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COMMENTARY

Supporting equitable cervical cancer elimination for Australia's culturally and linguistically diverse communities: A call for intersectoral action

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Abstract

Cervical cancer is a preventable disease and is related to persistent health equities. Whilst several priority populations face health inequities related to cervical cancer prevention, my co-authors and I bring special attention to those who identify as culturally and linguistically diverse (CALD). By reflecting on some of our research and work experiences, we propose four ways that governments and policymakers can enact the community engagement goals of the published and proposed cervical cancer prevention and treatment strategies for CALD communities. This includes: (1) Developing a culturally appropriate approach to collecting and interpreting cultural, ethnic and linguistic data; (2) Building and adapting the effective multicultural community policies and partnerships developed during COVID-19; (3) Incorporating national strategy recommendations across all relevant government policies and (4) Sustainably resourcing and supporting participatory health promotion activities and interventions. By implementing the recommendations above, Australia will continue to lead the elimination of cervical cancer as a public health problem. It will demonstrate how genuine and authentic CALD partnerships and collaborations can reduce national CALD health inequities.

KEYWORDS

Australia, cervical cancer, cultural diversity, goals, health equity, human papillomavirus, policy

1 | COMMENTARY

Cervical cancer is a preventable disease and persists due to barriers related to health equity. To address these health inequities in 2020 the World Health Organization (WHO) challenged all member countries to eliminate cervical cancer as a public health problem by 2030.[1] The WHO elimination target is a cervical cancer incidence of fewer than four new cases per 100 000 women.[1] To meet this elimination aim, the WHO outlines a 90–70–90 strategy which includes 90% of females being vaccinated for human papillomavirus (HPV), 70% of women participating in cervical screening twice (once by age 35 and again by age 45) and 90% of women with cervical disease treated.

Australia's National Strategy for the Elimination of Cervical Cancer (herein called the National Strategy) aims higher with Australia's

targets being 70% of women participating in 5 yearly screenings, 90% vaccination coverage of girls and boys and 95% treatment for the disease.[2] To support the national goal of eliminating cervical cancer as a public health issue by 2035,[2] the Australian Government has committed $48.2 million to the cause, with $8.3 million to support priority populations.[3]

Currently, cervical cancer outcomes in Australia are related to a person's Aboriginal and Torres Strait Islander status, their socioeconomic status (SES) and where a person lives (urban or rural).[2,4,5] The latest Australian Cervical Cancer Control report shows that compared to the WHO elimination target, cervical cancer incidence rates for the period 2015–2019 were more than three times higher (12.3 per 100 000 women) for Aboriginal and Torres Strait Islander women and twice as high for women living in very remote areas, while overall cervical cancer incidence was 6.4 per 100 000 women in 2019.[5] These disparities are also reflected in the preventative cervical screening and HPV vaccination coverage data.[5,6] For example, coverage data from 2022 for females who receive at least one dose of HPV vaccine before their 15th birthday shows a 3.2% difference between those living in major cities versus those living remotely (85.4% and 82.2%, respectively). For Aboriginal and Torres Strait Islander females, this gap is even wider at 6.2% (78.7% compared to 84.9% in non-Indigenous females).[6]

In addition to the priority populations identified above, both the National Strategy and the Australian Cancer Plan recognise that those who identify as culturally and linguistically diverse (CALD) also face barriers to preventative cancer care.[2,4] These reasons relate to the known inequitable barriers CALD community members face around health literacy, access to formal education, unfamiliarity with the Australian health care system and the availability of language support to engage fully with area health programs like vaccination and cervical screening.[7–9] Despite the known challenges facing CALD communities, we know little about how these communities are, or are not, accessing cervical screening, vaccination and treatment. As highlighted below:

> "You know, the media saying elimination of cervical cancer in Australia, we're going to be the first country and all this stuff, it is only as good as the paper you write it on….So we have a real agenda ahead of us to make sure that [cervical screening and immunisation] messages get really strongly articulated for our First Nations and our CALD populations…."
> —Jurisdictional Cervical Screening Manager[9] [p. 88].

2 | HOW TO ACHIEVE CERVICAL CANCER ELIMINATION FOR CALD COMMUNITIES

COVID-19 demonstrated how CALD health equity barriers can be addressed with effective partnerships, collaboration and a whole of government approach.[10–12] Based on our research and work experiences, we propose to take the lessons learned from the COVID-19 pandemic and tailor these to achieve the community engagement goals of not only the National Strategy,[2] the Australian Cancer Plan[4] and the next National Immunisation Strategy[13] but any strategy related to improving screening, vaccination and treatment:

2.1 | Develop and use the national cancer data framework and minimum dataset

Work with key CALD stakeholders to develop a culturally appropriate approach to collecting and interpreting cultural, ethnic and linguistic data

Without better CALD data linkage, we cannot tell if broader general population data is masking inequities in CALD communities.[14] Whilst ideally multiple cultural identity variables should be collected directly by providers and recorded in registries and data sets, currently this is not the case.[14] This data deficit is recognised by the National Strategy and the Cancer Plan, and both aim to improve data linkage in this health service area.[2,4] One example is the data linkage between the Australian Immunisation Register and the Person Level Integrated Data Asset (PLIDA).[15] If the National Cancer Screening Register is also linked to PLIDA, both screening and vaccination uptake can be assessed by CALD status. To avoid under-reporting in priority CALD populations though, data linkage projects (like PLIDA) will need to capture and combine different CALD status measures.[14] This brings up potential contextual challenges around the socio-cultural identity of a person and how this influences their health and well-being. For example, in one cultural context, the main language spoken at home data in combination with ancestry and country of birth data may reveal one health picture.[14] In another context, adding religious affiliation and period of residence in Australia may reveal another.

To address these contextual challenges of linked data, we strongly encourage those developing and interpreting the National Cancer Data Framework and Minimum Dataset to partner with relevant CALD stakeholders to contextualise community disease experiences and formally define and standardise CALD status measures.[14] As proposed by the Federation of Ethnic Communities Councils of Australia,[16] developing a working group to define and standardise relevant screening, vaccination and treatment CALD status measures will be key to supporting more relevant and representative linked health data.

2.2 | Build on what worked during the COVID-19 vaccination rollout

Build and adapt the effective multicultural community policies and partnerships developed during the COVID-19 vaccination roll-out

International and Australian research shows that HPV vaccination and screening interventions are most effective when they leverage or build on long-standing community partnerships.[17,18] Given the goals of the Australian Cancer Plan, the National Strategy and the proposed National Immunisation Strategy to work with priority population groups,[2,4,13] we urge all levels of government and non-government agencies to build on any successful CALD community and stakeholder partnerships formed during the COVID-19 pandemic.[10–12]

For example, the federal government has extended the remit of the CALD COVID-19 Health Advisory Group to include a range of public health matters.[19] This makes the CALD Health Advisory Group well-placed to advise and support how all policies related to the National Strategy (e.g., cervical screening, disease treatment and HPV vaccination) can be tailored for multicultural communities.

At a local level, our recommendation would mean creating and sustaining partnerships between the local immunisation providers, relevant Multicultural Health Services, local cancer prevention agencies and key local CALD community organisations and leaders.[20] Our co-authors working "on the ground" highlighted their successful community engagement practices including face-to-face meetings with school and cultural leaders, establishing effective local advisory groups, hosting community events and celebrations and developing appealing multilingual resources. Some example resources around cervical cancer prevention include films (e.g., 'Conquering Cancer'),[21] locally produced health videos in language, tailored websites and social media promotions.[8,18,20,22] These types of engagements leverage readily available resources which are then tailored locally at a low cost[8,20] or in conjunction with academic[8,20] and government institutions.[22] This can be helpful not only in building health literacy but also in community trust.

2.3 | Take a whole-of-system approach to all strategy recommendations

Incorporate national strategy recommendations across all relevant government policies

Across local, state, territory and federal governments, multiple health system departments and actors are involved with health promotion and prevention program planning.[23,24] Due to this, all federal, state, territory and primary health network policies and key performance indicators around immunisation and multicultural health must match and be aligned with the broader health equity aims and objectives of the National Strategy and the Australian Cancer Plan.[2,4,13] Aligning these key priority areas across strategies has already begun in some States, as noted in the 2024–2028 New South Wales Immunisation Strategy.[5,25] This way health service actors and CALD stakeholders across sectors can work together to optimise resources and achieve the same goal.[23–25]

2.4 | Commit to sustainable participatory health promotion activities and interventions

Sustainably resource and support participatory health promotion activities and interventions

Both the National Strategy and the Australian Cancer Plan highlight the need for better co-designed, tailored and culturally safe interventions.[2,4] From our experiences, this can be achieved when research partnerships and collaborations value and respect both consumer lived experience and evidence-based approaches.[10,18,20] Research led by the first author[20] and others in Australia during COVID-19[10] highlights how this can be achieved using more participatory approaches, like participatory action research. As these types of participatory research approaches support better two-way communication and collaboration with CALD stakeholders and partners it is an ideal approach when addressing barriers related to health equity.[10,20] It is difficult to achieve the full health equity, power sharing and social justice ideals of participatory approaches though, when funding is limited, and on-the-ground personnel lack institutional support to conduct these engagements properly.[20] For better and more effective community-engaged practices, prioritising and properly resourcing workers to conduct two-way community engagements will be critical. Allocation of these resources is important at this time to help build, maintain and in some cases, regain community trust in governments and vaccination programs following COVID-19.

3 | FINAL THOUGHTS

Australia is a known world leader in the prevention of cervical cancer and the government needs to seize the opportunity to address the nation's persistent inequities around cervical cancer elimination.[3] To address these inequities for CALD communities, the government and CALD stakeholders must unite to share their knowledge and spread effective, positive health promotion messages around cervical cancer prevention. Not only could these effective and respectful intersectoral alliances influence cervical cancer prevention, but they could act as a model to support other multicultural health collaborations around other immunisation programs and cancer screening (e.g., bowel and breast screening). By implementing the recommendations above, not only will Australia continue to lead the elimination of cervical cancer as a public health problem but also make genuine and authentic contributions to reduce national CALD health inequities.

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CONFLICT OF INTEREST STATEMENT

Tanya Buchanan was a member of the Australian Centre for the Prevention of Cervical Cancer's Expert Advisory Group to the Elimination Response (EAGER). The remaining authors have no conflicts of interest to declare.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

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