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## Facilitating uptake of cervical screening among Indigenous women to achieve equitable and timely elimination of cervical cancer

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In November 2020, the World Health Organisation (WHO) launched a strategy for the global elimination of cervical cancer [1]. In order to achieve elimination, action is required on three fronts: vaccination, cervical screening, and treatment. The WHO elimination strategy sets targets to be reached by 2030 for vaccination (90% of girls), cervical screening (70% twice-lifetime using HPV testing) and treatment (90% of identified disease). Countries like Australia, with well-established screening programs and high HPV vaccine uptake, are well placed to reach elimination at the national level, but given this is a global strategy, there is particular need to ensure that targets are met and timely elimination is achieved amongst all groups within the population. In Australia, a critical disparity exists for Indigenous Australian women, who experience much higher rates of cervical cancer, primarily due to lower screening participation [2,3]. In terms of Australia's performance against the WHO 2030 targets, among Indigenous women, Australia currently meets the HPV vaccination target (although course completion is lower for Indigenous people), but does not meet the targets for screening or treatment [4]. Cervical screening coverage is substantially lower in Indigenous women than in non-Indigenous women [4], and time to clinical investigation is longer [5]. Therefore, in order to achieve equitable and timely elimination among Indigenous women in Australia, there is an urgent need to increase screening participation, including completing the whole clinical pathway.

In December 2017, Australia updated its National Cervical Screening Program from Pap testing to primary HPV screening, in-

cluding a change in screening interval (from 2 to 5 years), and screening start age (from 18–20 to 25 years of age) [6]. It was anticipated that these changes would make the program more effective, and also more equitable; firstly because women did not need to be screened as frequently, and secondly due to the new option for under- or never-screened women to be screened on a self-collected sample [6]. Understanding how the changes impacted on Indigenous women, including on their attitudes and access to screening is needed. Findings from Moxham and colleagues [7] in this issue of *The Lancet Regional Health – Western Pacific* provide important information on this topic.

Moxham and colleagues conducted qualitative interviews and focus groups with 94 Indigenous women across New South Wales, a state where approximately 33% of Indigenous peoples live [7]. The findings from Moxham and colleagues, as well as previous research with Indigenous women in Australia [8], suggest there are potential avenues to facilitate uptake of cervical screening among Indigenous women. The authors suggest the need for targeted information and education for Indigenous women about cervical screening. Due to the importance of attitudes and social norms in these communities, involving influencers such as community leaders or Elders, in both developing and delivering these messages, is essential to overcome negative attitudes towards cervical screening such as shame and fear, and limited awareness of cervical cancer risk factors. These influencer roles were important to also share the new recommendation for cervical screening including the option of self-collection.

Self-collection is an important tool which could help increase cervical screening in Indigenous women, due to increased flexibility in where screening is offered. This could help overcome the invasive nature of a speculum clinician collected sample. Moxham et al however reported that a lack of confidence in be-

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ing able to correctly administer self-collection was concerning for many women. Previous studies of self-collection among Indigenous women suggest this is likely addressable, as they report very high uptake ( $\geq 80\%$ ) of self-collection when offered in an appropriately supportive environment, and that women described it as simple, convenient, and private, as well as providing control and bodily autonomy [4]. Community-driven education about self-collection may normalize it as an option and increase women's confidence to correctly administer the test, especially as Moxham and colleagues report most women did not know about self-collection as an option but were supportive of its implementation. Recognising similar barriers to Moxham et al for engaging with under-screened and never-screened Indigenous women, a toolkit developed by the Australian Department of Health [9] outlines engagement strategies such as providing cultural safety training, a culturally safe environment, service flexibility, a choice of provider, and appropriate communication.

The recent recommendation to offer all women the option to use self-collection would also facilitate clearer and more open and elevated communication, and reduce some of the current barriers faced by women and providers [10]. Nevertheless, the findings of Moxham et al emphasise the need for appropriate support and information when self-collection is offered, not simply removal of existing barriers. This emphasises the importance of consistent support for self-collection across the entire pathway of the National Cervical Screening Program, services and health professionals. By continuing to work with Indigenous women and with Indigenous health organisations in the design and development of messaging to encourage participation in cervical screening, these strategies could be effective in ensuring the Australian targets are met for the equitable elimination of cervical cancer.

#### Declaration of Competing Interest

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#### Author contribution

RD was responsible for the conceptualization and writing of the first draft of the manuscript. All authors contributed to the writing of the final version of the manuscript.

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