Can we better meet the healthcare needs of Aboriginal and Torres Strait Islander women?

Listening and responding to women will improve cervical screening and other women's health programs

When asked about features of women's health services that would best meet their needs, specific groups of Aboriginal and Torres Strait Islander women, despite their diversity, have given very similar responses.[1-3] They want women's healthcare that takes a holistic rather than a narrow "single-disease" or biomedical approach; services that are accessible, flexible and supportive; and providers they can trust, who are respectful and who can communicate well. For many Aboriginal and Torres Strait Islander women, having access to a female provider is critical to their acceptance of women's healthcare services.

The higher cervical cancer incidence and mortality for Aboriginal and Torres Strait Islander women compared with other women, and the available evidence about screening effectiveness, provide a strong imperative for healthcare providers and funders to listen carefully and respond to what women say they want.[4] The article by Coory and colleagues in this issue of the Journal (*page* 544) quantifies and compares women's participation in cervical screening by analysing data from the Queensland Health Pap Smear Registry.[5] Participation for women living in rural and remote Aboriginal and Torres Strait Islander communities in Queensland was generally lower than for women living in other areas. Proportions of women in these communities who had had a Pap smear over a two-year period ranged from 19% to 63%. These results suggest women's needs for women's health services are being better met in some communities than others.

In interpreting their analysis, Coory et al used residence in a community where most people were Aboriginal and/or Torres Strait Islander as a proxy for Indigenous status. We believe this is a resourceful and reasonably valid way around Indigenous status not being identified on the Pap smear register. However, one limitation is that we can learn nothing about Aboriginal and Torres Strait Islander women living in other localities (ie, the majority of Aboriginal and Torres Strait Islander women in both Queensland and Australia more generally). It is important that the needs of these women are not neglected because of the lack of quantitative data with which to measure them.

We commend the researchers for acknowledging the sensitivities of identifying data from individual Aboriginal and Torres Strait Islander communities in their research. However, rather than only obtaining permission to do so from a government department, we believe consulting directly with members of the communities concerned at an early stage of the project may have been beneficial. Although such a practice is uncommon in this type of research, and may be challenging and more time-consuming, it may also create or strengthen trust, links and understanding, which could be useful when implementing and evaluating subsequent interventions.

Coory et al suggest that the higher cervical screening participation rates in some communities are an indication of what is achievable, and express support for a strategy of strengthening primary health care. We agree with these conclusions, but disagree that an intervention study where communities are randomised would be an ideal next step. Although randomised-community intervention trials have been implemented in other settings,[6] for Aboriginal and Torres Strait Islander communities the barriers to delivery of women's health services are likely to be highly location-specific and the means to overcome them not amenable to random allocation. We believe any available resources would be better spent on (i) exploring in more detail the factors contributing to high and low levels of participation, and (ii) responding actively to identified issues in communities with lower levels of participation.

Barriers to Aboriginal and Torres Strait Islander women accessing women's cancer screening services, and ways of responding to them, have been reviewed — most recently in the context of considering how to support the roles of general practitioners.[1,4] We would like to highlight the need to also support the roles of Aboriginal Health Workers (AHWs). Because of their key role in providing primary health care for Aboriginal and Torres Strait Islander people, the need for improved clarity, recognition and support of AHW roles has been identified as a national priority.[7] We have worked with many female AHWs who have had personal experience of the impact of cervical cancer on Aboriginal and Torres Strait Islander women and their communities, and are keen to be involved in women's health education and promotion activities. Some AHWs also want to provide women's clinical care, including taking Pap smears. Some of the specific areas needing attention are the provision of better training for AHWs in women's health, and issues of accreditation, legal cover and quality assurance for those wanting to take Pap smears.

Finally, we urge caution about evaluating cervical screening programs solely on the basis of participation rates. Recent commentaries have begun to question a primary aim for screening programs of maximising participation, arguing that this may lead to the positive effects of screening being overstated, and the limitations and possible negative effects of screening and its sequelae being ignored or downplayed.[8,9] These commentators acknowledge that providing more balanced information about screening may have a negative impact on participation rates, but stress the importance of individuals being informed about screening and being able to choose for themselves whether or not to participate.[8]

Qualitative research conducted with women in one rural Aboriginal community with high rates of participation in cervical screening found that many of the women had little understanding of cervical screening or its implications.[10] For programs successful in terms of participation, questions may remain about the extent to which women are making an informed choice about screening. In many localities, providers' attempts to consistently give adequate information to Aboriginal and Torres Strait Islander women can be constrained by many factors, including lack of time, and language and cultural differences. These barriers, combined with a high level of concern about cervical cancer and evaluation criteria based mainly on participation rates, may lead to an emphasis on persuading women to have a Pap smear rather than on providing information and an opportunity for informed choice. We strongly advocate that evaluators of cervical screening programs take into account not only participation rates, but also Aboriginal and Torres Strait Islander women's views about available health services and their understanding of screening-related issues.

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