

8.6 PEOPLE LIVING IN RURAL AND REMOTE AREAS: STRATEGIC PRIORITIES AND ACTIONS

Note: italicised words indicate where the action has been tailored for this population.

1. **Ensure that Australia has access to timely and accurate cervical cancer incidence and mortality data.**
 - 1.1. Review the timeliness of cervical cancer notifications from each of the state and territory cancer registers to the Australian Cancer Database (ACD) and investigate opportunities to accelerate the availability of national cervical cancer data. Aiming to have the data available for the preceding year by November 1st of each calendar year.
 - 1.2. Ensure that this accelerated reporting also includes currently reported stratifications including rates for Aboriginal and Torres Strait Islander people, *by remoteness*, by socio-economic status and by state and territory.
 - 1.3. Build on the currently available breakdowns (*which includes remoteness area of residence*) to ensure timely reporting of cancer incidence and mortality for Aboriginal and Torres Strait Islander people in all jurisdictions, people of culturally and linguistically diverse backgrounds, people with disability, people who identify as lesbian, gay, bisexual, transgender, queer, and asexual, people who are intersex, and other priority populations as these data become available.
 - 1.4. Add cancer registry data into the data assets that are included as enduring linkages in the Multi-Agency Data Integration Project (MADIP) to facilitate this. *When cancer data are included in MADIP, consider reporting on individual-level socioeconomic status, rather than area-level measures.*



Vaccination

2. **Optimise the delivery of school-based HPV immunisation programs in all jurisdictions to maximise equity and achieve high coverage for students living in rural and remote areas.**
 - 2.1 Review and revise communication planning *materials for students and families living rural and remote areas* and provide educational opportunities in schools to improve adolescent, parent, family and caregiver as well as school staff understanding of HPV vaccination and the elimination strategy. This should occur through strong partnerships between health and education to provide an integrated approach to HPV vaccination literacy that spans key learning areas, is supported by a whole-of-school approach, and fosters health literacy.²²
 - 2.2 Utilise technology to support digital reminders and put clear communication and follow-up protocols in place to ensure that the school and the consenting carer are aware when a vaccine dose has been missed and receive clear remedial instructions, including how to access *vaccination locally through services available in rural and remote areas*.
 - 2.3 Provide in-school vaccination catch up opportunities where possible. Should a single dose vaccination strategy be introduced, ensure that the implementation plan does not reduce opportunities for in-school vaccination given the reduction in required doses; and that the evidence of equal efficacy is communicated clearly to providers and the community.
 - 2.4 Fund and develop routine program processes that can identify schools with lower coverage and develop tailored solutions to improve HPV vaccination uptake, *including working in partnership with rural and remote health services, peak bodies and community*.
3. **Optimise the reach and funding of complementary out-of-school HPV immunisation programs to achieve equity in delivery for all, including people living in rural and remote areas and medically high-risk populations (catch up).**
 - 3.1. Fund and promote catch up of an individual's allocated dose of HPV vaccination for adults 19 *and over in medically higher risk groups, and for people living in rural and remote areas*.
 - 3.2. Fund and promote HPV vaccine catch up strategies *with out-of-school adolescents including those living in rural and remote areas, their peak bodies, health services and communities*. Ensure equity in availability of catch-up opportunities across jurisdictions and for the most marginalised groups, for example, adolescents in youth detention. Consider alternative community locations and providers, for example, GP clinic settings, Aboriginal Community Controlled Health Organisations, pharmacies, and community events. Develop workforce strategies to expand reach, for example, *collaboration with the Royal Flying Doctors Service of Australia*.
 - 3.3. Implement GP and *rural and remote health care provider* education, training and quality improvement activities relating to immunisation that support routine use of the Australian Immunisation Register (AIR) data to check HPV vaccination status for all patients aged 14-19 years, address vaccine hesitancy, and assess decision-making capacity among vaccine recipients for the decision to vaccinate.

4. Develop a method to enable annual reporting of HPV vaccination coverage for *people living in rural and remote areas* and medically high-risk populations to monitor equity in immunisation.

- 4.1. Leverage data linkage through the MADIP, to monitor engagement, elimination progress and outcomes for priority populations, using demographic and other variables to define priority populations and medically higher risk groups within the linked dataset.

5. Promote cervical screening regularly with the public and strategically with under-screened groups.

- 5.1. Undertake regular targeted tailored campaigns and activities for under-screened groups *including rural and remote communities* complemented by evidence-based, inclusive population-wide public awareness activities and mass media delivered through appropriate channels²³.
- 5.2. Work with priority communities, *including rural and remote communities*, including respected members, cervical cancer survivors, and community-controlled organisations who serve these communities, to co-create, design and test best approaches to reach the community, including the content of campaigns and information materials. Ensure campaigns are informed by the success and implementation strategies from previous campaigns and formative research, noting that materials may need to enhance community health literacy about HPV and cancer of the cervix.
- 5.3. Trial and utilise technology to support digital invitations, reminders and navigation to follow-up activities for people with screening results that require further investigation.

6. Increase access to screening, colposcopy and follow-up *in rural and remote areas* by expanding who can offer these services, and where and how they are offered, to improve reach and uptake.

- 6.1. Provide a clear pathway to enable appropriately trained registered nurses, Aboriginal Health Workers and Practitioners, and midwives to independently request and sign the pathology form for a cervical screening test (and be eligible for Medicare reimbursement).
- 6.2. Establish a clear national pathway to train and accredit registered nurses, GPs and Aboriginal Health Practitioners to provide colposcopy.
- 6.3. Resource a pilot to scale up point-of-care HPV testing, with links to care, *for remote communities (see Screening Case Study 2 (The PREVENT Project) for example)*.
- 6.4. Resource pilots *in rural and remote communities* and, where successful, resource scale-up and routine provision of innovative screening and follow-up care models such as peer-led and community-developed services, *and innovative ways of providing and delivering colposcopy*. Work with community-controlled organisations *and key healthcare providers in rural and remote regions, such as the Royal Flying Doctors Service, to develop models for screening and follow-up services (for example point of care, mobile, or other approaches)*, scale up successful models, and share best practice approaches.

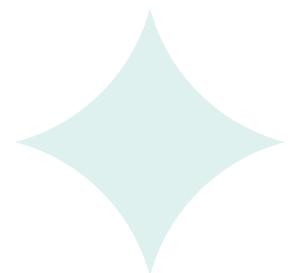
7. Collect, use, and release data to enable and monitor equity of access to cervical screening and precancer treatment services *for people living in rural and remote areas.*

- 7.1. Routinely report all program indicators stratified by key population demographics, expand reporting to include all priority populations, and introduce routine monitoring of performance against the WHO precancer treatment indicator.
- 7.2. Promote the importance of data collection, training all staff to collect demographic data sensitively in order to improve the recording of all demographic fields (Aboriginal and/or Torres Strait Islander status, country of birth, gender), including additional fields not yet captured on the National Cancer Screening Register (NCSR) and information that affects clinical management such as immune status.
- 7.3. Enhance clinical information systems in primary health care settings to enable automated uploading for relevant demographic information to integrate with NCSR.
- 7.4. Add cancer registry data and screening data from the NCSR into the data assets that are included as enduring linkages in the MADIP.
- 7.5. Enable clinicians and healthcare services to readily generate reports that can support continuous quality improvement initiatives by identifying patients who are under-screened and indicate current participation rates to inform efforts that drive engagement.
- 7.6. Provide visibility to primary care providers of current waiting times for colposcopy services, so that this can be factored into referrals and improve timeliness of care *for people living in rural and remote areas.*

Treatment

8. Ensure communities and patients have equitable access to quality information about cervical cancer symptoms and that each cancer patient has tailored information about their diagnosis, intended treatment and planned optimal care pathway.

- 8.1. Promote public understanding of cervical cancer signs and symptoms, the role of early detection and the opportunity for elimination, including campaigns and activities specifically focussed on and designed by *people living in rural and remote areas.*²⁴
- 8.2. Provide information, consultation and support (for example, utilising the expertise of nurses and allied health professionals) *allowing rural and remote* patients and their families/carers to fully understand and contribute their own preferences and needs to their individual care pathway.
- 8.3. Provide *rural and remote patients* with the information, access to financial support and support personnel they need to navigate the health system, including informing them that they can have a person/people of their choice accompanying them whenever needed.
- 8.4. Enable incremental improvement by conducting routine patient-related evaluation measures (PREMs) to assess patient satisfaction, feeding results back to shape training and development of personnel, patient information materials and health service systems as appropriate. Ensure information collected captures patient diversity and experiences according to their sex, gender and sexual orientation, ethnicity, Aboriginal and Torres Strait Islander, and disability status. Ensure this information accords to national standards for data collection.



9. Develop and implement a road map of coordinated care, with communities of practice, to optimise the delivery of safe, quality care to all patients.

- 9.1. Realise a coordinated approach to patient care from diagnosis to survivorship and palliative care that is tailored to local population needs and diversity. This includes: identifying and meeting the training and resourcing needs of key professionals (including but not limited to ensuring access to culturally safe services and a supportive workforce for Aboriginal and Torres Strait Islander peoples; inclusive and accessible care for those with disability; in-language culturally relevant resources and provision of care for culturally and linguistically diverse communities and; sex, gender and identity-sensitive services and care for LGBTQ+ people *who live in rural and remote areas*).
- 9.2. Establish communities of practice, where multidisciplinary teams oversee processes and standards of care, and take responsibility for actively building relationships within and across jurisdictions. This can enable a level of safety and trust when a patient is required to travel to receive quality care. Tertiary centres should actively nurture relationships with services expert in caring for priority populations (for example, Aboriginal and Torres Strait Islander Community Controlled Health Organisations) *located within rural and remote areas*.
- 9.3. Optimise a hub-and-spoke model ensuring continuity of care for those diagnosed with cervical cancer to bring “quality to patients” where possible (for example palliative care) and “patients to quality” where necessary for highly specialist care (for example brachytherapy). Noting that palliative care services should be integrated into all levels of health care systems including primary care, *especially to those living in rural and remote areas*.
- 9.4. Identify and leverage quick wins by translating successful service models to new jurisdictions and ensure longer-term solutions that may require policy change or workforce reforms. Consider models aimed at addressing workforce issues, such as building an additional supportive role for gynaecologic nurses. Genuine partnership with priority populations and communities will improve the provision of culturally safe care and enhance access to treatment.

10. Drive improvements in cervical cancer management through a data collection framework supporting systematic monitoring and enhancement of the quality of care, in alignment with the Australian Cancer Plan.

- 10.1. Enhance and harness the data collected in the National Gynaecological Oncology Registry (NGOR) cervical cancer module to inform continuous improvement in care *for rural and remote patients* (equity of access, quality, and safety) based on incidence, stage, and mortality data, key clinical quality indicators, as well as patient reported evaluation and outcome measures (PROMs).
- 10.2. Conduct annual cervical cancer audits using data from the NSCR, cancer registries and NGOR together with HPV genotype information determined and reported for all cervical cancers
- 10.3. Consolidate current clinical guidance and quality standards through developing national guidelines for the management of cervical cancer and utilise the NGOR to monitor adherence.

