

Addressing patterns of
care and unwarranted
variations in cancer care
for culturally and
linguistically diverse
communities:
A rapid review of the
current evidence

NEMICS, November 2025



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Executive summary

Background

In Australia (and specifically Victoria), people from culturally and linguistically diverse (CALD) backgrounds face substantial disparities in cancer care. These include poorer outcomes, lower participation in screening programs, and barriers to accessing services due to language difficulties, limited health literacy, and cultural misunderstandings. “Unwarranted variation” in this context refers to differences in care that cannot be explained by illness severity or patient preferences, pointing to avoidable inequities in quality and equity of care. Addressing these systemic issues through culturally appropriate, accessible, evidence-based approaches could improve health equity, system efficiency, and overall quality of cancer care.

Aim

To explore the known patterns of care cancer for CALD adults diagnosed with breast, colorectal, lung or prostate cancer and what strategies have been used to determine and address unwarranted variations for cancer care for CALD communities in Australia.

Methodology

A rapid literature search (conducted 25 August 2025) followed PRISMA guidelines, targeting PubMed (MEDLINE) and Embase for original, empirical research in English, published from 2018 onward, focused on CALD adult populations in Australia with breast, colorectal, lung or prostate cancer. Excluded were non-empirical studies, case reports, protocols, abstracts without full text, conference abstracts, editorials, letters, and opinion pieces. Reference lists from included studies were also scanned for additional relevant work.

Findings

The search yielded 150 studies, of which 72 were screened in full. A total of 29 studies met the inclusion criteria, including two from the grey literature and two identified through hand searching. These studies were summarised in a table with the following details: first author, year, state/national focus, study design and duration, objectives, participant number (N), outcomes/results, and key findings.

Approximately a third of the included studies (34.4%, $n = 10$) were qualitative analyses. The largest proportion of studies (44.8%, $n = 13$) examined patterns of care related to prevention and early diagnosis (Step 1 of the Optimal Care Pathway (OCP) framework) in particular detecting cancer in its early stages to improve outcomes. Notably, none of the included studies examined end-of-life care for CALD individuals diagnosed with breast, colorectal, lung or prostate cancer. Variation in care were frequently observed across screening participation and early detection, diagnostic pathways and risk stratification, access to guideline-concordant treatment, and survivorship care and coordination.

No studies that focused on CALD patients diagnosed with breast, colorectal, lung, or prostate cancer applied a formal framework to categorise unwarranted variation in care. Although Wennberg’s classification is frequently cited in the broader literature and used in other cancer types, it was not adopted in the studies included in this review. Most research relied on statistical approaches to identify variation and proposed potential strategies, but few explicitly defined what constituted “unwarranted” variation. This lack of consensus limited the ability to distinguish acceptable differences in care from those reflecting inequity.

Evidence on the effectiveness of strategies to address variation was also limited, and no study definitively labelled variations as unwarranted.

Conclusion

This review underscores critical gaps in the Australian evidence base on unwarranted variation in the care of CALD patients diagnosed with breast, colorectal, lung, or prostate cancer. While existing studies describe patterns of care and highlight variation by clinical factors, few explicitly define or categorise such variation as unwarranted. The absence of a CALD-specific Optimal Care Pathway or CALD considerations in existing Optimal Care Pathways and a consistent framework for identifying unwarranted variation, such as Wennberg's, constrains the ability to distinguish acceptable differences from those requiring intervention. Notably, no studies examined end-of-life care or evaluated the effectiveness of strategies aimed at reducing variation for CALD communities. Closing these gaps is vital to inform equity-focused improvements in cancer care for CALD communities and to guide the development of targeted, data-driven quality improvement initiatives within the Australian health system.

Abbreviations

Abbreviation	Definition
BCS	Breast cancer screening
BR	Breast reconstruction
CALD	Culturally and Linguistically Diverse
CRC	Colorectal cancer
FOBT	faecal occult blood test
GP	General practitioner
LEP	limited English proficient
MDT	Multidisciplinary team
NBCSP	National Bowel Cancer Screening Program
NEMICS	North Eastern Melbourne Integrated Cancer Service
NESB	Non-English-speaking background
NLCSP	National Lung Cancer Screening Program
OCP	Optimal Care Pathways
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
PSA	Prostate-Specific Antigen
VICS	Victorian Integrated Cancer Services

1. Introduction

Australia is home to approximately 8.6 million migrants, representing 31.5% of the population, with people originating from more than 190 countries.[1] In Victoria, individuals born in non-English-speaking countries account for an estimated 25% of all cancer cases.[2] The most common solid cancers diagnosed in Victoria are those of the prostate (16%), breast (13%), colorectal (CRC) (10%), and lung (9%), which together accounted for 48% of all new cancer diagnoses in 2023.[3] For people from culturally and linguistically diverse (CALD) backgrounds, patterns of incidence, screening participation, and survival across these cancers often differ from the non-CALD population, reflecting both variations in risk factor profiles and inequities in access to prevention, early detection, and treatment services.[4]

Evidence indicates that CALD communities experience disparities in accessing equitable and appropriate cancer care [5, 6] A thematic analysis of responses to the 2023 Cancer Patient Experience Survey by Victorians who received admitted cancer care in 2022 and self-identified as speaking a language other than English at home highlighted key aspects of these disparities, including the importance of clear communication, provision of information, timeliness of care, and receiving empathy and support from staff throughout all phases of care.[7] Recognising such inequities, both the Australian Cancer Plan and the Victorian Cancer Plan 2024–2028 identify CALD communities as a priority population, underscoring the need for cancer services to adapt to cultural diversity and ensure equity of outcomes.[8, 9]

There is no single, universally accepted definition of CALD. The Australian Bureau of Statistics applies a range of indicators including country of birth, ancestry, language spoken, English proficiency, year of arrival, parents' country of birth, and religious affiliation, to describe CALD status.[10] Broadly, definitions fall into two categories: cultural conceptualisations, which emphasise identity, community ties, and lived experience; and epidemiological approaches, which use measurable indicators that can be applied consistently in research.[11] In epidemiological research, CALD communities are commonly defined as individuals born in non-English-speaking countries and/or those who do not speak English at home.[11] These factors shape cancer risk profiles, influence access to health and social services, and contribute to disparities in health outcomes.[5] A recent retrospective study indicates that one in three CALD patients receiving cancer care in Australia experience at least one safety event with medication-related incidents representing a substantial concern.[12]

Disparities in cancer outcomes are evident for CALD communities in Australia, including differences in mortality and survival.[13] Tumour specific optimal care pathways (OCPs) have not fully addressed these equity gaps. One study indicated that CALD patients are more likely to present with advanced disease for certain cancers.[14] For example, a Victorian study reported that, after adjusting for sociodemographic factors, individuals from CALD backgrounds, particularly non-English speaking groups had higher odds of being diagnosed with high-risk, (regional or metastatic) prostate cancer compared with non-CALD individuals.[14] These findings point to inequities in pathways to diagnosis and access to timely care.[14]

Population-based analyses of cancer incidence by country of birth show that many migrant groups have lower rates of colorectal, breast, and prostate cancers than non-CALD residents.[4] The lowest incidence of CRC was observed among males born in Central America (IRR = 0.46, 95% CI 0.29–0.74) and females born in Central Asia (IRR = 0.38, 95% CI 0.23–0.64).[4] Prostate cancer incidence was lowest among males born in North-

east Asia (IRR = 0.40, 95% CI 0.38–0.43), while breast cancer incidence was lowest among females born in Central Asia (IRR = 0.55, 95% CI 0.43–0.70).[4] In contrast, lung cancer incidence was higher in several migrant groups compared with the non-CALD population.[4] The highest rates were observed among people born in Melanesia (males: IRR = 1.39, 95% CI 1.10–1.76; females: IRR = 1.40, 95% CI 1.10–1.78).[4] These findings suggest that patterns of cancer incidence among CALD communities in Australia vary by both cancer type and country of origin, highlighting the need for tailored cancer prevention and screening strategies. Such variation may reflect differences in lifestyle risk factors, cultural practices, migration history, and access to or uptake of screening services.[4]

Screening participation is critical for reducing late-stage disease and improving survival.[3] Despite the existence of national breast and bowel cancer screening programs, people from CALD backgrounds remain underserved, with participation rates of 31% for colorectal and 50% for breast screening, substantially lower than the national averages of 40% and 56.7%, respectively.[15–17] These disparities contribute to delayed diagnoses, poorer treatment outcomes, and reduced quality of life. Currently there are population-based screening tests or national screening programs for breast and CRC. Despite the benefits of cancer screening, people from CALD backgrounds have been consistently reported as an underserved group in cancer screening programs whose participation rates in CRC screening and mammograms are 31% and 50% respectively.[15] In 2023 this was significantly lower than the general population 40% (CRC screening) [16] and 56.7% (mammograms).[17] These disparities are particularly concerning, as CALD communities often experience delayed cancer diagnoses, which adversely affect treatment outcomes and result in poor quality of life.[18]

The launch of Australia's National Lung Cancer Screening Program (NLCSP) in July 2025 presents an opportunity to address these inequities from the outset. Cancer Australia and the Department of Health and Aged Care have emphasised the importance of co-design, culturally tailored resources, interpreter use, and community partnerships to ensure equitable access.[19] Key strategies include translating information into multiple languages, partnering with community leaders, and offering support through multicultural health workers and services.[19]

Equity in cancer care remains a national priority; however, research on the unmet supportive care needs of CALD cancer survivors in Australia is limited.[20] Existing studies are often constrained by low response rates, small sample sizes, and measurement issues, limiting their generalisability.[21] Furthermore, reliance on interpreter services alone is insufficient, as barriers extend beyond language to include cultural beliefs, systemic inequities, and structural constraints within healthcare delivery.[22] Equity in cancer care is a critical priority, yet research on the unmet supportive care needs of CALD cancer survivors in Australia remains limited.[20] Existing studies have been constrained by methodological challenges, including low response rates, small sample sizes, and survey tools prone to floor effects, limiting the reliability and generalisability of findings.[21] Moreover, reliance on interpreter services alone has been shown to be insufficient in addressing survivors' needs, as barriers extend beyond language to include cultural beliefs, systemic inequities, and structural barriers within healthcare delivery.[22]

To address these challenges, the Australian Cancer Plan (2023) and the Victorian Cancer Plan 2024–2028 emphasise improving outcomes for all Australians, including CALD communities, through consistent, evidence-based care across the cancer continuum.[19] The OCPs are central to this effort; however, no CALD-specific OCP currently exists, leaving a critical gap that risks perpetuating inequities in access, treatment quality, and outcomes.

Unwarranted variation in cancer care among CALD patients reflects a complex interplay of individual, organisational, and systemic factors. Individual factors include differences in health literacy, language proficiency, and cultural health beliefs; organisational factors include limited access to culturally competent staff, interpreters, translated resources, and coordinated multidisciplinary care; and systemic factors include the absence of CALD-specific frameworks and uneven healthcare resource distribution. These combined factors contribute to later-stage diagnoses, treatment delays, and poorer survival outcomes. Recognising these inequities, the first population-based cancer summit in Victoria, led by the Victorian Integrated Cancer Services (VICS) Optimal Care Summits Program, will be held in February 2026 with a focus on CALD communities diagnosed with breast, colorectal, lung or prostate cancers. Through a state-wide, mixed-methods consultation process (Figure 1) guided by an expert advisory group, the summit will analyse data from 2018–2023 to identify unwarranted variations in care and prioritise strategies to improve outcomes and experiences for CALD Victorians. For this review, unwarranted variation refers to differences in care not explained by illness severity or patient preferences, highlighting opportunities to improve both quality and equity in cancer care.[23]

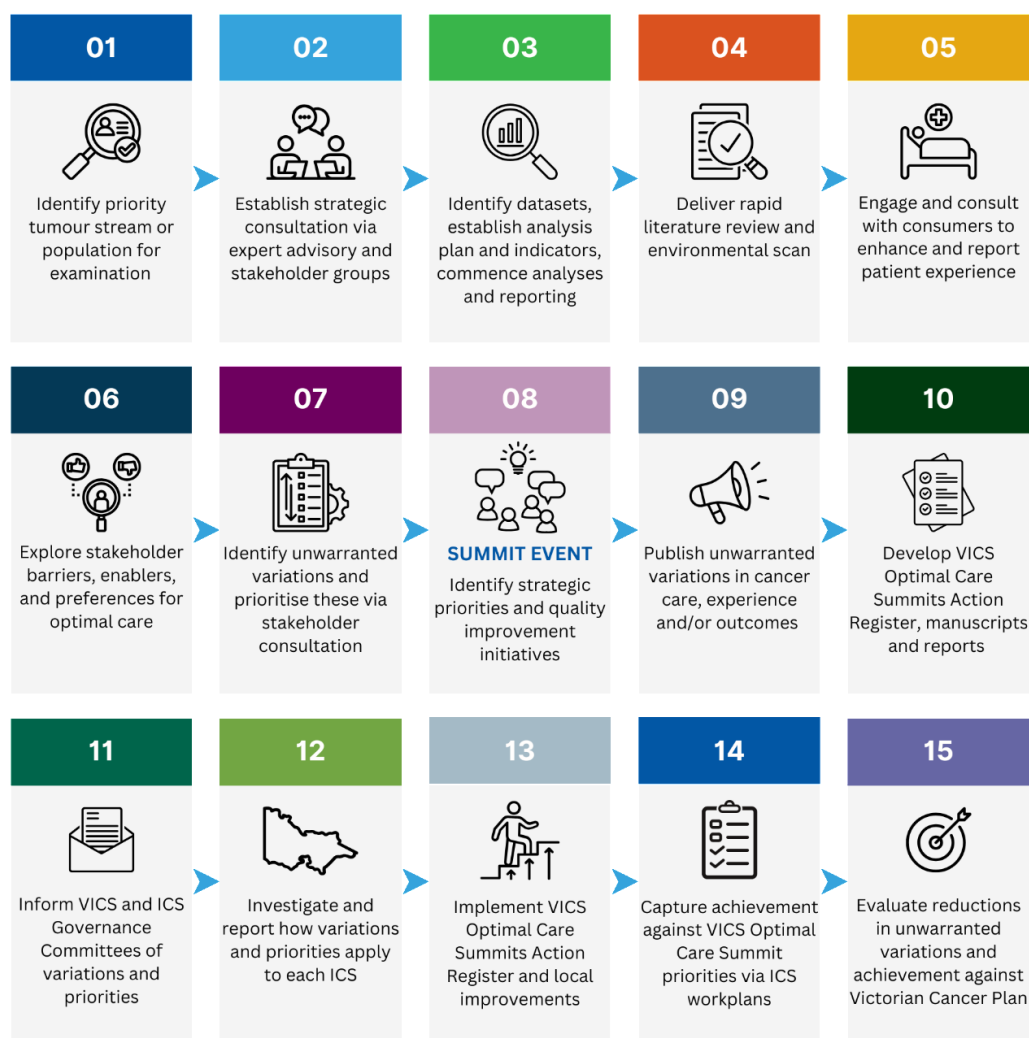


Figure 1. Steps undertaken pre and post of a VICS cancer summit event

2. Aim

This rapid literature review aims to assist the work of the 2026 summit event by synthesising the current empirical evidence published from 2018 onwards (aligned with the timeframe used for the accompanying quantitative analysis of linked administrative datasets) on unwarranted variations and patterns of cancer care for CALD adults diagnosed with breast, colorectal, lung, or prostate cancer in Australian healthcare settings for the following questions:

1. What are the known patterns of care for CALD adults diagnosed with breast, colorectal, lung, or prostate cancer in Australia?
2. What approaches or strategies have been used to (a) identify/determine unwarranted variation, and/or (b) address unwarranted variation in care for CALD communities diagnosed with breast, colorectal, lung or prostate cancer in Australia?
3. What are the implications for addressing unwarranted variation for those diagnosed with breast, colorectal, lung or prostate cancer in an Australian CALD care context?

3. Methods

A search of databases including PubMed (MEDLINE) and Embase was conducted. The search was limited to contemporary literature (2018 onwards), published in English with a focus on any CALD specific care improvements occurring in Australia specific to breast, colorectal, lung or prostate cancer. Population descriptors included: “culturally and linguistically diverse”, CALD, migrant, refugee, ethnic*, cultural*, linguistic*, non-English speaking, language barrier.

Grey literature searches were conducted through targeted internet searches of the following relevant websites:

- Cancer Australia, Victorian Department of Health, Cancer Council Victoria, Victorian Cancer Registry, Cancer Institute NSW, Cancer, SA/WA Health cancer services.
- Centre for Culture, Ethnicity and Health and Federation of Ethnic Communities Council of Australia.
- National Health and Medical Research Council reports, Sax Institute, Health Translation SA/Vic NHMRC centres.
- Trove (reports), Open Access repositories (e.g., University of Melbourne, Monash) using “institutional repository” searches as well as the keywords and date limits. Example query: "culturally and linguistically diverse" AND Australia AND ("breast cancer" OR "colorectal cancer" OR "lung cancer" OR "prostate cancer").

Web search engines such as Google/Google scholar were also used for searching grey literature using a simplified search string, limited by date (2018–present) and were applied as follows: ("culturally and linguistically diverse" OR CALD OR migrant OR refugee OR "ethnic minority" OR "non-English speaking" OR "language barrier")

AND Australia

AND ("breast cancer" OR "colorectal cancer" OR "bowel cancer" OR "lung cancer" OR "prostate cancer")

Google Scholar’s filter will be applied for relevant information such as “Since 2018” and Google’s advanced search to restrict file types (e.g., PDF, DOC) and sites (.gov.au, .edu.au).

A search of ProQuest Dissertations & Theses Global was undertaken for relevant theses with Australian data as well as manual hand searching of reference lists of included studies. The review was undertaken using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines.[24] The search strategy is presented in Table 1.

3.1 Eligibility criteria

3.1.1 Inclusion criteria

- *Population:* CALD adults (18 years and older) diagnosed with breast, colorectal, prostate and or lung cancer. CALD definition: those born in a non-English speaking country, those who speak a language other than English at home.
- *Types of publication:* Publications in English language that report original primary empirical work published since 2018 and are specific to Australian settings only.
- *Types of settings:* Public or private hospitals, general practice or other primary/community care facilities specific to Australian settings.
- *Types of study design:* Conceptual, theoretical, quantitative or qualitative studies of any research design.
- *Outcomes:* In the absence of an OCP, studies must include at least one of: diagnosis of cancer, participation in cancer care, access to cancer services, cancer treatment patterns or adherence, survivorship outcomes, patient safety, or policy recommendations relevant to cancer care.
- *Data focus:* Must include the identification and/or assessment of unwarranted variation in relation to any health care outcome specific to CALD communities diagnosed with breast, colorectal (bowel), prostate and or lung cancer.

3.1.2 Exclusion criteria

Non-empirical literature such as opinion pieces, narratives, systematic reviews, descriptions of protocols for clinical trials, study protocols, abstracts with no available full-text, case reports, conference abstracts, studies conducted outside Australia or published in a language other than English, studies focusing on children ≤ 17 years, letters to journal editors and editorials.

3.2 Data extraction and synthesis

After the inclusion criteria was applied to titles and abstracts (including executive summaries of grey literature), full manuscripts were reviewed using Covidence, a systematic review workflow management system.[25] The following data were extracted: first author, year, state/national, study design/duration, objective(s), participants (n), outcomes/results, and key findings.

Findings were analysed using a narrative empirical synthesis, conducted in stages based on the review questions. Despite the absence of a specific OCP for CALD communities in Australia, the existing OCPs for various cancer types were used as a framework to analyse and categorise the initial descriptions of eligible studies and results. Initial descriptions and results of the eligible studies were summarised and presented (Tables 2 to 7) and structured according to the seven-steps of the OCP.[26] Patterns across the data were explored to identify consistent findings in relation to the study questions. Interrogation of the findings explored the influence on different outcome measures, methods, and settings on the resulting data.

4. Results

4.1 Results of the search

The search identified 150 studies, with 72 undergoing full-text screening. Of these, 29 met the inclusion criteria, including two from grey literature and two located through hand searching (Figure 2). The included studies were summarised into tables detailing the first author, year, geographic focus (state or national), study design and duration, objectives, sample size (N), outcomes or results, and key findings (Tables 2 to 7).

In the absence of a formal Optimal Care Pathway specific to CALD communities, nearly half of the included studies (44.8%, $n = 13$) focused on Step 1: *Prevention and early detection*. Four studies each (13.8%) addressed Step 4: *Treatment* and Step 5: *Care after initial treatment and recovery*. Step 2: *Presentation, initial investigations and referral* and Step 3: *Diagnosis, staging and treatment planning* were each addressed by two studies (6.9%). Only one study (3.4%) addressed Step 6: *Managing recurrent, residual or metastatic disease*. No studies were identified that focused on Step 7: *End-of-life care*. Most studies were conducted across three Australian states: New South Wales ($n = 15$), Victoria ($n = 11$) and Western Australia ($n = 1$). Two studies were conducted across multiple states.

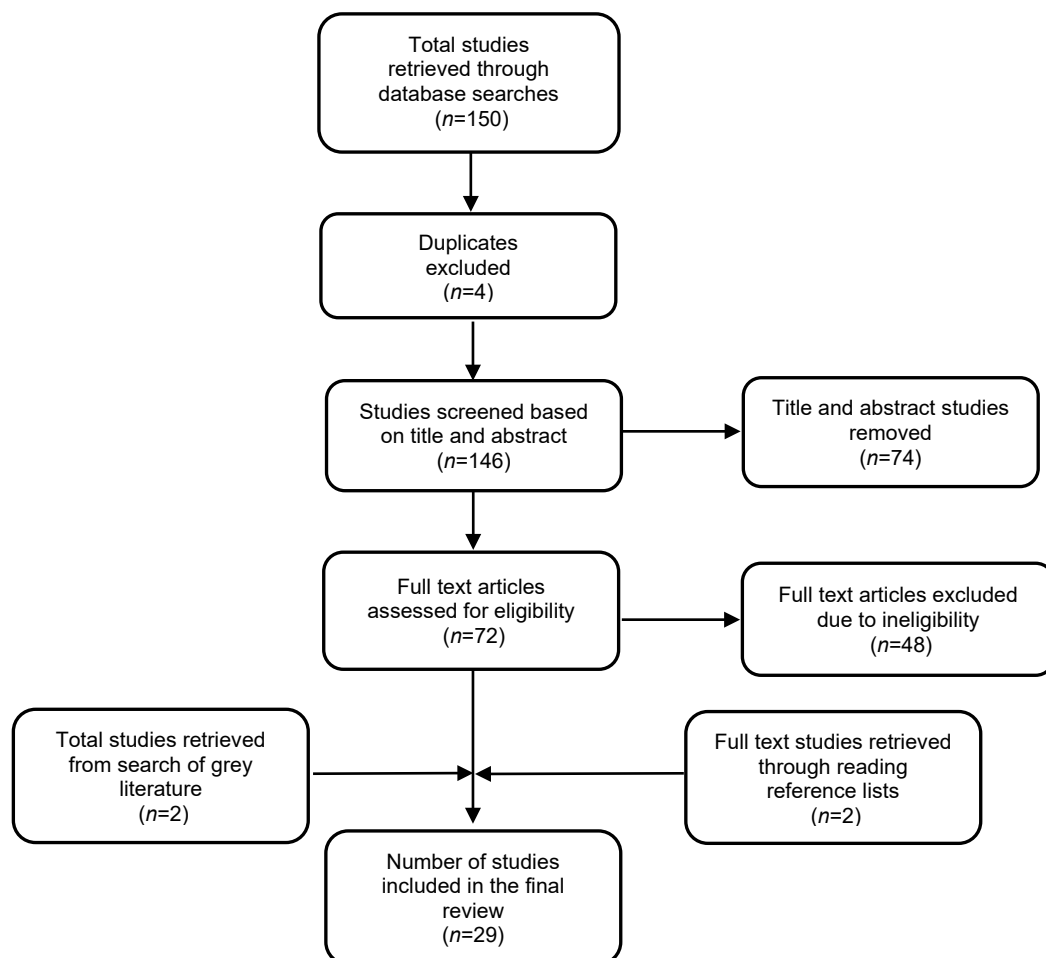


Figure 2. Flow diagram showing the selection process

4.2 Review findings

4.2.1 What are the known patterns of care for CALD adults diagnosed with breast, colorectal, lung, or prostate cancer in Australia?

Patterns of care for CALD communities with cancer in Australia show significant disparities, particularly for common cancers like breast, colorectal, lung, and prostate.[4] These patterns are influenced by systemic barriers such as language barriers and low health literacy, leading to lower health outcomes.[4] While Cancer Australia provides culturally appropriate resources and emphasises the need for interpreter services and culturally competent care, ongoing challenges persist, requiring improved data collection and targeted health strategies.[8]

Breast cancer

Women from CALD backgrounds consistently participate in breast screening at lower rates than the general population, with mammographic screening uptake at around 50% compared with 56–58% among non-CALD women.[27] This reduced participation contributes to later-stage presentation at diagnosis, reflecting barriers such as limited health literacy, language difficulties, and cultural beliefs about cancer.[28] Treatment patterns also show disparities, with some evidence of delayed initiation and lower use of breast-conserving surgery compared with non-CALD women.[28] Supportive care and survivorship outcomes further highlight inequities, as CALD women report higher unmet supportive care needs and lower utilisation of psychosocial support services due to stigma and limited culturally appropriate referral pathways.[29]

Migration appears to influence incidence patterns.[30] Epidemiological evidence indicates that a woman's risk of developing breast cancer increases following migration from low-risk to higher-risk countries.[30] For example, studies have shown breast cancer incidence to be more than twice as high among Japanese-American women compared to women in Japan,[31] with similar trends observed in Chinese women migrating to Australia.[32] This underscores the importance of promoting breast cancer screening among migrant women in Australia, particularly given that later diagnosis leads to more intensive treatment and poorer survival outcomes.[30]

Colorectal cancer

CALD communities also experience inequities in CRC care. Participation in the National Bowel Cancer Screening Program is lower among CALD groups (31%) compared with the general population (40%),[16] leading to potentially later-stage diagnoses and poorer outcomes.[16] Studies suggest that CALD patients are less likely to receive guideline-concordant treatment and multidisciplinary care, contributing to variations in treatment quality and timeliness.[28] Support care and survivorship experiences highlight ongoing gaps, with CALD patients reporting unmet needs around follow-up care, culturally tailored dietary advice, and health system navigation.[28]

Lung cancer

Although Australia's National Lung Cancer Screening Program has only recently started in July 2025,[19] CALD communities are already recognised as at risk of low participation, given persistent barriers observed in other screening programs. Existing evidence indicates that CALD patients are more likely to present with advanced-stage lung cancer, reflecting help-seeking delays, stigma, and miscommunication in primary care.[33] Treatment disparities are also apparent, with lower use of systemic therapies and reduced participation

in clinical trials.[33] In addition, there are reported communication challenges that limit shared decision-making.[33] In survivorship and end-of-life care, CALD lung cancer patients are less likely to use palliative care services, which may indicate the impact of cultural beliefs and gaps in culturally competent service provision.[27]

Broader evidence indicates that lung cancer detection relies heavily on symptom recognition and timely, cost-effective screening for high-risk groups.[33] CALD communities, including older adults, those with smoking or alcohol use histories, and those with limited English proficiency, face particular risks of delayed diagnosis and treatment.[33] These delays, whether due to patient-level factors (missed symptoms) or professional barriers (waiting times for diagnostic testing), have negative consequences on outcomes, such as poorer psychological wellbeing and quality of life.[33] Timely care is therefore a critical quality dimension in lung cancer management for CALD communities.[33]

Prostate cancer

Evidence on prostate cancer outcomes among CALD men is more limited but indicates consistent inequities. CALD men are less likely to engage in opportunistic Prostate-Specific Antigen (PSA) testing or prostate checks, partly due to cultural stigma and lower awareness.[34] Population studies report that CALD men are diagnosed with more advanced disease and are less likely to receive active surveillance or surgical management compared with non-CALD counterparts.[35] Supportive care and survivorship data highlights significant unmet needs, particularly around sexual and psychological health, which are often compounded by cultural sensitivities and reluctance to disclose symptoms.[35]

Diagnostic timeliness is a particular challenge. Recent Victorian registry published data suggest that men born in predominantly non-English-speaking countries present with more advanced prostate cancer than men born in mainly English-speaking countries.[14] These findings point to later presentation with symptoms and lower engagement in diagnostic follow-up, reinforcing systemic gaps that contribute to worse outcomes.[14] Such delays reduce survival, particularly for prostate cancer where stage at diagnosis is critical to prognosis.[36]

While Australia has not implemented an organised, population-based prostate cancer screening program, opportunistic early detection by Prostate-Specific Antigen (PSA) testing is supported by a world-first evidence-based multi-disciplinary early detection clinical guidelines. Originally developed in 2016, a recent update released in draft form in April 2025, proposes a shift towards individualised risk assessment. These new guidelines recommend offering a baseline PSA test to men at age 40 and initiating two-yearly discussions about PSA testing for men aged 50–69. This approach prioritises shared decision-making between patients and their doctors, acknowledging the benefits of early detection while also addressing the potential harms of treatment for slow-growing cancers.[37]

4.2.1.1 OCP Step 1: Prevention and early detection

- **Participation in National Screening Programs – Breast, Colorectal and Lung**

Across 14 Australian studies [15, 29, 30, 38-48], patients from CALD backgrounds consistently demonstrated lower participation in breast and colorectal cancer screening compared with non-CALD populations. Barriers to participation were multifactorial, including cultural beliefs, emotional concerns, limited health literacy, language difficulties, unfamiliarity with the health system, and structural challenges such as transport and lack of general practitioner referral.[38-42] Sociodemographic

factors, particularly age, marital and employment status, and length of residence in Australia, further influenced screening behaviours.[30, 42] Geographical disparities were shaped by both ethnocultural and socioeconomic factors, with cultural characteristics explaining much of the variation.[43]

Evidence also highlights the effectiveness of culturally tailored interventions. Community-partnership models, in-language SMS reminders, translated education, and targeted recruitment campaigns significantly improve awareness, screening intentions, participation, and cost-effectiveness[15, 29, 44-46, 48] For example, a Victorian study using the Ophelia (OPTimise HEalth LIteracy and Access) co-design process demonstrated that reminder phone calls in participants' preferred language dramatically increased mammography booking rates (64.2% vs 6%; $p < 0.0001$), whereas translated letters alone did not.[47] This approach has since been implemented into routine practice by BreastScreen Victoria.

Preliminary evidence from focus groups exploring the Australian National Lung Cancer Screening Program (NLCSP) found screening generally acceptable among Arabic, Macedonian, Italian, and Vietnamese communities, but barriers included stigma, fear of cancer, exclusion of non-cigarette tobacco users, reliance on family as interpreters, financial constraints, and lack of a regular GP.[49] Enablers included co-designed communication strategies, community champions, and materials in multiple languages.[49]

4.2.1.2 OCP Step 2: Presentation, initial investigations and referral

- **Barriers to Timely Presentation and Initial Investigations**

Evidence indicates that CALD communities encounter significant barriers at the stage of presentation and initial investigations. Limited awareness of cancer symptoms, reluctance to consult health professionals due to cultural norms or mistrust, and difficulties navigating the health system can delay help-seeking and initial care.[33] Communication barriers during early consultations may further compromise the diagnostic process, resulting in missed opportunities for timely referral and investigation.[50]

Evidence indicates delayed presentation among CALD men with prostate cancer: a Western Health study (2016–2022) found higher PSA levels and higher-grade disease at biopsy among non-English-speaking men compared to English-speaking men, though treatment access post-diagnosis did not differ.[34]

Similarly, a prospective cohort study across three states found CALD lung cancer patients experienced significantly longer hospital diagnostic intervals (median 30 vs 17 days; adjusted HR = 1.26), though prehospital intervals were not significantly different.[33] These findings underscore the need for culturally appropriate communication, early engagement, and targeted referral strategies.

4.2.1.3 OCP Step 3: Diagnosis, staging and treatment planning

- **Impact of being CALD on prostate cancer care**

Inequities in the provision of care to CALD patients with cancer can occur at every stage of the cancer care continuum, including access to screening, initial symptom management, diagnosis, treatment, survivorship, and palliative care.[6] In Australia, disparities in cancer detection among CALD communities are well documented, with

multiple studies identifying barriers to both the uptake of and access to cancer screening programs.[6]

Following diagnosis, evidence indicates that CALD patients often experience delays in commencing treatment and report poorer health-related quality of life and psychological outcomes compared to non-CALD counterparts.[51, 52] Victorian data indicate that non-English-speaking patients are more likely to be diagnosed with advanced prostate cancer than non-CALD individuals, highlighting the need for culturally responsive services that facilitate early detection and equitable management.[48, 49]

Similarly, inequities are evident in breast cancer outcomes among CALD women. Research examining Australian Chinese women with breast cancer found that they present on average, at a younger age than the general Australian population (mean age 56.7 years, approximately six years earlier). Tumour biology also differed: a significantly smaller proportion of Chinese patients had Luminal A tumours, a subtype typically associated with more favourable outcomes, compared with the broader Australian population (25.8% vs. 63.9%, $p < 0.001$). Although no significant differences were observed in other tumour subtypes, these findings highlight clinically relevant variations in disease presentation.[53]

Asian women also tend to have denser breast tissue, which can reduce the sensitivity of standard 2D mammography. Consequently, 3D mammography or ultrasound is often recommended to improve cancer detection in this population, as conventional 2D screening may miss malignancies in dense breasts.[54]

4.2.1.4 OCP Step 4: Treatment

Treatment for breast, colorectal, lung, and prostate cancers is influenced by tumour stage, age, comorbidities, and access to systemic therapies.[55] Early-stage disease is generally managed with surgery or radiotherapy, while advanced disease requires multimodal strategies.[55] However, CALD patients are underrepresented in clinical trials, contributing to disparities in treatment uptake and prognosis.[50]

For example, a retrospective study of 19,453 participants found lower chemotherapy trial participation among CALD patients (5.7% vs 8.4%; $p=0.001$).[55] In breast cancer, treatment patterns varied by country of birth: women from China, the Philippines, and Vietnam were more likely to undergo mastectomy, whereas women from Italy, Greece, and Lebanon were less likely.[55] Radiotherapy and systemic therapy use also differed by country of origin, influenced by cultural, clinical, and socioeconomic factors.[56] Despite treatment variation, five-year survival was generally high and improving, though differences reflect comorbidity profiles, health-seeking behaviours, and potential under-recording of deaths among migrants who returned overseas. [57]

Psychosocial and cultural factors shape treatment decision-making. Qualitative studies reveal that fear of stigma, cultural beliefs, and health literacy influence disclosure, choice of surgery, and recovery experiences among CALD women.[58-60] Culturally adapted decision aids, translated materials, and clinician guidance support informed choices and improved post-treatment outcomes.[61]

Health literacy also impacts timeliness of diagnosis and treatment. CALD lung cancer patients have longer hospital diagnostic intervals, highlighting the need for literacy-sensitive interventions.[62]

4.2.1.5 OCP Step 5: Care after initial treatment and recovery

- **Breast reconstruction post mastectomy**

Breast reconstruction (BR) following mastectomy is an important component of post-treatment recovery, yet evidence regarding its uptake and patient experience among CALD women in Australia remains limited. [63] A retrospective study conducted in the South Western Sydney Local Health District (2006–2015) found low overall reconstruction rates (9.4%), with no significant differences between CALD (8.6%) and English-speaking women (9.9%) in uptake, type, or timing of reconstruction.[63] Younger age and receipt of adjuvant therapy were associated with higher likelihood of reconstruction, while socio-economic disadvantage was not a significant factor.[63]

Complementing these findings, a qualitative study explored the experiences and decision-making processes of Vietnamese- and English-speaking women regarding BR.[64] Barriers identified included age, lack of information, concerns about surgery, potential complications, and fear of cancer recurrence.[64] Vietnamese-speaking women more frequently reported insufficient information as a barrier.[64] Facilitators included the desire to wear preferred clothing, partner influence, feeling ‘normal,’ and particularly, recommendations from doctors, which were a strong influence for Vietnamese patients.[64]

A further qualitative study evaluated the usability and acceptability of decision aids developed for Vietnamese and Arabic-speaking women considering BR.[61] Participants valued the resources as useful for clarifying options and supporting decision making, though improvements were needed to reduce medical jargon, address cultural sensitivities (e.g., taboos around the term “breast”), and fill remaining information gaps.[61] The study emphasised the importance of culturally adapted resources alongside the continued role of healthcare professionals in shared decision making.[61]

Collectively, these studies suggest that while reconstruction rates are comparable between CALD and non-CALD women, CALD communities experience unique informational and cultural barriers that influence decision making. Culturally sensitive communication and accessible, translated resources remain critical to supporting informed choices and optimising recovery following mastectomy.

- **Care Coordination and Survivorship in CALD Colorectal Cancer Patients**

A qualitative study conducted in Sydney explored perceptions of care coordination among colorectal cancer survivors from both English-speaking and non-English-speaking backgrounds.[65] Twenty-two participants took part through semi-structured interviews and a focus group, conducted in English, Spanish, or Vietnamese.[65] While survivors across both groups reported barriers to navigating follow-up care, non-English-speaking participants described additional challenges, including communication difficulties and perceived discrimination.[65] These participants often relied on family members and bilingual GPs for assistance with interpreting information and coordinating care.[65]

Care pathways varied, with some participants experiencing specialist-led models and others GP-led follow-up, depending on the complexity of care, accessibility of providers, and patient or practitioner preference.[65] For CALD participants in particular, bilingual GPs played a crucial role in bridging communication gaps, supporting understanding, and facilitating navigation of the health system after

surgery.[65] The study highlights the importance of culturally and linguistically responsive survivorship care models that strengthen coordination between primary and specialist services to improve outcomes for CRC survivors.[65]

4.2.1.6 OCP Step 6: Managing recurrent, residual or metastatic disease

One study included in this review indicates that although CALD patients may present with older age, higher comorbidity, and poorer performance status, overall survival and recurrence patterns are generally similar to non-CALD patients when treatment access is equivalent.[66] In colorectal cancer patients, research has shown that Integrated translation and language support (TALS) services facilitate equitable care, ensuring timely referral, treatment initiation, and comparable outcomes.[66]

4.2.1.7 OCP Step 7: End-of-life care

Providing culturally sensitive palliative care is essential to ensure that CALD patients with advanced cancer receive compassionate and appropriate end-of-life care.[67] Patients with limited English proficiency are particularly vulnerable to inadequate pain assessment and management, as well as unnecessary emotional and spiritual distress in the terminal phase of illness.[68] Although no studies were identified that specifically examined palliative care for CALD patients diagnosed with breast, colorectal, lung, or prostate cancer, an Australian qualitative study published in 2025 offers valuable insights into the experiences of CALD patients and their caregivers navigating cancer care.[69] Participants described the challenges of negotiating formal care alongside culturally shaped beliefs about treatment, death, and dying, as well as difficulties arising from language barriers and communication with clinicians regarding diagnosis, prognosis, pain, and symptom management.[69] These findings highlight the importance of culturally responsive communication, recognition of linguistic, cultural, and spiritual values, and sensitivity to the unique dynamics of each doctor–patient interaction, [69] which are directly relevant to palliative care for CALD patients across all cancer types. Moreover, the limited availability of culturally competent palliative care services in Australia further exacerbates inequities and contributes to disparities in end-of-life experiences for CALD patients and their families.[69]

4.2.2 What approaches or strategies have been used to (a) identify/determine unwarranted variation and/or (b) address unwarranted variation in care for CALD communities diagnosed with breast, colorectal, lung, or prostate cancer?

No studies specific to the care of CALD communities diagnosed with breast, colorectal, lung, or prostate cancer were identified that applied conceptual frameworks such as Wennberg’s classification, which is widely used to interpret unwarranted variation in specific cancer types.[70] Existing applications of the framework used to understand unwarranted variation have largely focused on specific cancers types only such as colorectal,[71] breast,[72] and ovarian cancer.[73] However, two broad groups of studies were identified that explored approaches to identifying variation in care of CALD communities diagnosed with breast, colorectal, lung, or prostate cancer, with some offering insights into potential strategies to address these variations.

4.2.2.1 Mixed Methods Approach

One study used a mixed-methods design to examine ethnic disparities in lung cancer diagnostic pathways.[33] Quantitative data from hospital and GP records for 577 and 99 patients, respectively, were complemented by survey responses from 189 patients.[33] Survival and Cox regression analyses adjusted for confounders, while patient surveys captured self-reported experiences.[33] This approach demonstrated that CALD patients

experienced significantly longer hospital diagnostic intervals than non-CALD patients, highlighting the value of integrating objective and patient-reported data to assess unwarranted variation comprehensively.[33]

4.2.2.2 Statistical Identification of Variation

Seventeen studies employed quantitative approaches to systematically identify variation and potential unwarranted disparities among CALD patients: nine retrospective, four cross-sectional, one prospective, one randomised control trial, one cost-utility analysis, and one economic evaluation.

- *Descriptive and Comparative Statistics*: Seven studies [15, 29, 39, 53, 61, 66, 74] used basic descriptive statistics and comparative tests such as chi-square and Fisher's exact test to explore care differences.
- *Multivariate Modelling*: Eight studies applied regression-based modelling to adjust for covariates and identify variation attributable to cultural and linguistic factors rather than confounders, often referencing evidence-based guidelines.[14, 33, 38, 42, 43, 56, 57, 63]
- *Other statistical approaches*: Markov microsimulation and cost-utility models have been used to quantify variation in cancer screening among CALD communities.[44] In Victoria, microsimulation evaluated bowel cancer screening uptake in Arabic- and Mandarin-speaking populations over a 50-year horizon, comparing usual care with culturally tailored recruitment (community education, paid media), with outcomes including intervention costs, Quality-Adjusted Life Year (QALYs), and additional adenoma and cancer cases detected.[44] Similarly, a cost-utility analysis assessed in-language SMS reminders for overdue breast screeners aged 50–72 years, estimating \$1.24 per person and \$1,595/QALY (95% UI \$763–\$7,637) and identifying additional cancers detected and deaths averted.[45] Both approaches capture individual trajectories and participation heterogeneity, identifying inequities in screening uptake and demonstrating that modest, culturally targeted interventions are highly cost-effective, highlighting their utility as policy tools for reducing unwarranted variation and improving equity.
- *Thematic analysis*: Three qualitative studies using thematic analysis highlighted important sources of variation in cancer care for CALD communities across the screening and survivorship continuum. Nickel et al. (2025) found that while CALD women strongly supported breast density notification, many faced barriers to understanding and accessing supplemental screening, raising concerns that notification may inadvertently exacerbate inequities.[46] Suwankhong and Liamputtong (2018) showed that Thai migrant women in Melbourne perceived low personal risk of breast cancer and encountered systemic barriers, including service accessibility, unfamiliar health system structures, and language difficulties, that limited engagement with mammography.[41] Extending beyond screening, Tan et al. (2018) explored shared care models in colorectal cancer survivorship and found that although both English- and non-English-speaking survivors reported barriers, non-English-speaking participants described additional challenges including communication difficulties, perceived discrimination, and reliance on bilingual GPs or family for care coordination.[65] Collectively, these studies demonstrate how cultural beliefs, health literacy, and systemic barriers interact to produce variations in access, engagement, and outcomes for CALD communities, underscoring the need for culturally tailored communication and care pathways to mitigate inequities.

- Key areas of variation include screening participation, early detection, diagnostic pathways, access to guideline-concordant treatment, and survivorship care. Most studies, however, did not formally confirm whether observed differences were clinically unwarranted.

4.2.2.3 Efforts to Address Unwarranted Variation

Fewer studies proposed actionable strategies, which included:

- *Health Belief Model (HBM) to Inform Culturally Sensitive Screening Interventions:* Suwankhong and Liamputtong (2018) applied the HBM to understand barriers among Thai migrant women.[41] Low perceived risk and service-related barriers limited screening uptake. Findings suggest that culturally tailored interventions guided by the HBM can improve understanding of personal risk and support engagement.[41]
- *Culturally Adapted Decision Aids:* Soons et al. (2024) evaluated decision aids for breast reconstruction among Vietnamese and Arabic-speaking women.[61] Participants reported high perceived usefulness (PrepDM score 4.8/5), with barriers including medical jargon and cultural sensitivities.[61] The aids improved understanding, reflection on options, and shared decision-making, demonstrating a practical approach to reducing variation in treatment decisions.[61]

Linked Administrative Data: Population-level linked datasets allow robust identification of disparities across multiple outcomes. Roder et al. (2021) used NSW Cancer Registry, hospital, and Medicare data to analyse 48,909 breast cancer cases, revealing variation in stage, comorbidity, surgery, radiotherapy, systemic therapy, and survival by country of birth.[56] Zhao et al. (2022) applied similar methods for 41,575 colorectal cancer cases, identifying differences in diagnosis, treatment, and survival across 12 cultural groups.[57] These approaches enable targeted interventions and service planning.

- *Health literacy assessment tools:* O'Hara et al. (2018) used questionnaires to assess barriers to breast screening among English, Arabic, and Italian-speaking women. Lower emotional barriers were linked to support from providers, social networks, and understanding of health information.[38] Arabic-speaking women reported greater difficulty, highlighting the need for culturally responsive communication and education to reduce variation.[38]

4.2.2.4 Grey Literature: Unpublished Thesis and Report

Grey literature reinforced the importance of culturally tailored approaches to prevention and early detection. An Australian thesis highlighted how South Asian women's attitudes, knowledge, and cultural perspectives shaped engagement with breast cancer prevention and care, identifying unmet needs for culturally appropriate information and support.[75] A Western Australian report showed lower breast and colorectal screening participation among CALD groups despite high awareness, recommending proactive GP engagement, clearer eligibility messaging, and translated resources to improve uptake.[76]

5. Implications

This review identifies persistent inequities in cancer care for CALD communities across prevention, diagnosis, treatment, and survivorship. Health services play a pivotal role in reducing these inequities through structured, system-wide action. The following implications outline priority areas for health service leaders and managers.

1. Strengthen Equity-Focused Governance and Accountability

- Embed equity goals for CALD communities within cancer service plans, clinical governance frameworks, and performance indicators.
- Establish local reporting mechanisms that monitor outcomes for CALD patients (e.g., screening participation, treatment timeliness, survival, and patient experience).
- Incorporate CALD equity measures into accreditation, service agreements, and quality improvement programs.

2. Implement Standardised Frameworks to Identify and Reduce Unwarranted Variation

- Adopt a standardised approach, such as a modified Wennberg framework, to systematically assess variation in care for CALD populations.
- Build internal capacity for data analysis and interpretation to distinguish warranted from unwarranted variation in cancer pathways.
- Use linked administrative and clinical data to provide feedback loops at service and regional levels, enabling targeted improvement.

3. Develop and Apply a CALD-Specific Optimal Care Pathway or include CALD elements into existing OCPs.

- Co-design a CALD OCP or CALD specific elements to include within existing OCPs with multicultural community partners, consumers, and interpreters.
- Map service processes against the CALD OCP or CALD specific elements to identify gaps in communication, navigation, and access.
- Align OCP implementation with cultural competency standards, workforce training, and patient-centred care principles.

4. Embed Culturally Safe and Accessible Care Models

- Ensure routine interpreter use, translated resources, and culturally adapted patient education materials are integrated into clinical workflows.
- Employ or partner with bilingual health workers, multicultural liaison officers, and community navigators to support patient engagement and continuity of care.
- Invest in staff training in cultural responsiveness, including shared decision-making and end-of-life communication skills.

5. Improve Data Capture and Real-Time Monitoring

- Enhance data collection on language, country of birth, and interpreter use within patient information systems to better understand service use and outcomes.
- Use real-time dashboards to monitor CALD patient pathways, identify bottlenecks, and guide quality improvement.
- Support cross-service and registry data linkage to identify systemic inequities across regions.

6. Strengthen Prevention, Early Detection, and Participation in Screening

- Partner with multicultural organisations and community leaders to co-design outreach and education programs that build trust and awareness.
- Use multilingual SMS reminders, community-led campaigns, and primary care engagement strategies to increase participation in screening programs.
- Apply lessons from proven interventions, such as culturally tailored reminders and co-designed health literacy initiatives, to other tumour streams.

7. Enhance Survivorship and Supportive Care

- Develop culturally appropriate survivorship care plans and psychosocial support programs in collaboration with CALD patients and carers.
- Integrate bilingual GPs and multicultural health workers into survivorship coordination to improve communication and follow-up.
- Fund CALD-specific peer and community support groups to address stigma and isolation post-treatment.

8. Prioritise Culturally Responsive Palliative and End-of-Life Care

- Strengthen staff capability to have culturally sensitive conversations about prognosis and preferences.
- Partner with multicultural and faith-based organisations to deliver tailored palliative care support.
- Establish systems to identify and refer CALD patients early to culturally responsive palliative care pathways.

6. Conclusion

Although this rapid literature review made efforts to evaluate existing literature on patterns of cancer care for CALD communities and approaches used to identify/determine unwarranted variation in cancer care for CALD individuals diagnosed with breast, CRC, lung or prostate cancer, some limitations should be acknowledged. First, despite careful development of search terms and inclusion criteria, these parameters may have inadvertently excluded relevant studies. To mitigate this, the reference lists of all included studies were systematically hand-searched to identify additional eligible publications.

Second, there was considerable heterogeneity in how CALD status was defined across the literature. As no universally accepted definition exists, this variability was managed by defining CALD in the inclusion criteria as individuals born in a non-English-speaking country or those who speak a language other than English at home.

Third, the review was restricted to English-language studies, which may have resulted in the omission of relevant studies published in other languages, potentially limiting the diversity of perspectives captured. Finally, and most significantly, the review uncovered a substantial lack of empirical evidence, leaving two of the three research questions insufficiently addressed. This gap underscores the broader scarcity of robust, CALD-specific cancer care research within the existing literature.

Nevertheless, this rapid review demonstrates that, despite ongoing efforts to improve cancer care equity, CALD communities in Australia continue to experience consistent disparities across the cancer care continuum. Evidence indicates lower participation in

screening, delayed diagnosis, variation in treatment access, and limited availability of culturally appropriate supportive and palliative care. Few studies formally define or address unwarranted variation, and no CALD-specific OCP currently exists to guide equity-focused improvement.

The findings highlight opportunities for health services to strengthen equity through coordinated and evidence-informed approaches. Priorities include developing a CALD-specific OCP, improving the collection and linkage of cultural and linguistic data, and embedding equity measures within performance and quality frameworks. These strategies can support more consistent identification and monitoring of variation in care and inform targeted quality improvement initiatives.

Further research and evaluation are needed to move beyond descriptive analyses toward the implementation and assessment of practical, co-designed interventions. Strengthening partnerships with multicultural communities, investing in culturally competent workforce development, and ensuring accountability for equitable outcomes will assist in reducing unwarranted variation and improving the quality and accessibility of cancer care for all Victorians.

Table 1. Search strategy

Search #	Limits English, Journal Article, Humans, Publication Date from 2018, Australian
1.	breast cancer/ OR colorectal cancer/ OR colon cancer/ OR rectum cancer/ OR prostate cancer/ OR lung cancer/
2.	(breast adj3 (cancer* OR neoplasm* OR carcinoma*)).ti,ab.
3.	((colorectal OR colon OR rectal OR bowel) adj3 (cancer* OR neoplasm* OR carcinoma*)).ti,ab.
4.	(prostat* adj3 (cancer* OR neoplasm* OR carcinoma*)).ti,ab.
5.	(lung OR pulmonary) adj3 (cancer* OR carcinoma* OR neoplasm* OR NSCLC OR SCLC).ti,ab.
6.	1 OR 2 OR 3 OR 4 OR 5
7.	minority group/ OR cultural diversity/ OR emigration/ OR immigration/ OR refugee/ OR language/ OR ethnicity/
8.	(cultur* adj3 (divers* OR minorit*)).ti,ab. OR CALD.ti,ab. OR NESB.ti,ab.
9.	(migrant* OR immigran* OR refugee* OR "new arrival*").ti,ab.
10.	("country of birth" OR "born overseas" OR "born outside Australia" OR "language spoken at home" OR "English proficien*" OR "limited English" OR LEP OR ancestry OR "year of arrival" OR "religious affiliation").ti,ab.
11.	7 OR 8 OR 9 OR 10
12.	health care delivery/ OR health care quality/ OR health care disparity/ OR medical error/ OR patient safety/ OR health care access/ OR clinical practice/ OR guideline adherence/ OR patient participation/ OR patient compliance/ OR survivorship/ OR continuity of care/
13.	(unwarrant* adj3 variation*).ti,ab. OR (practice adj3 variation*).ti,ab. OR (geograph* adj3 variation*).ti,ab.
14.	(disparit* OR inequit* OR access OR barrier* OR utilis* OR utiliz* OR uptake OR "time to diagnos*" OR "time to treatment" OR waiting time* OR timeliness OR screening participation OR participat* OR adheren* OR "treatment pattern*" OR "treatment receipt" OR "treatment decision*" OR survivorship OR survival OR mortality OR "patient experience*" OR safety).ti,ab.

15. 12 OR 13 OR 14

16. australia/ OR (Australia OR Australian OR Victoria OR Victorian OR Melbourne OR "New South Wales" OR Sydney OR Queensland OR Brisbane OR "South Australia" OR Adelaide OR "Western Australia" OR Perth OR Tasmania OR Hobart OR "Australian Capital Territory" OR Canberra OR "Northern Territory" OR Darwin).ti,ab,kw.

17. 6 AND 11 AND 15 AND 16

18. limit 17 to (english language and human and yr="2018 -Current")

Table 2. Summary of the evidence base – CALD and breast cancer (n=17)

First author	Year	State/National	OCP Step	Study design	Objective(s)	Participants (N)	Outcomes/Results	Key findings
Beauchamp et al [47]	2020	Victoria	Step 1: Prevention and early detection	Randomised control study	To evaluate the effect of providing translated mammography screening routine reminder letters or phone calls for Arabic and Italian women living in Northwest Melbourne.	Randomised control trial (RCT) #1 (letters) 1,032 women; for RCT#2 (phone calls), 195 women	For RCT#1 (letters) women were randomised into the intervention arm or to usual care. Uptake of screening bookings was similar between both groups, with no differences observed by language group. For RCT#2 (phone calls), women were randomised to the intervention group or to usual care. Overall, 64.2% of women in the intervention arm and 6% in the control arm booked a screening appointment within 14 days (p<0.0001). The IR (95% CI) of booking was 10.1 (3.9, 26.3) times higher among Italian women, and 11.6 (2.9, 46.5) times higher among Arabic women in the intervention compared to usual care groups.	A service improvement initiative derived from community members and breast screen providers was found to be highly effective. This evidence informed the service provider, BreastScreen Victoria, who have implemented these improvements into routine practice to improve screening among CALD groups and reduce health inequalities.
Hong et al [53]	2023	Victoria	Step 3: Diagnosis, staging and treatment planning	Retrospective	To investigate if a substantial difference in breast cancer subtypes exists between the Australian Chinese population and the general Australian population.	97	Mean age at diagnosis was 56.7 years, approximately 6 years younger than the general Australian population. There was a statistically significant difference in incidence of Luminal A tumours with 25 patients (25.77%) from the Chinese group affected compared to 310 patients (63.92%) from the general group (P < 0.001). There was no significant difference in proportions of the other tumour subtypes between the two groups.	Australian Chinese breast cancer patients present at a younger age compared to the general Australian population, with a smaller proportion of patients having Luminal A tumours.
Jamal et al [39]	2021	New South Wales	Step 1: Prevention and early detection	Qualitative	To qualitatively explore barriers and facilitators to breast screening from the perspectives of CALD women from South Western Sydney.	16	Women in this study reported absence of symptoms, fatalistic beliefs and embarrassment during the procedure to be the primary reasons for reluctance to screen. Lack of general practitioner (GP) endorsement, transport issues and pain associated with the procedure were also reported as additional barriers to screening. Common facilitators to screening included encouragement from family and friends, family history of cancer and media adverts.	CALD women have distinctive barriers to mammography, which lead to poor breast screening participation rates. Opportunistic health promotion in this area is warranted and may lead to better health outcomes amongst this population.
Karimi et al [63]	2020	New South Wales	Step 5: Care after initial treatment and recovery	Retrospective	To determine the rate of breast reconstruction in women who had mastectomy as treatment for breast cancer in SWSLHD and compare the rate of breast reconstruction in the CALD and non-CALD populations in this local health district.	374	The average rate of reconstruction in SWSLHD was 9.4% for 2006–2015. Although the reconstruction rate was higher among English-speaking women (9.9%) compared to women from a CALD background (8.6%), the difference was not statistically significant (p = 0.57). The type (autologous versus implant) and timing (immediate versus delayed) of reconstruction did not differ between groups (p = 0.19 and p = 0.22, respectively). The Index of Relative Socio-Economic Disadvantage was not significantly associated with reconstruction (p = 0.74). However, younger patients were more likely to have reconstruction (P < 0.0001) and patients with adjuvant therapy were more likely to have a delayed reconstruction (p = 0.01).	This study found a low breast reconstruction rate in public hospitals in South Western Sydney Local Health District (SWSLHD). The reconstruction rate did not differ between CALD or English-speaking patients, or between patients from diverse socio-economic backgrounds.
Kim [40]	2021	New South Wales	Step 1: Prevention and early detection	Qualitative	To gain a better understanding of the motivators and barriers associated with participation in breast cancer screening among women from a Korean background living in the Sydney metropolitan area.	Semi-structured individual interviews (n = 32) and small focus groups (n = 28) were conducted	The findings highlight the barriers to access breast screening services extend beyond language to include perception, a lack of knowledge and understanding of the services offered, unfamiliarity with the Australian healthcare system and distrust in breast screening services.	Supporting Korean women to understand and navigate the Australian healthcare system plays an important role in increasing breast screening participation rates. Key strategies to provide this support include the delivery of culturally sensitive health promotion and community engagement as well as the provision of translated health information.
Lal et al [45]	2025	Victoria	Step 1: Prevention and early detection	Cost-utility analysis	To promote equity in breast cancer screening for CALD communities, language-specific	3294	Booking response rates were higher for the lapsed in-language SMS than the lapsed SMS sent in English (12.7% and 8.2%, respectively). Intervention costs averaged \$1.24/person. The estimated cost/QALY was \$1595 (95% uncertainty interval dominated to \$7637). Because of the in-	In-language SMS reminders to increase breast cancer screening targeting lapsed screeners from CALD communities were effective and cost-effective relative to the willingness-to-pay threshold of \$50

First author	Year	State/National	OCP Step	Study design	Objective(s)	Participants (N)	Outcomes/Results	Key findings
					initiatives were implemented in Victoria, Australia; to evaluate the cost-effectiveness of in-language short message service (SMS) reminders for overdue clients.		language initiative, there were an estimated 14 more breast cancers and 5 more ductal carcinomas in situ detected and 3 fewer breast cancer deaths.	000/QALY. Introducing these types of initiatives as standard practice can potentially increase equity in breast cancer screening for CALD groups in well-resourced countries.
Lam et al [30]	2018	New South Wales	Step 1: Prevention and early detection	Secondary analysis was performed on the pooled sample from five cross-sectional studies of BCS rates among immigrant-Australian women, and the associated sociodemographic factors.	To evaluate breast cancer screening (BCS) practice and explore the relationship between sociodemographic factors and breast awareness (BA), clinical breast examination (CBE) and mammography in migrant-Australian women.	1,744	Only 19% of women participated in routine BA, 27.4% of women in the target group of >40 year presented for an annual CBE, and 60.6% of women in the target group of 50–74 years received a biennial mammogram. Associated sociodemographic factors differed by modality except for length of Australian residency. In multivariable analysis, age, length of Australian residency, marital status, and employment status accounted for more than 50% of the variance in regular BA and CBE.	These findings indicate suboptimal (BCS) rates persist among migrant-Australian women and suggest the importance of certain sociodemographic factors in BCS practice.
Levesque et al [29]	2020	New South Wales	Step 1: Prevention and early detection	Qualitative	To broadly explore the experience of breast cancer and coping strategies utilised by Chinese Australian women.	24	Two prominent themes emerged, related to information seeking, and communication with health care professionals. The theme of information needs and seeking highlighted unmet information needs and the multiple sources that are consulted for information. The second theme, communication with health care professionals, language barriers, and preferences, identified varying degrees of involvement in treatment decision-making, preference for information and interactions in Cantonese or Mandarin, and problems with interpreter services.	Chinese women with breast cancer face significant challenges in obtaining adequate information and can feel excluded from treatment decision-making. Women in this study expressed their eagerness for obtaining accurate information and engaging in open communication with their doctors. There is a need for culturally sensitive information resources and decision aids to enhance communication between Chinese migrant patients with cancer and health care professionals. Clinician participation in cultural awareness training is also recommended.
Nickel et al [46]	2025	National	Step 1: Prevention and early detection	Qualitative using online focus groups	To qualitatively explore CALD women's understanding and views of breast density, attitudes towards health services access, acceptability of notification and preferences for breast density communication ahead of population-based notification in Australia.	42	Thematic analysis revealed four themes indicating participants had overall strong desires to be informed of breast density, despite some associated worry. CALD women may also face significant barriers to understanding and accessing breast density information and seeking supplemental screening.	Although CALD women have a strong desire to be notified of their breast density, increased anxiety and confusion may exacerbate health inequalities and barriers women from these communities already face.
O'Hara et al [38]	2018	Victoria	Step 1: Prevention and early detection	Cross-sectional survey	To explore the association between health literacy, barriers to breast cancer screening, and breast screening participation	317	A total of 219 women (69%) reported having a breast screen within the past two years. Results revealed that health literacy was not associated with screening participation. Instead, emotional barriers were a significant factor in the self-reported uptake of screening. Three health literacy domains were related to lower emotional breast screening barriers, feeling understood and supported by healthcare providers, social	Interventions that can improve breast screening participation rates should aim to reduce emotional barriers to breast screening, particularly for Arabic-speaking women.

First author	Year	State/National	OCP Step	Study design	Objective(s)	Participants (N)	Outcomes/Results	Key findings
					for women from CALD backgrounds.		support for health and understanding health information well enough to know what to do. Compared with English and Italian-speaking women, Arabic-speaking women reported more emotional barriers to screening and greater challenges in understanding health information well enough to know what to do.	
Pawaskar et al [58]	2021	New South Wales	Step 4: Treatment	Qualitative	To explore CALD women's perceptions of breast cancer surgery in Australia to better understand the extent of cultural influences upon their decision-making and post-treatment experiences.	16	Three themes emerged through thematic analysis: (a) role of culture in surgical decision-making; (b) postsurgical impacts; (c) influence of health literacy on decision-making and impacts.	Overall, the findings highlight the need for greater breast cancer awareness even among educated, acculturated CALD women to improve understanding and minimise culturally driven stigma, thereby improving decision-making and wellbeing. Approaches include clearer communication during consultations, including confirming patient understanding, and through breast cancer campaigns more targeted to CALD women.
Roder et al [56]	2021	New South Wales	Step 4: Treatment	Retrospective cohort	To compare cancer stage, treatment (first 12 months) and survival for 12 country of birth categories recorded on the population-based NSW Cancer Registry	48,909	Compared with the Australia-born, women born in China, the Philippines, Vietnam and Lebanon were younger at diagnosis, whereas those from the United Kingdom, Germany, Italy and Greece were older. Women born in China, the Philippines, Vietnam, Greece and Italy lived in less advantaged areas. Adjusted analyses indicated that: (1) stage at diagnosis was less localised for women born in Germany, Greece, Italy and Lebanon; (2) a lower proportion reported comorbidity for those born in China, the Philippines and Vietnam; (3) surgery type varied, with mastectomy more likely for women born in China, the Philippines and Vietnam, and less likely for women born in Italy, Greece and Lebanon; (4) radiotherapy was more likely where breast conserving surgery was more common (Greece, Italy, and Lebanon) and the United Kingdom; and (5) systemic drug therapy was less common for women born in China and Germany. Five-year survival in NSW was high by international standards and increasing. Adjusted analyses indicate that, compared with the Australian born, survival from death from cancer at 5 years from diagnosis was higher for women born in China, the Philippines, Vietnam, Italy, the United Kingdom and Greece.	There is diversity by country of birth of stage, treatment and survival. Reasons for survival differences may include cultural factors and healthier migrant populations with lower comorbidity, and potentially, less complete death recording in Australia if some women return to their birth countries for treatment and end-of-life care. More research is needed to explore the cultural and clinical factors that health services need to accommodate.
Soon et al [61]	2024	New South Wales	Step 5: Care after initial treatment and recovery	Qualitative	To evaluate the usability and acceptability of decision aids (DAs) for Vietnamese- and Arabic speaking women with breast cancer about to undergo breast reconstruction (BR)	25 (Phase 1: Vietnamese-speaking women, n = 14; Phase 2: Arabic-speaking, n = 11)	Three themes were developed in Phase 1: (1) DA content and reception; (2) linguistic attributes and cultural appropriateness; and (3) factors that improve the DAs' impact. Three themes were developed in Phase 2: (1) varying perceptions of DA content; (2) linguistic and cultural suitability of information; and (3) impact of DA on decision making. Women from both phases identified areas for improvement: minimising the use of medical terminology, considering the cultural taboos associated with the word 'breast', and addressing remaining information gaps. Both language DAs were generally perceived as acceptable and useful in providing information about BR options and prompting women's reflections about the suitability of BR as part of their treatment. The mean Preparation for Decision Making (PrepDM) score for Arabic-speaking women in Round 2 was 4.8/5 (SD = 0.3).	Further work is needed to ensure that culturally adapted DAs take into account the myriad of information needs and health literacy levels. The key role of healthcare professionals in shared decision making among CALD populations should also be considered.
Soon et al [64]	2022	New South Wales	Step 5: Care after initial	Qualitative	To explore the factors that influenced Vietnamese- and	14 Vietnamese-speaking and 13	Participants identified age, lack of information, concerns regarding surgical procedure, fears about complications and cancer recurrence as barriers to breast reconstruction. Many	Lack of information about reconstruction was a persistent theme, though it was identified by more Vietnamese women as

First author	Year	State/National	OCP Step	Study design	Objective(s)	Participants (N)	Outcomes/Results	Key findings
			treatment and recovery		English-speaking women's decisions about breast reconstruction post-mastectomy for their breast cancer, in Australia.	English-speaking patients	more Vietnamese-speaking participants identified lack of information about breast reconstruction as a barrier compared to English-speaking participants. Both groups described the ability to wear clothing of their choice, partner influence, and the need to feel 'normal' as facilitators to having breast reconstruction. Vietnamese-speaking participants in particular identified doctor recommendation of breast reconstruction as a major facilitator.	a barrier to having breast reconstruction. The results reinforce the importance of doctors' recommendations in helping particularly the Vietnamese women make an informed decision about reconstruction following mastectomy as treatment for their breast cancer.
Stuart et al [43]	2022	Victoria	Step 1: Prevention and early detection	Cross-sectional	To examine the socio-economic and ethnocultural characteristics of geographical areas that may influence variation in breast cancer screening participation.	812,522	All the selected measures were related to screening participation. There was a high degree of association both within and between socioeconomic and ethnocultural characteristics of areas as they relate to screening. Ethnocultural characteristics alone accounted for most of the explained geographical disparity in screening participation.	Geographical disparities in breast cancer screening participation may be due to ethnocultural factors that are confounded with socio-economic factors.
Suwankhong and Liamputtong [41]	2018	Victoria	Step 1: Prevention and early detection	Qualitative	To discuss the barriers to attending screening services among Thai migrant women living in Australia	25	Basing on the Health Belief Model, most Thai migrant women did not perceive that they were at risk of breast cancer. Despite seeing a breast cancer screening programme as important, the women rarely paid attention to breast cancer screening and used the mammography services provided by the Australian health care system. The barriers included the location of the services, unfamiliar patterns of health care provision, and language difficulties.	There are many barriers that they encountered in Australia that prevent Thai migrant women living in Melbourne Australia to pay attention to mammographic screening service provided by Australia health system. Our findings suggest that health services and interventions need to be designed more sensitive to the needs and socio-cultural context of migrant women in general and Thai migrant women in particular
Wang et al [42]	2022	New South Wales	Step 1: Prevention and early detection	Cross-sectional quantitative survey	To investigate breast cancer screening practices and associated factors among Chinese Australian women.	115	69.8% of participants reported recent clinical breast examinations and 73.3% had mammograms. Age, religion, employment status, and length of residence were associated with having a clinical breast examination. Income was related to having a mammogram. Associations between knowledge of breast cancer, cancer-related beliefs, and screening participation were found. Length of residence in Australia was the strongest predictor of having a clinical breast examination and mammogram. The most common barrier to mammography was if women felt that doctors did not recommend it to them.	Chinese Australian women need to be educated about awareness of their usual breast health to be aware of any changes, especially if women are not eligible for mammography or have difficulty in accessing health services. Tailored programs, improving screening experiences, and minimizing perceived barriers are needed to promote early detection of breast cancer among Chinese Australian women.

Table 3. Summary of the evidence base – CALD and colorectal cancer (n=6)

First author	Year	State/National	OCP Step	Study design	Objective(s)	Participants (N)	Outcomes/Results	Key findings
Hodgson et al [66]	2023	Victoria	Step 6: Managing recurrent, residual or metastatic disease	Retrospective	To compare access to the initial management and overall survival with colorectal cancer for limited English proficient (LEP) patients compared with patients from an English background.	162	Interpreters were present at 687/782 appointments with LEP patients. There were no differences in demographics or cancer staging. There were no differences between English background and LEP patients with regard to times from referral to biopsy (1 vs. 0 days), specialist review (surgical: 4 vs. 6 days, oncological: 45 vs. 57 days), MDM discussion (23 vs. 15 days), or commencement of treatment (32 vs. 28.5 days). There were no differences in treatment for colorectal cancer, although a higher rate of stomas was noted in LEP patients. There was no difference in overall survival between groups.	Time to critical initial checkpoints and overall survival were similar in LEP and English background patients with colorectal cancer. An integrated translation and language support (TALS) department may abrogate the language and cultural barriers that are known to disadvantage LEP patients and may contribute to normalizing care for the culturally and linguistically diverse community.

First author	Year	State/National	OCP Step	Study design	Objective(s)	Participants (N)	Outcomes/Results	Key findings
Lal et al [44]	2024	Victoria	Step 1: Prevention and early detection	Economic evaluation	To estimate the cost-effectiveness and long-term health impacts of interventions targeted at Arabic and Mandarin speaking populations in Victoria, Australia to increase bowel cancer screening participation.	N/A	Intervention costs were \$6.90 per person for the Arabic speaking group and \$3.10 for Mandarin speakers. The estimated cost/QALY was \$2,781 (95% uncertainty interval [UI]: \$2,144–\$3,277) when screening increased by 0.2% in the Arabic group, and an estimated 5–6 additional adenoma and cancer cases were detected. In the Mandarin group, the estimated cost/QALY was \$1,024/QALY (95%UI: \$749–\$1,272) when screening increased by 1.1%, and an estimated 18–23 additional adenoma and cancer cases were detected.	Culturally specific recruitment interventions to increase bowel cancer screening are inexpensive and likely to be cost-effective. Improvements in capturing language spoken at home by the National program would facilitate more precise estimates of the effectiveness and cost-effectiveness of these interventions.
Phillipson et al [48]	2018	New South Wales	Step 1: Prevention and early detection	Qualitative	To explore the usability of Australia's NBCSP FOBT kit among two CALD groups.	33	Multiple factors contributed to low readiness and capacity to use the kit, including limited promotion of the program in community languages, complicated and poorly sequenced kit instructions, and confusion around the order and labelling of kit components. Participants suggested several ways to improve kits to improve uptake by CALD communities.	Simplified and targeted promotion of bowel screening programs in community languages, and improved kit design, may support participation of CALD populations in screening programs.
Tan et al [65]	2018	New South Wales	Step 5: Care after initial treatment and recovery	Qualitative	To explore how CRC survivors from CALD backgrounds who speak languages other than English at home, as well as those from English-speaking backgrounds, perceive care to be coordinated amongst various health practitioners in an Australian setting.	22	Twenty-two CRC survivors participated in the study. Participants from non-English-speaking and English-speaking groups described similar barriers to care, but non-English-speaking participants described additional communication difficulties and perceived discrimination. Non-English-speaking participants relied on family members and bilingual GPs for assistance with communication and care coordination. Factors that influenced the care pathways used by participants and how care was shared between the specialist and GP included patient and practitioner preference, accessibility, complexity of care needs, and requirements for assistance with understanding information and navigating the health system, that were particularly difficult for non-English-speaking CRC survivors.	Both non-English-speaking and English-speaking CRC survivors described a blend of specialist-led or GP-led care depending on the complexity of care required, informational needs, and how engaged and accessible they perceived the specialist or GP to be. Findings from this study highlight the role of the bilingual GP in assisting CALD participants to understand information and to navigate their care pathways following CRC surgery.
Thai et al [74]	2018	Victoria	Step 4: Treatment	Retrospective, single-centre analysis	To explore disparities in adjuvant chemotherapy utilisation in cancer patients from CALD groups.	211	Two hundred and eleven patients were identified. One hundred and forty-three (67.7%) patients had early-stage breast cancer, and 68 (32.2%) patients had early-stage colorectal cancer. No difference was detected in the acceptance of adjuvant chemotherapy between non-CALD (80.9%) and CALD patients (81.3%, $p = 0.984$) or between patients who identified English as their first-preferred language (80.8%) and those who did not (81.8%, $p = 0.870$). There was no difference in the rate of chemotherapy completion, with 75.6% completion in the non-English-speaking group and 81.1% in the English-speaking group ($p = 0.426$).	No difference was observed in adjuvant chemotherapy utilisation in patients who identified English as their first-preferred language compared to those who did not, as well as between non-CALD and CALD groups. This is the first study to assess these differences in Australia.
Zhao et al [57]	2022	New South Wales	Step 4: Treatment	Retrospective population cohort	To demonstrate the utility of data linkage for bringing population-wide data together for quantifying differences in CRC stage (degree of spread) at diagnosis, treatment, and 5-year survival in NSW by country of birth	27,524 with colon and 14,051 with rectal cancer	Compared with Australian born, the adjusted odds ratio for distant spread of colon cancer was higher for people born in Lebanon and the United Kingdom. Treatment was less common for people born in China (surgery), Germany (systemic), Italy (surgery), New Zealand (any treatment) and Vietnam (all treatments), while treatment for rectal cancer was more common for people born in Italy (surgery), United Kingdom (radiotherapy, systemic therapy), and Vietnam (surgery), and less frequent for people born in China (radiotherapy). Adjusted 5-year survival was higher for people born in China, Italy, Vietnam, Greece (colon), Lebanon (colon) and other non-English speaking countries. More advanced stage was negatively related to having surgery and survival.	This study illustrates how linked data can enable comparisons of multiple outcomes for colorectal cancer by country of birth across an entire population. Results disclose "big picture" variations in population characteristics, stage, treatment and survival. This will enable better targeting and prioritisation of services and inform research priorities to address disparities.

Table 4. Summary of the evidence base – CALD, breast and colorectal cancer ($n=1$)

First author	Year	State/National	OCP Step	Study design	Objective(s)	Participants (N)	Outcomes/Results	Key findings
Kwok and Xu [15]	2025	New South Wales	Step 1: Prevention and early detection	Co-design methodology for the development and implementation phase used; a quasi-experimental study design was employed in the evaluation phase	To assess the effectiveness of a co-designed culturally tailored cancer screening promotion program with Chinese Australian, with a focus on using a community partnership approach, the first of its kind in Australia.	Bowel screening (n=465); breast awareness (n=356)	Significant improvements were observed in participants' awareness of screening practices (bowel screening: 50.1% to 100%; breast awareness: 78.8% to 100%; mammogram: 65.8% to 95.6%; cervical screening: 86.5% to 96.9%). Screening intentions within 6months increased substantially across all cancer types (bowel: 7.4% to 37%; breast awareness: 21.2% to 77.6%; mammogram: 18.9% to 47.7%; cervical: 39.8% to 73.1%). About 9 out of 13 questions regarding cancer knowledge and beliefs showed significant improvement post-intervention.	The community partnership approach and culturally tailored cancer education effectively improved cancer screening awareness and intentions among Chinese Australians. This study provides a successful model for developing and implementing culturally sensitive cancer screening promotion programmes, which can be adapted for other CALD communities to address health disparities in cancer screening participation.

Table 5. Summary of the evidence base – CALD and lung cancer (n=1)

First author	Year	State/National	OCP Step	Study design	Objective(s)	Participants (N)	Outcomes/Results	Key findings
Mazza et al [33]	2021	Victoria, New South Wales and Queensland	Step 2: Presentation, initial investigations and referral	Prospective, observational cohort study (mixed method approach)	Lung cancer patients from ethnic minorities have poorer outcomes than their Caucasian counterparts. The researchers compared lung cancer intervals between CALD and Anglo-Australian patients to identify ethnic disparities.	577 (407 Anglo-Australian and 170 CALD)	CALD patients had longer hospital diagnostic interval [median 30 days, 95% confidence interval (CI) 26–34] than Anglo-Australian patients (median 17, 95% CI 14–20), $p = 0.005$, hazard ratio (HR) = 1.32 (95% CI 1.09–1.60). This difference persisted after relevant factors were taken into consideration, adjusted HR = 1.26 (95% CI 1.03–1.54, $p = 0.022$). CALD patients also reported longer prehospital intervals; however, these differences were not statistically significant. Conclusion	Target interventions need to be developed to address ethnic disparity in hospital diagnostic interval.

Table 6. Summary of the evidence base – CALD and prostate cancer (n=2)

First author	Year	State/National	OCP Step	Study design	Objective(s)	Participants (N)	Outcomes/Results	Key findings
Tamirat et al [14]	2025	Victoria	Step 3: Diagnosis, staging and treatment planning	Retrospective cohort study	To investigate differences in the National Comprehensive Cancer Network risk category classification at prostate cancer diagnosis between CALD and non-CALD populations.	5046	Of 4872 CALD individuals with preferred-language data, 498 (10%) preferred speaking a language other than English. Compared to non-CALD individuals, non-English-speaking CALD individuals presented with less low-risk (15% vs 22%) but more high-risk (32% vs 21%) and metastatic (18% vs 8%) disease. CALD individuals had significantly more advanced (regional or metastatic) disease than non-CALD individuals (adjusted odds ratio [aOR]=1.17, 95% confidence interval [CI]=1.06–1.29). Non-English-speaking CALD individuals had significantly more advanced prostate cancer (aOR=1.54, 95% CI=1.23–1.94).	Individuals from CALD backgrounds had greater odds of presenting with high-risk or advanced prostate cancer. Improving early detection of prostate cancer for CALD individuals requires investigation of underlying factors to plan effective interventions.
Yanada et al [34]	2025	Victoria	Step 2: Presentation, initial investigations and referral	Retrospective	To determine whether patients of non-English speaking background (NESB) are more likely to be diagnosed with higher-grade prostate cancer on biopsy, and whether their NESB status affects treatment.	779	The researchers identified 779 patients who were diagnosed with prostate cancer. Within this group, 136 (17.5%) were non-English speaking and required an interpreter. The median PSA (ng/mL) and PSA density (ng/mL/cc) pre-biopsy were 9.9 (IQR: 6.7–15.0) and 0.23 (0.15–0.46) respectively, in the NESB group, and 7.4 (5.2–12.3) and 0.19 (0.12–0.31) respectively, in the English-speaking group ($p < 0.001$). A greater proportion of men of NESB were diagnosed with higher-grade prostate cancer on biopsy compared with their English-speaking counterparts ($p < 0.001$). When the researchers controlled for pre-biopsy prostate cancer grade, there was no statistical difference in the proportion of patients managed with radical prostatectomy ($p=0.977$), radiotherapy ($p=0.544$), ADT ($p=0.113$) or chemotherapy ($p=0.792$).	Non-English-speaking background (NESB) men are more likely to be diagnosed with higher-grade prostate cancer on biopsy compared with their English-speaking counterparts due to delayed presentation. Language is not seen as a barrier to receiving appropriate treatment for their prostate cancer. Further studies with more granular data pertaining to cancer staging, sequence of treatments and oncological outcomes are required to ascertain the effectiveness of care delivery towards NESB patients living with prostate cancer.

Table 7. Summary of the evidence base – Grey literature (n=2)

First author	Year	State/National	Research design	Objective(s)	Participants (N)	Outcomes/Results	Key findings
Rajagopal, L [75]	2021	New South Wales	Thesis	To investigate the lived experience and role of social support among women of South Asian origin with breast cancer living in Australia. Five objectives addressed this overarching aim: 1) to examine the lived experiences of women of South Asian origin living in Australia with breast cancer; 2) to examine women of South Asian origin's meaning of breast cancer; 3) to explore women of South Asian origin's lived experiences of breast cancer; 4) to investigate how women of South Asian origin cope with their illness; and 5) to understand the different types of social support needs in these women.	17	<p>In the meta-synthesis, most women were emotionally supported following their diagnosis, yet there are still areas where women could be better supported such as when breaking the news of their diagnosis to their children, provision of ongoing emotional support for caregivers of women with breast cancer, emotional and informational support needs both at diagnosis and during treatment, and discussion of fertility treatments in a timely manner by healthcare professionals. These findings informed the direction of the qualitative study.</p> <p>Overall, findings of the qualitative study revealed that South Asian culture has a significant impact on these women's breast cancer experiences. Mixed healthcare experiences were apparent among the women who took part in this study. The lived experience of these women also differed from the existing literature exploring Anglo-Australian populations both in terms of coping strategies leveraged, and the support received while managing their cancer.</p>	While some similarities exist between the lived experiences of breast cancer among other Australian females as found in the meta-synthesis and the women of South Asian origin who took part in this study, multiple differences also exist which are connected to cultural norms and perceptions of the disease. These findings have been used to suggest recommendations for healthcare providers to optimise the experience of breast cancer among these women as well as inform directions for future research and health care practices.
Western Australian Department of Health [76]	2023	Western Australia	Report	To better understand CALD people's cancer information needs including cancer screening awareness and participation	175	Despite a high awareness of screening programs, participation in screening was low for breast and colorectal. Identified strategies to increase participation in screening programs for CALD people included GPs encouraging screening, improving messages around eligibility for screening, and providing translated resources for screening.	There were several cultural needs raised by participants throughout the consultation, including language needs, cultural beliefs about cancer, respecting religious, and cultural beliefs, the role of family, and empowering CaLD people to advocate for their healthcare needs.

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