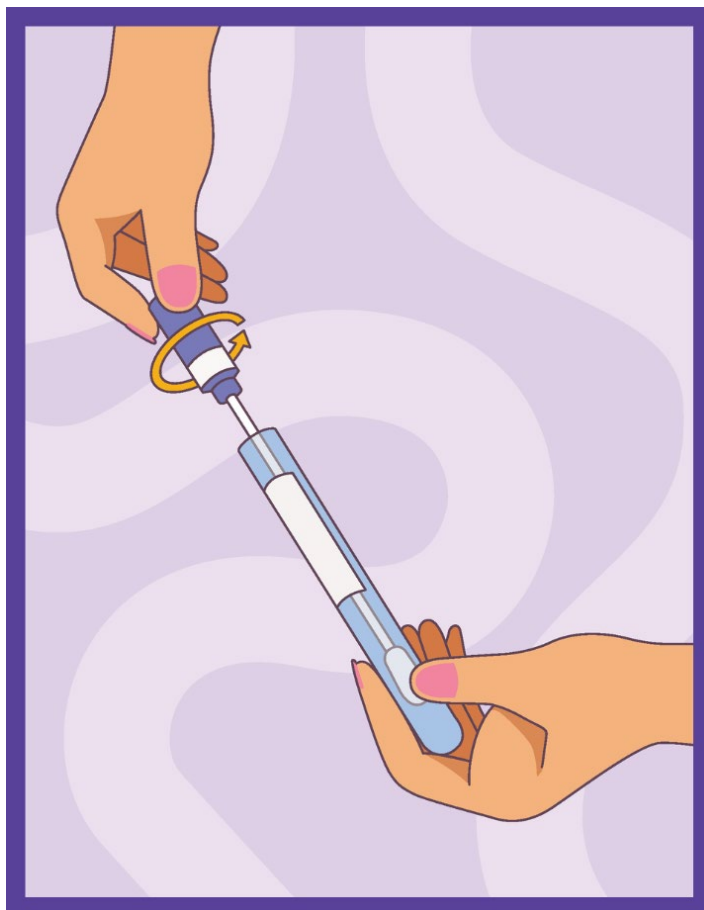


NATIONAL

CERVICAL SCREENING

PROGRAM

A joint Australian, State and Territory Government Program



Cervical Screening Test self-collection uptake report

as of 22 July 2024



NATIONAL CANCER SCREENING REGISTER



**This report was produced by the
National Cancer Screening Register**

This report covers the period from **1 December 2017 to 30 June 2024**.

The data was current when extracted on **22 July 2024**.

For this analysis, all Cervical Screening Tests conducted between **1 December 2017 to 30 June 2024** were included, where the reason for the HPV test was a primary screening test or follow-up test, and the participant's age at the time of the test was between 25 and 74 years of age.



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1. Summary

As of 1st of July 2022, the Australian National Cervical Screening Program (NCSP) was expanded to allow all eligible people the option to undertake their own Cervical Screening Test (CST) using a simple swab, rather than a clinician-collected test using a speculum. Self-collection allows a person to collect their own vaginal sample in a private space in a primary healthcare setting, potentially reducing barriers to cervical screening. Previously, self-collection was only available to people who were 30 years of age or over and had never participated in the NCSP or who were overdue for cervical screening by two years or longer.

This report summarises the uptake of self-collected screening tests since the commencement of the primary Human papillomavirus (HPV) screening program including HPV positivity rates for self-collected samples and adherence to follow-up recommendations for people testing positive for HPV.

Key findings of this report:

- **Overall test volumes:** Following the switch to HPV testing on December 1st, 2017, the overall volumes of HPV screening tests (with any collection method) increased in the program's first two years as per the recommendation to return two years after a negative Pap test. This was followed by a subsequent increase in test volumes from 2023 as people who screened HPV negative initially returned for their second round of screening at five years.
- **Overall self-collection uptake:** Following the expansion of self-collection eligibility on July 1, 2022, the volumes and proportions of self-collected tests increased from 10% in Q3 2022 to almost 34% in Q2 2024.
- **Self-collection uptake by demographics:** An increase in self-collected tests was notable across all age groups, states and territories, SEIFA quintiles and remoteness areas, with the highest uptake observed for Q2 2024 in:
 - people aged 70 to 74 years (41%),
 - Northern Territory participants (48%),
 - most disadvantaged SEIFA quintiles (35% for quintile 1, 36% for quintile 2); and
 - very remote areas (61%).
- **Self-collection uptake by screening history:** The policy expansion significantly increased uptake in hard-to-reach groups including:
 - never-screened people aged 30-74 years where uptake increased from 13% in Q3 2022 to 41% in Q2 2024; and
 - under-screened people aged 30 to 74 years where uptake increased from 14% in Q3 2022 to 50% in Q2 2024.
- **Unsatisfactory test rates:** The unsatisfactory test rate for self-collected tests decreased from 2.25% in Q3 2022 to 1.40% in Q2 2024. Despite this improvement, the unsatisfactory rate remained higher for self-collected tests than for clinician-collected tests in Q2 2024 (1.40% vs 0.20%; $p < 0.001$) and was like the prior cytology-based screening program.

- **HPV positivity rates:** HPV positivity rates (for any HPV subtype) were higher in self-collected tests than clinician-collected tests, likely due to a higher proportion of under-screener opters for self-collection. However, a decline in HPV positivity rates was observed from Q3 2022 for both self-collected and clinician-collected samples, likely reflecting rates in negative re-screener returning after five years and a possible impact of the HPV vaccine.
- **Follow-up rates:** For people with an HPV 16/18 positive clinician-collected screening test, the colposcopy rate at six months was 80.4%. For self-collected HPV, it was higher at 80.8%. For people with a self-collected HPV non-16/18 positive screening test, 81.9% had a follow-up liquid-based cytology test within six months.

Conclusion:

Expanding the National Cervical Screening Program's eligibility for self-collection has led to a substantial increase in uptake, particularly among previously hard-to-reach populations. For people utilising self-collection, the higher HPV positivity rates indicate an increased risk of cervical cancer; however, there is also a relatively high adherence to follow-up following a positive HPV test. Increasing the availability of self-collection among under-screened women is an essential step toward the elimination of cervical cancer in Australia.

2. Background

The National Cervical Screening Program

The Australian National Cervical Screening Program (NCSP) commenced in 1991. It offered Pap tests every two years to women and people with a cervix aged 18 to 69 years of age.

In December of 2017, the program switched to a clinician-collected Human papillomavirus (HPV) DNA test as the primary screening test every five years for women and people with a cervix aged 25 to 74 years.

In July 2022, restrictions on self-collection (i.e., people aged 30 years or older who either had never been screened or were two or more years overdue for their screening test) were removed, and the NCSP was expanded to allow all eligible people the option to perform an HPV screening test with a self-collected sample if they choose. This program expansion is known as the Self-Collection Eligibility Expansion (SCEE).

The Australian NCSP Guidelines recommend that people with HPV 16/18 positive test are referred directly to colposcopy (regardless of sample collection method), and those with HPV non-16/18 detected on a self-collected sample are recommended to have a Liquid Based Cytology (LBC) specimen collected by a health care provider for triage.

Australia was the first country to offer people the choice between a self-collected test and the traditional clinician-collected sample. Monitoring self-collection uptake across various demographic groups, particularly hard-to-reach groups, is essential to understanding access and barriers to cervical screening.

3. Methods

This report uses data from the National Cancer Screening Register (NCSR) and summarises self-collected HPV screening test data and trends. The information provided includes the uptake of self-collected screening tests by age group, state and territory, Socio-Economic Indexes For Areas (SEIFA) and Remoteness Areas (ARIA). Uptake for those aged 30-70 years and those who have never been screened or under-screened are also reported. The report includes information on unsatisfactory HPV test rates and HPV test positivity rates for clinician-collected and self-collected tests. It provides follow-up data on colposcopy procedures for those positive for HPV 16/18 and LBC follow-up for those positive for HPV non-16/18.

Self-collection uptake is reported as a proportion of all HPV screening tests (primary screening and follow-up tests) for each quarter in a calendar year except Q4 2017, which only had data for December 2017. HPV unsatisfactory rates were calculated as a proportion of all HPV screening tests that were unsatisfactory. HPV positivity rates were calculated as a proportion of all valid primary screening HPV tests (not follow-up tests) that were positive for any HPV subtype.

This quarterly report may include revised counts for previous quarters compared to previous reports.

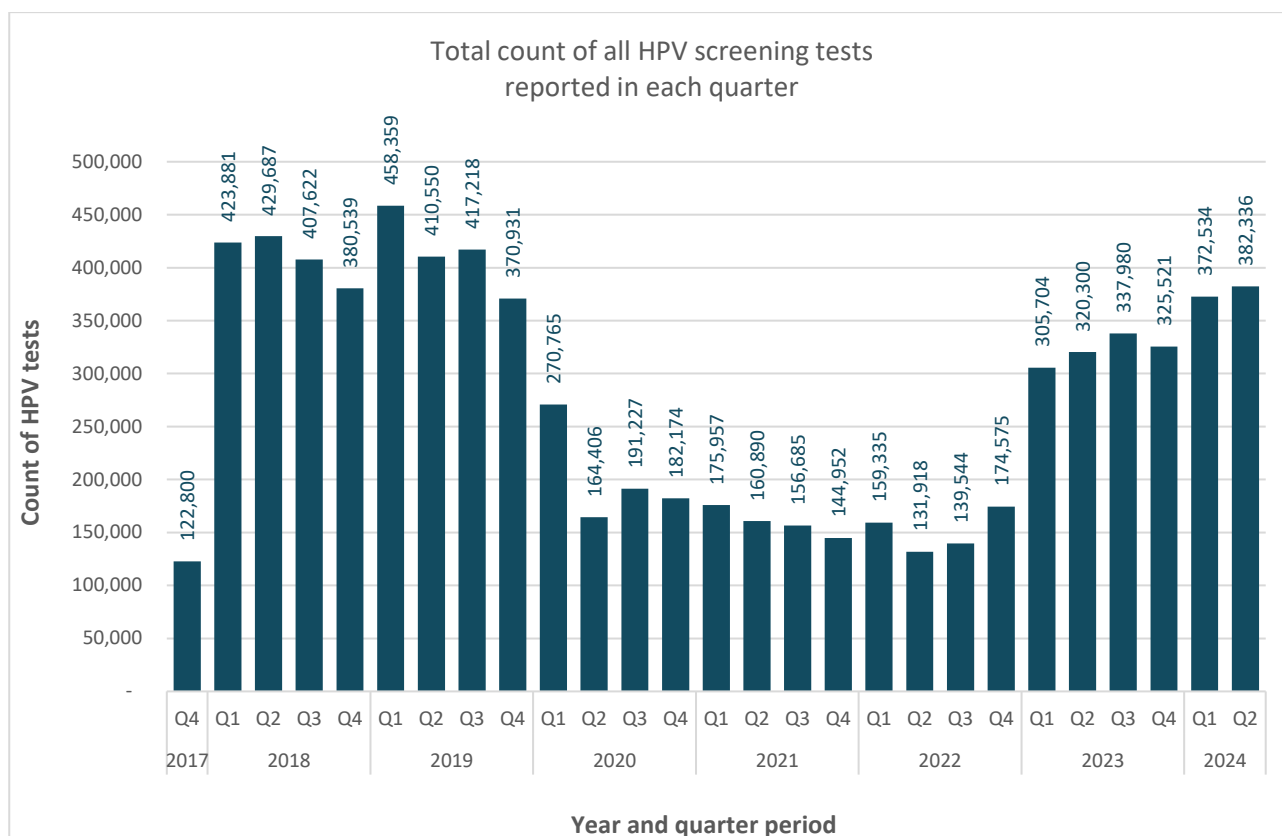
4. Results

4.1 Trends in the uptake of self-collected HPV screening tests

4.1.1 Count of HPV screening tests

Figure 1 below provides the national counts of all HPV screening tests, regardless of collection method, for each quarter since the start of the HPV-based screening program in Australia on 1 December 2017.

Figure 1: Total count of HPV screening tests by quarter



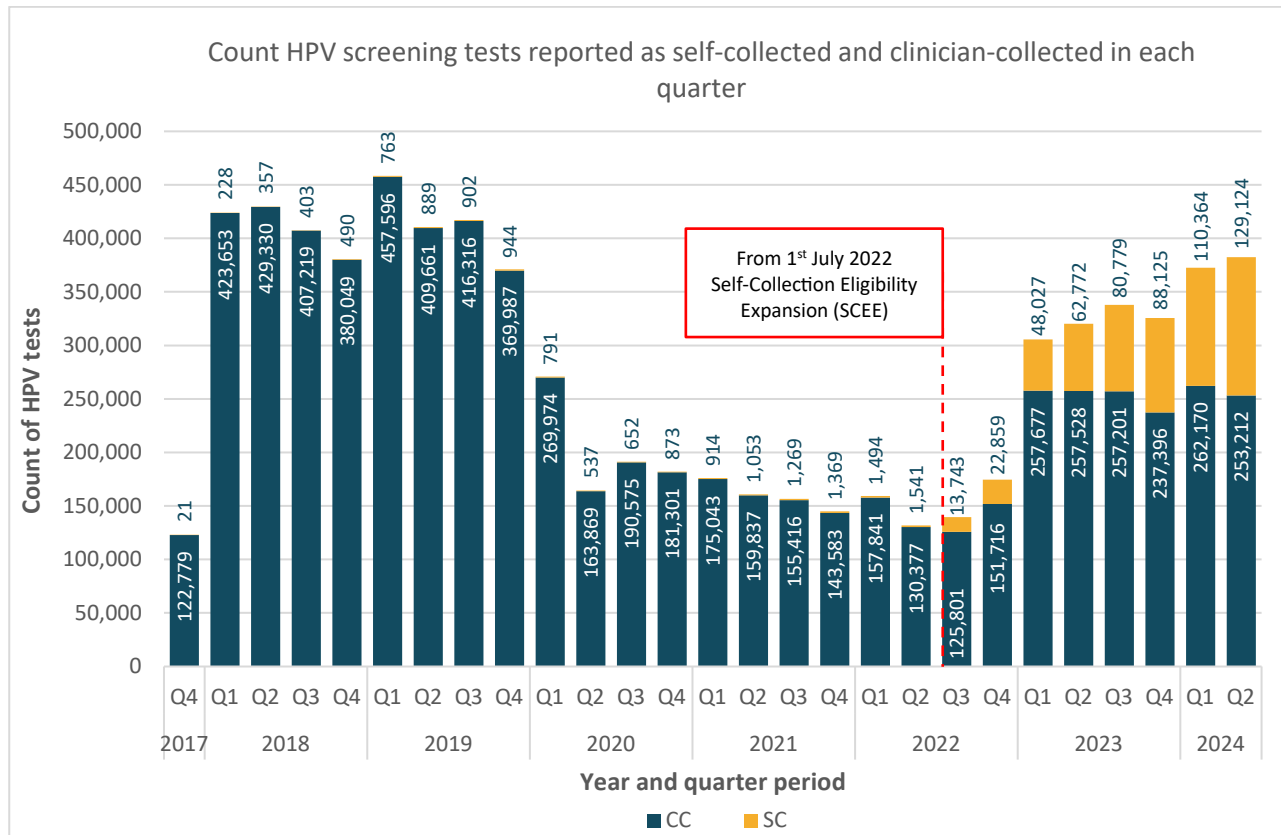
The figure shows an initial increase in HPV screening tests from 2018 to the end of 2019 as people return for their first HPV screening test after being recommended to return in two years following a negative Pap test under the Pap test program. Subsequently, test volumes decreased as the interval for screening following a negative HPV test extended to five years. From 2023, the number of tests will rise again as individuals with a previous negative HPV test result return for their next round of screening.

Since the commencement of the HPV screening program on 1 December 2017, 5,478,314 people aged 25-74 have undergone 7,518,390 HPV screening tests.

4.1.2 Count of HPV screening tests by collection method

Figure 2 provides the national counts of HPV screening tests for clinician-collected (CC) tests and self-collected (SC) tests for each quarter between 1 December 2017 and 30 June 2024.

Figure 2: Total count of HPV screening tests by collection method by quarter



Of all HPV tests conducted since the start of the HPV-based screening program in Australia, 7.6% (n=571,283) were self-collected. The number of self-collected samples has significantly increased since the second half of 2022, which aligns with the Self-Collection Eligibility Expansion as of 1 July 2022, and allows all people eligible for cervical screening the option to self-collect their sample.

4.1.3 Uptake of self-collected tests as a proportion of all HPV screening tests

Figure 3 below shows the uptake of self-collected (SC) tests as a proportion of all HPV screening tests for each quarter from 1 December 2017 to 30 June 2024.

Figure 3: Percentage of HPV screening tests that were self-collected by quarter

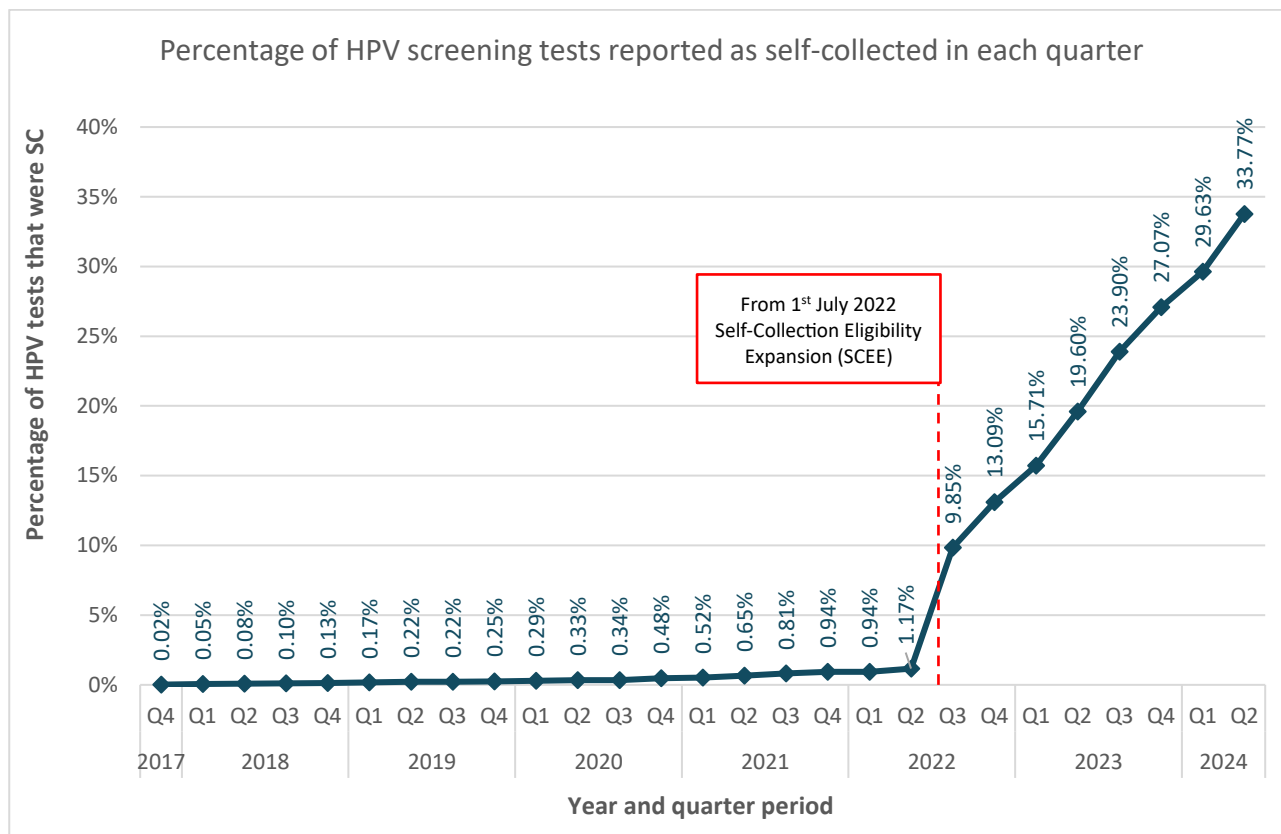


Figure 3 shows an increasing proportion of self-collected tests for each quarter, particularly evident since the program's Self-Collection Eligibility Expansion in July of 2022.

In Q4 of 2022, almost 10% of all HPV screening tests were self-collected, which increased to almost 34% in Q4 of 2024. The consistent rise in the numbers and proportions of self-collected samples on a national level indicates that more people are becoming informed of this option and are opting for self-collection as a choice of screening test.

4.1.4 Self-collection uptake by demographic characteristics

4.1.4.1 Age group

The figures below display the national counts and percentages of self-collected (SC) tests for each age group for each quarter from 1 December 2017 to 30 June 2024.

Figure 4: Count of self-collected tests and percentage of all HPV screening tests that were self-collected for women aged 25-29 years

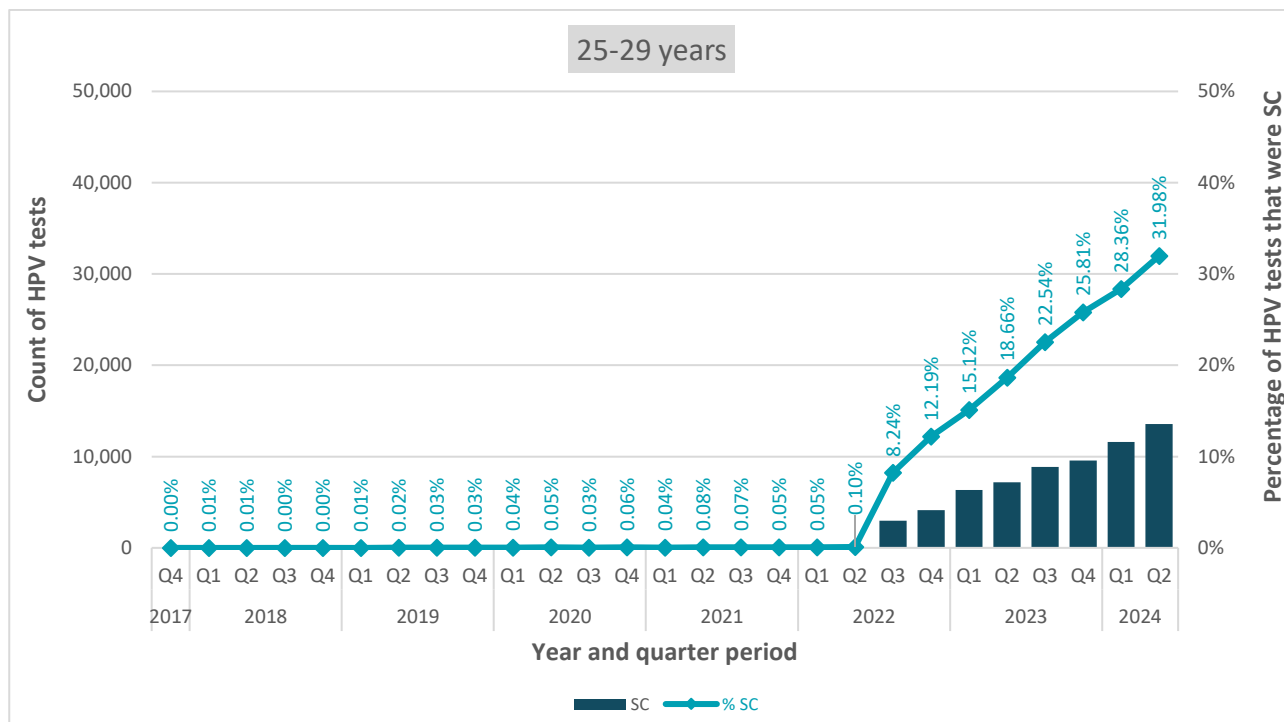


Figure 5: Count of self-collected tests and percentage of all HPV screening tests that were self-collected for women aged 30-39 years

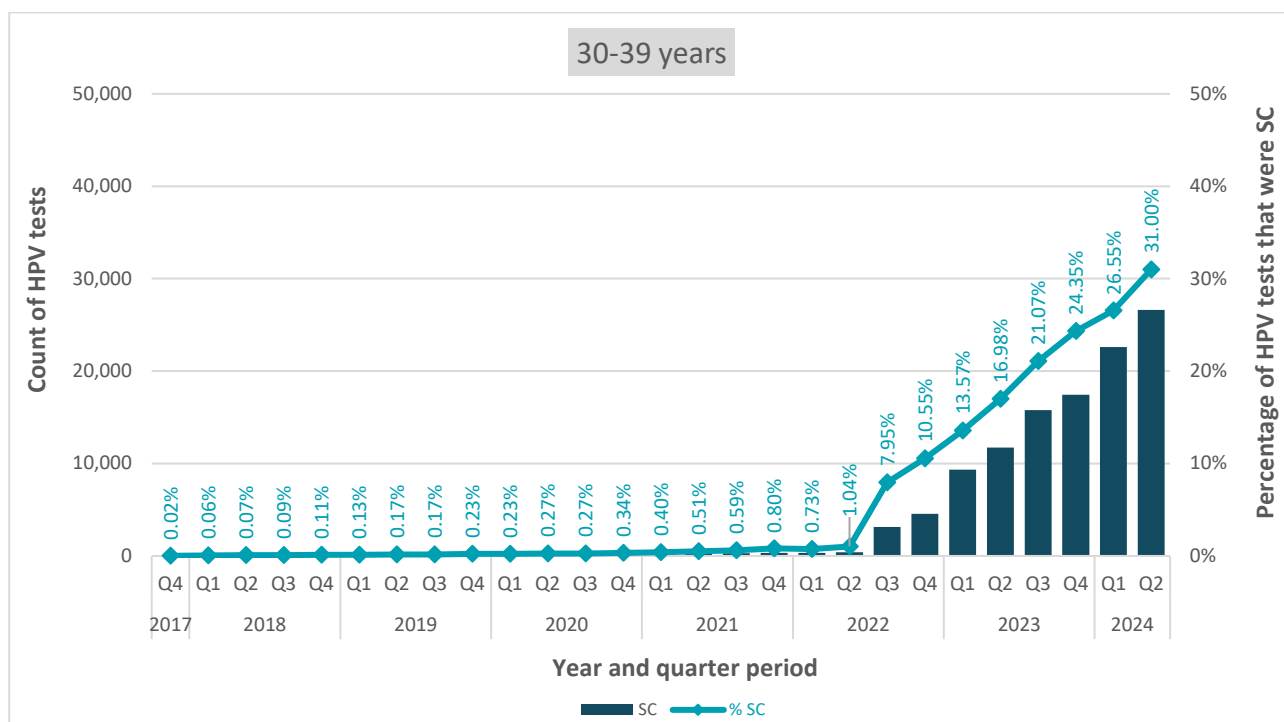


Figure 6: Count of self-collected tests and percentage of all HPV screening tests that were self-collected for women aged 40-49 years

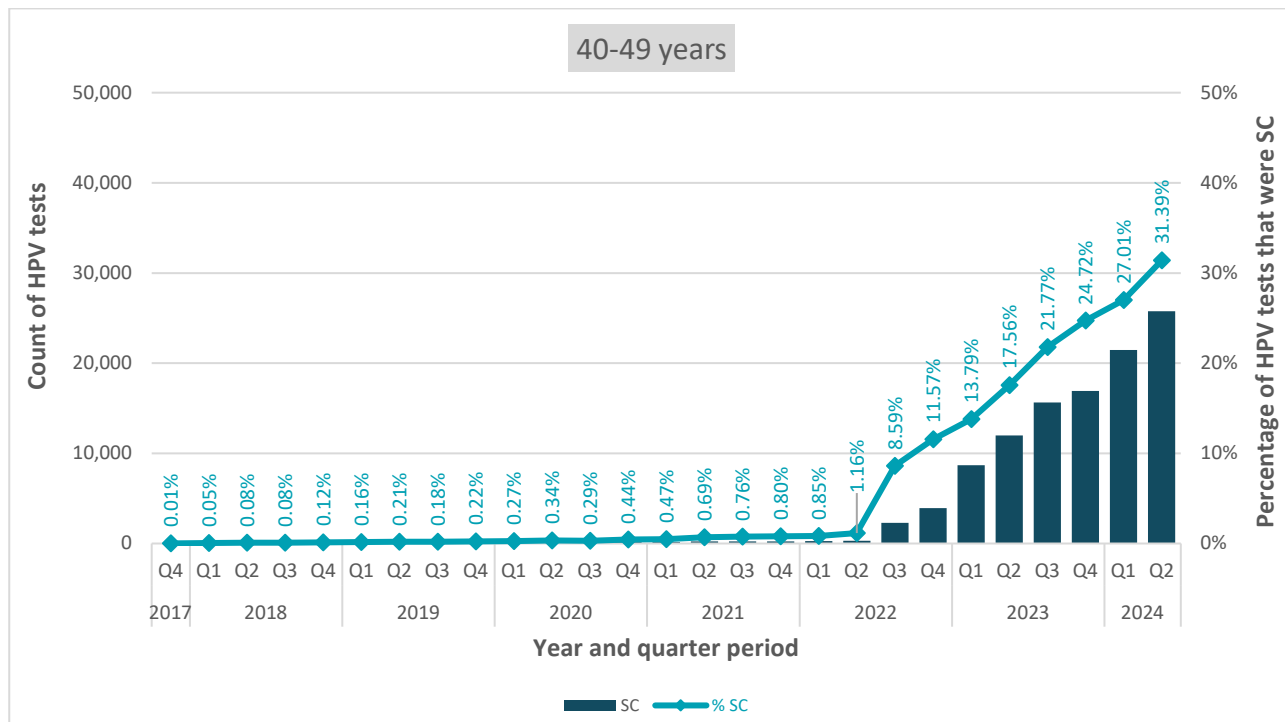


Figure 7: Count of self-collected tests and percentage of all HPV screening tests that were self-collected for women aged 50-59 years

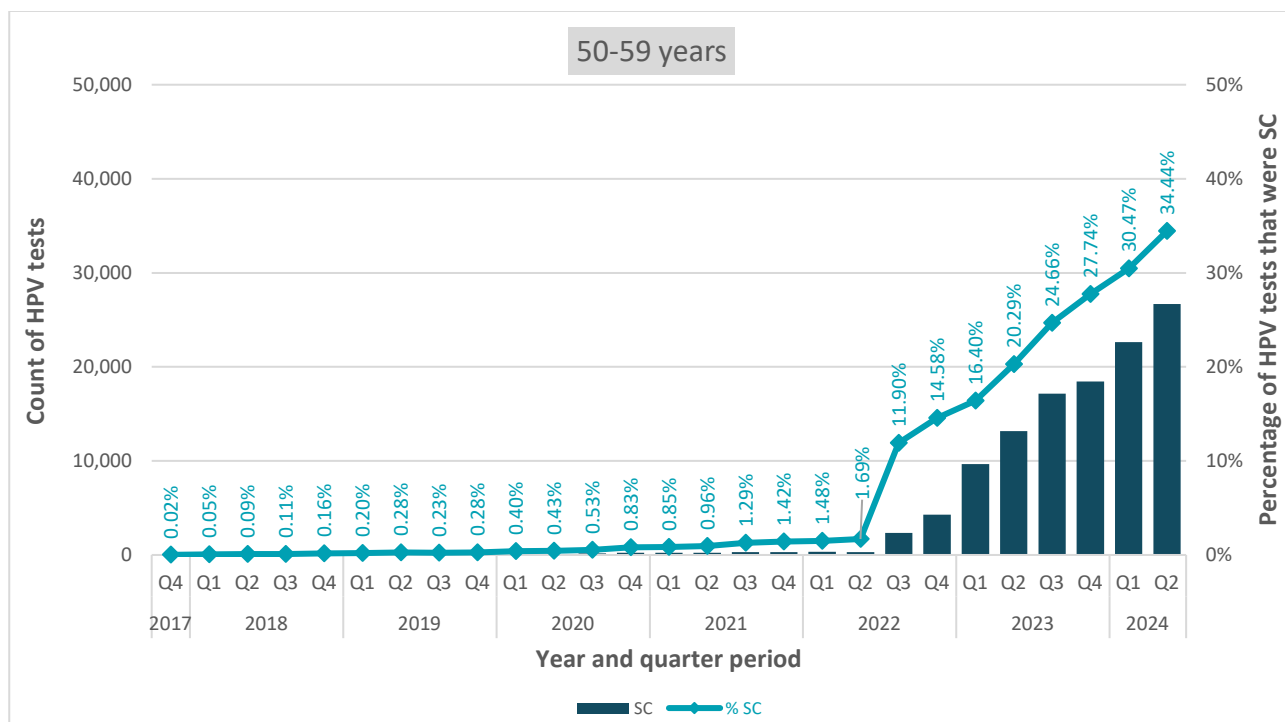


Figure 8: Count of self-collected tests and percentage of all HPV screening tests that were self-collected for women aged 60-69 years

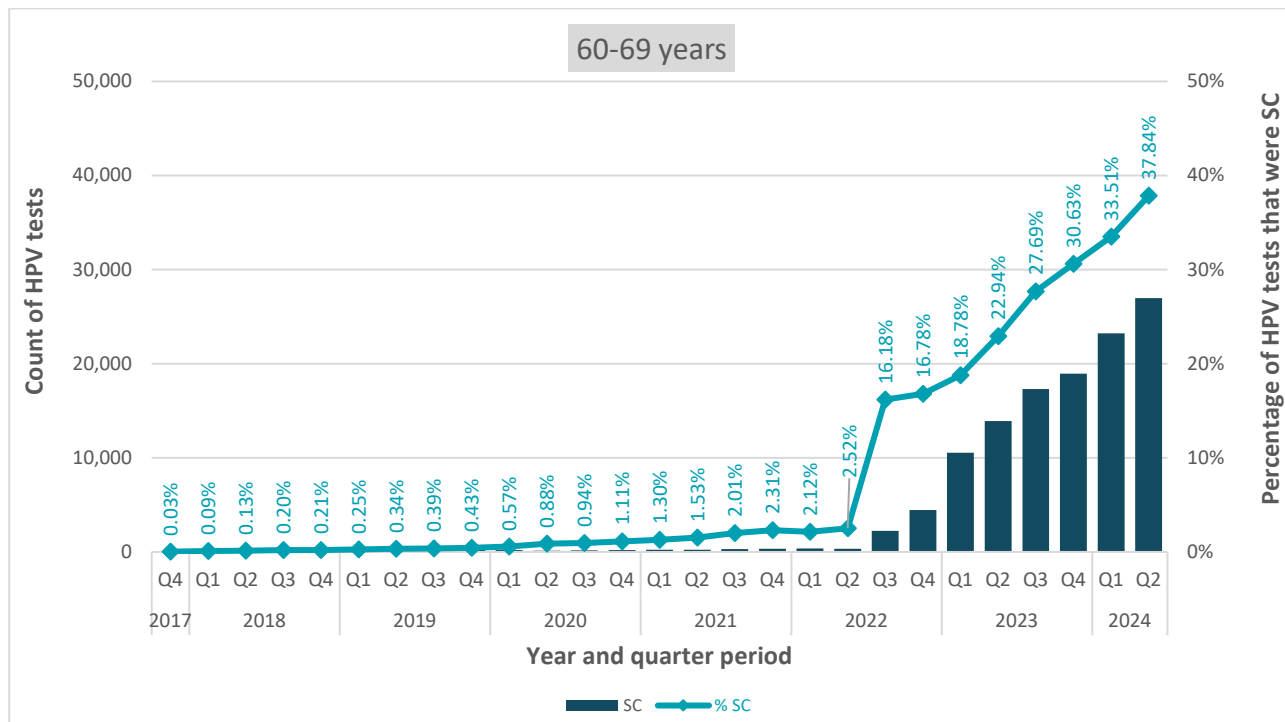
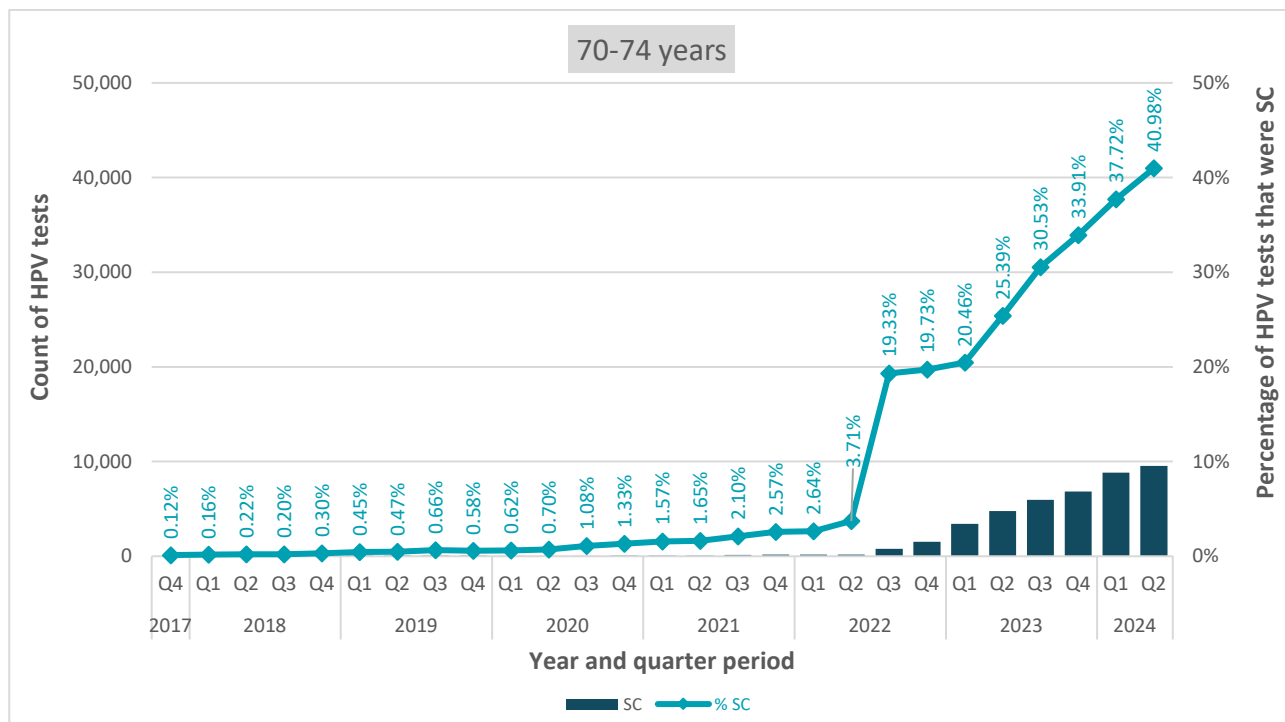


Figure 9: Count of self-collected tests and percentage of all HPV screening tests that were self-collected for women aged 70-74 years



As shown in each age group graph, the self-collect uptake increased across all age groups. The older age groups had a higher uptake of self-collected tests, with the highest uptake being observed in the 70–74 year age group where almost 41% of all HPV screening tests in Q2 of 2024 were self-collected tests.

4.1.4.2 State and Territory

The figures below display the national counts and percentage of self-collected (SC) tests for each quarter from 1 December 2017 to 30 June 2024 for each state and territory.

Figure 10: Count of self-collected tests and percentage of all HPV screening tests that were self-collected in the Australian Capital Territory

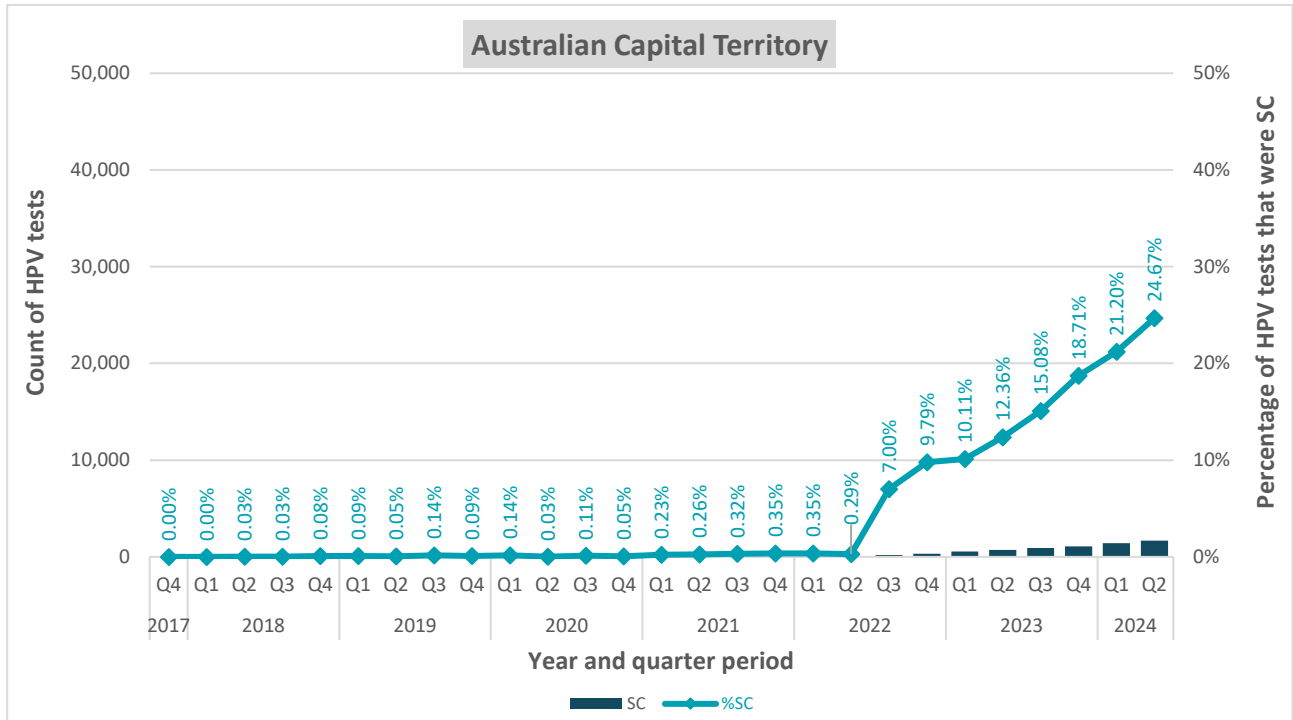


Figure 11: Count of self-collected tests and percentage of all HPV screening tests that were self-collected in New South Wales

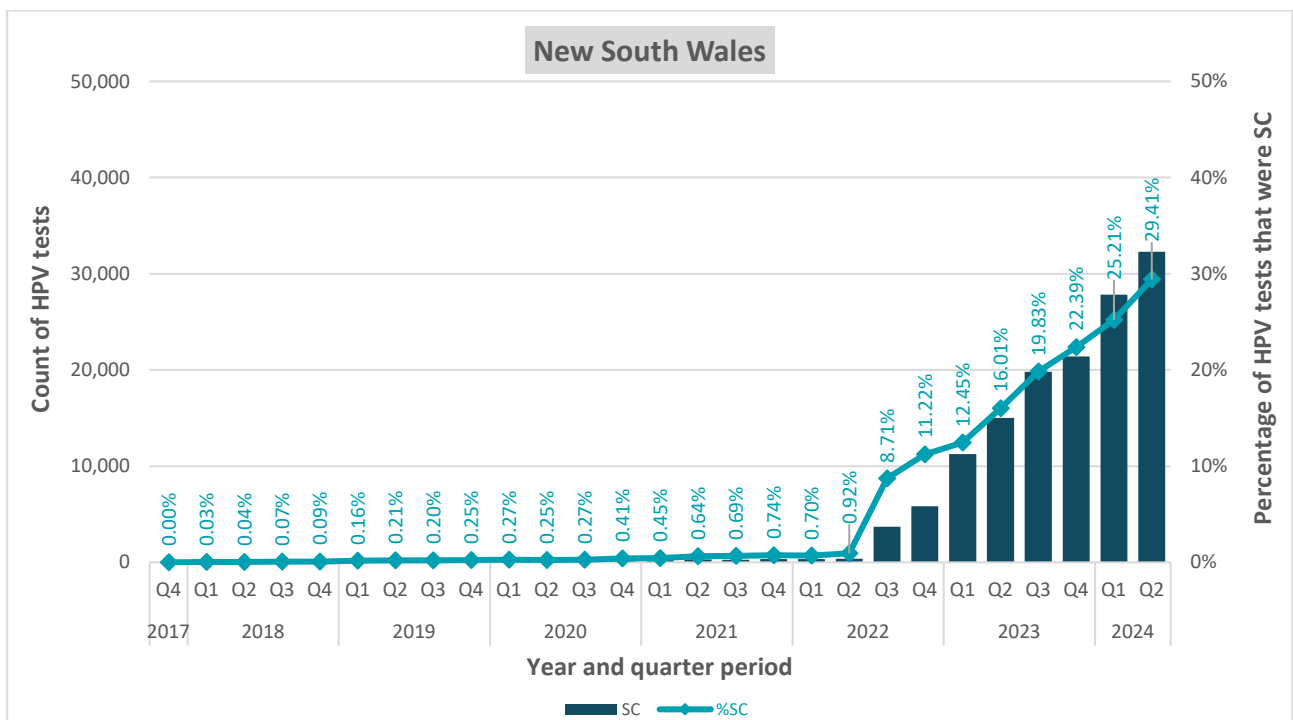


Figure 12: Count of self-collected tests and percentage of all HPV screening tests that were self-collected in the Northern Territory

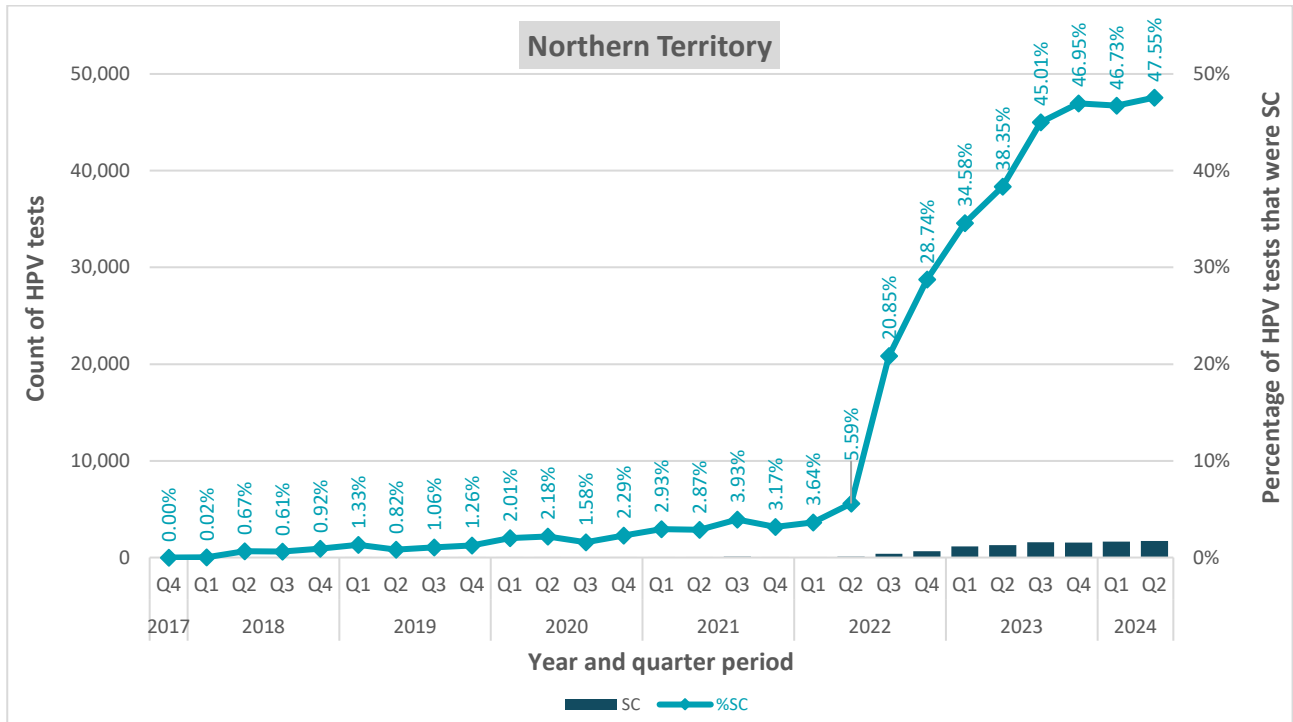


Figure 13: Count of self-collected tests and percentage of all HPV screening tests that were self-collected in Queensland

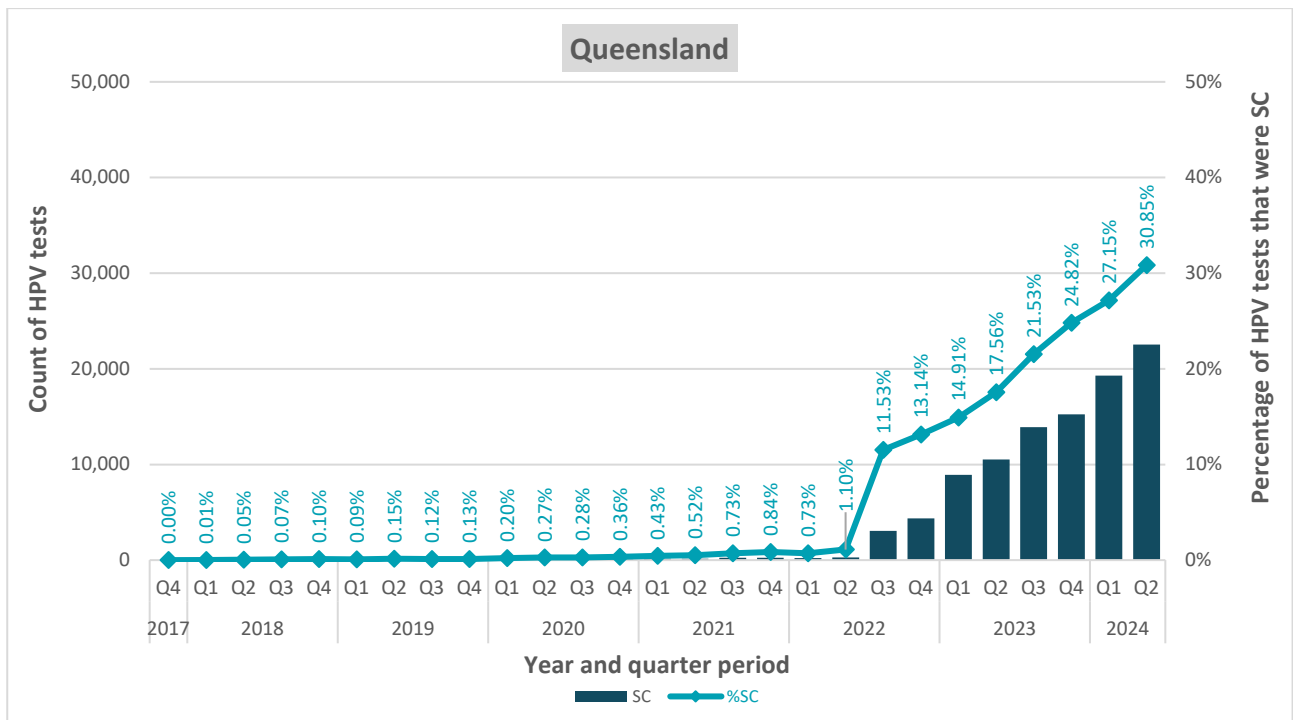


Figure 14: Count of self-collected tests and percentage of all HPV screening tests that were self-collected in South Australia

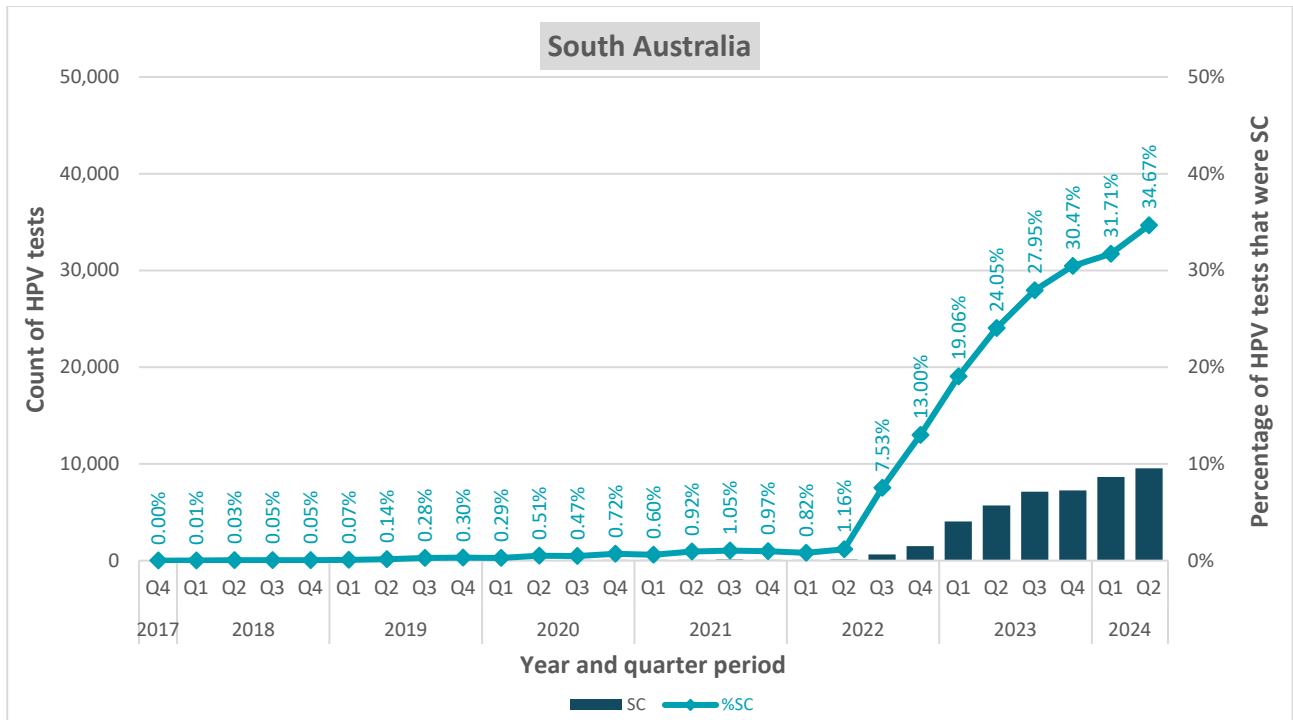


Figure 15: Count of self-collected tests and percentage of all HPV screening tests that were self-collected in Tasmania

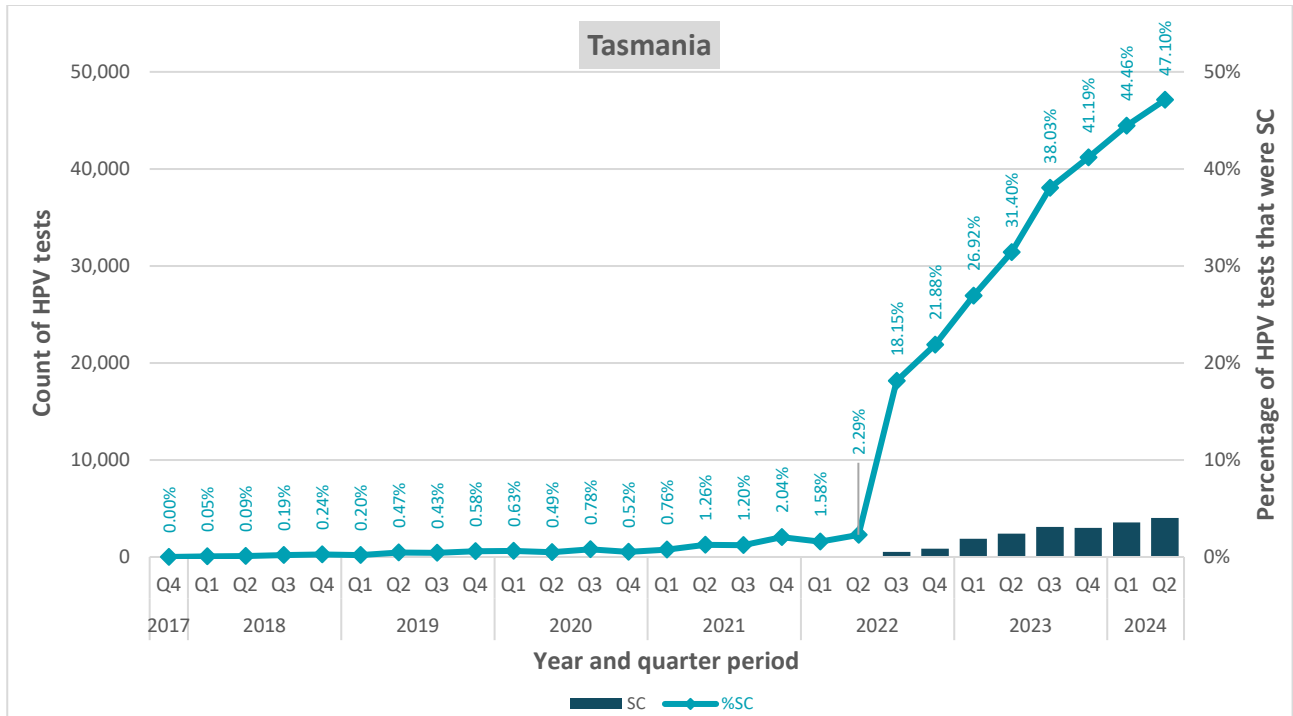


Figure 16: Count of self-collected tests and percentage of all HPV screening tests that were self-collected in Victoria

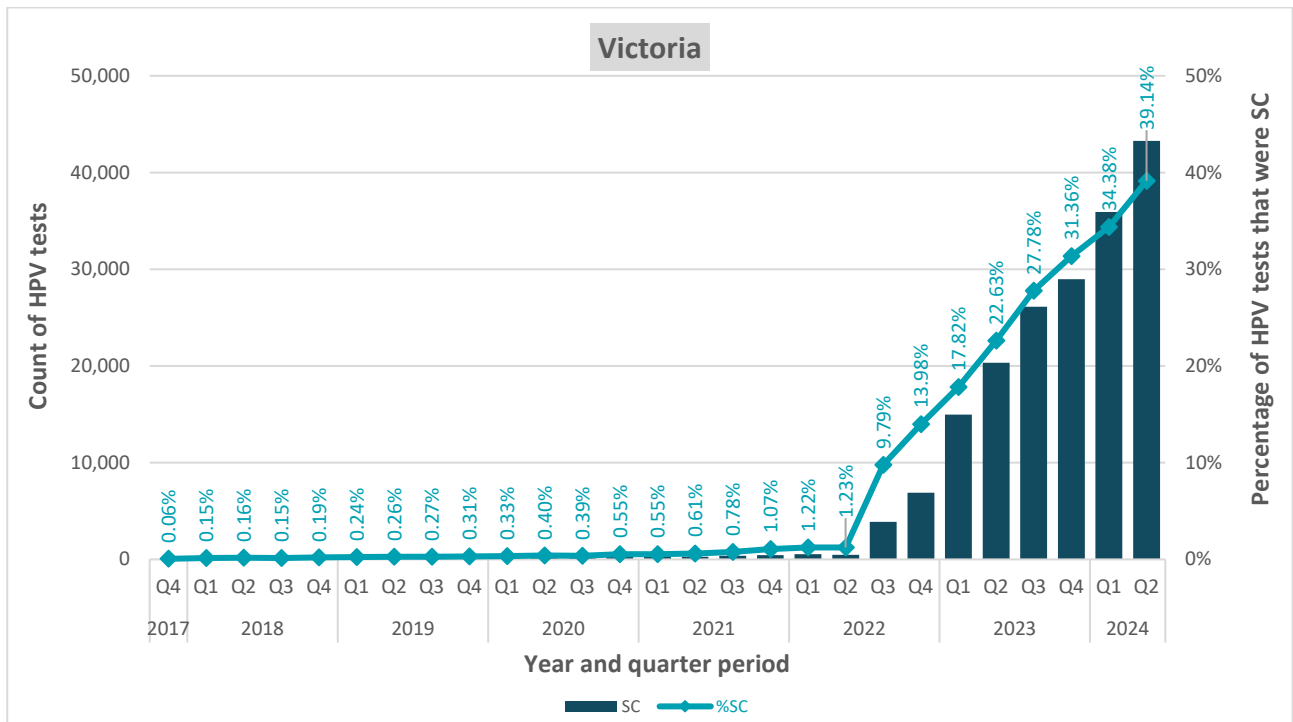
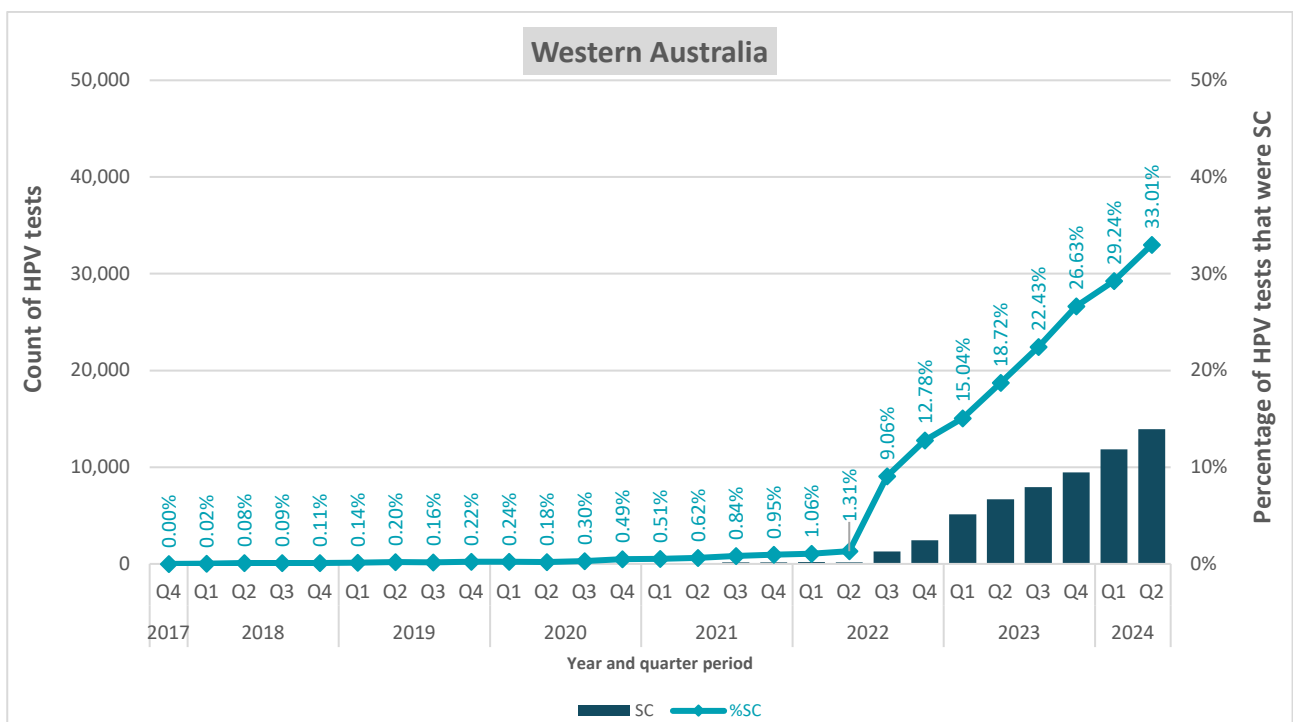


Figure 17: Count of self-collected tests and percentage of all HPV screening tests that were self-collected in Western Australia



As seen in the above figures, self-collect uptake increased across all states and territories, with the highest uptake observed in the Northern Territory, at over 45.5% for Q2 2024.

4.1.4.3 Socio-Economic Indexes for Areas (SEIFA)

The figures below display the national counts and percentages of self-collected (SC) tests for each quarter from 1 December 2017 to 30 June 2024 for each Socio-Economic Index For Areas (SEIFA) quintile using the Index of Relative Socio-Economic Disadvantage.

Figure 18: Count of self-collected tests and percentage of all HPV screening tests that were self-collected by SEIFA quintile 1 (most disadvantaged)

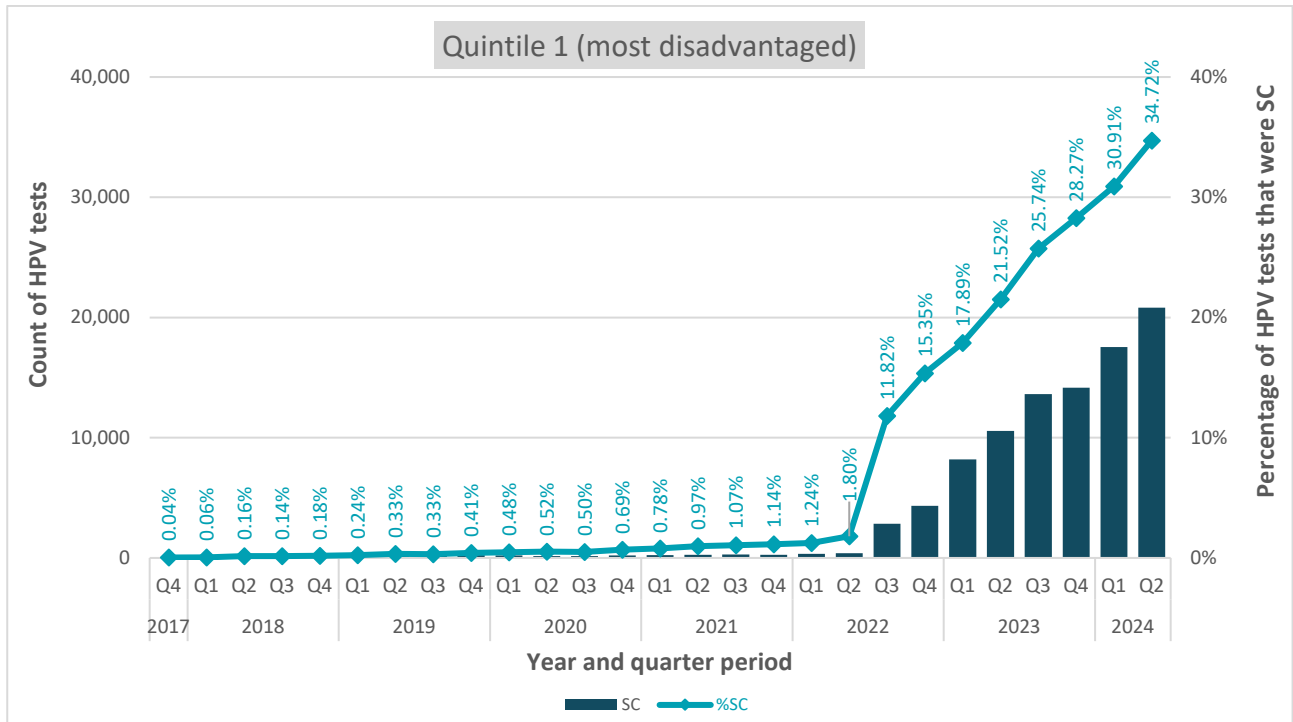


Figure 19: Count of self-collected tests and percentage of all HPV screening tests that were self-collected by SEIFA quintile 2

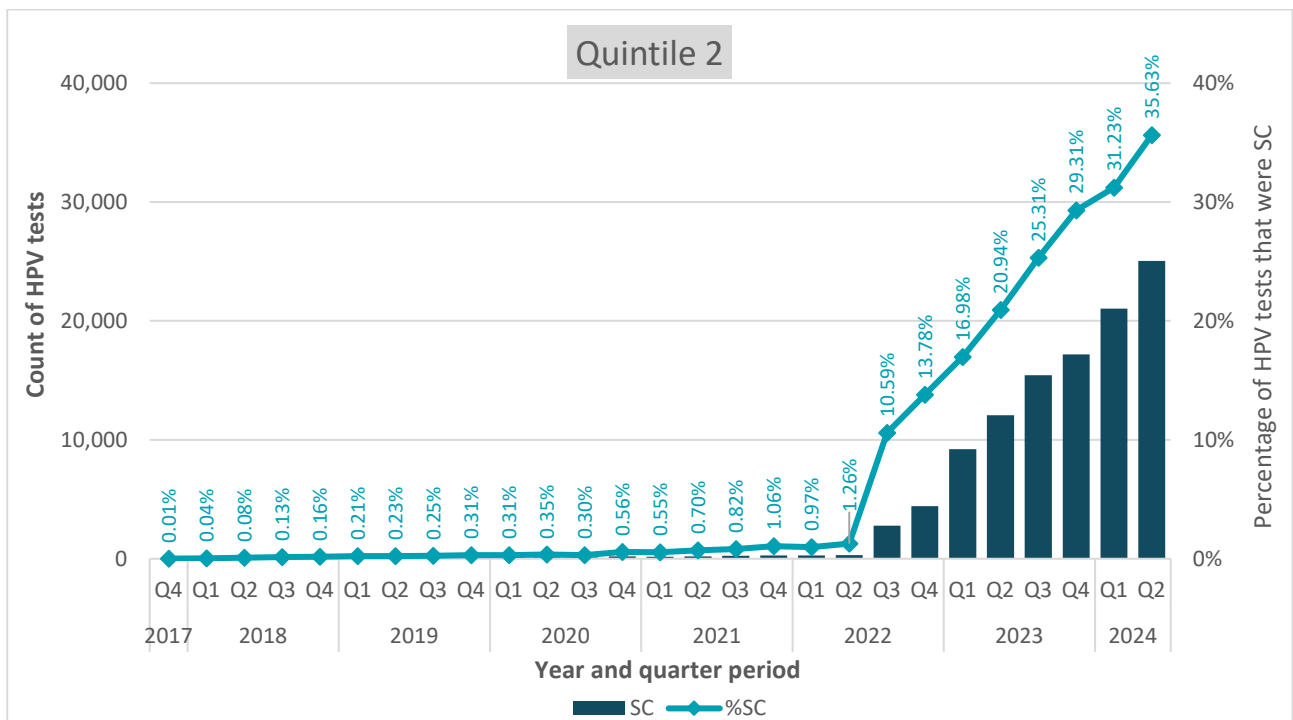


Figure 20: Count of self-collected tests and percentage of all HPV screening tests that were self-collected by SEIFA quintile 3

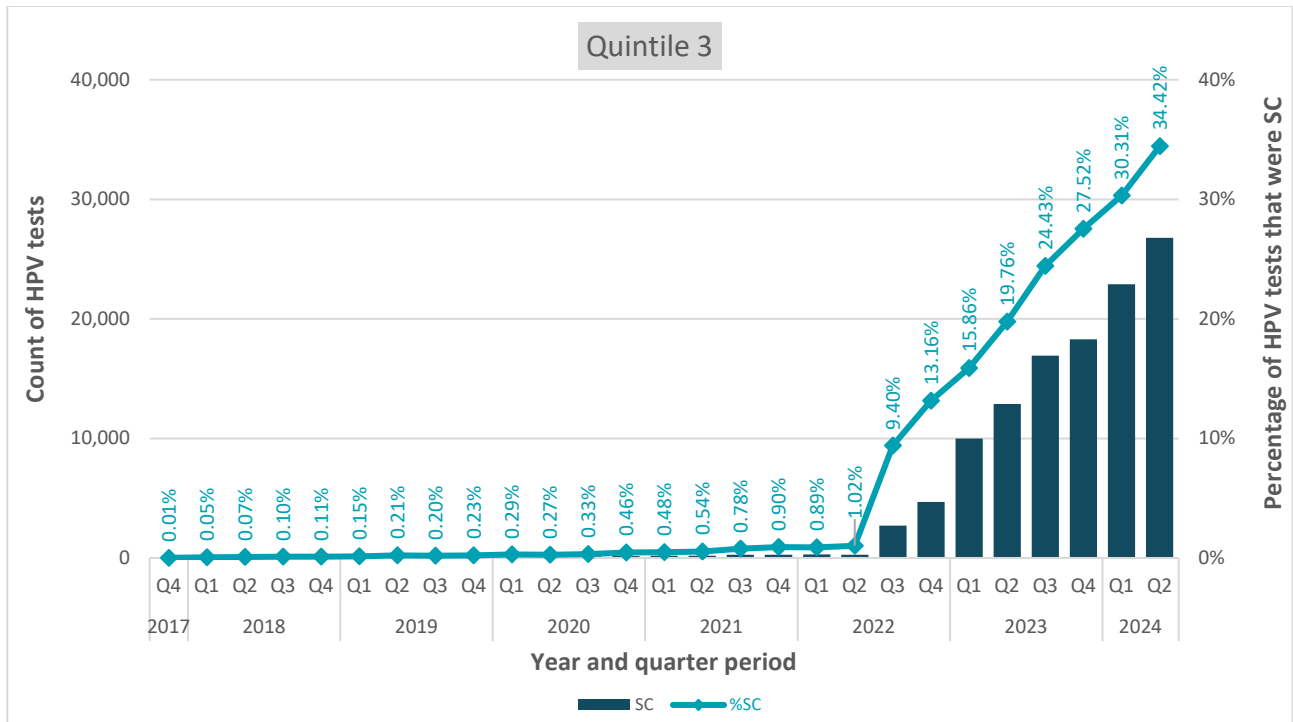


Figure 21: Count of self-collected tests and percentage of all HPV screening tests that were self-collected by SEIFA quintile 4

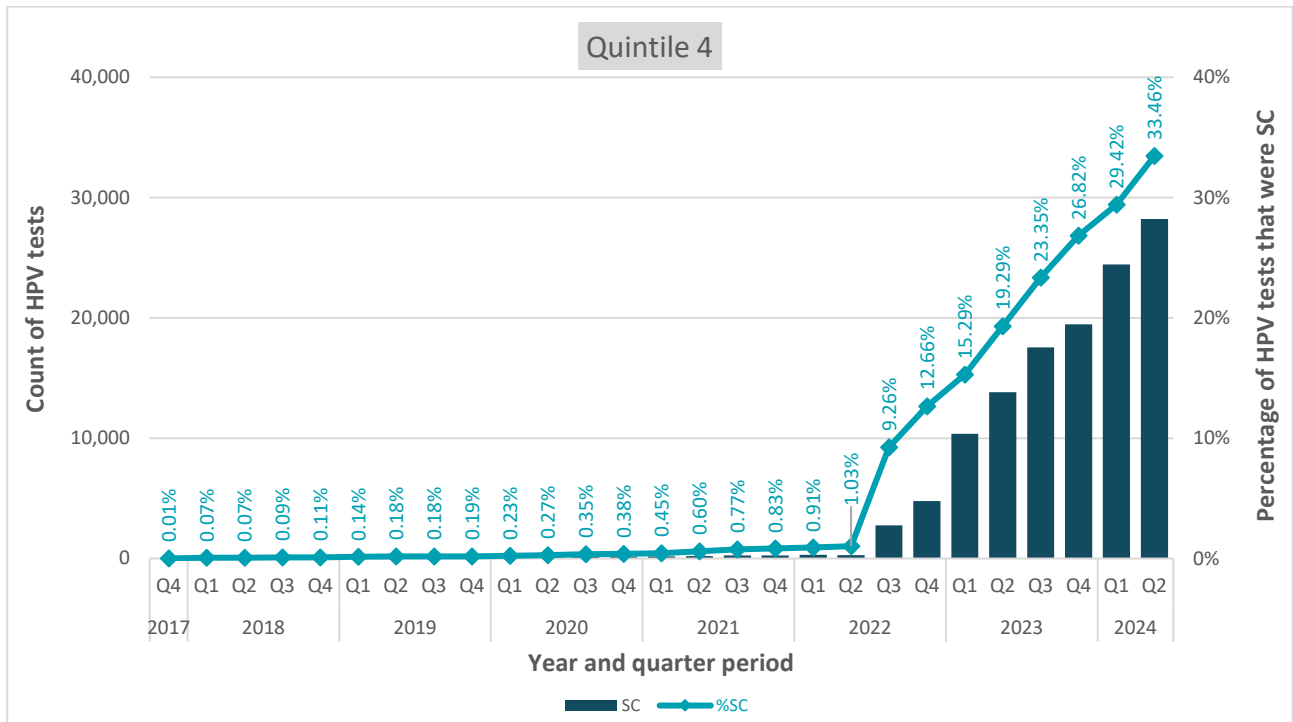
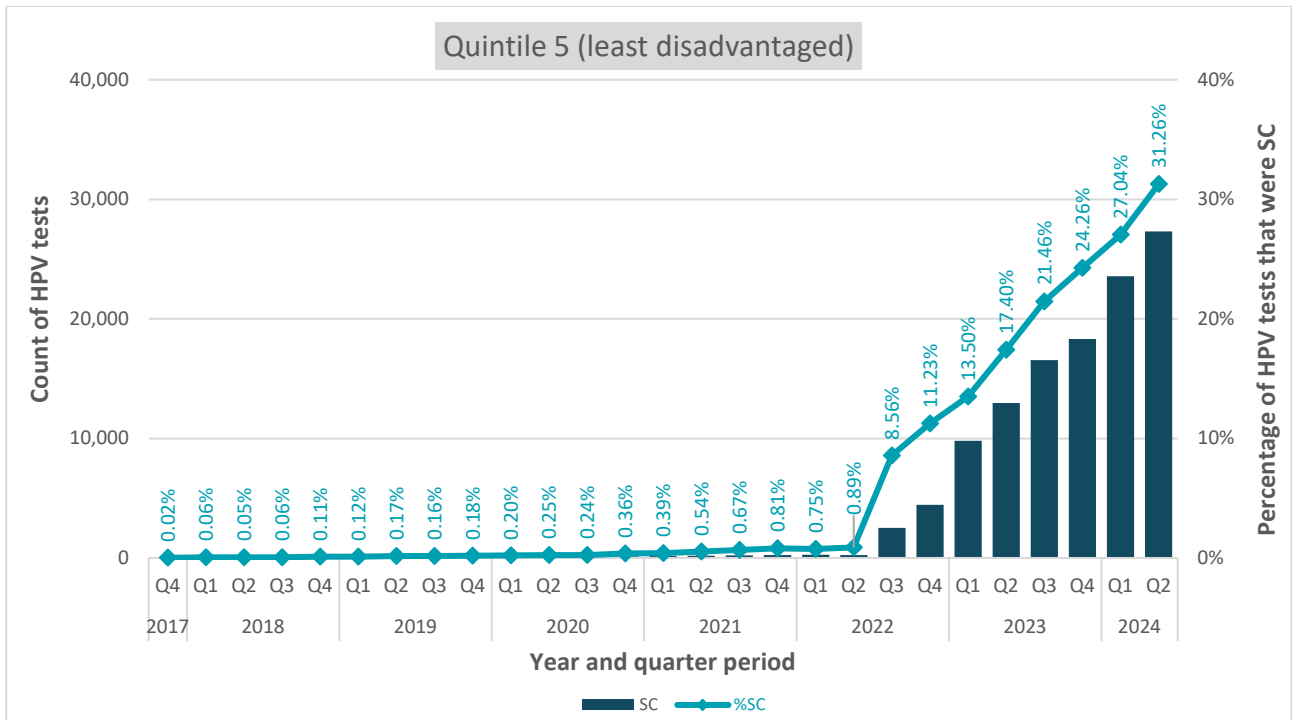


Figure 22: Count of self-collected tests and percentage of all HPV screening tests that were self-collected by SEIFA quintile 5 (least disadvantaged)



Self-collect uptake has increased across all SEIFA quintiles over time, with the highest uptake observed in quintile 1 (most disadvantaged) and quintile 2, reaching approximately 35% and 36%, respectively, for Q2 of 2024.

4.1.4.4 Accessibility/Remoteness Index of Australia (ARIA)

The figures below show the national counts and percentages of self-collected (SC) tests for each quarter from 1 December 2017 to 30 June 2024 for each remoteness area for the Accessibility/Remoteness Index of Australia (ARIA).

Figure 23: Count of self-collected tests and percentage of all HPV screening tests that were self-collected for Major Cities

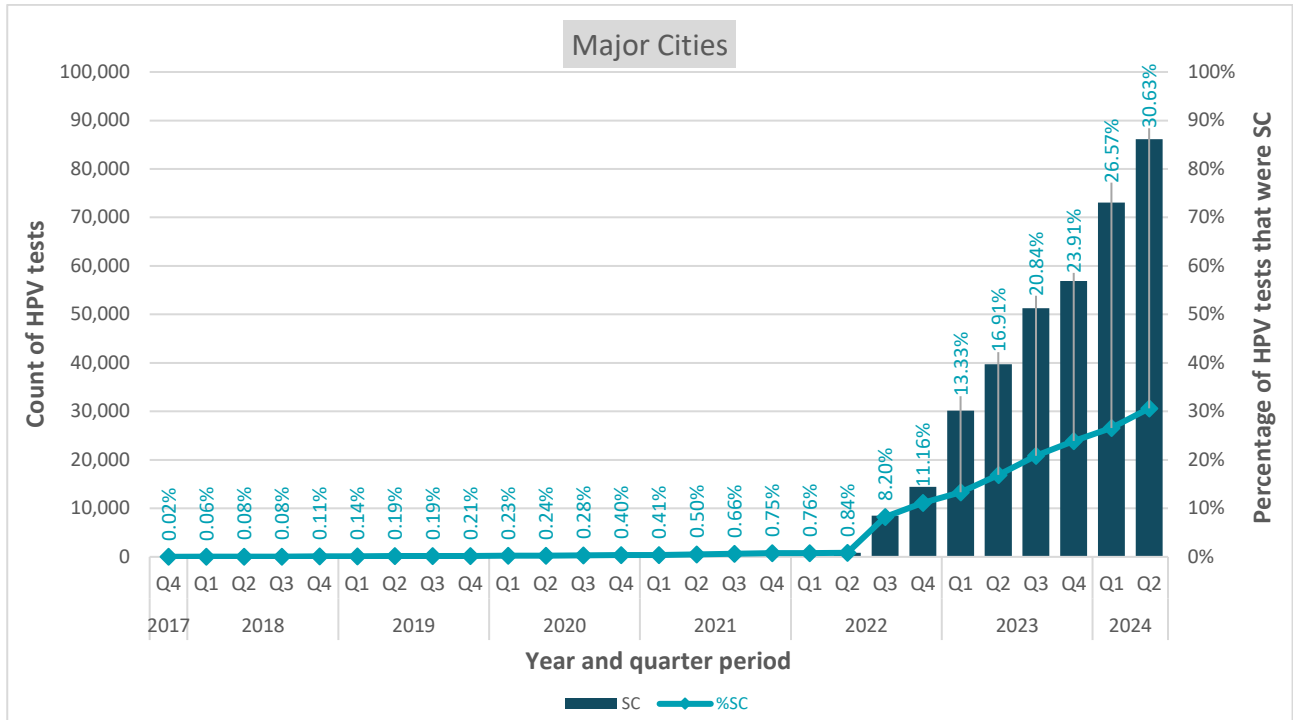


Figure 24: Count of self-collected tests and percentage of all HPV screening tests that were self-collected for Inner Regional

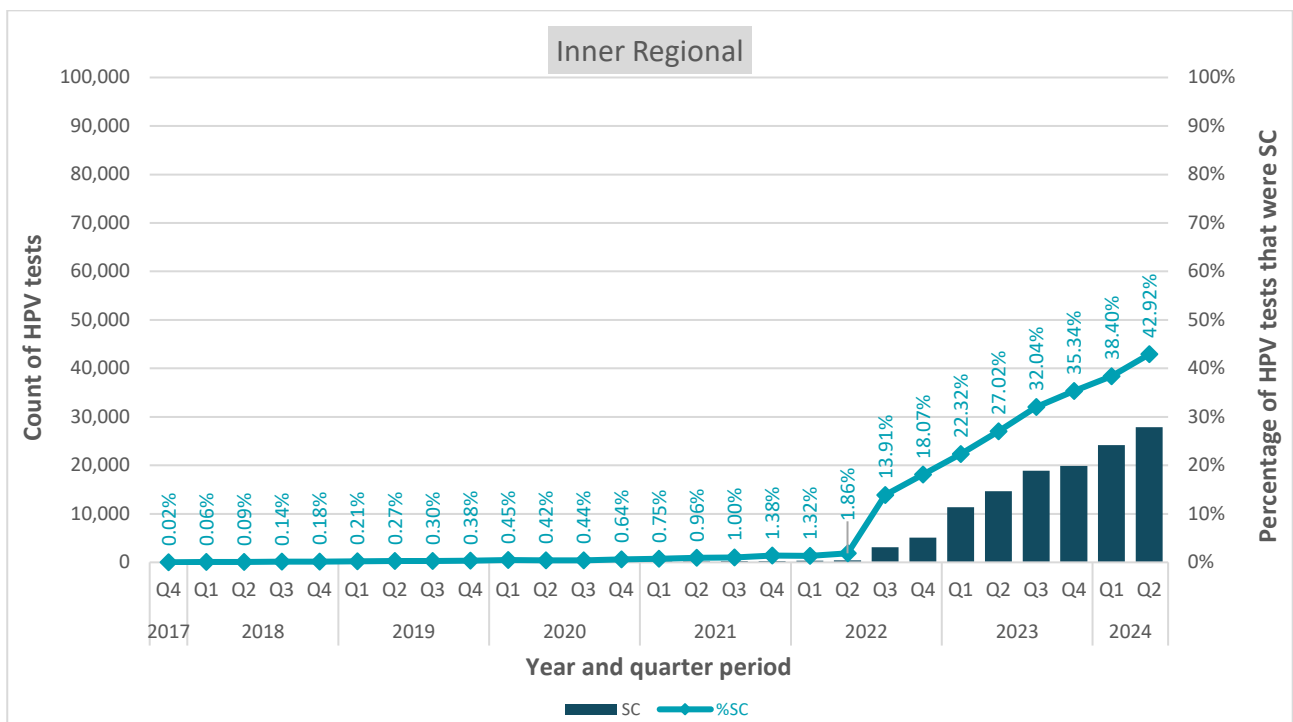


Figure 25: Count of self-collected tests and percentage of all HPV screening tests that were self-collected for Outer Regional

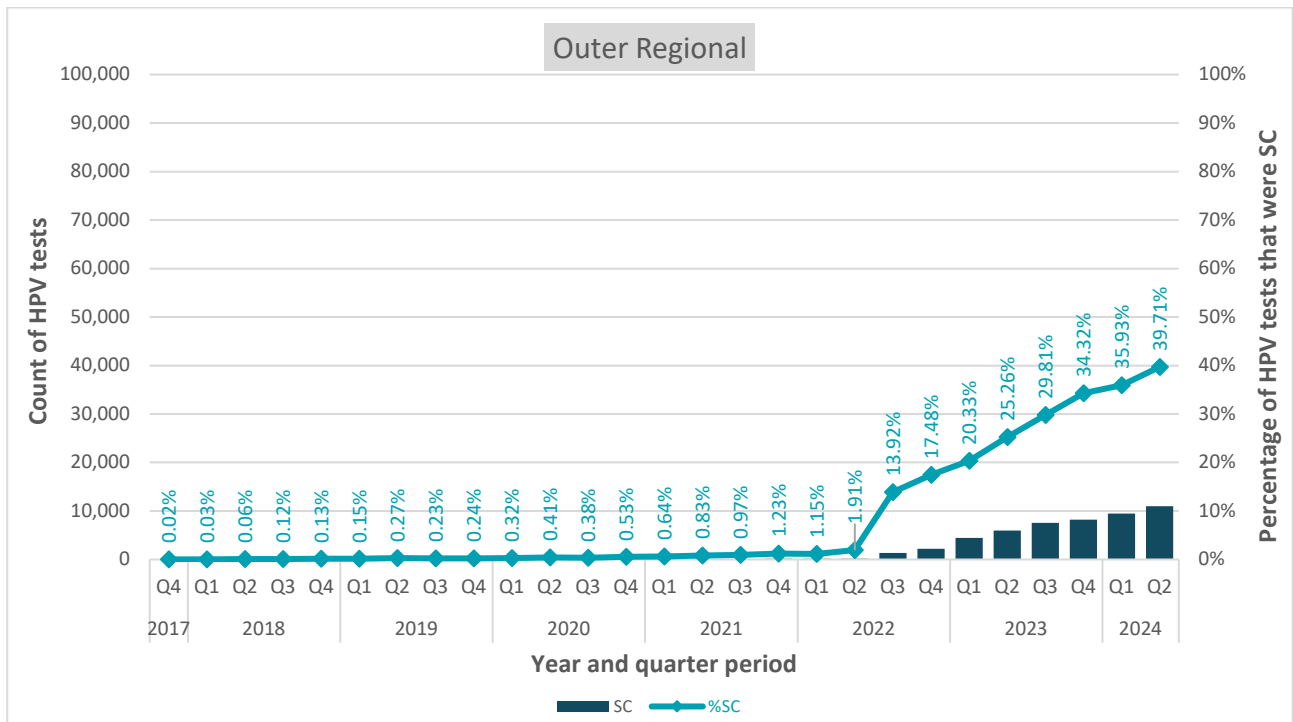


Figure 26: Count of self-collected tests and percentage of all HPV screening tests that were self-collected for Remote areas

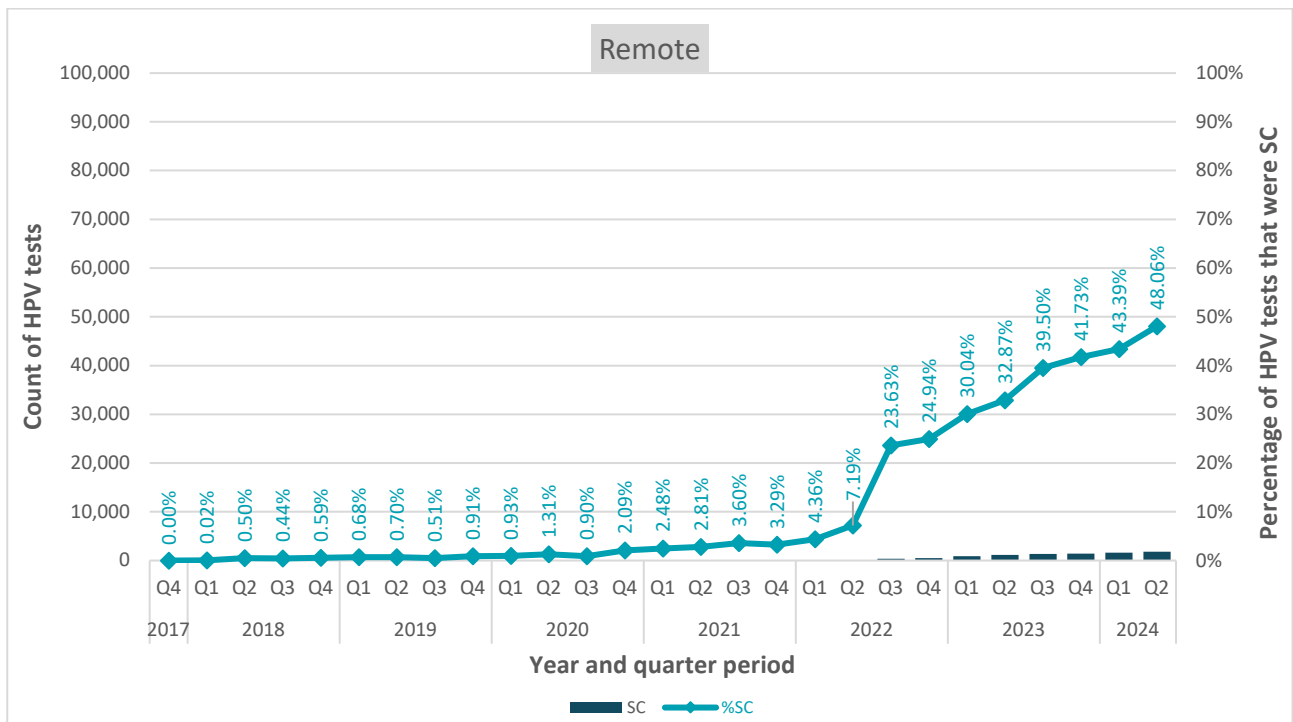
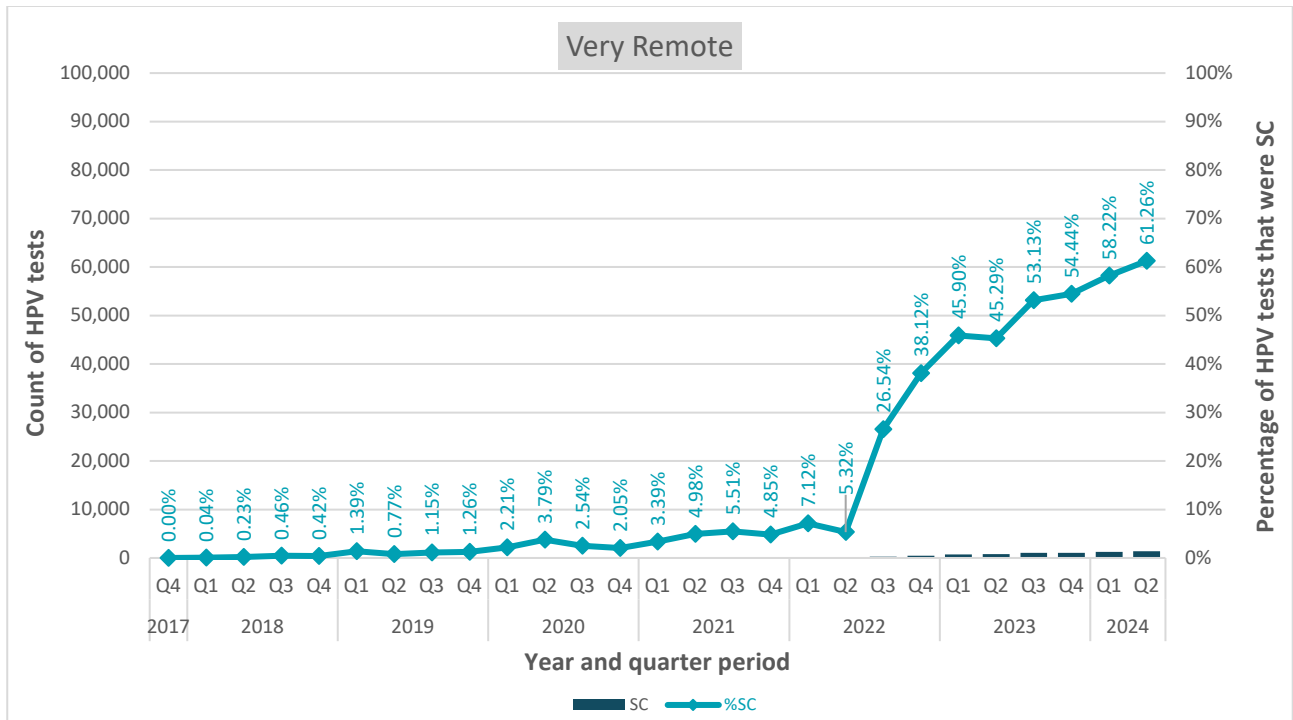


Figure 27: Count of self-collected tests and percentage of all HPV screening tests that were self-collected for Very Remote areas



As seen above, self-collect uptake has increased across all geographical remoteness areas since the expansion of self-collection eligibility. The highest uptake was observed in very remote areas at over 61% in Q2 2024.

4.1.4.5 Never-screened and under-screened aged 30 -74 years

The following figures provide counts of clinician-collected (CC) tests and self-collected (SC) tests, as well as the percentage of all HPV screening tests that were self-collected for each quarter, for people who either had never had a previous CST or were under-screened i.e. more than two years overdue for a CST.

Figure 28: Count of clinician-collected (CC) and self-collected (SC) screening tests and percentage of all HPV screening tests that were self-collected for each quarter for never-screened people aged 30-74 years

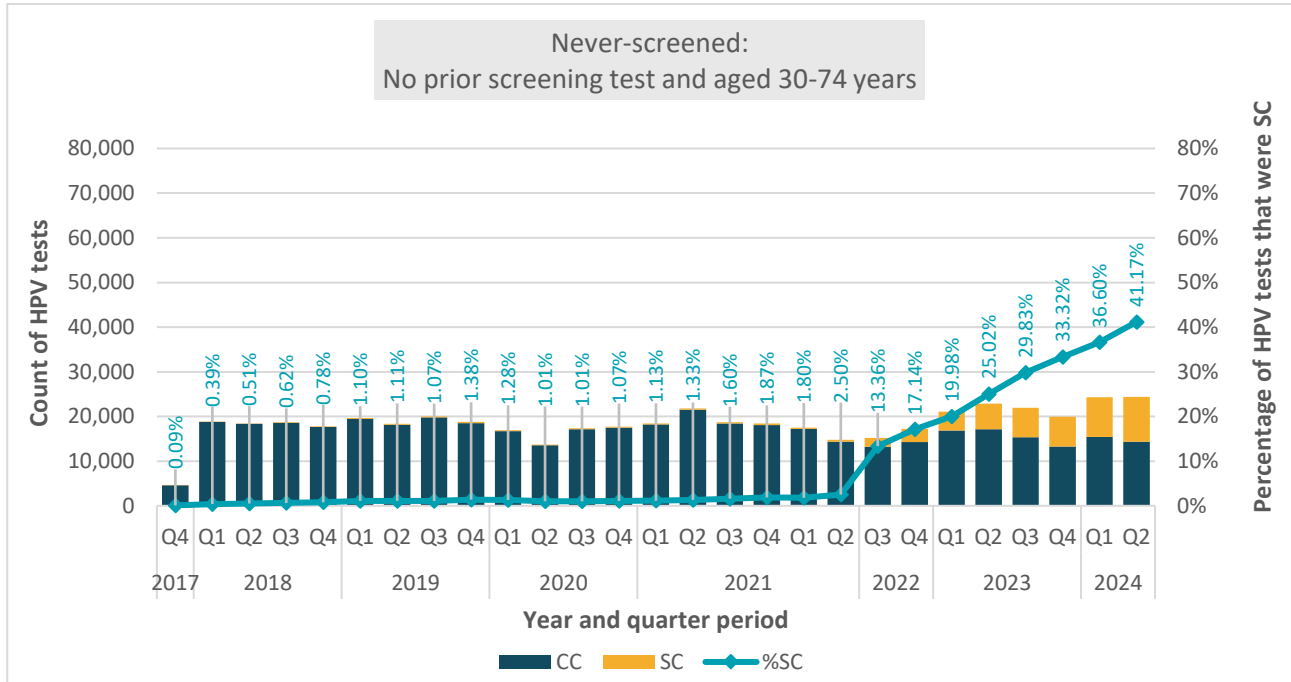
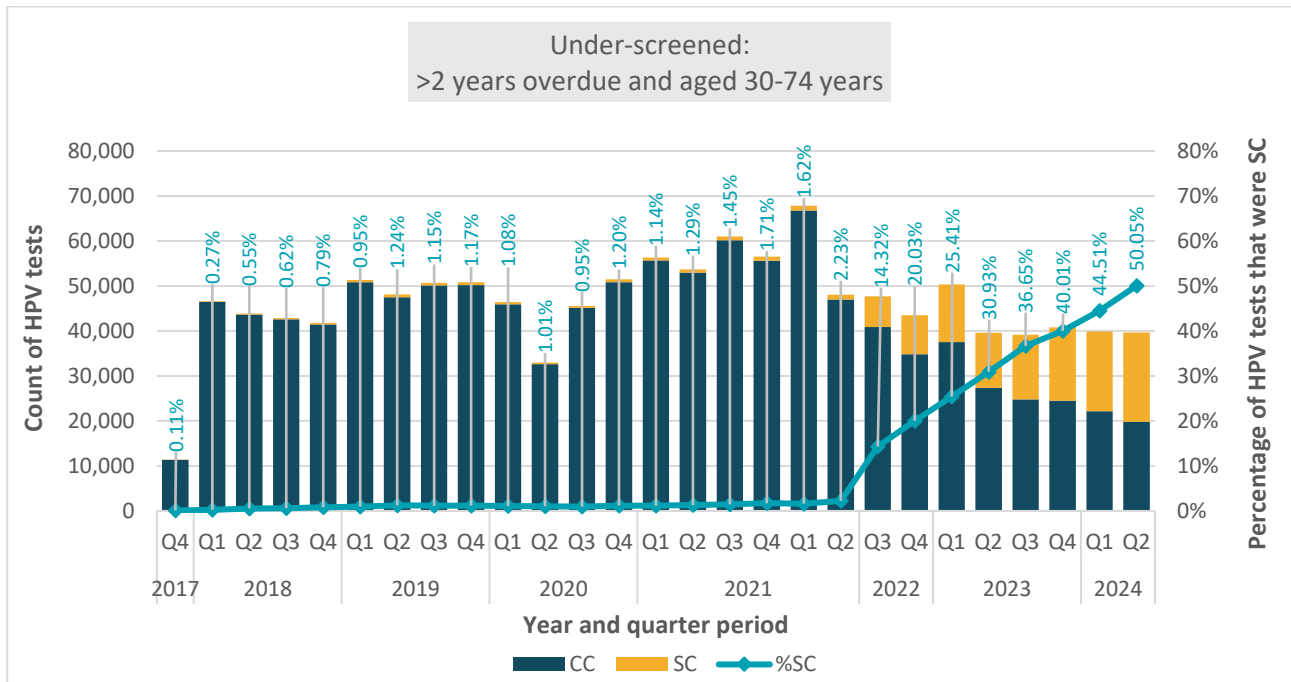


Figure 29: Count of clinician-collected (CC) and self-collected (SC) screening tests and percentage of all HPV screening tests that were self-collected for each quarter for under-screened people aged 30-74 years



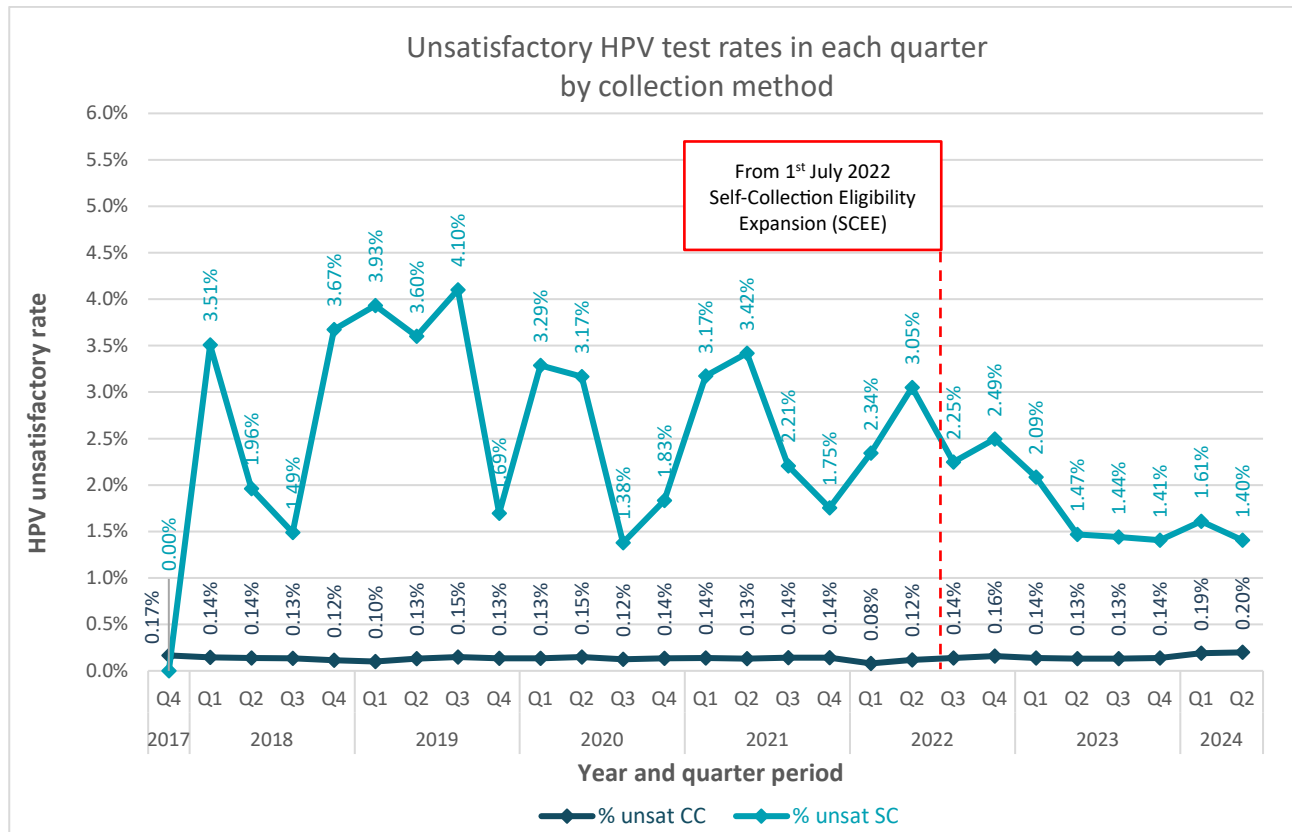
These figures illustrate a substantial increase in the uptake of self-collected tests among people aged 30-74 years who have either never been screened or were overdue for screening by two years or more. This increase was particularly notable after the policy change expanding eligibility of self-collection to all people, although these hard-to-reach groups were always eligible for self-collection since the implementation of HPV-based screening in Australia in December 2017. The uptake was higher in under-screened people compared to people with no prior screening test, at just over 50% and 41%, respectively, for Q2 of 2024.



4.1.5 HPV test unsatisfactory rates by collection method

Figure 30 below shows the unsatisfactory test rates for clinician-collected (CC) tests, expressed as a percentage of all clinician-collected tests with unsatisfactory HPV test results. Similarly, for self-collected (SC) tests, the percentage of all self-collected tests with unsatisfactory HPV test results is shown.

Figure 30: Unsatisfactory HPV test rates for each quarter by collection method



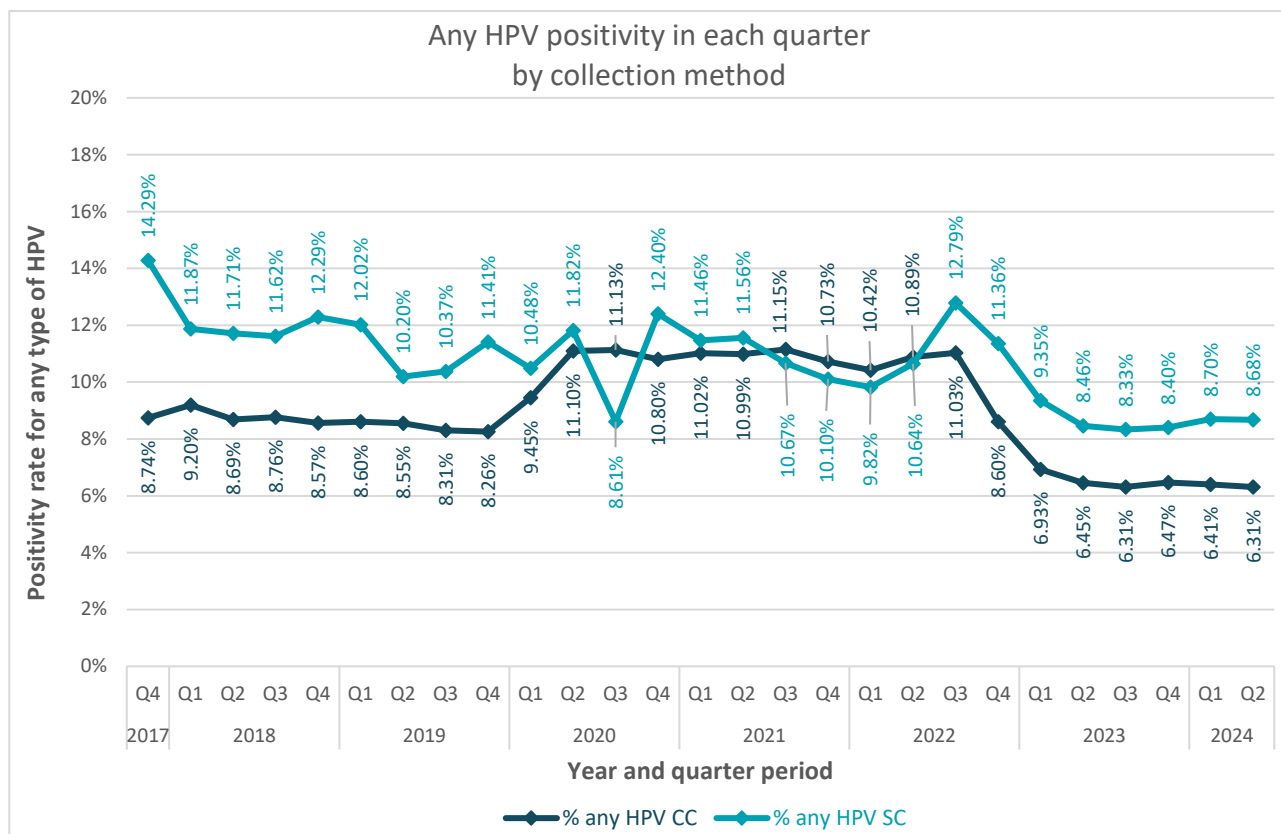
The unsatisfactory test rates for self-collected samples were like those found in the previous Pap program but significantly higher than the rates for clinician-collected samples.

For Q2 2024, the unsatisfactory test rate for self-collected samples was 1.4% compared to 0.2% for clinician-collected samples, a statistically significant difference ($p < 0.001$). However, it is important to note that there has been a decline in the unsatisfactory test rate for self-collected samples since the policy change, expanding eligibility for self-collection.

4.1.6 HPV test positivity rates by collection method

Figure 31 below provides HPV positivity rates for clinician-collected (CC) tests, expressed as a percentage of all valid primary screening tests that were clinician-collected for each quarter where any HPV subtype (HPV 16/18 or HPV non-16/18) was detected. Similarly, the HPV positivity rates for self-collected (SC) tests are expressed as a percentage of all valid primary screening tests that were self-collected for each quarter with any HPV positive result.

Figure 31: HPV positivity rate (any HPV type) for each quarter by collection method



Clinician-collected HPV positivity rates were consistently around 8% until late 2019 when they increased to around 11% between 2020 and 2021. However, from Q4 2022 onwards, clinician-collected HPV positivity rates declined and stabilised at around 6%. This decrease is likely due to people who previously tested negative returning to screen at five years, thereby lowering the overall positivity rates as these people tend to be at lower risk of a positive result.

Self-collected HPV positivity rates also followed a downward trend from the end of 2022 but remained higher compared to clinician-collected samples. Between 2023 and Q2 2024, the HPV positivity rates for self-collected tests were around 8-9%.

4.2 Adherence to recommendation for follow-up in HPV-positive people

4.2.1 Proportion of people with a positive HPV 16/18 test who had a colposcopy within six months

The clinical guidelines recommend that people who test positive for HPV types 16 or 18 undergo follow-up with a colposcopy, regardless of the collection method used. This recommendation is based on the higher risk associated with these HPV types, which are more likely to be associated with underlying cervical abnormalities and cancer.

Table 1 below shows the counts of people who tested positive for HPV types 16 or 18 by collection method (clinician-collected and self-collected). The table also presents the number and percentage of people who proceeded to have a colposcopy after receiving a positive HPV 16/18 result, overall and by collection method. The data for this table spans from 1 December 2017 to 31 December 2023 and shows colposcopies conducted within six months of an HPV 16/18 positive result as well as colposcopies by the end of the reporting period on 30 June 2024 (i.e., end of Q2 2024).

Table 1: Counts and percentages of people with an HPV type 16 or 18 result who went on to have a follow-up colposcopy by collection method

Collection method	Screening HPV tests positive for HPV 16/18 (1 st Dec 2017 – 31 st Dec 2023) (n)	Colposcopy within six months of HPV 16/18 positive result (n, %)	Colposcopy by the end of Q2 2024 after HPV 16/18 positive result (n,%)
Clinician-collected	105,066	84,510 (80.4%)	99,211 (94.4%)
Self-collected	6,469	5,226 (80.8%)	5,756 (88.9%)
Total	111,535	89,736 (80.5%)	104,967 (94.1%)

Overall, the clinical guidelines recommending colposcopy follow-up for people with positive HPV 16/18 results were highly adhered to, with 94.1% of all people attending colposcopy by 30 June 2024.

The majority had colposcopy follow-up within six months of the HPV 16/18 positive result (80.5%), and this was similar for clinician-collected tests and self-collected tests (80.4% vs. 80.8%; $p=0.491$).

When extending the follow-up time to the 30th of June 2024, the rate of colposcopy follow-up for HPV 16/18 self-collected samples increased to 88.9% but was significantly lower than clinician-collected samples (94.4%; $p<0.001$). This difference in colposcopy follow-up could be explained by the differential follow-up time in the two groups, with self-collected tests becoming more common after the expansion of eligibility from the 1st of July 2022.

4.2.2 Proportion of people with a self-collected positive HPV non-16/18 test who had an LBC test within 6 months

The clinical guidelines recommend that people who test positive for HPV types other than 16 or 18 undergo a follow-up Liquid Based Cytology (LBC) test. The result of this subsequent clinician-collected LBC triage test then informs further management decisions for these people regarding whether a colposcopy or repeat HPV test is required. Table 2 provides the number of people who tested positive for HPV non-16/18 on a self-collected sample and details the counts and percentages of those who subsequently underwent a follow-up LBC test (for any reason).

The data for this table spans from 1 December 2017 to 31 December 2023 and reports subsequent LBC tests within six months of an HPV non-16/18 positive result as well as LBC done by end of the reporting period on 30 June 2024 (i.e.: end of Q2 2024).

Table 2: Counts and percentages of people with a self-collected positive HPV non-16/18 result who went on to have a follow-up LBC test

Collection method	Self-collect HPV non-16/18 (1 st Dec 2017-31 st Dec 2023) (n)	Any LBC (all reasons included) within 6 months (n, %)	Any LBC (all reasons included) by end of Q2 2024 (n, %)
Self-collected	21,565	17,678 (81.9%)	18,811 (87.2%)

Of people who had a positive self-collected HPV test result that wasn't a 16 or 18 subtype 81.9% subsequently underwent a recommended follow-up LBC test within 6 months. This percentage increased to 87.2% when looking at LBC follow-up by 30 June 2024.