

**PEI Well Women's Clinics:
A Case Study of Gender Specific Clinics
to Increasing Screening Rates**

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Executive Summary

Increasing cervical cancer screening, other health promotion screening practices, and offering health promotion education plays a significant role in improving women's health. Opportunistic screening, defined as Pap smears "taken on the initiative of the woman and/or her physician" (Ballegooijen et al., 1998), which has been the traditional format that cervical screening has taken, is not reaching all women. There are many groups of hard-to-reach women who are not currently served by traditional screening methods.

One format used to increase screening rates of hard-to-reach women in various places, including Prince Edward Island, are Well Women's Clinics. These clinics offer cervical screening and other health promotion services in an accessible location, often times with a female provider. These clinics overcome many of the barriers that have been identified in the past with regards to reaching the unscreened or underscreened. The clinics have been a success in targeting women who are otherwise not being screened. Other clinic models that vary by target group, services provided, remuneration policies, and other issues can be used to overcome other structural barriers. As well, clinic models can be expanded to include Well Men, Well Teens, Well Seniors, and other services.

There are several policy and program implications for gender specific screenings that arise from the literature as well as from the experiences of people involved in other well women type services or other health promotion related clinics. Awareness should be increased about the seriousness of the issue of screening for cervical cancer. Women in Canada die needlessly from a disease that is almost 100% curable if detected early from screening. Accessibility of options for women should also be broadened. All individuals involved in supporting women in making health decisions should play a role in increasing screening. Multiple initiatives can be employed in order to encourage all women to be screened and to create a supportive environment for screening services and health promotion education. Alternative service providers can be sought – specially trained nurses performing screening have successfully overcome several barriers, including difficulties in recruiting doctors. Comprehensive services can be offered all in one place and at one time to maximize the benefit of attending. For example, being able to have a mammography and a Pap smear in the same visit has been shown to be effective in reaching older women. Health promotion education sessions are also important in conjunction with screenings. The location of the clinic or service is also important. The clinic ideally would be where the women are, including the workplace, the shopping centre, and anywhere else that will reach under or unscreened women. Communication and promotion of service options should be varied and suited to the population. Role models can also be important in increasing screening. Finally, research has a major role to play in illustrating the success of clinics. For all stakeholders involved, research can demonstrate what is successful, what aspects might be changed, and the level of need for a service.

Well Women's Clinics, as have occurred on Prince Edward Island and other provinces in Canada, offer an alternative to traditional opportunistic screening, which had limited success. These clinics overcome many of the barriers to screening that have been identified by hard-to-reach women, and should continue to play an important role in improving women's health.

Current challenges to these clinics can be overcome through involving all stakeholders, including the women themselves, through open communication, by investigating the different models that are described in this paper, and through a systematic and continuous research process.

PEI Well Women's Clinics: A Case Study of Gender Specific Clinics to Increasing Screening Rates

1.0 Summary of the Research Project

1.1 Introduction

Heart disease and cancer are the leading causes of death of women in Canada. Early detection of cervical and breast cancer through screening results in a better chance of survival, particularly in the case of cervical cancer which is nearly 100% curable if detected early. Other types of screening, such as screening for risk factors for heart disease (i.e., high blood pressure or cholesterol) can result in the changing of lifestyle behaviors than can positively affect a woman's health.

Because screening can save a woman's life, or increase one's quality of life, guidelines have been developed for Canadian women to follow. For example, it is suggested that women have a Pap smear annually, until two negative Pap smears have been taken, and then a Pap smear should be done once every three years (Miller et al., 1991). However, approximately 15% of women in Canada have never been screened for cervical cancer (Health Canada, 1998, p. 3). These rates are higher in Prince Edward Island and Nova Scotia (Sweet et al., 1991). In turn, many women in Canada are still dying as a result of cervical cancer that was not detected early enough. In a study of women in Alberta with invasive cervical cancer, 45.5% had not been adequately screened. This study "confirms that not all women are reached through opportunistic screening" (Stuart et al., 1997, pp. 517–518).

The Well Women's Health Coalition in Prince Edward Island was established to increase preventative screening of women. The Well Women's Health Coalition PEI membership includes the Canadian Cancer Society PEI Division, East Prince Health, Eastern Kings Health, Four Neighbourhoods Community Health Centre, Evangeline Community Health Centre, The Medical Society, Heart and Stroke Foundation of PEI, PEI Advisory Council on the Status of Women, PEI Department of Health and Social Services, PEI Women's Secretariat, Queens Health Region, Southern Kings Health, UPEI School of Nursing, West Prince Health, and the Women's Network.

Well Women's Clinics on Prince Edward Island are one intervention used for early detection of breast and cervical cancer and heart disease. These clinics were provided in PEI as an initiative of the Well Women's Health Coalition with the goal of increasing women's choices for accessing health promotion and disease prevention information and screening in order to reduce the incidence of preventable or premature morbidity or mortality.

The Well Women's Health Coalition of Prince Edward Island has established that the next step in the campaign to increase screening of women as well as increased access to health promotion education is to develop a synthesis paper on gender specific clinics as an intervention, using PEI Well Women's Clinics as a case study. The present paper will thus focus on the P.E.I. Well

Women's Clinic as one successful strategy to increase cervical screening rates in women, and show examples of interventions held in other areas and with other populations, including prostate cancer screening for men. Policy and program implications to increase screening rates will also be identified and discussed.

2.0 The Case of Well Women's Clinics on Prince Edward Island

Screening for cervical cancer is not a new initiative, as women have been screened for cervical cancer by family doctors or gynecologists for many years. However, Prince Edward Island has a high rate of cervical cancer, and the number of women who are screened for cervical cancer is low. A study by Sweet et al. (1991) stated that only "an estimated 38% of PEI women aged 20 years and over were screened" (p. 2). The number of Pap smears have steadily increased since 1967, but the highest risk groups may not be getting screening (Sweet et al., 1991).

2.1 History

Historically in Prince Edward Island there has been an interest in increasing screening rates through mass screening and educational initiatives. In 1979, the PEI Department of Health rejected the Women's Institute request to have ongoing cancer screening clinics for women. The next formal screening attempt on PEI occurred in 1987, when a one-time mass breast health program took place, in which breast exams and breast self-exam (BSE) education took place.

In 1993, the Chief Medical Officer suggested the idea of a provincial notification system based on the British Columbia model. This same year, a survey was conducted with all Women's Institute members (1986 responded out of 2,100 members). Although the Women's Institute's membership is comprised mostly of older women (67% of survey respondents were 46 years of age or older) and is not representative of Prince Edward Island women, this survey illustrated a need for gender specific screening clinics and provided some understanding as to why some Island women do not get screened. The results showed support for a province-wide registry (Report of Cervical Cancer Screening Program – PEI, 1993). A 1993 survey of physicians reported that 94.7% of doctors surveyed said that they include a Pap as part of a woman's annual physical exam. This conflicted with the results of the Women's Institute survey, in which 78% of respondents said that their annual check-up did not include a Pap smear. The physician survey showed that physicians also were supportive of a province-wide registry.

A variety of wellness days were held in the early 1990s in such places as Montague and Sherwood, including menopause workshops and women's health days. These initiatives were sponsored by the Women's Network and provided health promotion education but no screening services. In 1995, a Well Women's clinic was planned in conjunction with a health promotion fair sponsored by UPEI's nursing school. A physician's services were acquired, and the clinic at the University was available for the day. However, the clinic did not take place as it was perceived as a duplication of service that could be performed elsewhere.

Following this, a diverse number of stakeholders were invited to the “Action on Women’s Health Workshop” in 1996 to plan for the future of women’s health. Forty interested participants from volunteer groups, professional groups, and health system representatives (including UPEI, PEI Women’s Network, University’s Women’s Centre, and the Provincial Interministerial Women’s Secretariat) took part. The vision of the Well Women’s Clinic resulted from this workshop: “The Well Women’s Clinic would be a traveling clinic that offered holistic and complementary options in conjunction with the more traditional practices” (Action on Women’s Health Workshop Notes, April 23, 1996). The Well Women’s Health Coalition also emerged from this workshop (Dell, 1998).

2.2 Eastern Kings Well Women’s Clinics

Various public health initiatives on women’s health were taking place by this time, but Eastern Kings was the pioneer on the Island in developing and running Well Women’s Clinics. In the summer of 1996, a physician on contract to replace one of Eastern King’s permanent physicians agreed to conduct Well Women’s Clinics. This contract physician, along with a supportive CEO and dedicated Regional Management Team, were integral in the clinics getting off the ground. Nurses who took part conducted the clinics as part of their work time, not on a volunteer basis as was done in the 1987 breast screening day. The target group was women who had not had cervical screening for a number of years. Eight clinics were held in Souris between 1996 and 1998, and included a Pap and breast exam by a physician, breast self exam teaching, cholesterol and blood pressure testing, nutrition information, and health information displays. The clinics were only advertised through the church bulletin and word of mouth but attracted enough women to fill the eight clinics (with more on a waiting list).

One hundred and twenty two women attended in total. Seventy-two percent of participants stated that they had a history of cancer in their family. The average number of years since participants’ last Pap smear was 4.33 years, and the average number of years since their last breast exam by a doctor was 3.90 years (Rose et. al, 1998). Almost forty-four percent of the women had never conducted their own breast self-exam. The women reached with this Well Women’s Clinic were women who were not being reached through traditional opportunistic screenings. These clinics were extremely successful and were a catalyst for other clinics on Prince Edward Island.

2.3 First Province-wide Well Women’s Clinics

On January 16, 1997, the first meeting of the Well Women’s Coalition of Prince Edward Island was held. The goal of this group is to decrease the number of deaths of PEI women from invasive carcinoma of the cervix. As a result of Island representatives attending a June 1997 Workshop on “Planning a Well Woman Health Day” in Truro (sponsored by the Nova Scotia Cancer Society Division), it was decided to have Well Women’s Clinics across the Island in October 1997. The clinics were organized with Public Health Nursing in each region in conjunction with the Well Women’s Coalition. Planning for these clinics started, but the clinics were postponed until April and May of 1998 because of difficulty recruiting physicians for the clinics. The cytology lab was notified with regards to the increased samples that would occur as a result of the screenings. It was established that women’s lab reports would be directed to the

family doctor and if the women had no family doctor, the clinic physician would follow-up with regards to abnormal screenings.

Seven clinics were held in April and May of 1998 across Prince Edward Island. Clinics varied in structure, as some clinics offered osteoporosis screening, nutrition information, blood pressure and cholesterol tests, and other health information. All clinics had breast self-exam educational sessions and a physician performing Pap smears and pelvic exams. Most clinics also had a physician provide breast exams. In total, 214 women took part in the seven clinics and 150 women had a Pap smear. Forty percent of women who had a Pap smear had not had a Pap smear in three or more years (Van Til, 1999). Thirty-eight percent of women had not had a breast exam with a doctor for more than three years. Eight percent of participants had an abnormal Pap in the past. Other evaluation findings are described elsewhere (Van Til, 1999), but participants were overwhelmingly satisfied with the experience. Participants credited the 'easy access' (including weekend access and the closeness of the clinic), the 'friendliness', 'anonymity', and 'convenience' of the clinic, and the relaxed atmosphere. As one participant stated: "I enjoyed not feeling like you were bothering someone by asking questions. Sometimes a doctor is so busy you feel you are a bother". Having access to a female doctor was also mentioned by many participants as a motivating factor to have a Pap smear. One participant summarized many of the comments that were made, and points out the need for stakeholders and policy makers to be on board:

I feel that clinics like this one that was set up, *need* to be the wave of the future. In a well women's clinic, women can obtain the kind of professional help they need, plus they get unhurried information on a large group of women's health issues that so often get brushed aside in a doctor's office. Living in PEI it has now become a fact that many people cannot even obtain the services of a family doctor due to doctor shortage in our province. I only hope that these clinics will be welcomed with *open* arms by the Department of Health and the Canadian Cancer Society plus other organizations. Our health department has a responsibility to see that all its residents receive the best health care it can give.

Based on the high satisfaction of participants, as well as the fact that these clinics did reach women who were at risk of being under screened or never screened, these clinics were a successful initiative in increasing screening rates, and illustrate the benefit of gender specific clinics. As well, health promotion education, which was hands-on in many ways, was provided to a number of women in a short period of time. Continued efforts to reach the women most at risk by offering services first to women who have not had regular Pap smears would be beneficial. While it could be concluded that there was not a large increase in screening as a result of this clinic (as only 150 more women were screened), the Well Women's Clinic was successful at screening 60 women who had not been screened in three or more years, and there is evidence from waiting lists in some areas that more women would have taken part if given the chance. As well, word of mouth and social support are effective methods to increase screening, and therefore the full results of this initiative may not have been realized yet, as participants in these clinics talk with other women about their experience. Awareness is also raised by these clinics, which has an effect on compliance of future screening. For instance, in Nova Scotia, Well

Women's Clinics and information sessions are a part of the Annual Pap Test Awareness Week. In 1997, 15,000 women had a Pap smear in the month following the Pap Test Awareness Week (Nova Scotia Department of Health, 1998). After the province-wide clinics on PEI, 6,313 women were screened between April and June of 1998, up from 5,837 women screened in these same months in 1997.

2.4 Challenges

A number of challenges were identified throughout the development and implementation of the clinics that need to be considered:

- the difficulty in **recruiting** physicians and the possibility that physicians feel pressured into working these clinics
- the issue of **locums** for outside doctors
- the low physician **remuneration** for Well Women-type services. One of the suggestions for the fee for service issue has been to pay physicians \$100/hour from the public health budget rather than the physician service budget for any further clinics
- **continuity of care** if women do not have a family physician; the issue of interruption of continuity of care and follow-up if women do have a physician
- the **duplication of services** issue (i.e., the notion that opportunistic screening is sufficient to reach women)
- the **level of service** offered at the clinics, as there is a possibility of a false sense of security if women are given a Pap smear but no pelvic exam

Many of these issues were raised and need to be resolved before Well Women's Clinics on Prince Edward Island can be continued.

2.5 Recommendations for Future Clinics

As a result of this initiative, and some of the challenges that have arisen, recommendations for further clinics include:

- a need for **ongoing, permanent clinics** as opportunistic screening is limited in its reach (only 214 women were screened in the provincial Well Women's Clinics); Clinics should be offered more than once a year
- copies of Pap reports should be sent to both the participating clinic physician and family physician. A **consistent mechanism for reporting** to a woman's family physician should be implemented.
- an **appropriate clinic fee should be negotiated**
- **evaluations** need to show key stakeholders that clinics are an effective health promotion strategy
- **"hard to reach women" needs to be defined** to demonstrate that a gender specific clinic can provide a service that opportunistic screening does not

- **nurses could be trained** to perform Pap smears as is done in some areas of Nova Scotia, but this would require a change to the Shared Competency Act

2.6 Other Clinic Models

There are several other models of gender specific screening, ranging from in-hospital service to traveling clinics. Chart 1 outlines Canadian examples, indicating the services provided, the frequency of the clinics, remuneration issues, and other important subjects. These models illustrate the various ways clinics are running in Canada. Appendix 1 provides more in-depth descriptions of each clinic.

3.0 Current Barriers to Screening

The PEI Well Women's Clinics, as with many other clinic models throughout Canada, the United States, and other countries, focus on breaking down barriers for hard-to-reach women by offering various service options in conjunction with health promotion education. The next section explains some of the barriers to screening.

It has been suggested that in Canada there are three target groups for screening for Pap testing (Grunfield, 1997):

- The first group will get screened if they are aware of the benefit and importance of screening and if the screening is accessible (i.e., if they have access to a physician).
- The second group would benefit from a call/recall system.
- The third group is made up of hard to reach women. This is a small proportion of the population, but these women are at risk and screening rates need to be increased. Aggressive techniques for recruiting are needed and there is a need to look at barriers for screening.

3.1 Hard to Reach Groups

A number of under screened groups have been identified throughout the literature. They include certain ethnic groups, lower socioeconomic groups, and certain age groups.

Particular ethnic groups are more at risk of being under screened. First Nations women, both on and off the reserve, are less likely to have cervical screenings (Hislop et al., 1996; Grunfield, 1997; Health Canada, 1998). Older First Nations women are particularly at risk (Hislop et al., 1996). Immigrant groups are at risk for being under screened (Grunfield, 1997; Health Canada, 1998), and Canadian women born in Asia have the highest odds of never having been screened for cervical cancer – almost nine times more than Canadian-born women (Lee et al., 1998). Chinese women in particular have low rates of breast and cervical screening (Sent et al., 1998). In the United States, Hispanic women have been targeted to increase screening rates for breast cancer (O'Malley et al., 1999). In a study by O'Malley et al. (1999), factors such as immigrating to the United States before the age of 16 years, spending a large proportion of one's life in the

United States, and having a higher level of acculturation into society (including language) were positively related to having breast cancer screening. African American men are less likely to have prostate screenings (Weinrich et al., 1998; Barber et al., 1998) and African American women are among the most difficult to reach groups for breast cancer screening (Williams et al., 1997) and cervical screening (Health Canada, 1998).

Other groups may also be at risk of being under screened. A study by Price et al. (1996) found that lesbians thought themselves to be less at risk for cervical cancer than heterosexual or bisexual women, although 79% of the lesbians surveyed had had sexual intercourse with a male. Women living in a large urban area are more likely to have had their most recent Pap three or less years ago, which may have to do with better access to screening services than rural women (Lee et al., 1998). The more sexual partners a woman has had, the more likely she is to have had a Pap, which “may be related to practice by doctors of conducting a Pap test before prescribing or renewing prescriptions for birth control pills” (Lee et al., 1998, p. 16). A study in Iceland found that women with mental disorders were less likely to have cervical screenings (Bergmann et al., 1996). Having low self-esteem or a less positive relationship with one’s husband are also factors of women who are under screened (Wilson and Fazey, 1995).

Single women are less likely to be screened, both for breast (Gentleman and Lee, 1997) and cervical cancer (Bergmann et al., 1996). Older women are also more at risk of being under screened or never screened for cervical (Rowe, 1996; Mamon et al., 1991–1992; Lee et al., 1998; Grunfield, 1997) and breast cancer (Gentleman and Lee, 1997). As well, young women aged 18–19 are less likely to have had a Pap smear (Lee et al., 1998).

Both men (in the case of prostate cancer) and women (in the case of breast and cervical cancer) who have lower incomes are more likely to be under screened (Link et al., 1998; O’Malley et al., 1999; Weinrich et al., 1998; Barber et al., 1998; Lee et al., 1998; Grunfield, 1997). Women with higher formal education were more likely to have had a mammogram than those women less formally educated (Gentleman and Lee, 1997); the same is the case for cervical screening (Lee et al., 1998). Women between 50 years of age and 69 who were caregivers or retired had lower odds of having had a mammogram compared with those women working outside of the home (Gentleman and Lee, 1997).

Women are more likely to be screened if they have a usual source of care (O’Malley et al., 1999) or have a physician’s recommendation for screening (O’Malley et al., 1999; Mamon et al., 1991–1992). Women who had not been to a physician recently were less likely to have had a mammogram than those who had seen a doctor in the last year (Gentleman and Lee, 1997) and women who have never been to a gynecologist-obstetrician are less likely to be adequately screened (Mamon et al., 1991–1992). Women are less likely to be screened if they were unemployed (Stirland et al., 1996), living in overcrowded conditions (Stirland et al., 1996), or live further away from a clinic (Rowe, 1996). On Prince Edward Island, women who are not screened are more likely to be 50 years of age or older, living in both rural and urban locations, and although the vast majority (85%) had been to a physician in the last year, they did not ask for a Pap smear (reported in Van Til, 1999).

3.2 Barriers to Traditional Opportunistic Screening

There is a need to increase cancer screening rates of women (and men) in conjunction with health promotion education. Traditional opportunistic screening, defined as Pap “smears...taken on the initiative of the woman and/or her physician” (Ballegooijen et al., 1998), has reached a number of individuals, but there are still a number of hard to reach women (and men, in the case of prostate cancer screening) that need to be targeted for further screening initiatives.

Most studies concerned with increasing screening rates of women have also identified a number of barriers to screening. Reasons identified in the literature for not getting adequately screened include:

- Not perceiving to be at risk or not wanting to go to their regular doctor or local clinic (Stirland et al, 1996).
- Not liking to have Pap smears, feeling that they did not need to, or uterus had been removed (Bergmann et al., 1996).
- Cost (in the United States) as well as embarrassment, fear, discomfort, convenience (too busy, only day exams available), and misinformation (i.e., not knowing screening recommendations, not believing in effectiveness of screening, or thinking older women are less likely to get cervical cancer). Also lack of female physicians being available was mentioned, but less often (Sadovsky, 1997). Cost can be an issue with Canadian women as well, if transportation or access to day care is a challenge (i.e., Fitch et al., 1998).
- Focus groups with 32 African American women in Flint, Michigan, identified the following barriers to breast screening: women preferred female physicians because of embarrassment; women preferred to be examined at a hospital than clinic; access to health care facilities was a barrier because of hours of service, as well as cost and lack of transportation. Fear of finding a lump was a barrier to performing self-breast exams; mammograms were thought of as painful and uncomfortable, and there was a fear of detection of cancer or undependable results (Williams et al., 1997).
- First Nations Women in British Columbia cited similar barriers regardless of whether they lived on or off a reserve. Health care providers’ attitudes, the ability to establish a trusting relationship, and the ability to provide clear information were seen as important, illustrating that physicians are a significant source of motivation and information for cervical screening for this group of women (Hislop et al., 1996).
- Price et al. (1996) found that forgetting to get a Pap exam and not liking to get a Pap test were the main barriers. Other barriers less commonly mentioned were lack of transportation, feeling they were not at risk for cervical cancer, and being uncomfortable with their health care provider. Knowledge of risk factors for cervical cancer by all women in this study (bisexual, heterosexual, or lesbian) was also a barrier. Women who were not regularly screened indicated that they would have a Pap smear if encouraged by their physician.

- In the United States, a main barrier is not having health care insurance (O'Malley et al., 1999; Price et al., 1996; Mamon et al., 1991–1992).
- The results from ten focus groups with 100 North York, Ontario, women (Fitch et al., 1998) identified a number of suggestions for Pap smear initiatives. These included educating women about cervical screening through articles in women's magazines, notices in stores, and talks with women's groups. Suggestions for physicians included allowing enough time with the patient to ask questions, warming the speculum and using a plastic speculum as opposed to metal. Findings from these focus groups also illustrated women's desire for an alternative place to obtain a Pap smear besides their regular doctor, a place that has both breast and cervical screening available, as well as child care facilities.

As outlined in *Programmatic Guidelines for Screening for Cancer of the Cervix in Canada*, “opportunistic screening does not achieve optimal screening coverage and appears to have reached the limit of its effectiveness” (Cervical Cancer Prevention Network, p. 6). Hence it is suggested “the opportunistic approach has probably reached its limits and we need to address this problem in a more comprehensive manner” (Stuart and Parboosingh, 1996). A study by Ballegooijen et al. (1998) found that organized programs above and beyond opportunistic screenings were necessary in order to reach the largest number of women.

4.0 Overcoming Existing Barriers: Program and Policy Implications

No one technique for increasing screening rates will work on its own. Women need to have a number of choices available, in conjunction with health promotion education. Currently, opportunistic screening is one of the only options available to many women. Well Women's Clinics have been available, but not in an ongoing way on Prince Edward Island.

Upon review of the current literature and the various models of gender specific clinics that are currently available that go above and beyond traditional, opportunistic screening, there are a number of program and policy implications. Many of these directly illustrate the importance of ongoing services such as Well Women-type clinics.

4.1 Increase Awareness

The first step in increasing screening rates for hard-to-reach women is to increase awareness among the key stakeholders. All stakeholders, including physicians, public health nurses, policy makers, politicians, community organizations, and the women themselves, should continue to build on the progress already made including understanding and agreeing that there is a problem; i.e., that many women are not being screened and therefore are at risk. The stakeholders involved would benefit from the agreement of a definition of “hard to reach women” and development of a plan of action for the future. Women's health is the responsibility of everyone and each stakeholder should have a role in the betterment of women's health. Health promotion, which is often vulnerable to inadequate resources, needs to be identified as a significant issue where

funding needs to be applied, as screening initiatives along with health promotion education will result in long-term savings.

In the case of employing well women-type services, or other initiatives to increase screening rates and health promotion awareness, all stakeholders should continue to work on outstanding issues and concerns collectively. Some of these barriers can be overcome by ensuring that all stakeholders participate in the planning process and that challenges are worked through as they arise. The goal is to increase screening rates, and therefore these concerns should be addressed as they arise.

4.2 Increase Accessibility

One of the challenges to increasing screening rates is accessibility. Barriers to access include the hours that a physician's office may be open, rural versus urban locations, lack of family physicians, lack of female service providers, and the inability to locate a physician that is not one's own family doctor (as many women would like a physician that is unknown to them in their community to provide the service). Locally accessible options (Provost, 1996), such as local Well Women's Clinics or traveling clinics, address these barriers. As Mathieson and Poulin (1997) outline "Health care providers and researchers must address what factors create accessibility, especially women who are marginalized" (p. 13–14).

4.3 Everybody Needs to Play a Role

Often times, turf issues arise when discussing cervical screenings, particularly in the case of Well Women's Clinics. Is this a duplication of service? Or is it truly offering multiple options to underscreened women? In fact, the latter is the case. Patients are not being taken away from one physician to another physician or nurse. Instead, women are being offered an option to a service that they would not have through traditional opportunistic screening. As well, Well Women Clinics offer health promotion education to a large group of women which multiplies the benefits.

Everyone has a role to play in ensuring that women are screened. Saskatchewan's key recommendations for comprehensive cervical cancer screening focuses on all sectors that play a role in a woman's health. For example, the health districts would be responsible for ensuring access to a female health care provider, whereas physicians and nurses trained in screening would be responsible for providing tests in a sensitive manner, educating underscreened women about testing, and be accountable for high quality testing. Saskatchewan Health's role is to provide funding for an organized screening program and help with the training of female Pap providers (Health Services Utilization and Research Commission, 1997, p. 2).

Even in the case of ongoing Well Women's Clinics, family physicians play a key role "to promote actively the need to consider screening within each health care encounter" as a "physician's recommendation to a patient to have a Pap smear is a powerful tool to increase the uptake of screening" (Stuart and Parboosingh, 1996, p. 14). As has been found in other Well Women's Clinics, some women choose to return to their family physician after their first

screening at a clinic; in other cases the physician encourages women to attend a Well Women Clinic (Sent et al., 1996).

All stakeholders need input into any service offered, and need to be involved in the service. Multidisciplinary boards have worked well in keeping everyone involved informed on the progression of services. These advisory type boards would include women as the client, and the demand for services should be clearly supported by the consumers.

4.4 Use Multiple Techniques

Multiple techniques and strategies are the most successful at reaching the highest number of underscreened and unscreened women. A holistic approach, including educational sessions on such topics as nutrition, mental health, heart health, as well as the screenings themselves, is important. Skaer et al. (1996) outlines the need for both outreach and in-reach efforts. Outreach focuses on increasing the number of women at risk to have their first cervical and breast screening whereas in-reach is needed to ensure that women have mammograms, conduct breast self exams, and get Pap smears at the recommended intervals. Health education can assist with encouraging routine examinations and other preventative measures. Studies recommend strategies that target the health care delivery system and increase motivation of women to get Pap testing by implementing two initiatives – one in order to get physicians to improve Pap testing practice in conjunction with a community intervention (Mamon et al., 1991–1992). Some recruitment strategies suggested by the PEI Pap Advisory Committee (p. 3), include:

- a letter of invitation from a woman’s physician, with follow-up phone call
- practice-based call and re-call systems with letters and phone calls
- brief advice and offer of Pap during visit to physician
- mobile units for rural women
- financial incentives to physicians
- door-to-door canvassing
- offering Pap test to hospital inpatients
- educational messages by community nurses
- small monetary reward to women
- trained lay health educators
- Pap smear provision by non-local health professional
- community activities plus a personalized letter for rural women
- informal recruitment of women by word of mouth
- personal letter from an organized program and informational brochure to women
- television media campaign plus personal letter of recruitment.

4.5 Increasing Service Options

Increasing accessibility translates into increasing service options in order to achieve broader coverage. One of these service options is Well Women’s Clinics, as described above. These screenings give women another option when they are faced with taking control over their own

health. As Mathieson and Poulin (1997) found in their review of the cancer screening literature “well-women clinics may inadvertently address this accessibility problem by creating an environment conducive to more communication and by lowering anxiety and fears” (p. 13). Well Women’s Clinics have been shown in a number of cases to be an effective way of increasing screening rates of hard to reach women by overcoming some of the barriers that have been identified in the past.

Many places across Canada, the United States, and in other countries have gender specific clinics to increase population screening for various diseases. Breast cancer screening programs in various forms are available on Prince Edward Island, across Canada (i.e., Olivitto, 1999), throughout the United States (i.e., Marble, 1997), in the Netherlands (i.e., Kuska, 1998), in Australia (i.e., BreastScreen NSW) and in other developed countries. Initiatives to increase cervical cancer screening are taking place in Iceland, (i.e., Bergmann et al., 1996), Canada (i.e., Sent et al., 1998), the United States (i.e., Anderson, 1994), and the United Kingdom (i.e., Stirland et al., 1996) among other countries. Mass prostate cancer screenings are also being conducted (Weinrich et al., 1998; Barber et al., 1998).

In most cases, the purpose of these clinics and screening initiatives is to increase awareness and knowledge of the importance of early detection and screening, to provide a convenient and user friendly service (Key, 1997) and to increase screening rates, particularly among hard to reach women (or men, in the case of prostate screening) who have never been screened or who are not being screened on a regular basis. Health promotion education is also integral to these clinics. There is a vast amount of literature relating to these mass-screening initiatives, which discuss the groups that are at risk and possible ways to increase screening of these groups, communication strategies for these initiatives, barriers to attendance, various settings to increase screenings, and concerns that need to be addressed. For specific models of clinics, see Chart 1 and Appendix 1.

4.6 Offer Increased Practitioner Options

Stuart and Parboosingh (1996) suggest that in order to reach unscreened or underscreened populations, nurses or other trained health care workers should be increasingly involved in the screening process. The goal in the end is to “ensure that the entire target population is appropriately screened, and professional roles should facilitate rather than limit this” (Stuart and Parboosingh, 1996). This has been successfully implemented in Western Newfoundland, Kentville, and Halifax, where trained nurses conduct Pap smears. This option overcomes barriers of physician recruitment and fee challenges. At the same time, it increases the accessibility of clinics in rural areas. However, this service needs to be delegated under the provincial Shared Competency Act. Nurses need to be educated, trained, and certified in the process. The Red Door in Kentville, Nova Scotia, has a manual on training procedures for nurses.

It is important to have champion physicians onside as well. In Western Newfoundland, physicians were sent a letter asking for their support in taking part in one or more initiatives to increase cervical screening. Physicians were asked if they were willing to do a chart audit of the opportunistic screening that takes place in their office by pulling 50 files to see when women had their last screening. Another initiative involved giving the patient a form to fill out that included

the number of years since her last Pap smear, and then the doctor would ask if the woman would like to book in for a screening if appropriate. Another option was for the doctor to have posters or pamphlets on cervical screening, and to find out their willingness to hold a well-woman type clinic with a nurse. All of these initiatives were designed to increase doctors' awareness of the opportunity to offer screening. If physicians were not interested in having clinics, then nurses were approached to be trained.

In the long run, having nurses conduct this service may result in focusing other services to family physicians. Referrals can be made if necessary, leaving the physician to deal with other important medical issues. Many women also prefer the option of a female practitioner (whether this be a nurse or physician). This is another option that assists in increasing screening rates.

4.7 Offer “One-stop Shopping”

Another recommendation is to offer “one-stop shopping”. This is best exemplified through Well Women’s Clinics that can offer Pap smears, pelvic and breast exams, blood pressure and cholesterol testing, and education information. Increasingly, other types of screenings (e.g., glucose monitoring and urine analysis) are being offered at clinics and other initiatives assist women in identifying problems and in positively affecting their health behaviors. This notion of “one-stop shopping” can be further extended by providing cervical screenings at the same time as women have their mammogram (O’Connor, 1993). This results in increased cervical screening for underscreened women (i.e., aged 50–69). Expansion of Well Women’s Clinics to offer more health promotion and educational sessions is also important. For example, including mobile bone densitometry units (Nova Scotia Department of Health, 1999) and educational information on preventing NTD (neural tube disorders) by educating pregnant women on the importance of increasing folic acid intake (CDC, 1996) are two such possibilities.

The educational component of these clinics is important in both encouraging repeat screenings and in communicating other health information. For example, in a study on mammography screening of older minority women, education sessions were held on breast screening (including overcoming fears and barriers and increasing knowledge of the disease and the need for screening) and then mammograms were offered in a mammography van or at a health centre (Buelow and Zimmer, 1998).

Culturally sensitive and acceptable screening initiatives to reach at risk women of different ethnic groups are important as well (Skaer et al., 1996; Sent et al., 1998; Hodge et al., 1996; Provost, 1996). Recently, the IWK Grace Health Centre Well Woman Clinic in Halifax learned from Muslim women about the most comfortable and appropriate way to offer cervical screenings based on their culture. Other culturally sensitive and acceptable programs include having bilingual staff at clinics (Sent et al., 1998; Skaer et al., 1996) or taking an aspect of a group’s culture and developing it as part of the intervention (see Hodge et al. (1996) American Indian Talking Circle project). In the case of Prince Edward Island, taking culture into account translates into having female physicians available to do Pap smears for women who feel more comfortable with a female physician, as well as having health care providers from outside of the women’s home community providing the service.

4.8 Location, Location, Location ...

Various settings can also increase awareness and screening rates. As Gayle Hallin, Director of the Health Department in Bloomington, Minnesota, stated: “One of the missions of public health clinics is to go where the people are” (Marble, 1997). A clinic set up in the Mall of America offers breast exams, mammograms, Pap smears, pelvic exams, and breast self exam teaching to women. The site is highly visible and is free to women with no health insurance. In the United Kingdom, clinics have been set up in car parks at major stores. An increase in response rate of 30–50% for high risk groups has been shown as a result of this initiative (Stirland et al., 1996). The workplace is another popular place to have educational sessions and screenings (Weinrich et al., 1998; Greenwood and Henritze, 1995; Stirland et al., 1996). An urban senior center and a suburban church have been locales for prostate screening (Barber et al., 1998). In the United States, in order to increase screening rates, free breast and cervical cancer screenings for women over 50 years of age in the hospital were advertised at the beauty parlor. The beauty parlor also holds various education sessions (“Trip to beauty parlor means more than haircut”, 1996). Other settings that have been researched include a trained nurse performing a Pap smear (and scheduling a mammogram for a later date if needed) when women came into a hospital emergency department (Mandelblatt et al., 1997) and having a nurse practitioner set up an appointment for screenings by lay health educators in an outpatient clinic (Margolis et al., 1998; Ansell et al., 1994). Sexually transmitted disease (STD) clinics have also been researched as a setting for conducting Pap smears when women come in for other tests. Finally, prisoners in a women’s prison have been screened on-site (Martin, 1998).

When choosing a setting, it is important to be conscious of people’s wishes as well as the level of discretion people prefer. For example, Barber et al. (1998) found that African American men preferred private screening over mass screening.

4.9 Improve Communications and Promotion

Promotion of various clinics and programs has been achieved in various ways, depending on the target groups. For example, in prostate screenings initiatives, African American men are more likely to be reached by radio and white men by newspaper advertisements (Barber et al., 1998). Cervical screenings have been promoted by employing an outreach coordinator, through word-of-mouth, PSAs, and by partnering with other organizations with experience in serving the underserved population (Stovall and Wright, 1998). As well, posters, information leaflets, word of mouth by other employees, and personalized letters (Stirland et al., 1996) have been successfully employed. In one study, 10.8% of non-attenders in a cervical screening program eventually came for a Pap test after being reminded repeatedly by letter (Bergmann, 1996).

4.10 Use Role Models and Consider the Importance of Identity

The significance of role models and identity are illustrated in the literature on screening, particularly when trying to reach different hard-to-reach ethnic groups. In focus groups with African American women talking about breast cancer screening, Williams et al. (1997) found

that advertising campaigns that showed African American women would be an effective means of attaining the attention of African American women. Similarly, in studies of attempts to increase prostate cancer awareness and screening in African American men, resources such as a poster of George Foreman stating that “Real Men Get Checked” (American Cancer Society) (Weinrich et al., 1998) as well as a videotape showing the importance of regular prostate screening entitled “Male Call” narrated by Sidney Poitier (Barber et al, 1998) illustrate the use of identity and role modeling in the attempts to increase screening. As well, lay health educators (Altpeter, Earl, and Scholper, 1998) have been successful at increasing rates of screening in high risk women as social support from peers is important in increasing screening rates.

4.11 Research Plays an Important Role

It is also suggested that an evaluation framework that is agreed upon by all stakeholders be developed in order to meet the needs of all groups involved. This evaluation would provide appropriate results that the service provider as well as the funding providers need in order to understand what is working best and what needs to be changed. Short-term indicators should include satisfaction rates, indicators of need (i.e., waiting lists), and whether or not the target group is being reached (i.e., under or unscreened women). Long-term indicators should include cost savings to the health system as a result of early detection. Evaluation findings can also target concerns that stakeholders have identified, including tracking abnormal Pap smears to ensure that follow-up is completed.

Successful models that have worked in other areas of Canada or in other parts of the world, such as the one’s identified above, can be replicated and evaluated where appropriate. Different settings, promotion initiatives, and strategies should be tried. Ongoing evaluation of interventions is important, as well as publication of both successful and unsuccessful initiatives, so that different clinics can learn from one another with regards to what works best and what needs to be changed.

5.0 Conclusion

Well Women’s Clinics, as have occurred on Prince Edward Island and other provinces in Canada, offer an alternative to the traditional opportunistic screening that have been limited in its success. These clinics also provide important health promotion education opportunities that benefit women as well as their families. Comprehensive Well Women clinics overcome many of the barriers to screening that have been identified by hard-to-reach women and should continue to play an important role in improving women’s health.

Prince Edward Island, because of its size and commitment to the health of Islanders, has been successful in implementing exemplary health screening initiatives. One such example is the Well Baby Clinics, provided by Public Health across the Island. These Clinics reach almost all newborns on the Island as a result of their accessibility and the one-on-one contact by public health nurses. The same opportunity exists for broadening screening and health promotion education for women if ongoing Well Women’s Clinics are provided.

Challenges facing Well Women's Clinics can be overcome through involving all stakeholders, including the women themselves, through open communication, by investigating the different models, and through a systematic and continuous research process. The end result in recognizing the gap in screening options for women is to increase access for women, increase screening rates and availability of health promotion education, and thus save lives.

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Chart 1: Comparison of Well Women’s Clinics in Canada

	Well Women’s Clinics	IWK Grace Well Woman Clinic	The Red Door	Well Women’s Clinics (plus one Well Men’s Clinic)	Cervical Screening Initiative	Asian Women’s Health Clinic (Sent et al., 1998)
Setting	Mostly in public health clinics, medical clinics, and/or hospital	IWK Grace Hospital	A renovated house	Mostly in outpatient services, although information services have been at the local mall	Physicians offices or health centres	At first in city’s health department (East Health Unit); now located in the hospital
Location	Prince Edward Island	Halifax, NS	Kentville, NS	Yarmouth, NS	Western Nfld	Vancouver, BC
Target Groups	Women who have not been screened in a number of years	Women	Young women aged 18–30 years old; first Pap smear	Women without a physician, but also provide a service for women with a physician who would rather have screening done by another physician	Women with no physician; women with no female service provider; women with geography as a barrier	Asian women, particularly Chinese women
Services	Pap smears. Other services varied by setting but can include blood pressure, cholesterol, bone density, breast self exam education, breast exam by physician, haemoglobin, nutrition information, and other informational materials	Pap smears, breast exams, blood pressure monitoring, information on preventive health care, breast health, menopause, birth control, and PMS	Pap smears, educational information on AIDS, depression, STDs, nutrition, physical and sexual abuse, substance abuse, and sexuality	Pap smears, information such as nutrition and mental health, and breast exam if patient wishes	Services vary depending on the clinic but can include full clinical breast exam, Pap smear and pelvic exam, blood pressure, breast self exam (BSE) education, nutrition information, healthy heart information. Nurse examiners do BSE education and Pap smear only.	Educational videos on cervical screening and breast self exams; educational session with nurse including BSE; pelvic exam and Pap smear plus breast exams by physician; for eligible women, mammography is also on-site

	Well Women's Clinics	IWK Grace Well Woman Clinic	The Red Door	Well Women's Clinics (plus one Well Men's Clinic)	Cervical Screening Initiative	Asian Women's Health Clinic (Sent et al., 1998)
Frequency	Offered irregularly	Open 3 days a week (with one evening)	Open weekdays from 2:00 – 5:00 p.m. plus Tuesday evenings and one Saturday a month	Offered twice a year – once in the fall and once in the spring	Depends on location. Remote area clinics are once or twice a year. One day a week in Port-Aux-Basques and Doyles.	Started as one evening a month (with one doctor); now two doctors work three nights a week
Promotion	Church bulletins, newspaper, word of mouth, radio, posters, brochures	Word of mouth, brochures at Breast Screening Clinic	Business cards, pamphlets, the web, mailouts, student youth workers, fundraisers	Local newspaper advertisements and posters	Posters, word of mouth, church bulletins, contacts with the church, women's centres, radio and newspaper advertisements, and through public health nurses.	Radio and talk shows, lectures and workshops at Health Fair, Chinese newspaper articles, doctor referrals, Chinese language videos
Practitioner	Family physician	Nurses	Nurses	Family physicians	Family physician or nurse depending on situation	Family physician
Remuneration	Fee for service (\$5.70 per Pap smear)	Salaried nurses	One salaried nurse and two volunteer nurses	Fee for service	Physicians are paid fee for service. Nurses are paid as part of public health salary.	Fee for service

Appendix 1: Models of Clinics

Service: IWK Grace Well Woman Clinic (cervical screenings)

Setting: Hospital

Location: Halifax, NS

Target Groups: Originally, the clinic was developed to reach women in the lower economic categories, although this is not the group that originally attended the clinics. Over time, this group of women has been reached through the clinic.

Purpose / Background: The IWK Grace Well Woman Clinic opened in 1976/1977 as a nursing project in Women's Health, under gynecologist Dr. Murray Davis. The purpose of the clinic was to offer an option for women for screening. At first, the clinic operated on a smaller scale; four nurses worked four hours a week. An afternoon clinic was added due to high response.

The basis for this model currently is 1) services are self-referred (but doctors and other health professionals also make referrals) and 2) a women's centered philosophy.

Structure: The clinic is located in a hospital setting, and is open three days a week (with one evening).

Continuity of Care: Reports from the clinic's cervical screenings are mailed out to the woman's family physician so continuity of care is maintained.

Services Offered: Women self-refer themselves and are offered a range of services including access to information on preventive health care, breast health, menopause, blood pressure monitoring, birth control, and PMS. As well, the nurses can refer the women for bone density scans and other referral options. Mammographies are done through the Breast Screening Clinic. The nurses at the clinic also do community education sessions on a wide variety of topics. In this model, specially-trained nurses do Pap smears and breast exams.

Promotion Methods: Promotion is done through word of mouth and at the Breast Screening Clinic.

Utilization Patterns: There were 1,248 patients in 1998 (1 April 1997 to 31 March 1998), 12 community sessions which 670 women attended, and 120 counseling sessions (miscarriage support counseling).

Costs: Costs for the clinic include: travel, copying, supplies, continuing education, 1.8 FTE nurses, 1 FTE receptionist, plus other part-time salaries including a social worker. Total cost annually is approximately \$180,000 – \$200,000. With the current infrastructure at the hospital, it is estimated that community clinics (open a few days a week) could be implemented for between \$50–100,000 annually.

Remuneration Policies: Nurses are paid by salary

Evaluation Findings: Evaluation is anecdotal, plus number of women seen, files of satisfied women who have used service, and testimonials.

Success Factors: Commitment of health care management to women's health. In the late 1970s when the clinic began, there was more money in health care.

Outstanding issues/dilemmas: Historically, some of the challenges for the clinic include expanding clinic hours and issues with physicians. However, an administration that backed women's health resulted in the overcoming of these barriers. Clinic demand is very high, and therefore very little advertising of the clinic is done. Because of the urban location, the clinic is more accessible to urban women. Formal evaluation of the clinic is needed in order for it to evolve and grow as well as to compete with acute care budget items.

Future Initiatives: The clinic is in a period of evolution to a shift in focus on well women assessment screening. As well, increased community involvement will be needed in order to meet the needs of more women and to increase outreach.

Service: The Red Door (Pap smears plus educational information)

Setting: Renovated house

Location: Kentville, NS

Target Groups: Young women (aged 18 to 30 years old) who have never had a Pap smear

Purpose/Background: A volunteer board of directors, including students, supports the centre. The Red Door does not focus solely on Pap smears, but it is one service that it offered. The clinic's objective with regards to Pap smears is to make the woman's first Pap smear a positive experience.

Structure: Specially trained nurses do the Pap smears by appointment. The Centre is open from 2 p.m. until 5 p.m. everyday day plus on Tuesday evenings from 7–9 p.m., and also one Saturday a month from 11 a.m.–2 p.m.

Services Offered: The Red Door also offers a variety of other services including: information on AIDS, depression, STDs, nutrition, physical and sexual abuse, substance abuse, and sexuality. The clinic has had special programs including educational programs on bullies and Hepatitis B.

Promotion Methods: Promotion of the clinic is done through business cards, pamphlets, the web, mail outs, student youth workers, and fund raising activities.

Utilization Patterns: There have been 13,016 various visits to the Red Door over the past eight years; 5,262 of these were new visits. (These include all visits, not just Pap smears.)

Remuneration Policies: There is one part-time paid coordinator position (a nurse) and two volunteer nurses that do the cervical screenings.

Evaluation Findings: The Red Door has been evaluated using focus groups, interviews, and surveys. The evaluation does not focus specifically on the Pap smear experience, but rather all services. The satisfaction of clients is very high (44/51 participants said that the services received were excellent). All 51 respondents would recommend the Red Door to others (Beazley, et al., 1995).

Success Factors: Satellite 'Doors' have opened in schools, such as the Green Door in Central Kings and the Polka Dot Door in West Kings. Nurses are available at these schools at certain times during the week.

Outstanding issues/dilemmas: One challenge with the clinic is ongoing funding. The majority of staff are volunteers, and the Western Regional Health Board currently funds the salaries for the part-time coordinator and administrative support.

Service: Yarmouth Well Women's Clinics

Setting: The clinics are run on a Saturday and take place at the hospital, although one clinic took place at the local mall (with the Pap smears taking place at the hospital).

Location: Yarmouth, NS

Target Groups: The clinics do not specifically target high-risk women (i.e., women who are under screened or never screened) but the main focus of the clinic is for women who have no family physician. However, women with or without a family physician are accepted at the clinics.

Purpose/Background: These clinics took place over a decade ago but were discontinued when they were considered unneeded. However, five years ago the clinics were restarted as a result of doctor shortages in the area.

Structure: The clinics take place once in the spring and once again in the fall.

Continuity of Care: The Chief of Staff at the hospital is responsible for follow-up of any client with no regular physician. If the woman has a regular doctor, the report is sent to the woman's regular doctor.

Services Offered: The main focus of these clinics is Pap smears, although there are a variety of health promotion information sessions at the clinics, including nutrition and mental health. The physician will also perform a breast exam if the patient wishes.

Promotion Methods: The clinics are promoted through advertisements in the local newspaper and small newspapers, and through the distribution of posters.

Costs: Supplies are paid for through grants. For example, the Community Health Board provides funds and a pharmaceutical company provides supplies.

Remuneration Policies: The doctors conduct the Pap smears, as no specially-trained nurses are available at this point. The physicians are paid per Pap smear, and are paid a reasonable rate. Volunteers run the rest of the clinic.

Success Factors: There have been some comments from women that they prefer female physicians, and currently the physicians working at the Clinics are female. The Medical Society is informed of upcoming clinics and the physician bills fee for service.

Outstanding issues/dilemmas: One barrier is the difficulty of recruiting physicians for the clinics, although the physicians that do participate are very understanding and flexible. For example, because of an inability to get another physician to do a clinic day, over thirty women had to be canceled for a clinic. When the other two doctors who were working the clinic heard this, they agreed to do another day to accommodate these women. The fact that women with physicians are accepted at the clinics has created a challenge as some argue that women with physicians should not be screened at Well Women's Clinics.

Future initiatives: Another initiative that has been tried with the clinics in Yarmouth is prostate screening (DRE) with men. These clinics were a result of comments on evaluations from the Well Women's Clinics suggesting the inclusion of men. The clinic was called "Family Wellness" and was a success. Some men had to be turned away because of the demand for the

service coupled with the lack of physician participation. However, there were some criticisms from this initiative because of the belief that the organizers were combining men with the Well Women's Clinics. Other attempts have been made to coordinate the mobile breast screening van with the cervical screening clinics – but this has been unsuccessful to date because of timing for the two initiatives. Bone density screening may start at the clinics as a result of the potential availability of provincial mobile bone density monitors (Nova Scotia Department of Health, 1999).

Service: Cervical Screening Initiative

Setting: Health clinics, hospital, medical centre

Location: Western Newfoundland

Target Groups: Initially, women with lack of female service provider or none at all; women facing geography as barrier.

Purpose/Background: The Cervical Screening Initiative is a partnership with the Newfoundland Department of Health, Health Canada, and the regional health area. The program has three different components – education and recruitment, an information system, and quality assurance.

Structure: Various models of Well Women's Clinics. In Port Aux Basques and Doyles, clinics are held one day a week. In more remote places, clinics are held once or twice a year. Clinics will start in Cornerbrook in April 1999 and the initial plan is to have physician run clinics two times a month. As nurses are trained, the clinics will be more ongoing, probably once a week. The clinics try to have female physicians or screenings. Nurses that conduct Pap smears are public health nurses with a Bachelor degree in Nursing with 10–12 years experience in the area. Nurses are surveyed for their interest and if they had extra time because of the drop off in baby clinics. They revised a manual and video and include a practical component in their training. Nurses have one day of training (pre- and post-test) and then work with a gynecologist for one day. The nurse then performs Pap smears until the gynecologist feels that s/he is competent in that skill, at which time that nurse is certified. Policy and procedures on shared skills were drafted between the Medical Board and Nursing Board in order for this to occur.

Continuity of Care: If the woman has a doctor, the Pap report goes to the family doctor. If the woman has no doctor, the clinic physician doing the screening receives the Pap report and does the follow-up. If a specially trained public health nurse does the screening, the nurses are responsible for screening and follow-up in areas with no doctor. The gynecologist receives referrals from the nurse.

Services Offered: Services vary depending on the clinic: some of the clinics that are with physicians include a full breast, Pap and pelvic exam, and blood pressure test. Nurse examiners provide BSE education and healthy heart information, and do Pap smears (they do not do clinical breast or pelvic exams). In certain rural sites, nurses do Pap smears and BSE and other health professionals such as a dietician are available to provide educational information.

Promotion Methods: Clinics are promoted through posters, word of mouth, advertisements in church bulletins, and contacts with church and women's centres. As well the public health nurses are well known in the area. Promotion through newspaper articles, radio, and cable target the general public. A running list of women is kept when calls are received.

Costs: The nursing supervisor in the area helps to pay for replacement staff and travel expenses.

Remuneration Policies: Doctors are paid fee for service (although the amount is a barrier). Nurses are paid as part of their public health salary.

Evaluation Findings: In progress

Outstanding issues/dilemmas: Challenges included resistance from physicians, which was overcome by the lack of doctor recruitment to the area coupled with the realization that the service was not 'stepping on toes'. As well, doctors were asked to become involved in a variety of ways and were offered the chance to have a clinic. The process was facilitated by keeping in contact with doctors and always inviting physicians (i.e., before training the nurses). Nurses are trained only after physicians have been offered an opportunity to provide the service.

Service: Asian Women's Health Clinic (Sent et al., 1998)

Setting: Initially, the East Health Unit of Vancouver's health department, now at a centrally located hospital

Location: Vancouver, BC

Target Groups: Asian women, particularly Chinese women

Purpose: The purpose of the clinic is to educate Asian women about the need for periodic screening; to cooperate with women's doctors to ensure continuity of care; and to overcome cultural and linguistic barriers.

Background: In 1993, members of the British Columbia Chinese Canadian Medical Society were surveyed about the availability of cervical screening for Chinese women (including screening by family doctors in the office, referring to other colleagues, referring to specialists, or referring to a Pap clinic). Forty-five out of the 208 physicians replied and 52% were in favor of a Pap clinic. Barriers identified for physicians included doctors' lack of awareness of the low rates of Pap screening and concerns with continuity of care.

Focus groups with Chinese women were conducted to develop educational resources (a six-minute video "Taking Care of Your Health – the Pap test" in Cantonese and Mandarin was the result).

Barriers identified by Asian women for not being screened included lack of knowledge of Pap test or embarrassment, cultural differences (i.e., the belief that there is no need for screenings when child-bearing is complete; modesty and privacy issues), linguistic barriers (as there are few female doctors who speak Chinese), lack of knowledge of Canada's social and health care system, immigration issues (loss of support of extended family), and, for some women, a preference to see a different doctor than their own for these screenings.

Structure: Started as one evening a month (with one doctor); there are now two doctors working three nights a week. Women without health insurance are seen for free. Staff speak Chinese and include three volunteers (front desk), a clerical supervisor, two nurses and two doctors.

Continuity of Care: The Pap smear report is sent to the woman's own doctor and a recall is sent out for the next Pap smear from the clinic (the client then has the option to go to their own doctor or back to the clinic doctor).

Services Offered: Demographic and medical history are taken at registration; women view educational videos on cervical screening and breast self exams; a nurse spends 10–15 minutes on an educational session which outlines the significance of a Pap test, shows the procedure using a model of the pelvis, and explains follow-up procedures; the nurse then teaches the woman breast self exam techniques. The woman then meets with the doctor who reviews the woman's history, conducts pelvic and breast exams and the Pap smear. Educational materials on Pap smears and breast self exams are also available. Mammographies are also available on-site for eligible women.

Promotion Methods: Radio and talk shows (radio has been found to be most successful for this culture), lectures and workshops at Health Fair; Chinese newspaper articles; doctor referrals

Utilization Patterns: One year into operation, over 40% of women had never had a breast exam by a doctor so these were added along with BSE teaching. Four years into operation, there have been 1,090 patients seen (1,577 visits).

Costs: Start-up costs included start-up education programs, brochure development (\$3,000), Pap smear video development (\$12,000), breast health slides and binder (\$7,300), and seminar costs (\$1,500).

Annual costs include \$8,250 (nurses); \$2,250 (clinic clerk), \$1,350 (appointment clerk), \$2,250 (data entry clerk), \$6,960 (Medical Director), supplies (\$2,300), telephone (\$750) for a total of \$24,410. In addition, volunteers provide front desk support.

Remuneration Policies: Physicians are paid on a fee-for-service basis.

Evaluation Findings: There has been an increase in awareness and Chinese family doctors are now referring more patients to the clinic, or to other female physicians, or have hired part-time female doctors to do Pap tests. Clients have started to return to own physician for repeat screenings. In 1997, 115 out of the 608 visits were clients getting their first Pap smear. An evaluation of the need and effectiveness is currently taking place.

Success Factors: Success has been attributed to strong community partnerships, committed staff and volunteers, and the Chinese media as an effective promotional tool.

Service: Cervical screenings (Stirland et al., 1996)

Setting: Mobile screenings (car parks and workplaces) versus traditional setting

Location: London, England

Target Groups: Women who have not had a screen before or are not being screened regularly

Purpose/Background: To compare drop-in screenings in car parks of major shops (public screening) and workplace screenings versus traditional screening programs

Services Offered: Mobile (public and workplace) blood pressure, breast and pelvic exams, and cervical smears if had not had one in three years.

Promotion Methods: Posters and leaflets for public; personalized letter for workplace

Evaluation Findings: In the traditional program, fewer women were 40 years of age and older (37%) compared to public screenings (52%) and workplace screenings (79%). Women of lower social class were more likely to attend public screenings (39%) than workplace screenings (12%) or traditional screening (16%); 18% of participants at the public screenings were black (which was not significantly different than traditional screenings (11%) and workplace screenings (12%)). In the public screenings, 57% of women claimed to never have been given an invitation to be screened, and 28% had no regular physician. Only 17% of women at the public screening and 22% at the workplace screening had been screened in the past three years (therefore these mobile screenings are not attracting women who want testing more often).

Success Factors: People want more flexible times and would like a female Pap smear taker. Women like the informality and convenience of public screening and not having to miss work for the workplace program.

Service: Health checks (Ochera et al., 1993)

Setting: Clinical

Location: England (qualitative interviews with 18 group practices)

Target Groups: Adults who had not been seen by family physician for three or more years

Purpose/Background: 1990 contract required doctors to have health checks and invite any adult clients that had not been to the office for three years or more (although 55% of clinics in the present study started the clinics prior to the contract)

Structure: Some physicians offered checks for people from 16 to 75 years of age (as was in the contract); others only had checks for patients over 30 years of age

Services Offered: All health promotion screenings including blood pressure, weight, height, urinalysis, and life-style advice. Other information varied by clinic, but could include: stress management, smoking cessation strategies, cholesterol screening, contraception, allergies, AIDS advice, ECG's for those with high risk factors, blood sugar, and peak expiratory flow rate measurement. The majority of practices in this study had at least one clinic after 5:00 p.m. or on a Saturday morning. Other clinics included: well woman, well man, well person, smoking cessation, diabetes, stress management, hypertension, weight loss/diet, asthma, menopause, lipids, immunization, and travel.

Promotion Methods: Self-referral (posters in waiting room), word of mouth was encouraged (e.g., asking clients to invite family members), people who went to doctor for cervical screening or with risk factors for CVD, active recruitment by phone or letter

Utilization Patterns: None provided, although use varied by who were invited to clinic (i.e., over 30 years old or all age groups)

Remuneration Policies: Practical nurses as part of their position in physician's clinic

Outstanding issues/dilemmas: Four of the practices interviewed had not begun to contact patients who had not been to the physician for more than three years, despite the contract requirements.

Service: Cervical screening (Mamon et al., 1991–1992)

Setting: Existing medical care system

Location: Baltimore, Maryland

Target Groups: Women who had never had cervical screening or who had not been screened regularly

Purpose/Background: Lay peer educators were recruited mainly through churches to encourage women to have cervical screening using the existing medical care system (a Papmobile offered in one case). Churches were contacted, and ministers identified an active female member who was trusted, and then she sought others to be lay peer educators (and was in charge of supervising her group).

An Advisory Council was also formed with representatives from churches, community organizations, ethnic centres, housing projects, political leaders, the Cancer Society, and the Health Department in order to get feedback and input on the best strategies to motivate women to get Pap screenings.

Services Offered: Multiple physician and community interventions took place (Papmobile, clinics, etc.). Support, education and encouragement to get screening were offered. Women who were unscreened or underscreened were identified through a telephone survey. With the woman's permission, trained lay educators would then contact the assigned woman, look at her concerns surrounding Pap testing, help to resolve these barriers and encourage her to get a Pap, remind her of the test before the date, see if she had the test, and remind her to get results.

Promotion Methods: Lay peer educators

Utilization Patterns and Costs: 1,107 women identified by telephone with inadequate cervical screening were matched with a volunteer peer educator

Remuneration Policies: 144 lay peer educators were volunteers; women were encouraged to have Pap screening at physician's office

Evaluation Findings: Social support has positive impact on health promotion behaviors. 46% of the 702 women (for which lay educators had records of appointment-making status) had taken part in at least one screening appointment.

Outstanding issues/dilemmas: Ethnic groups and other organizations besides churches may also be ideal to locate lay peer educators. May need to have the minister identify more than one member to act as a supervisor, in case this person changes. Volunteer recruitment and satisfaction were also challenging issues.

Service: Mammography screening (Greenwood and Henritze, 1995)

Setting: Workplace

Location: Coors Brewing Company, Golden, Colorado

Target Groups: All female employees, spouses, and retirees

Purpose/Background: To decrease health care costs to the company by detecting breast cancer early; to increase awareness of breast screening. National mammography participation rates at the time of start up were 12–15%. (Coors had other health promotion screening programs in place, such as cardiovascular disease risk factor testing, which included treadmill testing, blood pressure, cholesterol, weight and body fat exams, and functional capacity testing).

Services Offered: Mammogram on site

Promotion Methods: Networking (40 women were identified by the worksite based on personal factors including enthusiasm); lectures by radiologist; invitations sent to home; posters in women's washrooms, tear-off sheets on Valentine posters in men's washrooms (sign up your wife to show you care); once a year mailing to all eligible women that included rates of attendance at mammographies, findings, and testimonials from women who had benefited from early detection; "Time to Join the Club" cards sent on 35th birthday; computerized recall system

Utilization Patterns: Between 1985 and 1993, 12,210 mammograms were done on 3,729 employees, spouses, and retirees; there was an 83% participation rate.

Costs: Forty-seven malignancies were found (in ten employees) and four late detections (two employees). Total savings were estimated at \$3,110,000 because of early versus late detection; screening costs were \$668,690, therefore the overall savings to the company was \$2,441,190.

Service: Prostate Cancer Screening (Barber et al., 1998)

Setting: Senior centre, church, senior apartments, public housing projects

Location: United States

Target Groups: African American men

Purpose: To increase minority screening (African American men and low-income men) by increasing education and providing more accessible settings

Background: African American men have lower screening rates than white men.

Structure: Participants completed a brief questionnaire on attitudes and knowledge of prostate cancer and the benefits of screening programs, and then watched a videotape by Sidney Poitier entitled “Male Call” which outlined the importance of early prostate cancer detection. PSA and DRE screenings were offered free of charge.

Services Offered: An education session followed by a free screening

Promotion Methods: Flyers mailed to local primary care providers and community organizations; program announcements on community television; local minority media and minority church leaders; advertisement in free newspaper for pastors

Utilization Patterns: In total, 944 men were screened as a result of this program (the average age was 57.5 years old).

Evaluation Findings: Most appointments were done in a clinic in a community-based urban senior centre; the second most popular location was a suburban church. Most consumers preferred private appointments over mass screenings; African American men were half as likely to decide on mass screening than white men (outlining the need for discretion with certain populations).

Newspapers, flyers, word of mouth, radio, and then health care provider were the most effective promotional methods. Radio reached more African American men; newspaper ads were most effective for white men.

There was a high satisfaction rate among participants – 95% would recommend the program to other men. After program involvement, knowledge scores with regards to prostate cancer and screening increased significantly for both white and African American men.

Service: Weinrich et al. (1998)

Setting: Workplace

Location: Central South Carolina

Target Groups: African American men aged 40 and over, white men aged 50 and older

Purpose/Background: Worksites have been found to be the most effective way to recruit African American men to prostate screenings. The present study tried to target African American men by targeting industries with large numbers of African American workers using an empowerment model in which men are educated about prostate screening and then offered a free screening.

Services Offered: Worksite prostate cancer education was offered followed by a voucher for a free visit to doctor of his choice to get screening

Promotion Methods: Notices in paychecks, signs on a centralized bulletin board, word of mouth by plant manager, plant nurse, and supervisors. Word of mouth was the best promotional tool.

Utilization Patterns: In the study, results from twenty-nine worksites and 179 men are reported.

Evaluation Findings: 64% of participants were African American, which indicates that worksites are an excellent place to recruit African American men for prostate screening. 55% of men who attended the educational session went to a free screening afterwards. White men were more likely to go to the screening (72% versus 47% African American men). Men with higher incomes were less likely to go for the free screening following the educational session. Age, level of education, marital status, pain symptoms, and previous prostate screenings (both DRE and PSA) were not factors in being screened in the present study.

Success Factors: Men were more likely to attend if given lieu time, even though the majority in this study were not. It was better to have the session close to where men worked. A reminder to the men the day before the session was important. Certain times were found to be better to have presentations (i.e., back to back so that both shifts could attend; sessions should not be held in July, August, or December or on Mondays and Fridays). For those men without a current doctor, the free prostate cancer screening to a physician gave men a chance to establish a doctor (which would not occur in on-site screening which is often one-time). As well, having to go to a doctor may promote having annual exam that may not occur with on-site screening.