collection Form
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Relational attributes

<i>Related metadata reference</i>	New data item
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M8 Location of service

Identifying and definitional attributes

<i>Data item name</i>	Location of service
<i>Definition</i>	An indication as to where treatment was performed.
<i>Collection status</i>	Desirable

Value domain attributes

<i>Representation class</i>	Code	
<i>Data type</i>	Number	
<i>Format</i>	{N}	
<i>Maximum character length</i>	1	
<i>Permissible values</i>	Value	Meaning
	2	Public Hospital
	3	Private Hospital
	4	Private Rooms
	9	Unknown/Other

Data item attributes

Collection and usage attributes

<i>Collection methods</i>	Colposcopy Data Collection Form
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Relational attributes

<i>Related metadata reference</i>	New data item
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M9 Eligible for test of cure flag

Identifying and definitional attributes

<i>Data item name</i>	Eligible for test of cure flag
<i>Definition</i>	An indication that, following treatment for a high-grade squamous intraepithelial lesion, a woman is eligible for test of cure.
<i>Collection status</i>	Conditional

Value domain attributes

<i>Representation class</i>	Code				
<i>Data type</i>	Number				
<i>Format</i>	{N}				
<i>Maximum character length</i>	1				
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Eligible for test of cure</td></tr></tbody></table>	Value	Meaning	1	Eligible for test of cure
Value	Meaning				
1	Eligible for test of cure				

Data item attributes

Collection and usage attributes

<i>Collection methods</i>	Calculate based on the date of the previous histologically-confirmed high-grade squamous intraepithelial lesion.
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Relational attributes

<i>Related metadata reference</i>	New data item
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M10 Eligible for test of cure date

Identifying and definitional attributes

<i>Data item name</i>	Eligible for test of cure date
<i>Definition</i>	An indication as to the date a woman became eligible for test of cure.
<i>Collection status</i>	Conditional

Value domain attributes

<i>Representation class</i>	Date
<i>Data type</i>	Date/Time
<i>Format</i>	{DDMMYYYY}
<i>Maximum character length</i>	8

Data item attributes

Collection and usage attributes

<i>Collection methods</i>	Derived from the date of treatment for previous histologically-confirmed high-grade squamous intraepithelial lesion.
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Relational attributes

<i>Related metadata reference</i>	New data item
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M11 Test of cure completion flag

Identifying and definitional attributes

<i>Data item name</i>	Test of cure completion flag
<i>Definition</i>	An indication that, following treatment for a high-grade squamous intraepithelial lesion, a woman has completed test of cure.
<i>Collection status</i>	Conditional

Value domain attributes

<i>Representation class</i>	Code				
<i>Data type</i>	Number				
<i>Format</i>	{N}				
<i>Maximum character length</i>	1				
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Test of cure complete</td></tr></tbody></table>	Value	Meaning	1	Test of cure complete
Value	Meaning				
1	Test of cure complete				

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	Successful completion of test of cure is as per the management guidelines, and comprises two negative co-test (HPV and LBC) results 12 months apart, commencing 12 months after treatment for a histologically-confirmed high-grade squamous intraepithelial lesion.
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Relational attributes

<i>Related metadata reference</i>	New data item
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M12 Test of cure completion date

Identifying and definitional attributes

<i>Data item name</i>	Test of cure completion date
<i>Definition</i>	An indication as to the date the test of cure was complete.
<i>Collection status</i>	Conditional

Value domain attributes

<i>Representation class</i>	Date
<i>Data type</i>	Date/Time
<i>Format</i>	{DDMMYYYY}
<i>Maximum character length</i>	8

Data item attributes

Collection and usage attributes

<i>Collection methods</i>	Derived from the date of the second negative co-test (contingent on test of cure being followed with co-tests at recommended intervals after treatment).
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Relational attributes

<i>Related metadata reference</i>	New data item
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Group N: Provider data items

Provider data items allow the collection and reporting by provider for all tests that may be performed within a screening round — HPV tests, cytology tests, colposcopy and histology tests. These can be used in combination with the data item Type of test to determine the provider details for each test.

- N1 Medicare provider number
- N2 Healthcare provider identifier—organisation (HPI-O)
- N3 Healthcare provider identifier—individual (HPI-I)
- N4 Provider type
- N5 Provider Australian state/territory
- N6 Provider Australian postcode
- N7 Identifier of a provider collecting specimen
- N8 Healthcare provider identifier—organisation (HPI-O) of a provider collecting specimen
- N9 Healthcare provider identifier—individual (HPI-I) of a provider collecting specimen
- N10 Type of provider collecting specimen

N1 Medicare provider number

Identifying and definitional attributes

<i>Data item name</i>	Medicare provider number
<i>Definition</i>	The Medicare provider number of the provider requesting a test.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Identifier
<i>Data type</i>	String
<i>Format</i>	X[X(7)]
<i>Maximum character length</i>	8

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	<p>Provider requesting test is the provider who is responsible for the test. Of the occupations of providers who collect specimens listed in only general practitioners, nurse practitioners and specialists have a Medicare provider number, and can therefore be considered responsible for the test.</p> <p>For screening tests, the provider requesting the test may not be the provider who collects the specimen; for example, a nurse may collect a sample.</p> <p>The Medicare-issued provider number is not always known or available. In these cases, a dummy provider number unique to the practitioner may be used. A generic dummy value of 0000000Y may also be used, if there is no requirement for the dummy number to be unique to the practitioner. Following a woman being referred to a colposcopist or specialist it may also be necessary for the provider number to be changed for contact purposes to reflect ongoing care by the provider, until any further information is received.</p>
<i>Comments</i>	Medicare provider numbers are allocated to individual providers and organisations to support payments and claims through government schemes such as Medicare Benefits and Pharmaceutical Benefits Schemes.

Relational attributes

<i>Related metadata references</i>	<p>Supersedes <i>National cervical cancer prevention data dictionary Version 1</i>, B1 Provider requesting test—Medicare provider number, Identifier X[X(7)]</p> <p>Supersedes <i>Standardised cervical screening data dictionary Cytology (first) sub-set data element 15</i> Provider taking specimen—provider identifier, Identifier N[N(11)] A</p>
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N2 Healthcare provider identifier—organisation (HPI-O)

Identifying and definitional attributes

<i>Data item name</i>	Healthcare provider identifier—organisation (HPI-O)
<i>Definition</i>	The healthcare provider identifier—organisation (HPI-O) of the provider requesting a test. A healthcare provider identifier—organisation (HPI-O) is a unique 16 digit number that will be allocated to organisations (such as a hospital or medical clinic) where healthcare is provided.
<i>Collection status</i>	Desirable

Value domain attributes

<i>Representation class</i>	Identifier
<i>Data type</i>	Number
<i>Format</i>	{N(16)}
<i>Maximum character length</i>	16

Data item attributes

Source and reference attributes

<i>Origin</i>	National E-Health Transition Authority (NEHTA)
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Relational attributes

<i>Related metadata reference</i>	Supersedes <i>National cervical cancer prevention data dictionary Version 1</i> , B3 Provider requesting test—healthcare provider identifier—organisation (HPI-O), identifier {N(16)}
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N3 Healthcare provider identifier—individual (HPI-I)

Identifying and definitional attributes

<i>Data item name</i>	Healthcare provider identifier—individual (HPI-I)
<i>Definition</i>	<p>The healthcare provider identifier—individual (HPI-I) of the provider requesting a test.</p> <p>A healthcare provider identifier—individual (HPI-I) is a unique 16 digit number that will be allocated to healthcare providers involved in providing patient care.</p>
<i>Collection status</i>	Desirable

Value domain attributes

<i>Representation class</i>	Identifier
<i>Data type</i>	Number
<i>Format</i>	{N(16)}
<i>Maximum character length</i>	16

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	Collection of this is essential if Medicare provider number is not available
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Source and reference attributes

<i>Origin</i>	National E-Health Transition Authority (NEHTA)
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Relational attributes

<i>Related metadata reference</i>	Supersedes <i>National cervical cancer prevention data dictionary Version 1</i> , B2 Provider requesting test—healthcare provider identifier—individual (HPI-I), identifier {N(16)}
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N4 Provider type

Identifying and definitional attributes

<i>Data item name</i>	Provider type
<i>Definition</i>	The occupation of the provider requesting a test.
<i>Context</i>	Administrative purposes.
<i>Collection status</i>	Desirable

Value domain attributes

<i>Representation class</i>	Code																		
<i>Data type</i>	String																		
<i>Format</i>	{A}																		
<i>Maximum character length</i>	1																		
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>G</td><td>General practitioner</td></tr><tr><td>N</td><td>Nurse Practitioner/Eligible Midwife</td></tr><tr><td>R</td><td>Registered Nurse/Midwife</td></tr><tr><td>E</td><td>Enrolled Nurse</td></tr><tr><td>S</td><td>Specialists (Obstetricians and gynaecologists)</td></tr><tr><td>A</td><td>Aboriginal and Torres Strait Islander health care worker</td></tr><tr><td>O</td><td>Other</td></tr><tr><td>U</td><td>Unassigned</td></tr></tbody></table>	Value	Meaning	G	General practitioner	N	Nurse Practitioner/Eligible Midwife	R	Registered Nurse/Midwife	E	Enrolled Nurse	S	Specialists (Obstetricians and gynaecologists)	A	Aboriginal and Torres Strait Islander health care worker	O	Other	U	Unassigned
Value	Meaning																		
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R	Registered Nurse/Midwife																		
E	Enrolled Nurse																		
S	Specialists (Obstetricians and gynaecologists)																		
A	Aboriginal and Torres Strait Islander health care worker																		
O	Other																		
U	Unassigned																		

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	The occupation needs to reflect the occupation of the provider requesting a test (this is not necessarily the same person who collected the sample).
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Relational attributes

<i>Related metadata reference</i>	New data item
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N5 Provider Australian state/territory

Identifying and definitional attributes

<i>Data item name</i>	Provider Australian state/territory
<i>Definition</i>	The name of the Australian state or territory in which the provider requesting a test is located.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Code																		
<i>Data type</i>	Text																		
<i>Format</i>	AA{A}																		
<i>Maximum character length</i>	3																		
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>NSW</td><td>New South Wales</td></tr><tr><td>VIC</td><td>Victoria</td></tr><tr><td>QLD</td><td>Queensland</td></tr><tr><td>WA</td><td>Western Australia</td></tr><tr><td>SA</td><td>South Australia</td></tr><tr><td>TAS</td><td>Tasmania</td></tr><tr><td>ACT</td><td>Australian Capital Territory</td></tr><tr><td>NT</td><td>Northern Territory</td></tr></tbody></table>	Value	Meaning	NSW	New South Wales	VIC	Victoria	QLD	Queensland	WA	Western Australia	SA	South Australia	TAS	Tasmania	ACT	Australian Capital Territory	NT	Northern Territory
Value	Meaning																		
NSW	New South Wales																		
VIC	Victoria																		
QLD	Queensland																		
WA	Western Australia																		
SA	South Australia																		
TAS	Tasmania																		
ACT	Australian Capital Territory																		
NT	Northern Territory																		

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	The order presented here is the standard for the Australian Institute of Health and Welfare, and reflects the current order of states and then territories in order of most populated to least populated.
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Relational attributes

<i>Related metadata reference</i>	Supersedes <i>National cervical cancer prevention data dictionary Version 1</i> , B10 Provider requesting test—Australian state/territory name, code AA{A}
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N6 Provider Australian postcode

Identifying and definitional attributes

<i>Data item name</i>	Provider Australian postcode
<i>Definition</i>	The code that represents a postal delivery area, aligned with locality, suburb or place for the practice where a provider requesting a test is located.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Code
<i>Data type</i>	Number
<i>Format</i>	NNNN
<i>Maximum character length</i>	4

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	Must accept zero as the leading digit to accommodate all Australian postcodes.
<i>Comments</i>	<p>Australian Postcode may be used in the analysis of data on a geographical basis, which involves a conversion from postcodes to the Australian Bureau of Statistics (ABS) postal areas. This conversion results in some inaccuracy of information. However, in some data sets postcode is the only geographic identifier, therefore the use of other more accurate indicators is not always possible.</p> <p>When dealing with aggregate data, postal areas, converted from postcodes, can be mapped to Australian Statistical Geography Standard codes using an ABS concordance.</p>

Relational attributes

<i>Related metadata references</i>	<p>Supersedes <i>National cervical cancer prevention data dictionary Version 1</i>, B11 Provider requesting test—Australian postcode, code NNNN</p> <p>Supersedes <i>Standardised cervical screening data dictionary Cytology (first) sub-set data element 22</i> Provider taking specimen (practice address)—postcode, code {NNNN}</p>
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N7 Identifier of a provider collecting specimen

Identifying and definitional attributes

<i>Data item name</i>	Identifier of a provider collecting specimen
<i>Definition</i>	Identifier number of the provider collecting specimen.
<i>Collection status</i>	Desirable

Value domain attributes

<i>Representation class</i>	Identifier
<i>Data type</i>	String
<i>Format</i>	[X(20)]
<i>Maximum character length</i>	20

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	Only to be used if the provider collecting the specimen is different to the provider who requested the specimen.
<i>Comments</i>	This identifier allows for the collection of a number allocated to a provider collecting specimen that is not a Medicare provider number; for example, registered nurse Pap test providers do not have a Medicare provider number (the provider number of the general practitioner or specialist responsible for the test will be used), but may have an identifying number.

Relational attributes

<i>Related metadata reference</i>	Supersedes <i>National cervical cancer prevention data dictionary Version 1</i> , B13 Provider collecting specimen—identifier, identifier [X(20)]
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N8 Healthcare provider identifier—organisation (HPI-O) of a provider collecting specimen

Identifying and definitional attributes

<i>Data item name</i>	Healthcare provider identifier—organisation (HPI-O) of a provider collecting specimen
<i>Definition</i>	<p>The healthcare provider identifier—organisation (HPI-O) of the provider collecting specimen.</p> <p>A healthcare provider identifier identifier—organisation (HPI-O) is a unique 16 digit number that will be allocated to organisations (such as a hospital or medical clinic) where healthcare is provided.</p>
<i>Collection status</i>	Desirable

Value domain attributes

<i>Representation class</i>	Identifier
<i>Data type</i>	Number
<i>Format</i>	{N(16)}
<i>Maximum character length</i>	16

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	Only to be used if the provider collecting the specimen is different to the provider who requested the specimen.
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Source and reference attributes

<i>Origin</i>	National E-Health Transition Authority (NEHTA)
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Relational attributes

<i>Related metadata reference</i>	Supersedes <i>National cervical cancer prevention data dictionary Version 1</i> , B15 Provider collecting specimen—healthcare provider identifier—organisation (HPI-O), identifier {N(16)}
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N9 Healthcare provider identifier—individual (HPI-I) of a provider collecting specimen

Identifying and definitional attributes

<i>Data item name</i>	Healthcare provider identifier—individual (HPI-I) of a provider collecting specimen
<i>Definition</i>	A healthcare provider identifier—individual (HPI-I) is a unique 16 digit number that will be allocated to healthcare providers involved in providing patient care.
<i>Collection status</i>	Desirable

Value domain attributes

<i>Representation class</i>	Identifier
<i>Data type</i>	Number
<i>Format</i>	{N(16)}
<i>Maximum character length</i>	16

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	Only to be used if the provider collecting the specimen is different to the provider who requested the specimen.
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Source and reference attributes

<i>Origin</i>	National E-Health Transition Authority (NEHTA)
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Relational attributes

<i>Related metadata reference</i>	Supersedes <i>National cervical cancer prevention data dictionary Version 1</i> , B14 Provider collecting specimen—healthcare provider identifier—individual (HPI-I), identifier {N(16)}
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N10 Type of provider collecting specimen

Identifying and definitional attributes

<i>Data item name</i>	Type of provider collecting specimen
<i>Definition</i>	The occupation of the person who collects a specimen.
<i>Collection status</i>	Desirable

Value domain attributes

<i>Representation class</i>	Code																				
<i>Data type</i>	String																				
<i>Format</i>	{A}																				
<i>Maximum character length</i>	1																				
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O	Other																				
X	None—self-collected (only applicable to HPV test)																				
U	Unassigned																				

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	Only to be used if the provider collecting the specimen is different to the provider who requested the specimen. The occupation needs to reflect the occupation of the person who collected the specimen, not on the occupation of the provider number under which the specimen was collected (that is, if a registered nurse collects the specimen under a GP's provider number, the occupation needs to be recorded as nurse, not GP).
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Relational attributes

<i>Related metadata references</i>	Supersedes <i>National cervical cancer prevention data dictionary Version 1</i> , B12 Provider collecting specimen—occupation of person collecting specimen, code {A} Supersedes <i>Standardised cervical screening data dictionary Cytology (first) sub-set data element 23</i> Provider taking specimen—occupation of person taking specimen, code A
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Group O: Pathology laboratory data items

- O1 Pathology laboratory identifier
- O2 Pathology laboratory name
- O3 Pathology laboratory accession number/identifier

O1 Pathology laboratory identifier

Identifying and definitional attributes

<i>Data item name</i>	Pathology laboratory identifier
<i>Definition</i>	A unique identification allocated to the pathology laboratories that perform analyses on cervical specimens.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Identifier
<i>Data type</i>	String
<i>Format</i>	XXX
<i>Maximum character length</i>	3

Data item attributes

Collection and usage attributes

<i>Collection methods</i>	Pathology laboratories
---------------------------	------------------------

Relational attributes

<i>Related metadata references</i>	Supersedes <i>National cervical cancer prevention data dictionary Version 1</i> , L1 Laboratory—pathology laboratory identifier, identifier XXX Supersedes <i>Standardised cervical screening data dictionary Cytology (first) sub-set data element 24</i> Pathology laboratory—laboratory, identifier X(3)
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O2 Pathology laboratory name

Identifying and definitional attributes

<i>Data item name</i>	Pathology laboratory name
<i>Definition</i>	The name of the pathology laboratory.
<i>Collection status</i>	Optional

Value domain attributes

<i>Representation class</i>	Text
<i>Data type</i>	String
<i>Format</i>	[X(250)]
<i>Maximum character length</i>	250

Data item attributes

Collection and usage attributes

<i>Collection methods</i>	Pathology laboratories
---------------------------	------------------------

Relational attributes

<i>Related metadata reference</i>	New data item
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O3 Pathology laboratory accession number/identifier

Identifying and definitional attributes

<i>Data item name</i>	Pathology laboratory accession number/identifier
<i>Definition</i>	A unique record identifier allocated by the pathology laboratory to a cervical specimen to distinguish it from all other specimens analysed by the laboratory.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Identifier
<i>Data type</i>	String
<i>Format</i>	X[X(19)]
<i>Maximum character length</i>	20

Data item attributes

Collection and usage attributes

<i>Collection methods</i>	Pathology laboratories
---------------------------	------------------------

Relational attributes

<i>Related metadata references</i>	Supersedes <i>National cervical cancer prevention data dictionary Version 1</i> , C1 Cytology test—laboratory accession number, identifier X[X(19)] Supersedes <i>Standardised cervical screening data dictionary</i> Cytology (first) sub-set data element 25 Pathology laboratory—cervical cytology accession number X(20)
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Group P: Screening history data items

- P1 Previously screened flag
- P2 Date of last screening test
- P3 Last screening test type
- P4 Number of days since last screening test

P1 Previously screened flag

Identifying and definitional attributes

<i>Data item name</i>	Previously screened flag
<i>Definition</i>	An indication as to whether a woman has ever had a screening test
<i>Collection status</i>	Conditional

Value domain attributes

<i>Representation class</i>	Code	
<i>Data type</i>	Number	
<i>Format</i>	{N}	
<i>Maximum character length</i>	1	
<i>Permissible values</i>	Value	Meaning
	1	Previously screened

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	<p>This flag should be used for all women who have ever had a screening test — either a Pap test through the previous NCSP or an HPV test through the current NCSP.</p> <p>This also needs to be recorded for women under the age of 25, even though they will not be invited to screen until they are aged 25 years.</p> <p>For women who are on a register but never screened, this flag should be raised when a woman has her first screening test.</p> <p>Exclude diagnostic or follow-up tests.</p>
<i>Rules for use</i>	If P2 'Date of last screening test is not null, P1 'Previously screened flag' should be = 1.

Relational attributes

<i>Related metadata reference</i>	New data item
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P2 Date of last screening test

Identifying and definitional attributes

<i>Data item name</i>	Date of last screening test
<i>Definition</i>	The date a sample for a woman's last screening test was collected (date of screening test).
<i>Collection status</i>	Conditional

Value domain attributes

<i>Representation class</i>	Date
<i>Data type</i>	Date/Time
<i>Format</i>	{DDMMYYYY}
<i>Maximum character length</i>	8

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	<p>This will need to be updated each time a woman has a screening test so that this reflects her most recent screening test date.</p> <p>If a histology diagnosis of cervical cancer is received by the register with a collection date within 6 months of the date of previous screening test, this date needs to be replaced with the immediately preceding screening test date until there is a screening test that is not followed by a diagnosis of cervical cancer within 6 months. If this was the woman's first screening test date, or if there is no screening test that is not followed by a cancer diagnosis, then it should be reverted to null, and P1 flag removed.</p> <p>This is to collect only screening tests. Screening tests that lead to a histological diagnosis of cancer within 6 months are likely to be part of the diagnosis process, rather than a true screen. These tests are important to remove, as this data item will be used to determine whether women have interval cancers diagnosed, and the inclusion of these would falsely elevate the number of interval cancers.</p> <p>Diagnosis of cervical cancer must be by histology (L7 = 4).</p> <p>Includes Pap tests under the previous NCSP and screening HPV tests under the current NCSP.</p>
<i>Rules for use</i>	If P1 'Previously screened flag = 1, P2 'Date of last screening test' should not be null.
<i>Comments</i>	Date of previous screening test can be combined with date of diagnosis of cervical cancer to assign a screening history to women diagnosed with cervical cancer (for example, never screened, lapsed screening, adequately screened) based on time since last screening test at time of diagnosis with cervical cancer.

Relational attributes

<i>Related metadata reference</i>	New data item
-----------------------------------	---------------

P3 Last screening test type

Identifying and definitional attributes

<i>Data item name</i>	Last screening test type
<i>Definition</i>	An indication as to whether the last screening test was a cytology test or an HPV test.
<i>Collection status</i>	Conditional

Value domain attributes

<i>Representation class</i>	Code						
<i>Data type</i>	Number						
<i>Format</i>	{N}						
<i>Maximum character length</i>	1						
<i>Permissible values</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Cytology test</td></tr><tr><td>2</td><td>HPV test</td></tr></tbody></table>	Value	Meaning	1	Cytology test	2	HPV test
Value	Meaning						
1	Cytology test						
2	HPV test						

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	<p>Cytology test should be selected where the previous screening test is a screening cytology test under the previous NCSP or cytology test that is used as a screening test under the current NCSP (as it is likely that some women will have a conventional Pap test after the commencement date of 1 May 2017).</p> <p>HPV test should be selected where the previous screening test is an HPV test under the current NCSP.</p>
<i>Rules for use</i>	P3 can only be populated if P1 = 1, otherwise should be left blank.

Relational attributes

<i>Related metadata reference</i>	New data item
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P4 Number of days since last screening test

Identifying and definitional attributes

<i>Data item name</i>	Number of days since last screening test
<i>Definition</i>	The number of days that have passed since the last recorded screening test for a woman.
<i>Collection status</i>	Essential

Value domain attributes

<i>Representation class</i>	Code
<i>Data type</i>	Number
<i>Format</i>	N[NNNNN]
<i>Maximum character length</i>	6

Data item attributes

Collection and usage attributes

<i>Guide for use</i>	<p>This is the number of days since a woman's previous screening test, calculated by subtracting the date of test/collection date of the previous screening test from the current date.</p> <p>When a new screening test occurs, this should be set to 0.</p> <p>The number of days will increase by one day every day.</p> <p>Number of days should be set to 999999 if no previous screening test is recorded (when P2 'Date of last screening test' is null).</p>
<i>Collection methods</i>	Derived from P2 'Date of last screening test' and current date.
<i>Comments</i>	This is used to determine the screening history of a woman, as never-screeners, lapsed screeners, regular screeners etcetera, based on time since a woman's last screening test.

Relational attributes

<i>Related metadata reference</i>	New data item
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4 Classification schemes

The following pages contain classification schemes developed for the new National Cervical Screening Program, based on permissible values from key data items included in Section 3. There is a classification scheme for each of the following:

- HPV Test Group;
- Cytology Test Group;
- Clinical Management Recommendation Group;
- Histology Test Group; and
- Colposcopy Group;

with additional tables developed to assist with the classification of:

- Screening episodes; and
- Follow-up Episodes.

HPV Test Group

HPV test collection method	1 Practitioner-collected sample		2 Self-collected sample		
HPV test specimen site	0 Not stated	1 Cervical	2 Vaginal	3 Other gynaecological site	
Reason for HPV test	1 Primary screening HPV test	2 Follow-up HPV test (Repeat HPV test after intermediate risk result or unsatisfactory test)	3 Co-test i. Test of cure ii. Investigation of signs or symptoms iii. Other, as recommended in guidelines		4 Other
HPV test result—oncogenic HPV ¹	U Unsatisfactory	0 Oncogenic HPV not detected	1 HPV 16/18 detected ² i. Type 16 detected ii. Type 18 detected iii. Type 18/45 detected	2 Oncogenic HPV (not 16/18) detected ³ i. One or more of the following types detected: 31, 33, 45, 52, or 58 ii. One or more of the following types detected: 35, 39, 51, 56, 59, 66, or 68	
HPV test type ⁴	1 Qiagen i. Hybrid Capture II	2 Roche i. cobas 4800 ii. cobas 6800 iii. cobas 8800	3 Abbott i. m2000 ii. Alinity m	4 Becton Dickinson i. Onclarity	5 Cepheid i. Xpert
	6 Hologic i. Cervista ii. Aptima	7 Seegene i. Anyplex	8 Genera i. PapType	9 Euroimmun i. Euroarray	999 Other
HPV test sample	0 Not stated		1 PreservCyt Solution		2 SurePath medium
	97 Other commercial self-collection device		98 Specimen transport medium		99 Flocked or cotton swab ⁵

¹ All oncogenic HPV types detected are required to be reported, if more than one type is detected, the codes for each detected type must be reported, comma separated. Reporting at the level of 'Not detected', 'HPV type 16/18 detected' and 'Oncogenic HPV (not 16/18) detected' is mandatory. Laboratories should report more detailed information if their test outputs allow, using the more detailed codes as suffixes.

² One or more oncogenic HPV types 16 or 18 detected

³ One or more oncogenic HPV types other than 16 and 18 detected— HPV 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 66, 68

⁴ The HPV test types listed here will be tests that are registered on the ARTG for HPV testing of cervical samples. It is not an indication of which tests are suitable for use in the NCSP. Only those HPV tests that meet the requirements set out in the NPAAC Standards and Performance Measures for cervical screening should be used in the NCSP. Tests that do not meet the requirements now may meet them in future and therefore all tests listed on the ARTG will be coded. The HPV tests currently listed are tests which were known to be registered on the ARTG at the time of development; there may be others that are on the ARTG and were not identified at the time of development or will be added in future. Any tests that are listed on the ARTG will be added if the NCSP is informed.

⁵ If a swab is received by the laboratory in sampling media such as PreservCyt or SurePath, then it must be coded as '99 Flocked or cotton swab'.

HPV test batch information ⁶					
Control kit	Lot number	Expiry date	Amplification kit	Lot number	Expiry date
Cellular (LBC) extraction kit	Lot number	Expiry date	Detection kit	Lot number	Expiry date
Nucleic acid extraction kit	Lot number	Expiry date	Wash buffer	Lot number	Expiry date

⁶ For each of these codes one or more Lot numbers and associated expiry dates need to be reported. The fields need to be able to accept both letters and numbers as well as N/A (in the case of LBC extraction on a self-collected sample). Where a 'kit' includes reagents for multiple testing steps the Lot numbers and expiry dates should be repeated for each of the codes.

Cytology Test Group

Cytology specimen type	A0 Not stated		A1 Conventional smear		A2 Liquid based specimen		A3 Conventional and liquid-based		
Cytology specimen site	B0 Not stated		B1 Cervical		B2 Vaginal		B3 Other gynaecological site		
Reason for cytology test	1 Reflex LBC cytology after detection of oncogenic HPV in primary screening HPV test			2 Cytology after detection of oncogenic HPV in self-collected sample			3 Reflex LBC after detection of oncogenic HPV in follow-up HPV test		
	4 Cytology at colposcopy		5 Co-test i. Test of cure ii. Investigation of signs or symptoms iii. Other, as recommended in guidelines			6 Other		P Conventional Pap test to screen for cervical cancer precursors	
Result	Squamous			Endocervical			Other/non-cervical		
Unsatisfactory	SU	Unsatisfactory for evaluation		EU	Due to unsatisfactory nature of the specimen, no assessment has been made			OU	Due to the unsatisfactory nature of the specimen, no assessment has been made
Negative	S1	Cell numbers and preservation satisfactory. No abnormality or only reactive changes		E- E0 E1	Not applicable: vault smear/previous hysterectomy No endocervical component Endocervical component present. No abnormality or only reactive changes			O1	No other abnormal cells
Low-grade	S2	Possible low-grade squamous intraepithelial lesion (LSIL)		E2	Atypical endocervical cells of uncertain significance			O2	Atypical endometrial cells of uncertain significance
	S3	Low-grade squamous intraepithelial lesion (LSIL) (HPV and/or CIN I)						O3	Atypical glandular cells of uncertain significance — site unknown
Possible high-grade	S4	Possible high-grade squamous intraepithelial lesion (HSIL)		E3	Possible high-grade endocervical glandular lesion			O4 O5	Possible endometrial adenocarcinoma Possible high-grade lesion — non-cervical
High-grade	S5	High-grade squamous intraepithelial lesion (HSIL) (CIN 2/CIN 3)		E4	Adenocarcinoma-in-situ Adenocarcinoma-in-situ with possible microinvasion/invasion				
	S6	HSIL with possible microinvasion/ invasion		E5					
Carcinoma	S7	Squamous carcinoma		E6	Adenocarcinoma			O6 O7 O8 O9	Malignant cells — uterine body Malignant cells — vagina Malignant cells — ovary Malignant cells — other

Clinical Management Recommendation Group

Recommendation
0 No recommendation
1 Rescreen in 5 years
2 Rescreen in 3 years
3 Repeat HPV test in 12 months
4 Co-test in 12 months
5 Retest in 6 weeks
6 Refer for colposcopic assessment
7 Test taken at time of colposcopy, no recommendation
8 Discharge from program
9 Other management recommendation
S Symptomatic—clinical management required
P Rescreen in 2 years

Histology Test Group

Specimen site	0 Not stated		1 Cervical		2 Vaginal		3 Other gynaecological site					
Procedure	1 Punch biopsy		2 Endocervical curettage		3 LLETZ/LEEP loop biopsy		4 Cone biopsy		5 Polypectomy			
	6 Subtotal hysterectomy			7 Hysterectomy			8 Amputated cervix			9 other gynaecological sites		
Result	Squamous histology cell analysis				Endocervical (glandular) histology cell analysis				Other/non-cervical histology cell analysis			
Unsatisfactory	SU	Unsatisfactory				EU	Unsatisfactory					
Not applicable	SN	Not applicable				EN	Not applicable				ON	Not applicable
Negative	S1	Negative				E1	Negative				O1	Negative/no abnormalities reported or benign changes only
Low-grade	S2	Low-grade intraepithelial lesion (LSIL)				E2	Endocervical atypia				O2	Low grade neoplasia/hyperplasia NOS
High-grade	S3.1	High-grade intraepithelial lesion (HSIL) (CIN NOS) HSIL (CIN 2) HSIL (CIN 3)				E3.1	Endocervical dysplasia Adenocarcinoma in situ Mixed carcinoma in situ/adenocarcinoma in situ				O3.1	High grade neoplasia/hyperplasia Carcinoma in situ
	S3.2											
	S3.3											
Carcinoma	S4.1	Superficially invasive squamous cell carcinoma (SISCCA) Squamous cell carcinoma (SCC)				E4.1	Endocervical adenocarcinoma, microinvasive Invasive adenocarcinoma of cervix Adenosquamous carcinoma Carcinoma of the cervix (other)				O4.1	Carcinoma, microinvasive Invasive carcinoma
	S4.2											

Colposcopy Group

Indication for colposcopy	0 Not performed		1 New patient with abnormal cervical screening result		2 Follow-up of patient with previous abnormal cervical screening result		
	3 Symptomatic		4 Abnormal appearance of cervix		5 At time of treatment		6 Other
Adequacy ¹	0 Inadequate				1 Adequate		
Transformation zone visibility	1 Type 1 Transformation zone		2 Type 2 Transformation zone		3 Type 3 Transformation zone		
Colposcopic impression	1	Normal					
	2	No visible lesion					
	3	LSIL					
	4	HSIL					
	5	Glandular abnormality (adenocarcinoma in situ)					
	6	Cancer					
	7	Other					
Biopsy this episode	0 No—biopsy not performed				1 Yes—biopsy performed		
Pregnancy flag	1 Pregnant at time of colposcopic episode						
Treatment this episode	0 No – treatment not performed				1 Yes—treatment performed		
Excision performed this episode	0 No		1a Yes—Type 1 excision (<10 mm)		1b Yes—Type 2 excision (>10 and <15 mm)		1c Yes—Type 3 excision (>15 mm)
Modality/method used for excision	0 Excision not performed		1a Loop Diathermy	1b Scalpel (Cold Knife)		1c Laser	1d Other
Ablation performed this episode	0 No		1a Yes—Laser		1b Yes—Thermal Coagulation (Semm)		1c Yes—Diathermy
Hysterectomy	0 No				1 Yes		
Treatment anaesthetic type	1 Local		2 Regional			3 General	
Location of service	1 Public hospital		2 Private Hospital		3 Private rooms		9 Unknown/Other

¹ Adequacy of colposcopy refers to the visibility of the cervix; 'Adequate' indicates that the view of the cervix is not obscured; 'Inadequate' indicates that the cervix cannot be adequately visualised, for example due to inflammation, bleeding, atrophy or scar tissue.

Screening episode

Screening HPV test result	Cytology test result	Screening episode risk	
Unsatisfactory	..	Unsatisfactory	
Oncogenic HPV types not detected	..	Low risk	
Oncogenic HPV (not 16/18)	None (applies to self-collected samples only)		
	Unsatisfactory	Unsatisfactory	
	Negative	Intermediate risk	→ Follow-up (repeat HPV test in 12 months)
	Possible or definite low-grade intraepithelial lesion (LSIL)	Intermediate risk	
	Possible or definite high-grade intraepithelial lesion (HSIL) or cervical cancer	Higher risk	
	Any glandular abnormality	Higher risk	
HPV 16/18	None (applies to self-collected samples only)	Higher risk	
	Unsatisfactory	Higher risk	
	Negative	Higher risk	
	Possible or definite low-grade intraepithelial lesion (LSIL)	Higher risk	
	Possible or definite high-grade intraepithelial lesion (HSIL) or cervical cancer	Higher risk	
	Any glandular abnormality	Higher risk	

Follow-up episode

Screening episode risk	Follow-up HPV test result	Cytology test result	Follow-up episode risk	
Intermediate risk	Unsatisfactory	..	Unsatisfactory	
	Oncogenic HPV types not detected	..	Low risk	
	Oncogenic HPV (not 16/18)	None (applies to self-collected samples only)		Higher risk
		Unsatisfactory		Higher risk
		Negative		Higher risk
		Possible or definite low-grade intraepithelial lesion (LSIL)		Higher risk
		Possible or definite high-grade intraepithelial lesion (HSIL) or cervical cancer		Higher risk
		Any glandular abnormality		Higher risk
	HPV 16/18	None (applies to self-collected samples only)		Higher risk
		Unsatisfactory		Higher risk
		Negative		Higher risk
		Possible or definite low-grade intraepithelial lesion (LSIL)		Higher risk
		Possible or definite high-grade intraepithelial lesion (HSIL) or cervical cancer		Higher risk
		Any glandular abnormality		Higher risk

5 Performance indicators

With the major changes that the new NCSP will bring, including an HPV test every five years and a commencement age of 25 years, there was both a need and an opportunity to develop new performance indicators for the new NCSP that will continue to meet the need for national monitoring of this important screening program.

These new performance indicators were developed concurrently with the development of new quality measures, safety monitoring measures, as well as standards and measures that are external to the NCSP (such as performance measures for pathology laboratories reporting on cervical screening tests). The new performance indicators are listed in Table 2.2.

These new performance indicators were developed by the AIHW in consultation with the Australian Government Department of Health and state and territory cervical screening programs, as well as the NCSP Quality and Safety Monitoring Committee, the Colposcopy Working Group convened to progress the collection and reporting of colposcopy data in the new NCSP, and cervical screening experts Professor Ian Hammond, Associate Professor Marion Saville, Dr Julia Brotherton, Professor David Roder and Professor Dorota Gertig.

Table 2.2: New performance indicators for the National Cervical Screening Program

Screening pathway	Performance indicator
Recruitment	1 Participation
	2 Response to invitation
	3 Rescreening
Screening	4 Screening results
	5 Correlation of screening results
Screening HPV test performance	6 Screening HPV test positivity
	7 Cervical cancer diagnosed after a low risk screening test result
Self-collection	8 Self-collection women positive for oncogenic HPV (not 16/18) who have an LBC test within 6 months
	9 Self-collection women positive for oncogenic HPV 16/18 who have a colposcopy within 6 months
Follow-up	10 Adherence to recommendation for follow-up
	11 Follow-up results
Assessment	12 Colposcopy rate
	13 Time to colposcopy
	14 Biopsy rate
	15 Yield of high grade abnormalities on biopsy among women who attend colposcopy with higher risk screening results
Diagnosis	16 Positive predictive value of colposcopy
	17a High-grade cervical abnormality detection rate
Outcomes	17b Cervical cancer detection rate
	18 Cervical cancers diagnosed by time since last screen
	19 Incidence of cervical cancer
	20 Mortality from cervical cancer

Disaggregation of performance indicators

The following features are common to all performance indicators. Features and any need for disaggregation specific to each performance indicator are included within the specification and/or consideration sections of each performance indicator.

Age groups

Most performance indicators are defined for the target age group 25–74, but are also reported for 5-year age groups within this range, and for ages under 25, and 75 and over.

Where appropriate, performance indicators will also be reported separately for birth cohorts that represent whether or not a woman was offered HPV vaccination. Women not offered HPV vaccination are defined as those born on or before 30 June 1980; women offered HPV vaccination are defined as those born after 30 June 1980 (1 July 1980 onwards).

Population groups

Performance indicators will be disaggregated, where numbers allow, by state and territory of residence, remoteness area of residence, socioeconomic area of residence, Indigenous status, CALD status and HPV vaccination status, as appropriate.

Remoteness area of residence, socioeconomic area of residence, and other areas of interest such as Primary Health Networks will be assigned using the most accurate geographic area available.

Clinical or program relevance

Performance indicators will also be disaggregated into different categories, where this is clinically relevant and/or provides important program information.

These categories include reason for HPV test, HPV test collection method (practitioner-collected sample or self-collected sample), and test results (related to the numerator, denominator, or both, as relevant for the performance indicator).

Indicator 1 Participation

Definition:

Number of women aged 25–74 screened in a 5-year period as a percentage of women in the population

Rationale:

Higher participation in cervical screening means that more women with precancerous abnormalities can be detected and treated, which is necessary for achieving the overall aim of reducing incidence and mortality from cervical cancer.

Calculation:

$$\frac{\text{Number of women aged 25–74 who had at least one HPV test in a 5-year period} \times 100}{\text{Estimated resident population for women aged 25–74 averaged over the 5 years of the reporting period, adjusted for the estimated proportion of women who have had a hysterectomy}}$$

Count is of women

Specifications:

Numerator specifications

<i>Definition</i>	Number of women aged 25–74 who had at least one HPV test in a 5-year period
<i>Source</i>	State and territory cervical screening registers; National Cancer Screening Register
<i>Data items</i>	A1 Client identifier
	B4 Date of birth
	G1 Type of test
	H1 HPV test date

Denominator specifications

<i>Definition</i>	Estimated resident population for women aged 25–74 averaged over the 5 years of the reporting period, adjusted for the estimated proportion of women who have had a hysterectomy
<i>Source</i>	Australian Bureau of Statistics; AIHW National Hysterectomy Fractions

Indicator 2 Response to invitation

Definition:

The percentage of women aged 25–74 invited to screen or rescreen in a calendar year and who screened within 6 months.

Rationale:

How many women screen in response to an invitation provides a measure of the effectiveness of sending invitations. Measuring this by mode of invitation will also provide useful information as to the most effective method of inviting women (which may differ by age or other factors).

Calculation:

$$\frac{\text{Number of women aged 25–74 invited to screen or rescreen in a calendar year who had an HPV test within 6 months of the invitation being sent} \times 100}{\text{Number of women aged 25–74 invited to screen or rescreen in a calendar year}}$$

Numerator is a subset of the denominator

Count is of women

Specifications:

Numerator specifications

<i>Definition</i>	Number of women aged 25–74 invited to screen or rescreen in a calendar year who had an HPV test within 6 months
<i>Source</i>	State and territory cervical screening registers; National Cancer Screening Register
<i>Data items</i>	A1 Client identifier F2 Date of contact G1 Type of test H1 HPV test date

Denominator specifications

<i>Definition</i>	Number of women aged 25–74 who are invited to screen or rescreen through the NCSP in a calendar year
<i>Source</i>	State and territory cervical screening registers; National Cancer Screening Register
<i>Data items</i>	A1 Client identifier B4 Date of birth F1 Type of contact F2 Date of contact

Indicator 3 Rescreening

Definition:

The percentage of women aged 25–69 whose screening HPV test in the index calendar year did not detect oncogenic HPV who rescreened within a specified period of time.

Rationale:

The proportion of the target population screened within the recommended screening interval is a key determinant of the success of a screening program; screening more frequently increases costs with minimal or no gain in a reduction in incidence and mortality; screening less frequently results in a decrease in overall participation in screening and means that fewer women with precancerous abnormalities can be detected and treated, necessary for achieving the overall aim of reducing incidence and mortality from cervical cancer. This indicator measures the proportion of women who rescreened early, appropriately, or late.

Calculation:

Early rescreening

$$\frac{\text{Number of women aged 25–69 whose screening HPV test in the index calendar year did not detect oncogenic HPV who had an HPV test before 4.5 years} \times 100}{\text{Number of women aged 25–69 whose screening HPV test in the index calendar year did not detect oncogenic HPV}}$$

Adequate rescreening

$$\frac{\text{Number of women aged 25–69 whose screening HPV test in the index calendar year did not detect oncogenic HPV who had an HPV test between 4.5 years and 5.5 years} \times 100}{\text{Number of women aged 25–69 whose screening HPV test in the index calendar year did not detect oncogenic HPV}}$$

Late rescreening

$$\frac{\text{Number of women aged 25–69 whose screening HPV test in the index calendar year did not detect oncogenic HPV who had an HPV test after 5.5 years} \times 100}{\text{Number of women aged 25–69 whose screening HPV test in the index calendar year did not detect oncogenic HPV}}$$

Numerator is a subset of the denominator

Count is of women

Specifications:

Numerator specifications

<i>Definition</i>	Number of women aged 25–69 whose screening HPV test in the index calendar year did not detect oncogenic HPV who had an HPV test within 4.5 years, between 4.5 years and 5.5 years, or after 5.5 years
<i>Source</i>	State and territory cervical screening registers; National Cancer Screening Register
<i>Data items</i>	A1 Client identifier G1 Type of test H1 HPV test date

Denominator specifications

<i>Definition</i>	Number of women aged 25–69 whose screening HPV test in the index calendar year did not detect oncogenic HPV
<i>Source</i>	State and territory cervical screening registers; National Cancer Screening Register
<i>Data items</i>	A1 Client identifier B4 Date of birth

G1	Type of test
H1	HPV test date
H4	Reason for HPV test
H5	HPV test result—oncogenic HPV

Indicator 4 Screening results

Definition:

The percentage of screening episodes in each risk category in a calendar year in women aged 25–74

Rationale:

Distribution of screening episode results is a key measure for the screening program and any changes in these distributions over time will require investigation within the broader context of the screening program.

Calculation:

Unsatisfactory

$$\frac{\text{Number of screening episodes that were unsatisfactory in women aged 25– 74 in a calendar year} \times 100}{\text{Number of screening episodes in women aged 25– 74 in a calendar year}}$$

Low risk

$$\frac{\text{Number of screening episodes that were low risk in women aged 25– 74 in a calendar year} \times 100}{\text{Number of screening episodes in women aged 25– 74}}$$

Intermediate risk

$$\frac{\text{Number of screening episodes that were intermediate risk in women aged 25– 74 in a calendar year} \times 100}{\text{Number of screening episodes in women aged 25– 74 in a calendar year}}$$

Higher risk

$$\frac{\text{Number of screening episodes that were higher risk in women aged 25– 74 in a calendar year} \times 100}{\text{Number of screening episodes in women aged 25– 74 in a calendar year}}$$

Count is of screening episodes

Specifications:

Numerator specifications

<i>Definition</i>	Number of screening episodes in women aged 25–74 in a calendar year that had a risk of significant cervical abnormality of: unsatisfactory low risk intermediate risk higher risk
<i>Source</i>	State and territory cervical screening registers; National Cancer Screening Register
<i>Data items</i>	A1 Client identifier B4 Date of birth

J1 Primary screening episode commencement date

J4 Primary screening episode risk of significant cervical abnormality

Denominator specifications

Definition Number of screening episodes in women aged 25–74 in a calendar year

Source State and territory cervical screening registers; National Cancer Screening Register

Data items A1 Client identifier

B4 Date of birth

J1 Primary screening episode commencement date

J4 Primary screening episode risk of significant cervical abnormality

Indicator 5 Correlation of screening results

Definition:

The level of agreement between screening results in a calendar year and subsequent histology test results within 6 months in women aged 25–74

Rationale:

The correlation between a positive screening test result and the histology test or 'truth' (where this is performed) is a key measure of the accuracy of the HPV test, LBC test, and overall risk assigned to a screening episode.

Calculation:

$$\frac{\text{Histology test results within 6 months}}{\text{Screening episodes in women aged 25–74 in a calendar year that are followed by a histology test within 6 months}}$$

Numerator is a subset of the denominator

Count is of tests

Specifications:

Numerator specifications

<i>Definition</i>	Histology test results within 6 months
<i>Source</i>	State and territory cervical screening registers; National Cancer Screening Register
<i>Data items</i>	A1 Client identifier G1 Type of test J2 Primary screening episode completion date L1 Histology test date L7 Histology test result

Denominator specifications

<i>Definition</i>	Number of screening episodes followed by histology within 6 months in women aged 25–74 in a calendar year
<i>Source</i>	State and territory cervical screening registers; National Cancer Screening Register
<i>Data items</i>	A1 Client identifier B4 Date of birth J1 Primary screening episode commencement date J2 Primary screening episode completion date H4 Reason for HPV test H5 HPV test result—oncogenic HPV

SCREENING HPV TEST PERFORMANCE

Indicator 6 Screening HPV test positivity

Definition:

The percentage of screening HPV tests that are positive for HPV in a calendar year in women aged 25–74

Rationale:

Monitoring the positivity rate provides important information about a screening test. There are three measures of positivity relevant to the NCSP; any oncogenic HPV positivity is the proportion of HPV test that are positive for any oncogenic HPV type, oncogenic HPV 16/18 positivity is the proportion of HPV tests that are positive for oncogenic HPV 16/18, and oncogenic HPV (not 16/18) positivity is the proportion of HPV tests that are positive for oncogenic HPV (not 16/18).

Calculation:

Any oncogenic HPV positivity rate

$$\frac{\text{Number of screening HPV tests in which any oncogenic HPV type is detected in women aged 25–74 in a calendar year} \times 100}{\text{Number of screening HPV tests in women aged 25–74 in a calendar year}}$$

Oncogenic HPV 16/18 positivity rate

$$\frac{\text{Number of screening HPV tests in which oncogenic HPV 16/18 is detected in women aged 25–74 in a calendar year} \times 100}{\text{Number of screening HPV tests in women aged 25–74 in a calendar year}}$$

Oncogenic HPV (not 16/18) positivity rate

$$\frac{\text{Number of screening HPV tests in which oncogenic HPV (not 16/18) is detected in women aged 25–74 in a calendar year} \times 100}{\text{Number of screening HPV tests in women aged 25–74 in a calendar year}}$$

Count is of tests

Specifications:Numerator specifications

<i>Definition</i>	Number of screening HPV tests in women aged 25–74 in a calendar year in which: any oncogenic HPV detected oncogenic HPV 16/18 detected oncogenic HPV (not 16/18) detected
<i>Source</i>	State and territory cervical screening registers; National Cancer Screening Register
<i>Data items</i>	A1 Client identifier B4 Date of birth G1 Type of test H1 HPV test date H4 Reason for HPV test H5 HPV test result—oncogenic HPV

Denominator specifications

<i>Definition</i>	Number of screening HPV tests in women aged 25–74 in a calendar year
<i>Source</i>	State and territory cervical screening registers; National Cancer Screening Register
<i>Data items</i>	A1 Client identifier B4 Date of birth G1 Type of test H1 HPV test date H4 Reason for HPV test

Indicator 7 Cervical cancer diagnosed after a low risk screening test result

Definition:

The percentage of women aged 25–74 who are diagnosed with cervical carcinoma within 5 years of a screening HPV test that did not detect oncogenic HPV.

Rationale:

This measures the false negative rate of the screening HPV test.

Calculation:

$$\frac{\text{Number of women with cervical carcinoma diagnosed within 5 years of a screening HPV test that did not detect oncogenic HPV}}{\text{Number of women aged 25–74 who had a screening HPV test that did not detect oncogenic HPV in a calendar year}} \times 100$$

Numerator is a subset of the denominator

Count is of women

Specifications:

Numerator specifications

Definition Number of women with cervical carcinoma diagnosed within 5 years of a screening HPV test that did not detect oncogenic HPV

Source AIHW Australian Cancer Database

Denominator specifications

Definition Number of women aged 25–74 who had a screening HPV test that did not detect oncogenic HPV in a calendar year

Source State and territory cervical screening registers; National Cancer Screening Register

Data items

- A1 Client identifier
- B4 Date of birth
- G1 Type of test
- H1 HPV test date
- H4 Reason for HPV test
- H5 HPV test result—oncogenic HPV

SELF-COLLECTION

Indicator 8 Self-collection women positive for oncogenic HPV (not 16/18) who have an LBC test within 6 months

Definition:

The percentage of women aged 30–74 who self-collect and test positive for oncogenic HPV (not 16/18) in a calendar year who have an LBC test within 6 months.

Rationale:

Women who self-collect and who test positive for oncogenic HPV (not 16/18) are recommended to have a practitioner-collected sample taken within 6 weeks. This indicator monitors compliance with this recommendation within 6 months, by which time it is considered that most women would have been able to attend an appointment with a practitioner.

Note that only women aged 30–74 will be eligible for self-collection.

Calculation:

$$\frac{\text{Number of women aged 30–74 who self-collect and test positive for oncogenic HPV (not 16/18) in a calendar year who have an LBC test within 6 months}}{\text{Number of women aged 30–74 who self-collect and test positive for oncogenic HPV (not 16/18) in a calendar year}} \times 100$$

Numerator is a subset of the denominator

Count is of women

Specifications:

Numerator specifications

<i>Definition</i>	Number of women aged 30–74 who self-collect and test positive for oncogenic HPV (not 16/18) in a calendar year who have an LBC test within 6 months
<i>Source</i>	State and territory cervical screening registers; National Cancer Screening Register
<i>Data items</i>	A1 Client identifier G1 Type of test H1 HPV test date I1 Cytology test date

Denominator specifications

<i>Definition</i>	Number of women aged 30–74 who self-collect and test positive for oncogenic HPV (not 16/18) in a calendar year
<i>Source</i>	State and territory cervical screening registers; National Cancer Screening Register
<i>Data items</i>	A1 Client identifier B4 Date of birth G1 Type of test H1 HPV test date H2 HPV test collection method H4 Reason for HPV test H5 HPV test result—oncogenic HPV

Indicator 9 Self-collection women positive for oncogenic HPV 16/18 who have a colposcopy within 6 months

Definition:

The percentage of women aged 30–74 who self-collect and test positive for oncogenic HPV 16/18 in a calendar year who have a colposcopy within 6 months.

Rationale:

Women who self-collect and who test positive for oncogenic HPV 16/18 are recommended to have a colposcopy within 8 weeks. This indicator monitors compliance with this recommendation within 6 months, by which time it is considered that most women would have been able to attend an appointment with a colposcopist. Note that only women aged 30–74 will be eligible for self-collection.

Calculation:

$$\frac{\text{Number of women aged 30–74 who self-collect and test positive for oncogenic HPV 16/18 in a calendar year who have a colposcopy within 6 months}}{\text{Number of women aged 30–74 who self-collect and test positive for oncogenic HPV 16/18 in a calendar year}} \times 100$$

Numerator is a subset of the denominator

Count is of women

Specifications:

Numerator specifications

<i>Definition</i>	Number of women aged 30–74 who self-collect and test positive for oncogenic HPV 16/18 in a calendar year who have a colposcopy within 6 months
<i>Source</i>	State and territory cervical screening registers; National Cancer Screening Register
<i>Data items</i>	A1 Client identifier G1 Type of test H1 HPV test date K2 Date of colposcopy episode

Denominator specifications

<i>Definition</i>	Number of women aged 30–74 who self-collect and test positive for oncogenic HPV 16/18 in a calendar year
<i>Source</i>	State and territory cervical screening registers; National Cancer Screening Register
<i>Data items</i>	A1 Client identifier B4 Date of birth G1 Type of test H1 HPV test date H2 HPV test collection method H4 Reason for HPV test H5 HPV test result—oncogenic HPV

Indicator 10 Adherence to recommendation for follow-up

Definition:

The percentage of women aged 25–74 who are determined to be of intermediate risk as the result of a screening episode in a calendar year who have a follow-up HPV test between 9 and 15 months.

Rationale:

Women who test positive for oncogenic HPV (not 16/18) and have a negative or pLSIL/ LSIL reflex LBC test result are considered to be of intermediate risk, and are recommended to have a follow-up HPV test in 12 months. This indicator monitors compliance with this recommendation (allowing 3 months either side of the recommended 12 months).

Calculation:

$$\frac{\text{Number of women aged 25– 74 who are determined to be of intermediate risk as the result of a screening episode in a calendar year who have a follow- up HPV test between 9 and 15 months} \times 100}{\text{Number of women aged 25– 74 who are determined to be of intermediate risk as the result of a screening episode in a calendar year}}$$

The numerator will be additionally disaggregated into the following two groups:

Percentage of women whose follow-up HPV test did not detect any oncogenic HPV

$$\frac{\text{Number of women with a follow- up HPV test that did not detect any oncogenic HPV} \times 100}{\text{Number of women aged 25– 74 who are determined to be of intermediate risk as the result of a screening episode in a calendar year who have a follow- up HPV test between 9 and 15 months}}$$

Percentage of women whose follow-up HPV test detected oncogenic HPV (any)

$$\frac{\text{Number of women with a follow – up HPV test that detected oncogenic HPV (any)} \times 100}{\text{Number of women aged 25– 74 who are determined to be of intermediate risk as the result of a screening episode in a calendar year who have a follow- up HPV test between 9 and 15 months}}$$

Numerator is a subset of the denominator

Count is of women

Specifications:

Numerator specifications

<i>Definition</i>	Number of women aged 25–74 who are determined to be of intermediate risk as the result of a screening episode in a calendar year who have a follow-up HPV test between 9 and 15 months
<i>Source</i>	State and territory cervical screening registers; National Cancer Screening Register
<i>Data items</i>	A1 Client identifier G1 Type of test H1 HPV test date J2 Primary screening episode completion date

Denominator specifications

<i>Definition</i>	Number of women aged 25–74 who are determined to be of intermediate risk as the result of a screening episode in a calendar year
<i>Source</i>	State and territory cervical screening registers; National Cancer Screening Register
<i>Data items</i>	A1 Client identifier B4 Date of birth J1 Primary screening episode commencement date J4 Primary screening episode risk of significant cervical abnormality J5 Primary screening episode recommendation

Indicator 11 Follow-up results

Definition:

The percentage of follow-up episodes in each risk category in a calendar year in women aged 25–74

Rationale:

Follow-up results are the follow-up HPV test result and reflex LBC (where indicated) that occur 12 months after an intermediate risk screening episode result. Distribution of follow-up episode results is a key measure for the screening program and any changes in these distributions over time will require investigation within the broader context of the screening program.

Calculation:

Unsatisfactory

$$\frac{\text{Number of follow – up episodes that were unsatisfactory in women aged 25– 74 in a calendar year} \times 100}{\text{Number of follow – up episodes in women aged 25– 74 in a calendar year}}$$

Low risk

$$\frac{\text{Number of follow- up episodes that were low risk (follow- up HPV test did not detect oncogenic HPV) in women aged 25– 74 in a calendar year} \times 100}{\text{Number of follow – up episodes in women aged 25– 74}}$$

Higher risk

$$\frac{\text{Number of follow- up episodes that were higher risk (follow- up HPV test detected oncogenic HPV (any) in women aged 25– 74 in a calendar year} \times 100}{\text{Number of follow- up episodes in women aged 25– 74 in a calendar year}}$$

Count is of follow-up episodes

Specifications:

Numerator specifications

<i>Definition</i>	Number of follow-up episodes in women aged 25–74 in a calendar year that had a risk of significant cervical abnormality of: <ul style="list-style-type: none"> – unsatisfactory – low risk – higher risk
<i>Source</i>	State and territory cervical screening registers; National Cancer Screening Register
<i>Data items</i>	A1 Client identifier B4 Date of birth J6 Follow-up episode commencement date J9 Follow-up episode risk of significant cervical abnormality

Denominator specifications

<i>Definition</i>	Number of follow-up episodes in women aged 25–74 in a calendar year
<i>Source</i>	State and territory cervical screening registers; National Cancer Screening Register
<i>Data items</i>	A1 Client identifier
	B4 Date of birth
	J6 Follow-up episode commencement date

Indicator 12 Colposcopy rate

Definition:

The percentage of women aged 25–74 who are referred for colposcopy who attend colposcopy within 3 months.

Rationale:

The success of a screening program is reliant on assessment being performed when required. This measures compliance with referral for colposcopy based on a screening episode result that places them at higher risk of significant cervical abnormality, and should be calculated for each screening episode result.

Calculation:

Oncogenic HPV 16/18 detected + any reflex LBC result

$$\frac{\text{Number of women aged 25– 74 with an HPV test in which oncogenic HPV 16/18 is detected in a calendar year who had a colposcopy within 3 months} \times 100}{\text{Number of women aged 25– 74 with an HPV test in which oncogenic HPV 16/18 is detected in a calendar year}}$$

Oncogenic HPV detected (not 16/18) + reflex LBC result of pHSIL/HSIL/cervical cancer/any glandular abnormality

$$\frac{\text{Number of women aged 25– 74 with an HPV test in which oncogenic HPV (not 16 or 18) is detected and who had an LBC result of pHSIL/HSIL/cervical cancer/any glandular abnormality in a calendar year who had a colposcopy within 3 months} \times 100}{\text{Number of women aged 25– 74 with an HPV test in which oncogenic HPV (not 16 or 18) is detected and who had an LBC result of pHSIL/HSIL/cervical cancer/any glandular abnormality in a calendar year}}$$

Any oncogenic HPV type detected at follow-up HPV test + any reflex LBC result

$$\frac{\text{Number of women aged 25– 74 with a follow- up HPV test in which any oncogenic HPV is detected in a calendar year who had a colposcopy within 3 months} \times 100}{\text{Number of women aged 25– 74 with a follow- up HPV test in which any oncogenic HPV is detected in a calendar year}}$$

The numerator is a subset of the denominator

Count is of women

Specifications:

Numerator specifications

<i>Definition</i>	Number of women who had a colposcopy after each specified screening episode result within 3 months
<i>Source</i>	State and territory cervical screening registers; National Cancer Screening Register
<i>Data items</i>	A1 Client identifier B4 Date of birth G1 Type of test K2 Date of colposcopy episode

Denominator specifications

<i>Definition</i>	Number of women aged 25–74 who have a screening episode result that places them at higher risk of significant cervical abnormality in a calendar year
<i>Source</i>	State and territory cervical screening registers; National Cancer Screening Register
<i>Data items</i>	A1 Client identifier B4 Date of birth G1 Type of test J2 Primary screening episode completion date J3 Primary screening episode result J7 Follow-up episode completion date J8 Follow-up episode result

Indicator 13 Time to colposcopy

Definition:

For women aged 25–74 who have a screening episode result that places them at higher risk of significant cervical abnormality, the time between the screening result and colposcopy, measured as median and 90th percentile values, as well as within specified timeframes.

Rationale:

Women who receive a screening episode result that places them at higher risk of significant cervical abnormality will be referred to colposcopy. The recommended timeframe in which she should undergo colposcopic assessment is as per the NCSP 2016 Guidelines (Cancer Council Australia and Cervical Cancer Screening Guidelines Working Party 2016). Monitoring actual time between screening result and colposcopy provides important information as to whether women are receiving timely assessment, as delay in assessment may lead to poorer outcomes.

Calculation:

Oncogenic HPV 16/18 detected + any reflex LBC result

For women aged 25–74 with a screening HPV test in which oncogenic HPV 16/18 is detected in a calendar year who had a colposcopy within 365 days, time to colposcopy in number of days

Oncogenic HPV detected (not 16/18) + reflex LBC result of pHSIL/HSIL/cervical cancer/any glandular abnormality

For women aged 25–74 with a screening HPV test in which oncogenic HPV (not 16/18) is detected and who had an LBC result of pHSIL/HSIL/cervical cancer/any glandular abnormality in a calendar year who had a colposcopy within 365 days, time to colposcopy in number of days

Any oncogenic HPV type detected at follow-up HPV test + any reflex LBC result

For women aged 25–74 with a follow-up HPV test in which any oncogenic HPV is detected in a calendar year who had a colposcopy within 365 days, time to colposcopy in number of days

Count is of days

Specifications:

Specifications

<i>Definition</i>	For women who had a colposcopy within 365 days of a screening episode result that places them at higher risk of significant cervical abnormality, the number of days to colposcopy
<i>Source</i>	State and territory cervical screening registers; National Cancer Screening Register
<i>Data items</i>	A1 Client identifier B4 Date of birth G1 Type of test J2 Primary screening episode completion date J3 Primary screening episode result J7 Follow-up episode completion date J8 Follow-up episode result K2 Date of colposcopy episode

Indicator 14 Biopsy rate

Definition:

The percentage of colposcopies in women aged 25–74 in which a biopsy was performed.

Rationale:

Although there are reasons why a biopsy would not be performed at colposcopy, a lower than expected biopsy rate would require further investigation.

Calculation:

$$\frac{\text{Number of colposcopy episodes at which a biopsy was performed in women aged 25–74 in a calendar year} \times 100}{\text{Number of colposcopy episodes in women aged 25–74 in a calendar year}}$$

Numerator is a subset of the denominator

Count is of colposcopy episodes

Specifications:

Numerator specifications

<i>Definition</i>	Number of colposcopy episodes at which a biopsy was performed in women aged 25–74 in a calendar year
<i>Source</i>	State and territory cervical screening registers; National Cancer Screening Register
<i>Data items</i>	A1 Client identifier B4 Date of birth G1 Type of test K2 Date of colposcopy episode K9 Biopsy this episode

Denominator specifications

<i>Definition</i>	Number of colposcopy episodes in women aged 25–74 in a calendar year
<i>Source</i>	State and territory cervical screening registers; National Cancer Screening Register
<i>Data items</i>	A1 Client identifier B4 Date of birth G1 Type of test J2 Primary screening episode completion date J7 Follow-up episode completion date K2 Date of colposcopy episode

Indicator 15 Yield of high grade abnormalities on biopsy among women who attend colposcopy after higher risk screening results

Definition:

Percentage of women aged 25–74 with a higher risk screening result who had a colposcopy in a calendar year who were diagnosed with a high-grade abnormality or cervical cancer on histology within 6 months of colposcopy.

Rationale:

As women who are referred to colposcopy are at higher risk of significant cervical abnormality, it is expected that a proportion of these will be diagnosed with a high-grade abnormality or cervical cancer. This indicator can be used as a measure of the accuracy of colposcopy in identifying and sampling a high-grade abnormality or cervical cancer that is present.

Calculation:

$$\frac{\text{Number of women aged 25–74 with a higher risk screening episode result who had a colposcopy in a calendar year who were diagnosed with a high- grade abnormality or cervical cancer on histology within 6 months of colposcopy} \times 100}{\text{Number of women aged 25–74 with a higher risk screening episode result who had a colposcopy in a calendar year}}$$

The numerator is a subset of the denominator

Count is of women

Specifications:

Numerator specifications

<i>Definition</i>	Number of women aged 25–74 with a higher risk screening episode result who had a colposcopy in a calendar year who were diagnosed with a high-grade abnormality or cervical cancer on histology within 6 months of colposcopy
<i>Source</i>	State and territory cervical screening registers; National Cancer Screening Register
<i>Data items</i>	A1 Client identifier B4 Date of birth K2 Date of colposcopy episode L1 Histology test date L7 Histology test result

Denominator specifications

<i>Definition</i>	Number of women aged 25–74 with a higher risk screening episode result who had a colposcopy in a calendar year
<i>Source</i>	State and territory cervical screening registers; National Cancer Screening Register
<i>Data items</i>	A1 Client identifier B4 Date of birth J4 Primary screening episode risk of significant cervical abnormality K2 Date of colposcopy episode

Indicator 16 Positive predictive value of colposcopy

Definition:

Percentage of women aged 25–74 with a higher risk screening result who had a colposcopic impression of HSIL, glandular abnormality (adenocarcinoma in situ) or cancer in a calendar year who were diagnosed with a high-grade abnormality or cervical cancer on histology within 6 months of colposcopy.

Rationale:

This indicator correlates the colposcopic impression with histological findings to determine the predictive value of colposcopy for high-grade cervical abnormalities. This is an important measure of the quality of colposcopy.

Calculation:

$$\frac{\text{Number of women aged 25–74 with a higher risk screening result who had a colposcopic impression of HSIL, glandular abnormality (adenocarcinoma in situ) or cancer in a calendar year who were diagnosed with a high-grade abnormality or cervical cancer on histology within 6 months of colposcopy}}{\text{Number of women aged 25–74 with a higher risk screening result who had a colposcopic impression of HSIL, glandular abnormality (adenocarcinoma in situ) or cancer in a calendar year}} \times 100$$

The numerator is a subset of the denominator

Count is of women

Specifications:

Numerator specifications

<i>Definition</i>	Number of women aged 25–74 with a higher risk screening result who had a colposcopic impression of HSIL, glandular abnormality (adenocarcinoma in situ) or cancer in a calendar year who were diagnosed with a high-grade abnormality or cervical cancer on histology within 6 months of colposcopy
<i>Source</i>	State and territory cervical screening registers; National Cancer Screening Register
<i>Data items</i>	A1 Client identifier K2 Date of colposcopy episode L1 Histology test date L7 Histology test result

Denominator specifications

<i>Definition</i>	Number of women aged 25–74 with a higher risk screening result who had a colposcopic impression of high-grade or higher in a calendar year
<i>Source</i>	State and territory cervical screening registers; National Cancer Screening Register
<i>Data items</i>	A1 Client identifier B4 Date of birth J4 Primary screening episode risk of significant cervical abnormality K2 Date of colposcopy episode K7 Colposcopic impression—primary diagnosis

Indicator 17a High-grade cervical abnormality detection rate

Definition:

Number of women aged 25–74 with a high-grade abnormality detected on histology in a calendar year per 1,000 women screened.

Rationale:

The detection of high-grade abnormalities is an indicator of program performance. High-grade abnormalities have a greater probability of progressing to invasive cancer than do low-grade lesions. Detection of high-grade abnormalities provides an opportunity for treatment before cancer can develop, thus the NCSP aims to detect high-grade abnormalities in line with its broader aim to reduce the incidence of cervical cancer.

Calculation:

$$\frac{\text{Number of women aged 25– 74 with a high- grade abnormality detected on histology in a calendar year} \times 1,000}{\text{Number of women aged 25– 74 screened in a calendar year}}$$

Count is of women

Specifications:

Numerator specifications

<i>Definition</i>	Number of women aged 25–74 with a high-grade abnormality detected on histology in a calendar year
<i>Source</i>	State and territory cervical screening registers; National Cancer Screening Register
<i>Data items</i>	A1 Client identifier
	B4 Date of birth
	G1 Type of test
	L1 Histology test date
	L4 Squamous histology cell analysis
	L5 Endocervical (glandular) histology cell analysis

Denominator specifications

<i>Definition</i>	Number of women aged 25–74 screened in a calendar year.
<i>Source</i>	State and territory cervical screening registers; National Cancer Screening Register
<i>Data items</i>	A1 Client identifier
	B4 Date of birth
	G1 Type of test
	H1 HPV test date

Indicator 17b Cervical cancer detection rate

Definition:

Number of women aged 25–74 with cervical carcinoma on histology per 1,000 women screened.

Rationale:

The cancer detection rate will be measured alongside the high-grade detection rate.

Calculation:

$$\frac{\text{Number of women aged 25– 74 with a cervical carcinoma detected on histology in a calendar year} \times 1,000}{\text{Number of women aged 25– 74 screened in a calendar year}}$$

Count is of women

Specifications:

Numerator specifications

<i>Definition</i>	Number of women aged 25–74 with a cervical cancer detected on histology in a calendar year
<i>Source</i>	State and territory cervical screening registers; National Cancer Screening Register
<i>Data items</i>	A1 Client identifier B4 Date of birth G1 Type of test L1 Histology test date L4 Squamous histology cell analysis L5 Endocervical (glandular) histology cell analysis

Denominator specifications

<i>Definition</i>	Number of women aged 25–74 screened in a calendar year
<i>Source</i>	State and territory cervical screening registers; National Cancer Screening Register
<i>Data items</i>	A1 Client identifier B4 Date of birth G1 Type of test H1 HPV test date

Indicator 18 Cervical cancers diagnosed by time since last screen

Definition:

Number of women aged 25–74 diagnosed with cervical carcinoma categorised into never screened, lapsed screening and adequately screened based on time since last screen.

Rationale:

A measure of the burden of disease of a lack of participation in the screening program. Time since last screen is used to categorise all women diagnosed with cervical carcinoma as never screened, lapsed screening, or adequately screened. Most cervical carcinomas have historically been diagnosed in never screened women, which is evidence of the benefit of participation in cervical screening.

Only cervical carcinomas (cervical cancers of epithelial origin) are included, as cervical cancers not of epithelial origin are not expected to be detected through cervical screening.

Never screened is defined as no record of having had a screening test in Australia prior to cancer diagnosis.

Lapsed screening is defined as last screening test >5.5 years, >7.5 years or >10 years prior to cancer diagnosis.

Adequately screened is defined as last screening test ≤5.5 years prior to cancer diagnosis.

Calculation:

Never screened

Women aged 25–74 diagnosed with cervical carcinoma in a calendar year who are either on a register with no record of a screening test or not on a register

Lapsed screening

Women aged 25–74 diagnosed with cervical carcinoma in a calendar year whose last screening test was >5.5 years before the cervical cancer diagnosis date

Women aged 25–74 diagnosed with cervical carcinoma in a calendar year whose last screening test was >7.5 years before the cervical cancer diagnosis date

Women aged 25–74 diagnosed with cervical carcinoma in a calendar year whose last screening test was >10 years before the cervical cancer diagnosis date

Adequately screened

Women aged 25–74 diagnosed with cervical carcinoma in a calendar year whose last screening test was ≤5.5 years before the cervical cancer diagnosis date

Specifications:

Specifications

<i>Definition</i>	Women aged 25–74 diagnosed with cervical carcinoma in a calendar year categorised into never screened, lapsed screening and adequately screened
<i>Source</i>	AIHW Australian Cancer Database; State and territory cervical screening registers; National Cancer Screening Register

Data items

A1 Client identifier

B4 Date of birth

P2 Date of last screening test

P3 Last screening test type

Indicator 19 Incidence of cervical cancer

Definition:

Number of new cases of cervical cancer in women aged 25–74 per 100,000 estimated resident population in a calendar year.

Rationale:

Incidence data provide contextual information about the number of new cases of cervical cancer in the population that is an indicator of program performance against its aim to reduce cervical cancer through organised screening.

Calculation:

$$\frac{\text{Number of new cases of cervical cancer diagnosed in women aged 25–74 in a calendar year} \times 100,000}{\text{Estimated resident population for women aged 25–74 in a calendar year}}$$

Count is of new cases

Specifications:

Numerator specifications

Definition Number of new cases of cervical cancer diagnosed in women aged 25–74 in a calendar year

Source AIHW Australian Cancer Database

Denominator specifications

Definition Estimated resident population for women aged 25–74 in a calendar year

Source Australian Bureau of Statistics

Indicator 20 Mortality from cervical cancer

Definition:

Number of deaths from cervical cancer in women aged 25–74 per 100,000 estimated resident population in a calendar year.

Rationale:

Mortality data provide contextual information about the number of deaths from cervical cancer in the population that is an indicator of program performance against its aim to reduce mortality from cervical cancer through organised screening.

Calculation:

$$\frac{\text{Number of deaths from cervical cancer in women aged 25–74 in a calendar year} \times 100,000}{\text{Estimated resident population for women aged 25–74 in a calendar year}}$$

Count is of deaths

Specifications:

Numerator specifications

Definition Number of deaths from cervical cancer in women aged 25–74 in a calendar year

Source AIHW National Morbidity Database

Denominator specifications

Definition Estimated resident population for women aged 25–74 in a calendar year

Source Australian Bureau of Statistics

6 References

AIHW 2014. National Cervical Cancer Prevention Data Dictionary version 1: working paper. Cancer series no. 88. Cat. No. CAN85. Canberra: AIHW.

Cancer Council Australia and Cervical Cancer Screening Guidelines Working Party 2016. National Cervical Screening Program: Guidelines for the management of screen-detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding. Cancer Council Australia: Sydney.

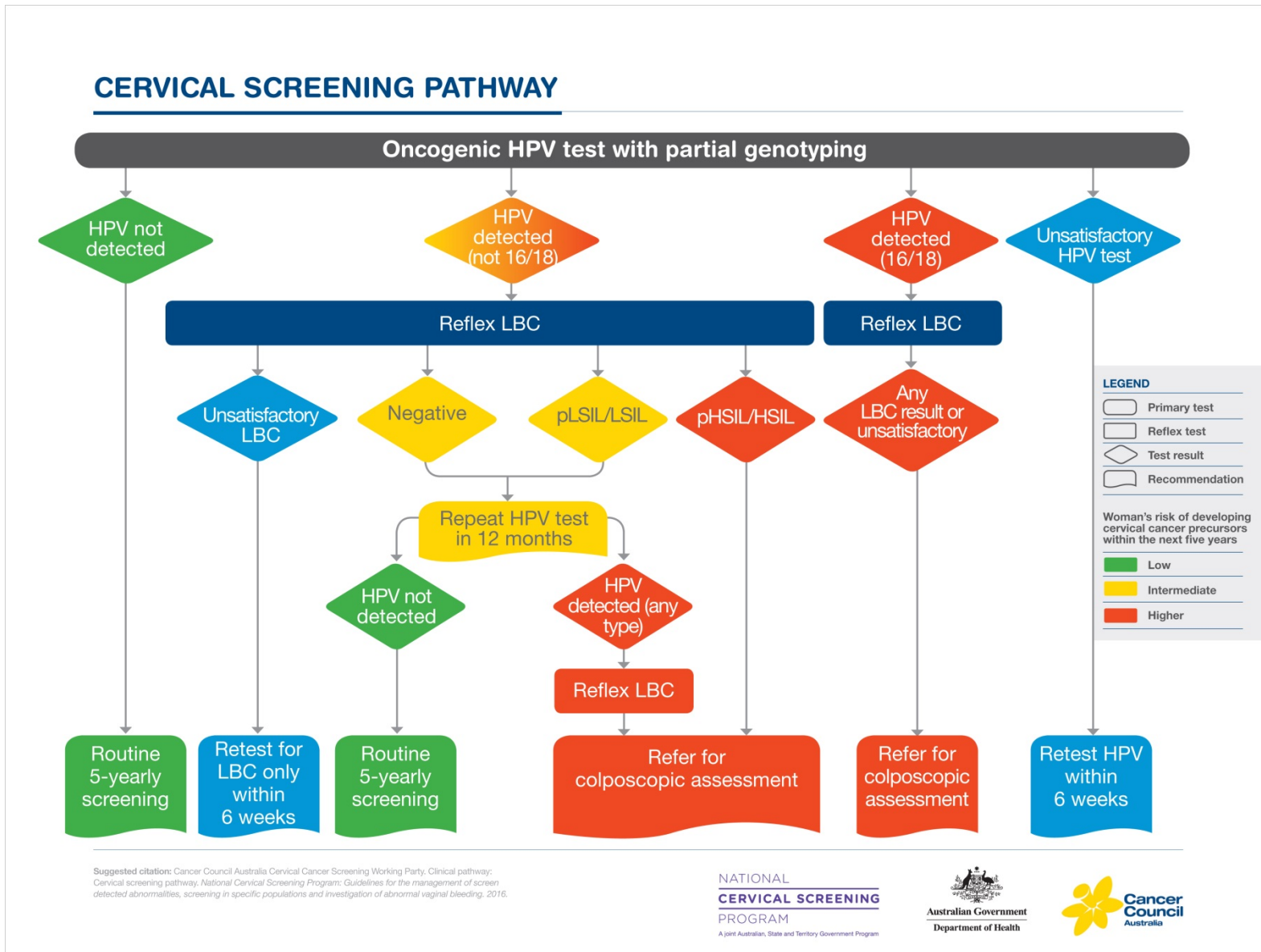
Medical Services Advisory Committee (MSAC) 2014. Outcomes from Application No. 1276 – Renewal of the National Cervical Screening Program. Canberra, Australia.

7 Screening pathways

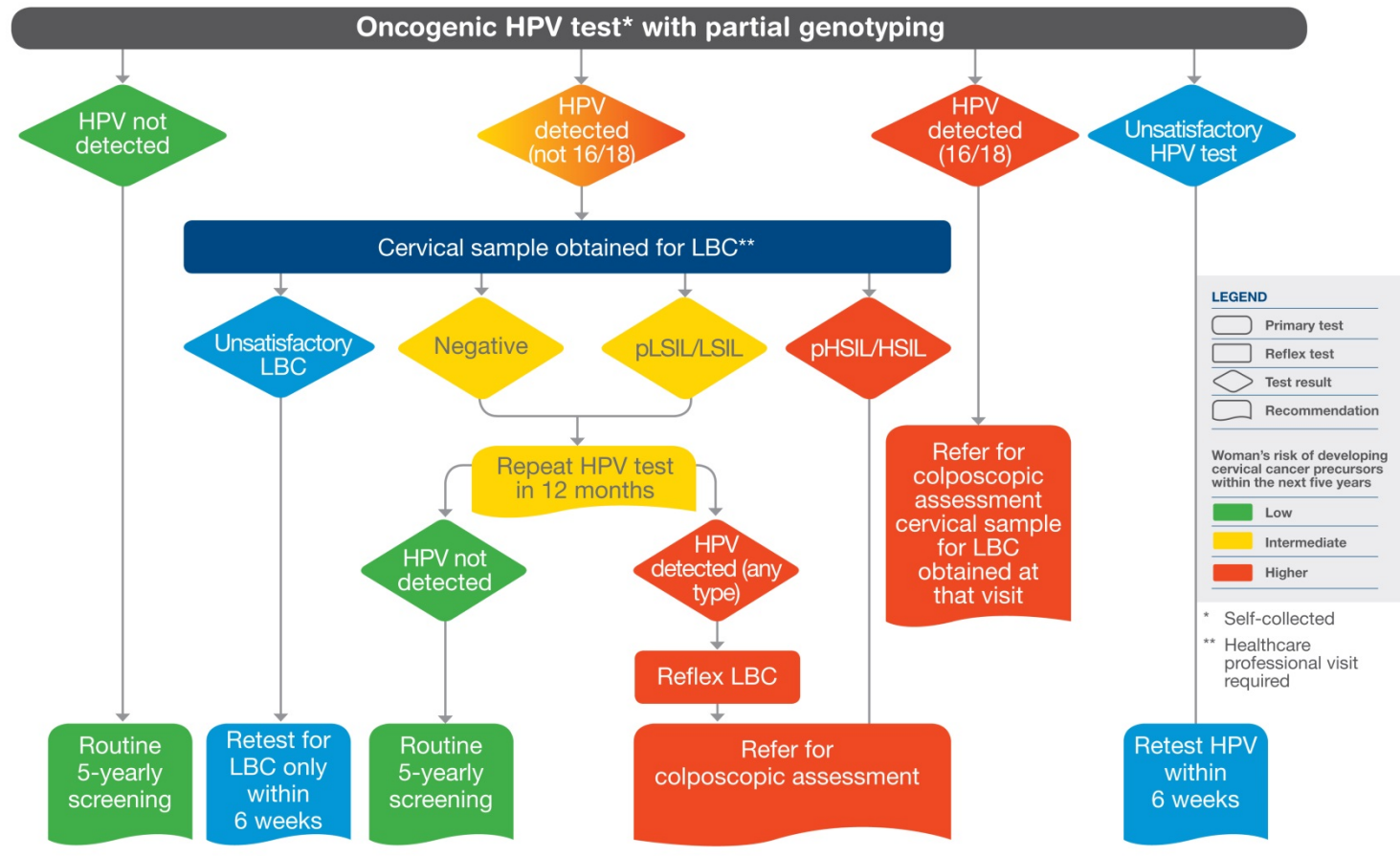
The following pages illustrate the two cervical screening pathways for the new National Cervical Screening Program. The first is for women who have their screening HPV test sample collected by a practitioner; the second is for women who self-collect their screening HPV test sample (they are very similar, except that women who self-collect and return an HPV test result that is positive for oncogenic HPV (not 16/18) will need to have an LBC test sample collected by a practitioner¹, as it is not possible to conduct the recommended reflex LBC test on the self-collected sample.

¹ Healthcare professionals that provide cervical screening services may include but are not limited to medical practitioners and specialists as well as non-medical providers such as nurse practitioners, registered and enrolled nurses, direct entry midwives and eligible midwives, and Aboriginal health workers under the supervision of a medical practitioner; or non-medical providers such as registered and enrolled nurses and Aboriginal health workers in the public health system.

CERVICAL SCREENING PATHWAY



CERVICAL SCREENING PATHWAY FOR SELF COLLECTION



Suggested citation: Cancer Council Australia Cervical Cancer Screening Working Party. Clinical pathway: Cervical screening pathway for self collection. National Cervical Screening Program: Guidelines for the management of screen detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding. 2016.

NATIONAL
CERVICAL SCREENING
PROGRAM
A joint Australian, State and Territory Government Program

Australian Government
Department of Health



The National Cervical Screening Program aims to reduce incidence, morbidity and mortality from cervical cancer in Australia. A new National Cervical Screening Program is scheduled to commence on 1 December 2017—this new National Cervical Screening Program data dictionary is a key document that has been developed by the Australian Institute of Health and Welfare with the assistance of state and territory cervical screening programs and other cervical screening experts, to support monitoring and reporting by the Australian Institute of Health and Welfare for the new National Cervical Screening Program.