Evaluation of the National Cervical Screening Programme: the early years

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Executive Summary

The National Cervical Screening Programme (NCSP) was implemented as a result of the 1988 Cartwright Report recommendations. The aim of the programme is to reduce the incidence of, and mortality from, cervical cancer among New Zealand women. The NCSP consisted of:

- the establishment of a centralised cytology Register based on a regionalised network
- the appointment of regional managers to ensure that eligible women were screened, enrolled on the Register, and that services were of a high quality, and
- the development of policies and support systems for the regions at a central level in the Department of Health.

Funding has been committed to the programme for the three years from June 1990 to June 1993 by the government. The objectives of the NCSP for those years relate to increasing the number of women who have been screened in the last three years. Priority group women were identified as being Maori and Pacific Island women, and women aged 35 years and over.

Aims of the Evaluation

Health Research Services was contracted by the NCSP to evaluate the second year of the programme (June 1991-June 1992).

Three key issues were identified as having an impact on the effectiveness of the national programme. To maximise its effectiveness, the NCSP would have to ensure high levels of the following:

- coverage: screening and enrolling all eligible women
- quality: ensuring that screening services are of high quality, and
- follow-up: ensuring that women are recalled and that abnormalities are followed up appropriately.

The aims of the evaluation were to monitor and document programme processes in terms of those three issues. Potential indicators for each of the issues included enrolment rates, community consultation and education, publicity, and the provision of screening services (coverage); the quality of smear taking and reading (quality); and the follow-up and treatment of abnormalities (follow-up).

Methods

In the first part of the evaluation, each of the 14 regions was visited to document the regional aims and objective, resources, strategies, priorities, problems and existing methods of documentation and monitoring. The regional managers and other programme staff were interviewed, and documentation about the programme was reviewed.

The quarterly reports from the regions to the Department were also reviewed.
The information that was collected was analysed in terms of coverage, quality and follow-up information. In December 1991, HRS recommended that the information that was collected on a regular basis by the regions should be made more consistent and comprehensive, and to that end the quarterly reporting format should be reviewed.

HRS reviewed and piloted a revised version of the quarterly report format in order to collect information about the period January-March 1992. The results were added to the existing information about coverage, quality and follow-up that was collected in 1991.

**Results**

The results of the evaluation indicated that there was a wide range of objectives, priorities, resources, strategies, activities, and monitoring procedures across the regions. While all regions identified that the focus of the programme was priority group women, they varied in the way that the programme was organised to meet the needs of those women.

Each region was also at a different stage of development, which made comparison across regions difficult. The length of time that the Register has been processing enrolments in that region was related to the number of participating smear takers per eligible woman and the overall coverage rates. There was generally an average increase in enrolments of seven percent across the regions. The highest coverage rate was 37 percent of all eligible women in one region, and the lowest five percent in another.

Most regions collected information on the education sessions and smear clinics sponsored by the programme. The information was not, however, always consistent or readily available. Information about aspects of programme quality and follow-up was even more difficult to obtain. Managers reported that it was particularly difficult to collect information about aspects of cervical screening services that were not directly contracted to the programme, such as GP services, laboratory quality control measures, and treatment services.

**Conclusions**

The diversity of the regional programmes, the variation in stages of development in the regional programmes at the present time, and the lack of consistency in the information that is currently being collected by the regions, makes it difficult to draw conclusions about current regional performance.

The regular collection of consistent information by the regions is still an issue that needs to be addressed, so that accurate and meaningful monitoring and evaluation can occur. HRS recommends that the quarterly report format is further developed so that monitoring of coverage, quality and follow-up issues is consistent.

The development of other monitoring activities, such as the measurement of consumer satisfaction, and the collection of indicators of programme quality and follow-up, also needs to occur for ensuring adequate evaluation.
Introduction

1 Background to the National Cervical Screening Programme

The National Cervical Screening Programme (NCSP) is the name given for the development of an organised system of cervical screening in New Zealand. The programme is aimed at reducing the incidence of, and mortality from, cervical cancer among New Zealand women.

Details of the history of the NCSP are provided elsewhere (Adams 1991). Essentially, the NCSP was established as a result of recommendations made in The Report of the Cervical Cancer Inquiry (1988), otherwise known as the 'Cartwright Report'. On the recommendation of the report, the government agreed that a nationally planned, New Zealand-wide cervical screening programme should be implemented. Part of the programme included the establishment of a centralised cytology Register based on a regionalised network. The function of the Register was to act as a recording and recall system for cervical screening.

In the period 1989-1991 the Register was developed and piloted, national policies were formulated, and the national programme and regional (Area Health Board) cervical screening programme managers were appointed.

2 Organisation of the NCSP

The regional managers were responsible for implementing screening in their areas. Policy on issues such as the age range of women that should be screened, the frequency of screening and the management of abnormalities were determined nationally. Support was provided by the central Cervical Screening Programme based in the Department, and ongoing advice was provided to the Department and the Minister of Health by an independent Advisory Group.

In 1991, the key national policies on cervical screening were that:

- all women between the ages of 20-70 years should be offered cervical screening every three years;
- women should have a second smear within one year if they have never had a smear before or if more than five years have passed since their last smear;
- routine screening after the first two negative smears should be repeated every three years.

The initial focus of the programme was on women who had never had a smear, or had not had a smear in more than three years. Three priority groups were identified whose members had lower screening coverage and higher rates of cervical cancer. The priority groups were:

- midlife and older women;
- Maori women; and
- Pacific Island women.
The government made a commitment to the funding of the NCSP for a period of three years (1990-1993).

3 Objectives of the NCSP

The objective of the NCSP are to:

- to increase the proportion of all women aged 20 to 69 years who have been screened in the last three years and who have been provided with appropriate follow-up diagnosis and therapeutic services;
- to reduce the incidence of invasive cancer; and
- to reduce the death rate from cervical cancer.

4 The Evaluation Model

The model used for the evaluation of the NCSP provides a framework to explore the relationships between the resources that go into the NCSP (inputs), the way in which the resources are managed (processes), the immediate or short term results (outputs), and the long term health consequences (outcomes) (see Figures 1 and 2 in Appendix A).

The long term aim of an evaluation of the NCSP would be to assess whether the programme had achieved its aims in terms of mortality, incidence, early detection and coverage. However, because of the time lag before the impact of the programme is reflected in statistics, monitoring of various aspects of programme planning and implementation was identified as being important.

Therefore, the focus for the evaluation of the first year of the programme (the second year of funding) was largely on the programme processes- that is, the ways that the programme was planned and delivered. There was also some monitoring of early outputs such as numbers of women enrolling on the Register per month.

Based on a review of international literature on cervical screening programmes (Adams 1991), five key issues were identified as being related to the potential success of the NCSP: coverage, quality, follow-up, costs and monitoring/evaluation. The focus of this report is on coverage, quality, follow-up and monitoring/evaluation. A brief definition of the issues and key indicators is provided below:

- **Coverage**: the programme needs to achieve maximum coverage of eligible women (ie. number of eligible women screened and enrolled on the Register). Coverage can be affected by factors such as the level of community consultation and consumer involvement in service planning; the amount and type of health education and publicity; and the availability, cost and types of services.

- **Quality**: the programme needs to ensure that all the components of the programme are of high quality. Quality issues include the provision of service provider training; the quality of smear taking and smear reading; data quality and other Register issues; and the overall monitoring and evaluation of the programme.

- **Follow-up**: it is important that women are adequately followed up following their smear. Factors relating to follow-up issues include the generation of...
result and reminder letters by the Register; and diagnosis and treatment services.

A more detailed analysis of the potential process and output indicators for each issue is provided in Appendix B.

5 Methodology

As the NCSP was regionally implemented, it was identified that information about each of the above issues needed to be monitored at a regional level. When the evaluation began, the regional programmes had already been established for over six months. Existing procedures and systems needed to be taken into account.

The first stage of the evaluation was to visit each of the 14 regions, to document the following areas of each programme:

- aims and objectives;
- available resources;
- strategies used and action taken;
- priorities and focus;
- problems; and
- documentation and evaluation.

Each region was visited at least once during the period October-November 1991. Information was collected by interviewing programme manager and other programme staff, observing programme activities, and reviewing programme documentation.

Based on the information collected from the regional programmes, a NCSP evaluation proposal for discussion was written by the researcher in December 1991 and circulated to all managers. A copy of the report is included in Appendix C. The report recommended that there was a need to develop a system where key minimum information was collected, compiled and analysed. Recommendations were made about the type of coverage, quality and follow-up information that should be collected. A draft quarterly report form (see Appendix D) was also developed to replace the form that had been used by the regional managers to make their quarterly reports to the Department.

As a final stage of the evaluation, the quarterly report form format was refined and piloted in June 1992 (see Appendix E for a copy of the form).

The results of the regional visits and the quarterly reports (including the pilot form) were analysed using the model outlined above. The information was grouped and analysed using the above categories of coverage, quality, follow-up and general comments.

The following indicators were included in the analysis:

Coverage: Numbers of smears
Enrolments
Smear Takers
Community Consultation and Education
Publicity
Screening Services
Monitoring and Evaluation

**Quality:**
- Service Provider Training
- Quality of Smears and Smear Reading
- Data Quality and Register Issues
- Overall Monitoring/Evaluation

**Follow-up:**
- Numbers of Abnormal Smears
- Result and Reminder Letters
- Colposcopy, Biopsy and Treatment Services.

The term *coverage* refers to the number of eligible women who are enrolled on the programme; *risk groups* refers to the groups of women identified above (Maori, Pacific Island and older women); *adequacy* refers to whether a cervical smear is considered to have adequate endocervical cells; *non optimal* refers to smears that are of poor quality but still acceptable for diagnostic purposes; *inadequate* refers to smears that have insufficient cells for diagnostic purposes.

The next section provides a region-by-region analysis according to the issues and indicators identified above.
Region-by Region Analysis of Programmes: January-December 1991, and January-March 1992

Introduction

The results of the evaluation of the 14 regional cervical screening programmes for the period January-December 1991 and (where the information was available) January-March 1992 are presented below in alphabetical order. The results are analysed based on the model outlined in Section 1, and fall under the four categories:

1) Coverage
2) Quality
3) Follow-up
4) General Comments

Results for the period January-December 1991 are based on information collected through the interviews with regional managers and other regional programme staff and the quarterly reports. Information for the first quarter of 1992 is also presented where available (from 9 of the 14 regions), based on the pilot of the revised quarterly report format. The quantity and nature of the information varies from region to region, depending on the stage of development of the programme, the programme orientation and available resources. The term "manager" refers to the manager of the programme for that particular region, unless otherwise specified (ie. national programme manager).

1 Auckland

1.1 Overview of the Auckland Programme

Programme Objectives, Organisation and Management 1991

The Auckland cervical screening programme was the largest of the 14 regional programmes. An average of approximately 40 percent of all eligible Auckland women were regarded as needing screening (Auckland Area health Board Cervical Screening Programme 1990), compared with approximately 20 percent of all New Zealand women (Bonita & Paul 1991).

The operations of the programme were divided into four districts: Central, North Harbour, West and South.

While the manager and her team directed overall policy and monitoring, the coordinators of each region were responsible for specific priorities and service development. The different sets of priorities for each district reflected the varied populations and services in each part of Auckland.

Following need analyses of their population, the districts developed strategies and targets for their areas including:
West: an emphasis on older women; the development of an invitation system for general practitioners;

South: a community development approach involving Maori and Pacific Island women and local media;

Central: a pilot of Area Health Board staff and community education training sessions; and

North: reaching older women through a number of strategies including local media.

For the period 1990-1991, the Auckland programme had a total of over 28 stated objectives (Auckland Cervical Screening Programme Plan 1990-1991). Results relating to those objectives are reported below.

A major part of the Auckland programme was to support initiatives by general practitioners in order to extend coverage of unscreened women in their practices. Education strategies were based on a community development model, using community consultation and trained "at risk" women to educate other women from their community. Priority groups were identified as being Maori and Pacific Island women, women in the paid workforce, women in lower socioeconomic areas and women aged 50-70 years.

Other objectives were to provide low cost services, and to monitor the quality of service. The emphasis was to develop services that are sustainable in the long term - services that are not solely dependent on resources from the cervical screening programme.

1992

A new manager was appointed in March. Three full-time data entry staff were also employed, and three administration/clerical staff (two part-time casual, one full-time). The districts employed the equivalent of ten full time staff, including the district coordinator, health educators, and smear takers.

The key objectives of the manager were similar to the previous year- to continue to support the District coordinators to provide a programme that is acceptable and accessible to women.

Staffing levels

1991

Core staff included the manager, four regional coordinators and systems administrator. During 1991, there were also coordinators appointed to oversee the Maori and Pacific Island components of the programme. Funding was specifically tagged for those components. Other staff who were employed on contract included a practice nurse consultant and Register promoters by the regional programme, and health educators by the districts.
1.2 Coverage

Numbers of Smears

A total of 138,301 smears were recorded in laboratories between March 1991 and September 1991, with an average of 46,100 smears per month. A 31 percent rise in the number of smears in women aged 35 years and over was reported by the programme in September 1991. A rise of 21 percent in the total number of smears was reported for that period.

Enrolments

The Auckland programme went "live" in September 1991. They had several problems with their Register during that time, including several "crashes" (the computer being temporarily inoperable). The Register recorded 54 smears in September.

Smear takers

The programme has compiled a database, which is frequently updated, of every smear taker in the Auckland district. A total of 1,800 smear takers were recorded on the database in 1991. In 1991, all smear takers were health professionals, although there was a proposal by the Maori coordinator to look at training Maori lay smear takers.

Community Consultation and Education

Consultation with the community was reported by the programme as being ongoing and informal in many cases. There were three formal committees that met regularly, that addressed such issues as the implementation of the Cartwright report and evaluation. Ongoing consultation occurred with over 20 groups, which included members from at least four ethnic groups, and representatives of the disabled and lesbian community.

All smear takers were scheduled to be visited by 5 Register promoters between March and June 1992. In total, over 50 health educators were trained and employed by October 1991, including Pacific Island, Maori, older and disabled educators.

Publicity

The programme developed leaflets in six different languages in consultation with the relevant ethnic groups. The leaflets were to go out with the invitation letter provided by the programme to participating general practitioners. A special letter was also used to invite women aged 60 years and over. A newsletter went out to identified interested groups and individuals. Other resources included a poster for Maori women, a leaflet for lesbian women, videos on colposcopy, and a Register pack including a video on the Register and information on informed consent.

A scrapbook of stories in local community newspapers, and advertising in journals and magazines was being compiled by the programme.

A radio campaign occurred in mid-October, and a newspaper campaign was planned for February 1992.
Services

The programme had negotiated 10 contracts with different groups who provided a range of services, including low cost services, and services for Maori, Pacific Island and disabled women. Smears were offered in a variety of centres including workplaces, Marae, and polytechnics. The emphasis of the programme was to provide support to established services that would continue to exist if the programme was no longer able to provide that support. The manager of the programme believed that Area Health Board services were a small part of screening services, and there were only two 2 Board smear takers.

As noted above, there were problems with the Register in 1991, including it "crashing" several times, and it being unable to generate some relevant information (eg. district data). The three regional laboratories had been supplying regular reports of numbers of smears, although they had stopped supplying the number of abnormalities.

Monitoring/Evaluation

There were three key research projects relating to coverage, which were funded by the programme in 1991:

- a general practitioner project, where contracted researchers evaluated the effectiveness of four different strategies (completed December 1991);
- a coverage survey of Pacific Island women, to be followed up at one and three years (data collection complete end 1991); and
- a Maori research project, which was still to present a proposal to the ethics committee.

The programme was committed to ensuring that all initiatives were monitored by those involved. The 10 service provider contracts included provision for the evaluation of knowledge and behaviour of consumers, as did the contracts with health educators and smear takers.

Independent researchers were contracted to work alongside the district coordinators, to assist in developing ways of documenting processes for themselves and the community educators. The manager believed that while such evaluation had several limitations (eg. reliance on self report; variations in recording styles), at this stage, it was the only formal monitoring information about programme processes that was available.

1992

The overall number of enrolments in the period April-June reduced by 15 percent from the period January-March. However, the average number of enrolments for each month of 1992 (up until mid-June) were 50 percent higher than the average number in the previous year. The number of enrolments for women aged 35-70 years was 20 percent less in the second period of April-June. The Maori data were not yet available.

The manager reported a reduction in the number of smear takers who were enrolling women, from 874 in the period January-March, to 801 in the period April-June (a reduction of 8%). The reasons given by smear takers were reported to be related to the time it takes to fill in forms, and problems with the Register.
Information on community education was not available to the researcher at the time of writing this report. A range of promotional talks were given to service providers, including at a GPs training scheme, a local Obstetricians and Gynaecologists Society meeting, Family Planning courses, the Homebirth Association conference, and a numerous GPs surgeries.

Information on screening services was also not yet available. A pilot project for central hospital staff was being run under the Central District and colposcopy clinic. A pilot was also being run for women with disabilities.

The manager reported that the results of the GPs strategies research, and the Pacific Island research, had been received. The information that was collected from the Register promoters was also being collated.

1.3 Quality

Service Provider Training and Quality Control

The Auckland Technical Institute ran two courses on cervical screening and community development for community educators.

Family Planning ran smear taker training courses approximately every two months.

Quality of Smears and Smear Reading

The Register began collecting information in September 1991, and at the time of the interviews with the programme manager, no data on smear quality in 1991 were available. As the laboratories no longer provided information on quality, the programme manager reported that it was difficult to monitor. This means that a number of performance indicators were unavailable.

Data Quality and Register Issues

The programme reported problems with PAXUS and PAXUS links. There was some reluctance reported by general practitioners to filling in forms.

The Auckland Area Health Board Ethics Committee were "extremely positive" about the security, confidentiality and informed consent procedures for the Register.

Overall Programme Monitoring and Evaluation

Overall monitoring by the programme manager included regular management meetings with the systems administration staff and the Register promoters.

1992

Quality

The length of time for the programme to receive a smear result ranged for two days from one private laboratory to 120 days from a hospital laboratory.

Information on service provider training was not yet available.
1.4 Follow-up

Percentage of Women on the Register

The percentage of enrolled women was very small in 1991, as the Register was only in operation from September of that year.

Colposcopy, Biopsy and Treatment Services

Monitoring follow-up was reported by the programme to be difficult because of lack of access to information, including the overall number of abnormalities. By October 1991, however, a colposcopy audit was in place, which indicated that the waiting lists for colposcopy were low.

1992

The manager was waiting for returns from the Department on related Health Indicators.

1.5 General Comments

Generally, the programme staff believe that the programme is progressing well, and is well resourced. There was some concern that risk groups such as Maori women were still not being accessed.

2 Bay of Plenty

2.1 Overview of the Bay of Plenty Programme

All the information presented on the Bay of Plenty programme relates to its 1991 activities. Information on the activities in 1992 was not available at the time of writing this report.

Programme Objectives, Organisation and Management

The Bay of Plenty (BOP) District was host to the Kawerau Pilot project. The regional manager began work for the national programme, based in Te Puke, in August 1990. She had had previous involvement with the pilot. The manager identified the need for a community development approach which would address such issues as: the need for low cost services, the problems of accessibility to rural women, and the need for alternative providers.

General practitioners and practice nurses were also identified by women as their preferred smear takers (with a choice of female smear taker), rather than smear takers such as Public Health Nurses. Women had also indicated that they preferred clinics.

The programme was divided into three broad geographical regions: East, West and South.
At the end of 1990, the manager also reviewed the colposcopy, cytology and obstetrics and gynaecological services. An objective of the 1991-1992 programme plan is to improve the quality of those services.

Staffing Levels

In 1991, core staff consisted of the regional programme manager and the systems administrator/data entry person. Three district coordinators were employed on a part-time basis (2FTE). A Maori Health Consultant was also employed on contract. A part-time clerical assistant to assist with the Register was also appointed. The remaining personnel were employed by the community initiatives (see 2.3.2 below).

2.2 Coverage

Enrolments and Smears

The Bay of Plenty Register went "live" in September 1991. In the period September/October, 1,200 women were enrolled on the Register. A total of 2,693 smears were read during that time. The manager estimates that approximately half of those women that had a smear in September, enrolled on the programme. Also, some women were reported to have pre-enrolled, but their smear report was never received after they had had a smear.

Problems were reported in going live, including problems in establishing a PAXUS link and in generating some information relating to age group and smear status.

Overall, the number of smears went up by 25 percent in September, when compared with the rest of the year's average. The total number of smears for the period January 1991 to October 1991 was 18,875, with an average of 2,097 smears per month.

Smear takers

A list of smear takers has been produced and distributed. There were 122 general practitioners in the Bay of Plenty in 1991. The manager estimated that most of the general practitioners in Eastern BOP, one half in the east and one quarter in the West were enrolling women.

There were 13 certificated female nurse smear takers, including two lay smear takers.

Community Consultation and Education

Community consultation began in November 1990. A hui was held in Rotorua to initiate the process, and launch the Department of Health's Resource Kit. Following that, women's groups and organisations were invited to nominate members of a Community Forum. The Forum met once a month in a different area, and included Maori and Pacific Island women, general practitioners, organised women's group representatives, and former Area Health Board members.

The Forum assisted in policy and planning and liaising with their groups. The 14 members were paid to attend. The group was estimated by the manager to be equally represented in numbers by both consumers and providers. The Forum attended study days on the programme and clinical aspects of cervical screening.
Other community education included promotion days, talks to groups such as Plunket, and visits to general practitioners (approximately half had been visited by November 1991). All written comments from GPs received phoned and written response. A meeting was to be held with the Chairperson, Royal College of GPs, in December 1991.

Publicity

In 1991, a series of newspaper and radio advertisements (on 5 stations) were run, identifying Community Clinics and contact numbers. The newspaper advertisements were regarded by the manager to be particularly successful. Articles were also published in newspapers identifying individual smear takers. Talkback radio was included, with talks in both English and Maori. The programme was intending to develop an advertising contract with radio Whakatane in 1992.

Leaflets on the Register and abnormal results were developed and distributed to chemists, libraries, football club and workplaces. A woman’s bike ride was also sponsored by the programme, and it put forward a team of riders.

Services

In 1991, a Cervical Screening Taskforce of Area Health Board representatives selected eight community initiatives to provide cervical screening services for each district area. The services provided were based on the policies and protocols developed by each community initiatives and included a range of clinics and responses to community education. Nearly all the services offered were at no cost to women, apart from a koha. Clinics were held in health clinics, Marae-based health centres, client’s homes, and health centres.

The two lay smear takers provided services to rural women. There was a steady increase in Practice nurses taking smears.

Monitoring/Evaluation

The contracts agreed upon by the eight community initiatives included a requirement for evaluation and reporting every three months. The community initiatives were required to provide information such as numbers of clinics, hours, and numbers of women seen. It did not appear, however, that regular and consistent reporting had become established in 1991.

The manager also provided supervision for the initiatives. A group of the Maori Women’s Welfare League and the Community Health Committee supervised the lay smear takers.

The programme was looking to develop consumer satisfaction measures and auditing procedures for 1992.

2.3 Quality

Service Provider Training and Quality Control

There were no lay smeartaking programmes in BOP in 1991. The two lay smear takers were trained in Waikato. The course for training nurse smear takers was discontinued, and preliminary evaluation indicated that the course had areas which
needed improving. The 14 nurses who attended the course had technical smear taking ability but were not certificated. Otherwise, nurses attended courses in other regions.

Basic accounting/administration, communication skills, planning and marketing skills courses were run for the members of the community initiatives. Counselling skills courses were run for nurses and obstetricians/gynaecologists.

Each district brought together its smear takers once a month, and there were regional hui at least once a year.

Quality of Smears and Smear Reading

There was a variation in the reporting between laboratories, and a lack of quality assurance protocols perceived by the manager. She believed that 1993 is too long for all laboratories to become TELARC Registered.

Data Quality and Register Issues

The laboratory forms were changed to make them easier to use. Changes included reporting chlamydia results on the same form, and asking whether women wanted the result sent to their GP.

The Protocols for Register were well received and approved.

2.4 Follow-up

Percentage of Women on the Register

There was a steady increase in enrolments from September, although by December the proportions were not yet known.

Abnormalities, and Result/Reminder Letters

An increased number of abnormalities was reported. The manager reported that a number of women were "lost" to the Register when they were removed from the recall system during treatment. She also reported that smear takers and women were unhappy with the letters and that they had been changed.

Colposcopy, Biopsy and Treatment

A "worrying" variation was reported in referral patterns for women with an abnormal smear history.

High grade abnormalities were seen by a colposcopist within two weeks of referral, low grades were seen within four to six weeks. One clinic upgraded, another established.

Adequate follow-up was seen by the manager to be hindered by the lack of histology being included on the Register.
2.5 General Comments

The BOP programme was reported to be well resourced. The budget allocated by the NCSP was supplemented by the Area Health Board, who were perceived by the manager to be very supportive of the programme.

Although some gatekeeping was occurring among GPs and practice nurses, the manager seemed optimistic about the level of enrolment that could be achieved.

The issues around the use of Maori Health statistics were still unresolved. The manager of the programme believed that it would be helpful to meet with, or have input into, the Advisory group.

3 Canterbury

3.1 Overview of the Canterbury Programme

Programme Objectives, Organisation and Management

1991

The Canterbury programme was based in Christchurch. The manager of the Canterbury Cervical Screening Programme was appointed in August 1990. The priority groups emphasised by the programme included older women, adolescents, Maori, rural and low income women. The programme worked closely with both service providers, such as GPs, and women, to raise public awareness and increase screening coverage. The programme itself does not provide services, but contracts them out to community initiatives.

Staffing Levels

The core staff of the programme were the manager and a part time data entry person. A systems administrator was seconded to the programme. Three health liaison workers, including a Maori and Pacific Island Worker, were also appointed, along with a nurse education supervisor.

1992

A total of eight FTE were employed in the programme until June 1993, including the manager, data entry and administration workers (4 full-time), and part time community health and community educators.

The key objectives for the first quarter were to run a publicity campaign for women who had never had a smear; to increase screening coverage of women aged 30 years and over; to develop resource material for Maori women; and to have implemented a culturally appropriate media campaign for Maori and Pacific Island women.
3.2 Coverage

1991

Numbers of Smears

The number of smears in September was over 20 percent higher (6133) than the average for the last eight months (5348). Otherwise, there appeared to be no obvious trends.

Number of Enrolments

The number of enrolments were highest in March (886), August (882) and September (893). The rates in April-July were about half of those in the other three months.

A refusal rate of less than two percent was reported in those surgeries that offered women enrolment on the Register. Community initiatives reported no refusals. Enrolment rates were regarded as going well by the manager. There were no pre-enrolments.

Smear takers

In surgeries, approximately 75 percent of smears were taken by GPs and 25 percent by practice nurses. Other smear takers that were available included Family practice doctors and nurses, independent nurse practitioners, a homoeopathic smear taker, and specialists.

Community Consultation and Education

When the programme began, the manager reported a high level of interest and support in the community. A Canterbury Cervical Screening Programme Committee was established, which was in regular mail contact with 90 organisations and met every three months. Four subcommittees were established: service delivery (monthly meetings); education and publicity (monthly meetings); evaluation (6 times per year); training (as required). A 12-member South Canterbury Core Group also met every month.

All specialists, practices (50) and their general practitioners (111) were visited. Eleven different health providers were also consulted.

In the period July-September, 12 talks were given to 158 people. A 95 percent satisfaction rate with the educational talks was recorded by the programme. Consultation also occurred with Maori, Pacific Island and Trade Union groups. Earlier in the year a display was put on in a shopping centre, and 60 women were recorded as approaching with enquiries.

Publicity

A media campaign was carried out in October for women aged 35-70 years. A specially developed commercial also ran on the local television station. Articles were placed in Public Health Nurses, and Social Services, newsletters.
Services

Under contract, community initiatives provided a number of services including subsidised clinics and suitcase clinics (Family Planning), free and low cost outreach clinics, and rural mobile clinics.

All GPs were able to enrol women. There were 25 certified nurses trained with 10 more still to be certified.

Monitoring/Evaluation

Health Research Services Christchurch researched several aspects of the programme including women's preferred choice of smear taker, and GP attitudes. Those studies and their results are reported elsewhere.

A pilot programme with GPs was being negotiated towards the end of the year. The pilot was to examine the effects of invitations to women on screening rates.

The Canterbury programme had developed a quality assurance (QA) programme, which was due to report in February 1992. The QA programme included data concerning consumer satisfaction, the processing of results, and enrolment figures. Education workshops and talks were also evaluated using an evaluation sheet.

1992

There was a decrease in the average number of smears per month, in the first few months of 1992, and an overall decrease of -13 percent in the total number of smears from the last quarter.

The number of enrolments increased by 25 percent in the period January-March 1992 from the previous period (October-December 1991).

A total of 193 smear takers (GPs and practice nurses) were enrolling women in the programme, with an adequacy rate of 90 percent.

Twenty community education sessions were held, with 241 women in attendance, although information was not available on the type of session (e.g. Maori women, older women etc).

In accordance with the objectives for the first part of the year, the programme had a publicity campaign focusing on Maori and Pacific Island women. Regular meetings were also held with the established committees and groups. Letters and publicity were sent to four groups with older women members.

The programme contracted a total of 19 screening services, including community clinics and services for Maori and Pacific Islanders. Almost 200 women attended.

Consumer satisfaction with education sessions and quality assurance measures were reported to be ongoing.
3.3 Quality

1992

Service Provider Training and Quality Control

In 1991, 35 nurses were trained as smear takers. The training of lay smear takers was being developed by the programme.

Quality of Smears

For the period July-September, 88 percent of smears were adequate, one percent were inadequate, and 13 percent were non-optimal.

Data Quality and Register Issues

There were problems with data entry. For example, the categories for ethnicity on the enrolment form did not correspond with those in the Register.

A statement on informed consent was prepared for smear takers.

1992

Four visits were made to GP service providers to promote the Register. A lay smear taker training course was held for 15 women, and an in-service training session was run for six community educators.

3.4 Follow-up

1991

Result/Reminder Letters

There were several problems with the letters generated by the Register. The appropriate letters were not always generated, which resulted in delays in women receiving their results. The manager also believed that abnormal letters should not be sent to women where the smear result indicated an inflammation/infection, rather than an abnormality.

Colposcopy, Biopsy and Treatment Services

A total of 33 hours of colposcopy services were available in the region for the period July-September, with eight staff.

1992

There was no information on quality issues in 1992 at the time of writing this report.

3.5 General Comments

Meeting with the other South Island managers was reported to be beneficial by the Canterbury manager.
Funding was perceived to be "more than adequate".

4 Hawkes Bay

4.1 Overview of the Hawkes Bay Programme

1991

Programme Objectives, Organisation and Management

The Hawkes Bay programme is based in Napier. The main focus of the programme is to target older and Maori women. Access to female smear takers was also an issue, as fewer than 10 percent of GPs in the area were female. The manager of the programme believed that establishing a profile and identity as a service in the area was important.

Staffing Levels

The core staff of the programme consisted of the manager and data entry/office coordinator. Other staff also included a Maori coordinator, 10 part-time nurse smear takers, three part-time clinical supervisors (female GPs) and one part-time education officer.

1992

The core staff continued to be the manager and the Register coordinator. Other staff included 15 part-time nurse smear takers and a full-time Maori coordinator.

The key objectives for the quarter were to: continue training nurse smear takers; provide a low cost AHB cervical screening service; plan a pre-enrolment campaign; and visit resistant GPs to encourage them to enrol.

4.2 Coverage

1991

Numbers of Smears

Smear numbers were highest in November (2242), with an increase of 35 percent from January (1454).

Over 65 percent of women using Area Health Board clinics were reported to be with an outdated smear history and over 50 years of age.

Enrolments

The Register went live in August. Since then, the manager reported that an average of 250 enrolments were received per week. There were no pre-enrolments. A Maori Advisory Group was established to supervise the data. Half of the GPs in the area were said to be enrolling.
Smear takers

A list of over 92 smear takers was included in the "Fact Pack" produced by the programme (see below). Smear takers included GPs, specialists, practice nurses, public health nurses, occupational health nurses, Maori Nurses and a Pacific Island nurse.

Community Consultation and Education

A Cervical Screening Task Force met every 6 weeks. The Task Force was an advisory group of Pakeha, Maori, and Pacific Island consumers, and providers. Between January and May, the manager gave a series of GP and Practice Nurse seminars. All GPs were visited and given material on the programme. A smear "Know How" newsletter was circulated to all practices, and a memo system was established.

The community were consulted during the development of the Handbook for Smear takers.

Taiwhenua representatives were consulted to draw up the Maori coordinator job description. A network was established with the continence service. Several area health board nurses were helping target disabled women.

Publicity

Material for the programme with a daisy logo was developed by the Manager. A large advertising campaign was carried out in the local newspaper. There was a session on talkback radio and articles in the local newspaper. The Register was launched at the end of May.

Posters and a "Fact Pack", including brochures on screening (both smears and follow-up) were distributed to GPs, supermarkets and pharmacies.

Services

A number of Area Health Board free clinics were run in two areas, with a view to extending them to two others. Other services included GPs, Practice nurses, Family Planning clinics and 15 nurse smear takers. Attempts to contract out services to Maori groups were unsuccessful.

Monitoring

Consumer satisfaction measures were being developed for the clinics.

The manager believed that the information that was being collected on coverage was fragmented. The information collected for the Contracts Management section of the Department was also seen as being of little use.

1992

Enrolments for all women were approximately 40 percent less in the first few months of 1992 than for the last months of 1991. Maori enrolments decreased forty percent and women aged 35-70 years 49 percent in the same period.
Sixty GPs and specialists, and 36 nurses were enrolling women. A total of 36 education sessions were held. Attendance rates were not recorded. Leaflet drops were made in three locations. A free smear day was held at a women's recreation festival.

Fifty one clinics and other screening sessions were held with a total number of 229 women attending.

4.3 Quality

1991

Service Provider Training and Quality Control

Three week-long Area Health Board courses were run to train Practice nurses and Area Health Board Nurses.

Quality of Smears

GPs were encouraged by the manager to use the spatula and the cytobrush. Few smears were reported by the manager as being of poor quality.

Data Quality and Register Issues

An informed consent brochure was produced for smear takers. The Area Health Board Ethics Committee requested that a form be attached to the enrolment form, which would indicate that the woman had read and understood the attached sheet.

The programme developed their own enrolment, change of status and change of detail forms, although the manager believed it would have been more efficient to produce them nationally. There was also some problem with the difference between the ethnicity coding on the forms and on the register.

1992

The smear takers who were enrolling women had a smear adequacy rate of 82 percent (GPs) and 86 percent (nurse smear takers).

The turn around time between the date of smear and the result being recorded on the Register decreased slightly in the period January-March 1992 to 32 days. The average time between the programme obtaining the result and it being recorded on the Register increased by 31 percent to 22 days (from 15 days in the period October-December 1991).

The programme manager made 36 visits to GPs to promote the Register.
4.4 Follow-up

1991

Result Reminder Letters

The wording in the letter for benign inflammation was changed from "abnormal" to "this is not uncommon"; and for a general abnormality: "This is not related to cancer in any way".

Colposcopy, Biopsy and Treatment

Earlier in the year, colposcopy waiting lists were longer than the recommendations in the national guide-lines. Extra clinics were introduced to address that problem.

The manager reported a lack of communication from the laboratories to the GPs about how to interpret the smear results. She also believed that there was a failure to treat inflammatory smears appropriately.

1992

There was a 17 percent increase in the number of abnormalities diagnosed from the last quarter, and an increase in colposcopies, and colposcopy waiting times (from 0 week in the last quarter of 1991 to six weeks for the first quarter for CIN 3).

4.5 General Comments

A large proportion of the budget was spent on print material, particularly the glossy brochures for women. The manager believed that the brochures that existed were unsatisfactory and that new ones should have been produced for national use.

The coordination of information about the programme, including the monitoring reports generated by the programme itself and the Area Health Board, was also an issue.

5 Manawatu/Wanganui

5.1 Overview of the Manawatu/Wanganui Programme

1991

Programme Objectives, Organisation and Management

Organised cervical screening began in Manawatu/Wanganui with the Wanganui pilot project. The programme was is based in Palmerston North. The Board is divided into Wanganui, Manawatu, Horowhenua and Tararua, with a coordinator for each district.

The programme was intended to be integrated into existing Area Health Board services in an attempt to ensure long term existence. The emphasis of the programme was on providing alternative services, particularly by building them on existing ones, so that women's health groups organise them, the Area Health Board provides the
smear takers and the programme provides the funds. The aim was to assist in providing a mix of services to supplement existing ones.

Activities were directed at Maori, older and Pacific Island women.

Staffing Levels

The core staff consisted of the manager, a part time data entry operator and the district coordinators.

1992

The manager, a part time administration/data entry person, and the part time district coordinators and Maori coordinator continued to be the primary programme staff.

5.2 Coverage

1992

Number of Smears

Numbers of smears peaked in September, with 5,081 smears recorded in laboratories, compared with an average of 4,240 in the preceding months.

Enrolments

Enrolments increased by 5,000 since the programme went Board-wide, with total of 10,553 in October. The manager reported that 70-80 percent of women that attended Area Health Board rural clinics were aged 35 years and older and had outdated histories.

Smear takers

A range of smear takers were available, including 3 Pacific Islanders, 4 Maori, Area Health Board nurses, occupational health nurses, and 12 practice nurses.

Community Consultation and Education

An Advisory Group was established which met once a month. The members were a range of health professionals and consumers, from a range of ethnic and geographical backgrounds.

The District Coordinators visited all GPs to explain the programme. The Associate Minister of Health also visited GPs in Wanganui. The national manager of the screening programme also visited. A regular newsletter was produced for smear takers and other interested groups. Otherwise, a range of meetings took place, including visits to Pacific Island families by Pacific Island smear takers.

Publicity

A leaflet about the programme was produced, and articles published in community newspapers. There was an Area Health Board promotion in August.
Services

Area Health Nurses provided screening services in most districts in venues such as community centres, Public Health Nurses rooms, Maori Health and Women's Health centres. Suitcase clinics were provided in all districts, in response to requests. There were special clinics such as evening clinics and rural clinics for older Maori women.

Polytechnics had their own Occupational Health Nurses. Free Maori clinics and services for the disabled were offered by Women's Health Collectives.

In general, local women organised the clinics.

Monitoring

The manager was looking at developing ways of monitoring consumer satisfaction. The clinics were monitored by recording details such as venue, numbers of women attending, and smear history. The evaluation of services provided by the practice nurses and Women's Health Collectives was completed.

1992

The average number of enrolments per month in the period January-May increased by 76 percent from the last year.

The number of GPs increased from 122 in 1991 to 137 in 1992. There were 62 nurse smear takers, nine specialists and one lay smear taker (one less than 1991) as at March 1992.

The number and type of community education sessions were not available. The programme sponsored two weeks of radio promotion board-wide in March, and held promotion stands at Health and Recreation Festivals in two districts.

5.3 Quality

1991

Service Provider Training and Quality Control

Smear taker training programmes for nurses were held at the Polytechnic. The courses were 3-5 days long. The courses were evaluated by the Research and Advisory Section of the Area Health Board. A total of 36 women were trained, consisting of approximately half Area Health Board and half other nurses. All the Area Health Board smear takers were trained, including a one day follow-up, and had ongoing supervision.

Data Quality and Register Issues

The manager reported problems obtaining consistent reporting from laboratories, as they used different systems. One laboratory had made errors on data entry. Errors also occurred at the laboratory/Register interface.

Suboptimals were also over-reported by one laboratory, according to the manager.
Permission had been sought to use Maori data. A leaflet on informed consent had been produced.

1992

No further information on follow-up and quality was provided by the programme at the time of writing this report.

5.4 Follow-up

Result/Reminder Letters

The manager reported a difference in the letter that women received from the Register, and what their GPs told them.

Colposcopy, Biopsy and treatment Services

There was a backlog in colposcopy services. Extra clinics were provided in order to address the problem. The problem of non-attendance was being addressed by the manager.

5.5 General Comments

There were problems in the initial establishment phase of the region becoming part of the national programme. The manager believed that more assistance from the Department at that stage would have been helpful. The manager also believed there were "hangovers" from the pilot project, in the form of resistance from some Wanganui GPs who saw no benefits in the Register.

The Area Health Board had poor mechanisms of consultation with Maori, and this had an impact on the programmes' ability to assist in the development of appropriate services.

6 Nelson/Marlborough

6.1 Overview of the Nelson/Marlborough Programme

1991

Programme Objectives, Organisation and Management

A pilot project was based in Nelson since 1988. Although the Register went "live" as part of the national programme in August 1990, the pilot project was not phased out until the end of 1991.

The programme was divided into two districts: Nelson and Blenheim. The Register was located in Blenheim.
Staffing Levels

The core staff consisted of the manager and a data entry person. Community workers were also employed, including two Maori and two Pacific Island workers for six hours per week.

1992

The core staff remained the programme manager and part-time data entry person. The remaining staff consisted of part-time community workers (8) and nurses (22) (the equivalent of approximately 3-5 FTE).

The objectives for the quarter were to increase the number of practice nurses trained to take cervical smears; to train at least one Maori nurse in smear taking in the Nelson region; and to increase the number of GPs enrolling women on the programme.

6.2 Coverage

1991

Numbers of Smears

The number of smears peaked in September at 1172, compared with an average of 961 for the preceding eight months (an increase of approximately 20%).

Enrolments

The number of enrolments tripled in September, particularly among women aged 35 years and over. Nelson GPs were slow to be enrolled. The manager estimated that one third of eligible women had enrolled.

Smear takers

There were over 100 smear takers in the region. Three Nelson practice nurses were taking smears, however, in Blenheim they were none. In Piston there were also three practice nurses. There were 25 trained nurses in Nelson and 5 in Marlborough, with six more to reach competency. GPs were estimated to take 80 percent of smears.

Community Consultation and Education

All GPs were visited at least once. The national manager visited those GPs identified by the regional manager as being resistant. The manager and community workers held talks to both women's and mixed groups. The Maori and Pacific Island community workers were included in the nurse smear taker training. One of the Pacific Island workers took aerobics classes, which was identified by the manager as being a good opportunity to contact women.

Publicity

Radio and newspaper advertisements were run. The Department's radio advertisements were run all through September, and Radio Nelson provided one free advertisement for every paid one. The newspaper advertisements were run three times a week during September; and in addition, on Saturday they included enrolment forms. Other publicity included posters, a GP radio interview (and talkback off air),
use of community radio noticeboards (to publicise free clinics), and a cervical screening video that was run in the Nelson Postbag and Post Office.

Services

The manager reported that there was extended coverage and frequency of clinics in Blenheim. Extra clinics included evenings and Saturday. Venues were geographically broad. A central city Nelson venue was also being piloted.

1992

The average number of enrolments per month in the period January to March 1992 decreased by over 50 percent from the period October-November 1991, despite reports by the manager of extra clinics in January prior to the user part charges. In the last quarter of 1991, however, 210 enrolments were transferred from the pilot project, which may partially account for the difference. Statistics on Maori enrolments, and those of women aged 35-70 were unavailable due to incorrect statistical compilation.

The number of pre-enrolments fell by 20 percent in the period January-March, from 17 percent of all enrolments to 13 percent.

Of the smear takers in the region (over 100), approximately 91 were participating in the programme (50 GPs and 40 nurses). Some, however, had only taken one smear through the programme.

One education session was given to older women, 19 to Maori women, four to Pacific Island women, and one session for Polytechnic and Access groups. Workplace education also began at one factory.

In January, the manager was involved in media articles about the impact of user part charges on nurses clinics. She also had two meetings with nurses and 11 with individual GPs. There were ongoing fortnightly newspaper advertisements for clinics and the availability of information. The use of the radio community noticeboard continued.

Community clinics, workplace clinics and ad hoc clinics were held regularly, with a total of over 28 clinics attended by 484 women. The manager reported major reductions in numbers of women attending after the introduction of user part charges. The clinics included three special clinics for Maori and Pacific Island women. Home visits were provided by district nurses on demand.

Other services included those provided by GPS, practice nurses (including regular women’s health check clinics by one), and Family Planning (including clinics twice a week).

6.3 Quality

1991

Service Provider Training and Quality Control

The pilot project trained two groups of nurse smear takers, and the regional programme trained two more using the same model. The training programme
involved four days of theoretical and one day of practical training. Nurses also met with a cytologists/pathologist. The programme was evaluated using an assessment form and assessment by a general practitioner.

Quality of Smears and Smear Reading

The overall quality of smears was reported to be excellent. Results were processed in less than one week.

The manager pointed out that practice nurses were not required to meet standards of competency.

Data Quality and Register Issues

Permission was granted for the release of Maori data.

According to the manager, the register should be located on the same site as the manager's base.

Errors in the data entry by laboratories, and errors in the result letters, were reported by the manager. Some GPs were sent other GPs results by the Register. There was no space on the laboratory form to put the BETHESDA (result) code.

There were problems with the PAXUS links.

1992

A further training session was run for three practice nurses and six other nurses. Programme staff made 11 general practice visits with an aim of educating receptionists, practice nurses and GPs about the programme. A community educator training session was run to train a Maori educator for one district.

Monitoring of the free nurse smear taker clinics indicated that over 20 percent of those attending had an outdated history (their last smear was over 5 years ago). There was a poor response (1/14) by the disabled to the leaflet about home visits distributed to their representative groups.

GPs had an adequacy rate of 87 percent "satisfactory", nurses a rate of 93 percent, and a specialist a rate of 96 percent. There was an increase in overall quality of one percent, although the volume of smears was down. Results were received by smear takers approximately seven days after the smear was taken.

6.4 Follow-up

1991

Results/Reminder Letters

There was a difference between what the letters said and what GPs told women; and women with inflammatory smears were told by the letters that their smear was abnormal. This led to the letters being changed.

Some GPs were not sending out their own reminder letters, but were waiting for letters from the programme (3 months later) to be sent to women.
There were problems with the "change of status" forms, because often both GPs and gynaecologists did not fill them out. There were also problems with "cross boundary flow" (ie. where women moved into another Area Health Board). Those women were subsequent lost to the Register.

Colposcopy, Biopsy and Treatment Services

The manager reported that it was difficult to track follow-up except by word of mouth, because histology information was not linked to other information. The manager also had no input into service provision such as colposcopy.

1992

There was an increase in abnormalities of two percent, but no CIN III or CIS results.

6.5 General Comments

According to the programme manager, the programme had had limited funds that year. Although the Area Health Board supported the programme in principle, it did not support it with resources.

The manager found that the pilot project had an impact on the initial effectiveness of the programme. GPs were slow in supporting the programme because of their negative experience with the pilot project. It was difficult for the manager to separate the pilot from the programme at first. She believed that the pilot should have been wound down before the programme was introduced, and that running them concurrently led to a blur in focus.

The managers meetings were very helpful for sharing ideas about the programme.

7 Northland

At the time of writing this report, no information on the Northland programme was available for 1992.

7.1 Overview of the Northland Programme

Programme Objectives, Organisation and Management

The programme is based in Whangarei and has a well woman's focus. The main aim is to provide choice for women. Choices for women include the availability of free services, choice of venue and smear taker. Education of Maori women was also a priority, as a survey of over 800 women in the area indicated that 58 percent of Maori women wanted to know more about cervical screening (compared with 27 percent European).

The region is divided into six districts. The programme has contracts with four of them.
Staffing Levels

The core staff consisted of the manager (half time during 1991) and the Register coordinator (1991-92). There were also a Maori education coordinator, a midlife educator (0.6), a part time Maori community educator and 60 community health workers (who got reimbursed for their travel).

7.2 Coverage

Numbers of Smears

Smear numbers remained reasonably constant between March and September 1991, with an average of over 1,300 smears each month.

Number of Enrolments

Enrolments were reported to be good. In November, 51 out of 88 GPs enroled over five women each. All GPs in the region had agreed to offer enrolment to women, although a small number only enroled women if they asked.

Smear takers

Smear takers in the region were mainly GPs and Practice nurses.

Community Consultation and Education

A Cervical Smear Programme Liaison Group of health providers met regularly to assist with programme policy and planning.

All GPs in the region were visited by the end of August. The midlife coordinator assisted some GPs with establishing recall systems. Also early in the year, 20 out of the 35 local Whangarei GPs attended a meeting on the Register and enroling women, which was run by the programme.

Bi-monthly Community Network meetings were attended by members of the programme, and contact was maintained with Community Health Committees. Early in the year, the manager met with Maori groups and later visited a Marae with the Maori coordinator.

A Cervical Screening Support Group was established. Over 20 talks were given by programme staff and unpaid workers at a range of venues and meetings, including workplaces and Marae.

Publicity

A leaflet was developed by the programme for Maori women. It was to accompany the existing Cancer Society leaflet that is given to women when they enrol.

Several articles on the programme were published in the local newspaper. Interviews were produced every two months for Radio Northland news.

The "Letter to a Friend", part of the launch of the programme in October, was translated in local colloquial Maori. An open day was held to mark the launch, and the Education Kit was launched in four out of the six districts.
A General Practice newsletter and quarterly newsletter were also produced.

Services

The cervical screening services in Northland were mainly run by GPs and Family Planning. Family Planning held regular clinics in three different areas, and provided low cost smears to the disabled. In September a nurse smear taker was employed for nine months to hold clinics in Whangarei.

Four Maori nurses were trained in one area. In two other areas four midwives were training to work for eight hours a week with priority women. In another rural area two enrolled nurses were in training. In the far North, four Maori enrolled nurses were completing their training in order to hold clinics.

Monitoring/Evaluation

In each region the number of women smeared in clinics and other services is monitored. Family Planning have a target number of women to screen in their contract. The midwives monitor the number and smear status of who they talk to.

7.3 Quality

Service Provider Training and Quality Control

Through Family Planning, smear taker training was held early in the year, and another course was offered in November. Cervical Screening Education training sessions were run in three locations to equip health care providers and key community women with skills and knowledge in using the Smear taker Education Kit.

The midlife education courses were evaluated. A minimum content "talk plan" was developed to monitor the minimum quality of the education information provided at education sessions.

Quality of Smears and Smear Reading

A two monthly quality assurance meeting was held for Area Health Board smear takers.

Data Quality and Register Issues

The Register was trialed initially with Auckland laboratories before the Auckland Register went live. Problems included getting the data from the Auckland laboratories, smear takers not filling in smear taker numbers, mistakes on information enrolment forms, problems with the data on discs, and difficulty in obtaining the right data from the Register.

Gaps in the interface between primary and secondary services and the Register meant that some women were potentially lost to the Register (eg. "Change of Status").

Overall Monitoring and Evaluation

The Programme Manager’s performance was evaluated by the programme and, within the existing constraints, the measures were met. The systems coordinator produced a
weekly report on processing information (eg. numbers of enrolments processed, letters sent).

7.4 Follow-up

Result/Reminder Letters

Some minor changes were made to the wording of the letters.

Colposcopy, Biopsy and Treatment Services

The manager reported that it was difficult to follow-up the progress of women who had been recorded as having an abnormal smear.

There was one colposcopy service with two specialists operating that service. The manager saw a need for statistics on urgent and non-urgent colposcopy (the numbers and the waiting list for each).

7.5 General Comments

Other points noted by the manager included:

- there was a resistance to the Working Party Recommendations by specialists in the region;
- the information produced by the different services involved in the programme was not coordinated;
- the programme in Northland was under-resourced -having a half time manager was not effective- and cervical screening was not a priority for the Board;
- working with the Maori community was a complex and sometimes frustrating task, particularly because of the number of different tribes in the region; and
- the minimum amount of information and direction from the Department, and the isolated nature of the region, meant that establishing the programme was a difficult task.

8 Otago

At the time of writing this report, the information about the 1992 activities of the Otago programme were not available.

8.1 Overview of the Otago Programme

Programme Objectives, Organisation and Management

The Otago programme was divided into four districts- North, South, Central and Dunedin city.

The manager was appointed in July 1990. She identified that the main focus of the programme was to support existing services, particularly those provided by GPs and
Family Planning. Priority groups were midlife and older women (35-70 years), Maori women and Pacific Island women. She also found that the GPs in the different regions varied in their attitude to the programme. Feedback to GPs on their performance was regarded to be very important.

Staffing Levels

Core staff consisted of the manager and systems administrator. There was also a Maori health coordinator. A casual full time data entry person was employed in September as enrolments were getting behind. Two students were employed in the holidays to work on age/sex registers in practices.

8.2 Coverage

Numbers of Smears

The number of smears peaked in November at 2234. The average number of smears for September-November was 2363, an increase of over 20 percent for the remaining months (average 1822 smears).

Number of Enrolments

The Register began to record smears in June, after being installed at the end of March. Numbers of women on the Register for the year (including pre-enrolments) increased from June (393 enrolments) and peaked in October (1363 enrolments).

The release of Maori data was requested.

Smear takers

Approximately 80 percent of all smears were taken by private practitioners or practice nurses, and the remaining were taken by Family Planning. The manager reported that more GPs encouraged their practice nurses to take smears during the course of the year. About one-third of the city practices had female GPs, although there were fewer in rural areas. Rural areas had more practice nurses taking smears.

There was one Maori lay smear taker.

Community Consultation and Education

Every GP in Otago was visited by the manager over a period of four months.

A range of talks were given to different groups including the Maori Women's Welfare League, National Council of Women, Plunket Society, and the Cancer Society Auxiliary. Both the manager and other health professionals held the talks, often using the Smear takers Kits.

The manager also talked to a range of public health nurses, practice nurses, and key people in Maori and Pacific Island groups. There was a Smear takers Kit in all districts, two with Family Planning, one was circulating GPs, and one was with the Cancer Society.

The manager estimated that she gave an average of one talk per week.
Publicity

There were several radio sessions, including a talkback show, a question and answer show and five other radio interviews. Radio advertising accompanies the national television campaign.

There were also articles in the Otago Daily Times and smaller ones in the regional papers.

All GPs have leaflets on the programme.

Services

A Maori mobile unit offered free screening services, including cervical screening, and particularly targeted priority groups. The Unit visited all areas.

The programme offered to mail out invitations to women to invite them to have a smear on the behalf of the practice. Enrolment forms and SAEs were also enclosed.

Monitoring/Evaluation

The number of smears taken per district was monitored and varied widely between them.

Response to the advertising was investigated. Approximately half of the women said they had seen the television advertisements but not many had heard the radio spots. The spontaneous feedback received was good.

Family Planning and the programme wrote to all women's groups asking about levels of satisfaction with cervical screening services. There were no requests for extra clinics.

8.3 Quality

Service Provider Training and Quality Control

Otago Polytechnic provided a training course which was being attended by midwifery students and public health nurses.

A GP training weekend was held, and GPs were offered assistance with developing an age-sex register. Eight out of 20 were offered assistance.

Quality of Smear Taking and Smear Reading

According to the manager, the quality of SMEartaking and reading was very high (0.01 percent unsatisfactory).

Data Quality and Register Issues

There were some problems with the public hospital laboratory.

The pre-enrolment forms were changed to include the month and the year of the last smear.
Some time was spent by the programme following up incomplete enrolment forms.

According to the manager, the programme was unable to generate all the information they needed from the Register for monitoring purposes (eg. how many women had out of date smear histories; how many previous abnormals women have had).

There were tight security measures to control access to the computer, including the use of swipe cards to access the room, and personal identification numbers.

Overall Monitoring and Evaluation

Regular reports were sent by the programme to GPs, showing them their enrolment rates compared to others.

The manager personally checks and signs the letters to all women.

Other evaluation was not seen as a priority for the manager at that stage.

8.4 Follow-up

Result/Reminder Letters

Some problems with the recall of pre-enrolled women were reported by the manager. There were also problems with the letters, with a conflict between what women were told and what the Register-generated letters said in the case of inflammatory smears.

Colposcopy, Biopsy and Treatment Services

The follow-up of abnormal smears would be easier if the cytology and histology record were linked. All abnormalities were followed up manually by the manager.

The waiting time was reported to have come down slowly during the year. A third clinic a week was established.

Not being able to fund treatment services made it difficult for the programme to influence the services provided.

8.5 General Comments

The manager also made the following general points:

- she was disappointed that the pilots hadn't addressed some of the problems that appeared to be commonly experienced across the regions;
- the Area Health Board was supportive of the programme and the central physical location of the office was ideal;
- the resources allocated were reasonable although that is not the case for all the regions;
- there was a lack of communication with the Advisory Group; and
- the meetings with the other South Island programme managers were valuable.
9 Southland

9.1 Overview of the Southland Programme

1991

Programme Objectives, Organisation and Management

The Southland programme is based in Invercargill. It is the largest geographical area in New Zealand. The programme manager started in August 1990. Using her contacts in the Southland community (the manager was previously the Hepatitis B coordinator), she identified a need for appropriate accessible health information, and a preference for smear taking to remain in general practices but with a choice of a female smear taker.

Because of the limited budget, existing services were supported where possible rather than establishing new ones. The programme was launched in July 1991.

Staffing Levels

The core staff were the manager and a part-time data entry person.

Seven part-time temporary cervical screening health educators were employed to work with five different geographical areas and older, Maori and Pacific Island women.

1992

The manager was still the only full-time worker on the programme, although a full-time data entry person was employed on a temporary basis to train on the Register so that she could cover the manager's leave. Seven community education workers were employed on a part-time basis (2.5 FTE), although two of the positions were terminated at the end of February due to lack of funding.

9.2 Coverage

1991

Number of Smears

The number of smears peaked in September (1351) compared with an average of 1072 smears for the preceding months.

Number of Enrolments

The Register was installed in May 1991. Enrolments began to be recorded that same month. Enrolments increased until October (1558 enrolments for that month) and then decreased again. The average per month for 1991 was 412 enrolments.

Smear takers

A list of smear takers was made available at a variety of venues, including health clinics, Citizens Advice Bureau, and Women's Resource Centres.
The main smear takers that were available were GPs and practice nurses. Nine practice nurses had passed the Polytechnic course. Two Maori nurses were taking smears.

Community Consultation and Education

Consultation occurred monthly with the Southland Consumer/Smear takers Committee. Membership of the Committee consisted of a GP representative, 2 representatives from the National Council of Women, a nurse, a representative of Family Planning, a representative of the Women's Resource Centre, and one Maori and one Pacific Island representative.

Bi-monthly contact was also made with local Maori and Pacific Island Cervical Screening Advisory groups.

One third of GPs attended the launch of the programme in July, and the other two thirds were visited by the manager.

Women's groups were contacted, indicating that the manager would be available to give talks.

Cervical health educators were trained and employed temporarily to implement high profile, time limited initiatives for rural women, Maori women and Pacific Island women.

Publicity

A logo was developed for the programme.

Good written and verbal networks were established with the local media. During the national publicity campaign a full page add appeared every week in the three local newspapers. A revised version of the "Letter to a Friend" was also published. A leaflet was also put through a newspaper with the pre-enrolment form.

A monthly report, including the minutes of the Consumer/Smear takers Committee, was sent to interested groups and individuals.

There were regular mailouts to service providers.

Services

Some practice nurse smear takers provided lower cost services.

Community Health Days incorporating the offer of low cost smears were held regularly. Pacific Island Health Days were also held.

Pacific Island women generally appeared to choose to have their smears taken in general practice.

A regular low cost smeartaking clinic was held on Stewart Island.

Monitoring/Evaluation

Disables women were surveyed jointly by the programme and Department of Social Welfare about the increased option of female smear takers.
On average, there were fewer enrolments for the first few months of 1992 than for the end of 1991. By the end of 1991, 48 percent of women aged 35-70 years had enrolled, and 58 percent of all Maori women.

A total of 63 education sessions were held for older women with a total attendance of 651. Twenty sessions were held for Maori women, and the manager noted that they needed "a lot of visiting to build trust before being able to share an education session". Five sessions were also held for Pacific Island women with 20 in attendance, and 30 general workplace sessions were held (attendance numbers were not available as, according to the manager, "people come and go").

There were five requests from print and radio media for responses to news items. Several meetings were held with health providers. There were also "numerous" telephone discussions that were not tallied.

Two community clinics were held: one for a geographically isolated area, and another for Pacific Island women at a Health Day. Two clinics were held at community health days. A total of 34 women attended the clinics.

The programme was unable to separate smears taken into groups of smear takers.

9.3 Quality

1991

Service Provider Training and Quality Control

A part-time Cervical Health Education training programme was offered on a temporary basis. The programme included teaching skills, group work, medical training, and communication and marketing skills.

There was a smear taking training course for practice nurses run through the Southland Polytechnic. Family planning assessed the skill levels of some of those that passed and were satisfied with the results.

Quality of Smears

The quality of smears was "very poor" and was an issue for the programme, which was being addressed by the Colposcopist and the Laboratory.

Smear takers were provided with a record of their quality of smears every month.

Data Quality and Register Issues

A leaflet about informed consent was developed and was made available to women via smear takers, cervical health educators and other provider networks.

There was a problem with cross boundary transfer (ie. women moving from one Area Health Board to another).
Overall Monitoring and Evaluation

A Service providers Consultative Group was established mid-year to establish liaison between providers (eg. colposcopist, pathologist, GP representatives, programme manager). The group met regularly, and also established subcommittees to address issues such as poor smear quality.

Register reports were sent monthly to smear takers.

There was ongoing evaluation of the cervical health educators to identify accessibility, affordability, cultural appropriateness and gaps in service. The manager held weekly supervision meetings with the educators, and they completed weekly reports.

1992

A nurse smear taker training course was run, with 12 nurses attending four sessions. Ten GP visits were made by the programme to address the issue of sub-optimal smear results. There was also a regular in-service day for the four community educators.

The collective smear taker adequacy rate was 55 percent, with an average of 17 smears per enrolled woman. The manager was unable to collate nurse smear taker adequacy rates, but noted that they were higher than the collective rate.

The rate of poor quality smears increased in the period January-March 1991 to two percent from a rate of 0.6 percent in the period October-December.

9.4 Follow-up

1991

Result/Reminder Letters

The manager believed that the letters should state explicitly that the Register notifies the smear taker that the smear is due, and only if the smear is not taken does the Register send the woman another letter.

Colposcopy, Biopsy and Treatment Services

The manager was concerned that GPs were not treating inflammation when it was reported.

At the beginning of 1990 there was no colposcopy service. The programme was working closely with the Colposcopy clinic to clear the resulting waiting list. The waiting list for urgent cases was cleared, but there was still a waiting list for non-urgent cases. A colposcopy recall system was manually kept by the programme.

1992

The waiting time for urgent colposcopy was four weeks; for semi-urgent 12-24 weeks; and for non-urgent 52-72 weeks.
9.5 General Comments

Other points made by the manager included:

- the budget was cut by $30,000 in 1991, which limited strategy options
- limitations on using "community representatives" as community consultation
- resistance by some GPs was still a large problem
- there was a difference (and sometimes friction) between North and South Island tribes which sometimes hindered the Maori educators in making contact with key people.

10 Tairawhiti

The information on the 1992 activities of the Tairawhiti programme was not available at the time of writing this report.

10.1 Overview of the Tairawhiti Programme

Programme Objectives, Organisation and Management

The Tairawhiti programme is based in Gisborne. The focus of the programme is to reach and enrol priority groups. Because of the large geographical area, the aim of the programme was to reach people by community action and the utilisation of existing resources such as public health nurses and practice nurses.

Staffing Levels

The core staff consisted of the manager and a part time systems administrator/data entry person.

10.2 Coverage

Number of Smears

There was no information available to the author on the numbers of smears.

Number of Enrolments

Maori groups agreed to the release of Maori data if individual informed consent was given for personal data to be used for statistical purposes.

The Register went "live" in May 1991.

Smear takers

A list of smear takers was produced in leaflet form, which was delivered to all city and rural houses. The leaflet was also available in GP and specialist rooms.
A range of choice of smear takers was available in addition to GPs and specialists. Choices included two general practices with nurse smear takers; a female smear taker at a Well Women's Clinic; a female doctor at family planning and a rural public health nurse; and district female GP.

There were some problems in promoting practice nurses as smear takers because of resistance from the GPs who employ them.

Community Consultation and Education

Initially, meetings were held with a range of groups such as Iwi authorities, Health Professionals, and cancer groups. A public meeting was also held. A GP liaison group was established, as was a Women's Health Advisory Group.

The programme held monthly meetings with Runanga O Turanga T Kiwa. Regular meetings were also held with a Maori Women's Cervical Screening Support Group. The manager believed that involvement of Maori women in the programme was inhibited because of the lack of a Maori coordinator. The Area Health Board did not allow that appointment because of lack of funds.

The manager also held ongoing negotiations with a Maori Women's Community Group. At the end of the year, they were seeking funding to provide cervical screening education to Maori and Pacific Island women.

Meetings were held with the Pacific Island Women's Project.

Discussions were held with the Tairawhiti Maori Community Health Committee and a district group of GPs and practice nurses. All GPs were visited by the manager twice before the Register went "live". Programme news items were included in the Medical Officer Health newsletter to GPs.

In association with the Polytechnic, education sessions were held with all adult IHC clients. Education session were also held at high schools and a Kaumatua Day.

Educational sessions were held with groups such as Access Courses, workplace groups, the Women's Division of Federated Farmers, a Young Mothers group, and a Polytechnic Foundation course.

Publicity

An advertising campaign was run on local radio stations (including Maori radio) during May and September to coincide with a mail drop of pamphlets and enrolment forms. The Well Women's clinic was advertised in local newspapers, and an article on the programme was included in the Country Women's Magazine.

The programme was also promoted through venues such as an A&P show stand, a Quality Ageing show stand, shop windows and GPs surgeries.

Services

A range of free services was available. In one district a Maori female GP runs a free suitcase clinic. A Well Women's clinic offered a free service one day a week. Free workplace clinics were available, and a free occupational health clinic was held one afternoon a week. Free smears were taken by a nurse smear taker at the STD clinic.
There was a free rural suitcase clinic available on request. The polytechnic health centre service was also free.

A suitcase clinic was held at the workplace of adult IHC clients as the result of a needs analysis.

Other venues included GPs surgeries and city-based clinics.

Monitoring/Evaluation

A survey of a selected sample of 234 women was conducted in the first quarter asking about women's screening history, smear taker preference, and information needs. The results indicated that 24 percent were overdue or had never had a smear, and that there was a high level of preference to have a smear in general practice rooms, but with a choice of female smear taker.

An evaluation of the programme pamphlet indicated that 280 out of 10,000 mail enrolments used the pamphlet.

An evaluation of women's clinics showed that 70 percent of the patients had outdated smear histories, and that 80 percent were from priority groups.

Evaluation of total Register enrolments (June) showed that 68 percent of enroled women were from priority groups.

10.3 Quality

Service Provider Training and Quality Control

Two smear taker training courses were held at Gisborne Hospital.

Data Quality and Register Issues

Register information sheets for women were distributed to all GPs and specialists.

Overall Monitoring and Evaluation

The programme carried out a review of colposcopy services.

A planning group of service providers developed local protocols on a range of cervical screening issues, including management of abnormalities.

A medical officer was employed on a casual basis to supervise the clinical experience of smear taker trainees.

10.4 Follow-up

Results/Reminder Letters

The register letters were causing concern among GPs, who did not like patients receiving letters notifying them of an inflammatory smear result. The manager subsequent changed those letters so that they reported a normal smear result.
The manager has suggested to GPs that their practice nurse telephone the patient before they receive their smear result.

Colposcopy, Biopsy and Treatment Services

Following a review of colposcopy services, strategies were implemented to provide a more positive experience for women undergoing colposcopy.

10.5 General Comments

These further points were made by the manager:
- the development of the Tairawhiti Cervical Screening Programme was seriously inhibited by lack of funds;
- the Area Health Board was not supportive of the programme;
- the combination of lack of resources and geographical isolation has meant that effectiveness of the programme with Maori and Pacific Island women has been compromised, and that a choice of service and smear taker was not always available;
- the timing of the installation of the Register had an impact on community consultation - where it was introduced later, there was more time and resources for consultation;
- there was a large variation between attitudes of GPs;
- targets were set and indicators developed without consultation, which meant that they were not achievable and/or relevant - generally, more communication between the regions and the Department is needed;
- "opt off" legislation is needed; and
- information produced about different parts of the programme needs to be more closely linked.

11 Taranaki

There was no information on the activities of the Taranaki programme at the time of writing this report.

11.1 Overview of the Taranaki Programme

Programme Objectives, Organisation and Management

The programme is based in New Plymouth. Some resistance by GPs was detected by the manager before the programme was launched in May. Pre-enrolment was used to try and give those women who wished, a chance to enrol without relying on their GP. Women also expressed a wish for alternative services to GPs. One of the key focuses of the programme was to provide choices for women, and to use cervical screening as a starting point from which to develop other women's health services and programmes.
Staffing Levels

The core staff consisted of the programme manager and systems administrator. A health educator was employed on contract.

Three nurse smear takers were contracted to run clinics in their areas.

11.2 Coverage

Numbers of Smears

The number of smears increased overall between the first quarter of 1991 (an average of 806 smears) and the last quarter (an average of 1144 smears).

Enrolments

Enrolments began in April. Enrolments increased overall until September, where they peaked for the year at 603.

Of the pre-enrolments received, 32 percent of women had an outdated smear history. Of those that pre-enrolled at women's clinics or Family Planning, 80 percent had an outdated or no smear history.

Participating medical practitioners took an average of 18 smears each from enroled women. Nurses took an average of over 28 smears each from enroled women.

To the year ending September 1991, of the 6052 women that had enroled, over 75 percent were aged 35-69 years, and over 95 percent were aged 20-69 years. Over 40 percent of enroled women had had a smear taken since enrolling.

Although some women have pre-enroled, some GPs were not sending their smears through with a Register laboratory form. The programme reported that some of those GPs had over 100 enroled women as their patients.

Smear takers

The programme prepared a list of smear takers. In the period July-September, 533 medical practitioners and eight nurses were taking smears. Nurse smear taker numbers were increasing. The Board employed five Nurse Smear takers within other positions.

Nine practice nurses were certificated.

Community Consultation

Initially, the manager consulted with a range of health related and other community groups, including the Women's Health Advisory Group to Women's Health Services, Maori Women and the Board's Maori Health Unit, disabled groups (eg. IHC, Blind Foundation) and Community Health Committees. A Cervical Screening Advisory Committee was established.

Questionnaires were sent by the programme to differently abled women to investigate their cervical screening service needs. The programme negotiated services with the IHC and the Disabled Living Centre.
Regular educational sessions were run by the programme at Whare Rupuora.

Community consultation also took place through the pre-enrolment forms. Many were sent back without a nominated smear taker. A letter was sent to those women asking them to ring, and when they did, they indicated that they wanted alternative smearing services (particularly ongoing services in workplaces).

All nurse smear takers had a poster on their walls asking for a donation and suggestions on ways that the service could be improved.

All GPs in the region were phoned by the manager to make an appointment, although some GPs thought a meeting was unnecessary.

Publicity

In May, the programme posted a personal pack to all women aged 35-67 who were listed on the National Master Patient Index. Over 14,000 packs were posted. The pack included information on cervical screening, informed consent, an invitation to pre-enrol, and a list of all smear takers and venues. Voluntary women's groups also made the pack available at a variety of locations. Approximately 12 percent of pre-enrolment forms were returned.

The programme developed 15 static display charts which were displayed at a city centre shopping complex. Displays were also set up in all pharmacies, GPs surgeries, libraries and other community venues.

Also during the programme launch, both local radio stations had advertisements in Maori and English running several times a day for six days. The stations also ran some of the advertisements free of charge during the promotion, and for an extra two days. There were also interviews with the manager and Maori coordinators, and "many" newspaper articles.

Five hundred laminated posters were also put up in a range of venues such as women's toilets and hairdressers.

The local radio promotion that was to coincide with the national media campaign in September-November did not eventuate. There was no noticeable impact of the media campaign on smear rates.

Services

Free clinics were run on a regular basis in seven different locations, including a Women's Wellness Centre, a Maori Health Centre and two Polytechnics. Nurse smear takers also offered regular community clinics in five permanent centres.

The programme provided Maori, Pacific Island and disabled women with cervical screening services in their own homes where requested. Te Whare Rapiuora, Maori Health Clinic, was set up in response to a request from the community, but it appeared that women were going there less than they were to services such as Family Planning.

Nine permanent alternative venues were established.

Workplace clinics began in September.
The programme manager reported a heavy demand for clinics that sometimes could not be met.

**Monitoring/Evaluation**

The programme reported that notes and messages had been included on the enrolment forms approving the programme and the choices for women. Over 430 requests for smears to be taken at clinics not run by GPs were received by the programme.

History sheets were developed to record the medical history of women who had smears. Clinic evaluation forms were also used to collate data about each clinic that was not available from the Register.

**11.3 Quality**

**Service Provider Training and Quality Control**

Service provider packs were developed and made available by the programme.

Two training courses were run. One course was particularly designed for occupational health nurses and nurses in districts where there were no women's clinics.

A protocol for the relationship between the supervising doctor and nurse smear takers was drawn up by the programme.

Competency of smearing reports were sent out regularly.

**Quality of Smears and Smear Reading**

Following the pilot by the Colposcopist, all Area Health Board nurse smear takers used cervix brushes instead of cytobrushes, with good results reported by the programme.

The programme assessed the quality of smears processed by Medlab (about 80% of smear takers). For GPs, quality ranged from 33 percent satisfactory to 94 percent satisfactory over a period of three months (April-June). For the same three months, nurse smear takers had a range of 70-82 percent satisfactory. The Board average was 81 percent.

For the period July-September, the overall area adequacy rate increased to 84 percent.

**Data Quality and Register Issues**

There were initial problems with the quality of the laboratory reports, although they have since improved with the use of a new system.

Some women had multiple NMPI numbers, others had changed address with no follow-up record. Parts of the enrolment form for the programme did not fit the NMPI information (eg. maiden name not included in the form but used by the NMPI).
The change of status and change of detail forms were no longer used by the programme, as GPs were not using them.

Overall Monitoring/Evaluation

The Register was piloted before it went live on a wide scale.

A colposcopist trialed a spatula/brush combination.

The welcome/recall letters were pretested.

11.4 Follow-up

Result/Reminder Letters

Initially there was some problem with the laboratories' interpretations of the BETHESDA codes. The problem has since been rectified.

Laboratories were overloaded, and the time to analyse a result and send it to the Register took three months in September, whereas earlier in the year the turnaround time was one week.

Recall lists were sent to GPs each month. A grant was made to one large rural practice to create a women's health recall list.

The Maori Health Unit translated the welcome and recall letters into Maori.

Colposcopy, Biopsy and Treatment Services

The manager believed that all smear results should go through the Register, as some women who were enrolled were not being followed up by the programme because their result had not been sent to the Register.

The programme was concerned at the interface between colposcopy services and other aspects of the programme, including the Register, and was looking at addressing those problems.

11.5 General Comments

The manager also noted the following:

- some GPs were very negative about the programme, and some believed that it was "deliberately excluding GPs";
- not all women were being offered cervical screening and enrolment in the programme by their GPs- although GPs say that women don't wish to enrol, this was not supported by nurse smear takers; and
- the "opt-off" option would make the programme safer and more accurate.
12 Waiora Waikato

12.1 Overview of the Waiora Waikato Programme

1991

Programme Objectives, Organisation and Management

The programme is based in Hamilton. The Waiora Waikato programme was one of the last programmes to employ a manager. Because of this, the cervical screening service needs were only beginning to be investigated and some services, such as Area Health Board clinics, were not available.

The first priority of the programme was to contact, inform and involve GPs by using a market approach which involved selling the programme and the Register as an asset to their business. Following that, the programme would look at working further with women's groups.

The cervical screening programme is part of the Special Projects Development Unit, which provides support to the programme with issues such as community consultation and evaluation, and with practical details such as clerical and media liaison services.

Staffing Levels

The manager and systems administrator were the core staff. A Women's Health educator was also employed. The position of Maori Women's Health Coordinator was shared with the Mammography Pilot Project. Two Kaiwhakahaere mo Te Whare Tangata (Maori Women's Health Coordinators) were selected to represented tribes in the north and south.

A temporary clerk/typist was also employed.

1992

The staff of the programme remained the same as in 1991, consisting of the manager, systems administrator, two part time data entry and administration workers, three full time community health and education workers, and one contract worker.

The objectives for the first part of 1991 were to develop a strategic plan for the two Maori health educators and to assist with the development of iwi-based initiatives; the develop plans for service contracts for women with disabilities, low paid women and women aged 35 years and over; and to complete the promotion of the programme to all smear takers.

12.2 Coverage

1991

Numbers of Smears

The number of smears peaked in October (4019) and November (3812), with an average of 3147 for the remaining months.
Enrolments

The Register went live in September. Enrolments increased from 236 in September to an average of 606 per month for the rest of the year.

Seventy six smear takers were enrolling women by October 18. Approximately one third of the 205 GPs were enrolling women.

Smear takers

A list of smear takers was compiled by the programme. In September, there were 22 certificated nurse smear takers in the region.

Community Consultation and Education

After some initial difficulties, a Community Forum on Cervical Screening was established. The Forum met monthly with small group working parties assisting the Manager with specific projects. Working parties involved women with specific skills and interests, and included evaluation of smear taker training, selection of a Women’s Health Educator, and promotion and launch. Forum minutes were distributed regionally across 24 women’s health and allied professional groups.

A GP Advisory Group, including two practice nurses, was established which met every four-six weeks. The manager also attended Practice Nurse Association monthly meetings. By the end of September, 61 GPs and nurse smear takers had been visited.

Consultation with the Maori community included seven iwi representatives on the selection panel of the two Kaiwhakahaere. The two staff conducted ongoing consultation with individual iwi. A Maori Advisory Group was also established, and consulted about the use of Maori data on the Register.

Meetings with Pacific Island women’s groups were held. Pacifica were involved in the selection of the Women’s Health Educator. A Pacific Island Advisory Group was also formed.

The manager met with disabled women to discuss their service needs.

A Cervical Screening Newsletter was produced three monthly and circulated to interested groups and individuals. The newsletter discussed such issues as policies, the Register, the Resource Kit and the list of smear takers.

Other educational activities that occurred independent of the programme included women’s health days and use of the Resource Kit. Those activities were not always known to the programme.

Publicity

A series of promotional activities were held around the national promotion during September-November. They included a media conference and media package that was made available to 24 regional newspapers and 13 regional radio stations; radio advertisements on eight stations; a radio talkback session; and a nationwide discussion and talkback session.

High profile women from sporting, disabled, Maori and Pacific Island communities agreed to promote the programme and appear in publicity material.
A poster was developed by the promotional working party and was distributed throughout general practices, workplaces and public health nurses.

Services

Seven permanent free or low cost services were offered in different districts and venues in the region, including services at Family Planning, a Women's Health clinic, a Union Medical Centre, and a Maori Health clinic.

Work was beginning with staff of the Union Health Centre to provide low cost services.

Monitoring and Evaluation

A pre Cervical Screening Programme promotion random telephone survey was conducted in August by a research company. The information was supplemented with interviews with Pacific Island, Maori and low income women in the workforce. The aim of the research was to investigate the level of understanding of the smear test and the purpose of cervical screening, and to identify barriers to screening and consumer preferences. The findings of the study were unavailable at the time of writing this report.

Another survey was conducted of GPs, practice nurses and occupational health nurses. The survey found a wide variation in the cost of screening, ranging from $10 to over $30. Two third of GPs in the survey supported smear training for practice nurses. The majority were also supportive of offering screening services as a service separate from normal consultations, and many indicated the provision of women's health clinics.

In one district a group from the local iwi were doing a door-to-door survey which included questions about cervical screening. The results of that survey were also not available to the author at the time of writing this report.

The Health Services Research Unit of the Board was developing process and outcome evaluation measures to assist the programme.

1992

The average number of enrolments per month increased by 35 percent in the first months of 1992. Approximately five percent of all eligible Maori women were enroled, and Maori enrolments made up approximately 15 percent of all enrolments.

A total of 149 GPs and 26 nurses participated in the programme by enroling women, although some GPs enroled only one woman whereas others enroled 150. On average, GPs took approximately 11 smears per enroled woman, and nurse smear takers took 18.
12.3 Quality

1991

Smear Provider Training

There were three smear taker training courses at Waikato Polytechnic.

A study day for public health nurses and community health workers was combined with the Mammography pilot. Public health nurses developed promotional activities using the material from the study day.

The Department of Nursing and Health Studies at Waikato Polytechnic developed programmes for midwives.

Quality of Smears and Smear Reading

The Medlabs that serviced the area provided monthly reports giving details of smear results including suboptimal and unsatisfactory, and levels of abnormality.

The need for ante- and post-natal smears was being investigated by the programme, because of their suboptimal nature and the lack of evidence for effectiveness.

Data Quality and Register Issues

A pamphlet on informed consent was developed by the programme in consultation with the Forum.

The manager reported multiple difficulties in streamlining the Register forms. They were subsequent changed in consultation with the laboratory.

Problems in transcription and form filling such as women not writing clearly, the smear takers using an incorrect smear taker number or not recording the date caused some problems with the accuracy of information.

The programme questioned the accuracy and value of recording ethnicity, because of the variation in interpretation and consistency in recording.

Overall Monitoring/Evaluation

A small questionnaire was included as part of the pamphlet on informed consent, to assess its effectiveness.

The smear takers training courses were evaluated and several changes made, including: an informed consent leaflet was provided for women to sign; the format for the session on Maori women's health issues was altered; and practical training at community clinics was included. The manager reported that the changes had resulted in significant improvements in participant satisfaction and practical skills.

Quality assurance systems were seen by the manager as being urgently required.

1992

Further nurse smear taker training courses were held, with 15 nurses attending. A Pacific island and Maori training course was in the planning phase.
The programme made 52 visits to general practices, involving 120 GPs and practice nurses. The total ever seen by the programme staff was 258 GPs.

GPs had an adequacy rate of 88 percent. The turn around time for the smear taker to receive smear results was 14 days.

12.4 Follow-up

1991

Colposcopy, Biopsy and Treatment Services

Minimal data were kept on colposcopy services. The programme attempted to establish a working party to address the services, but was held up by leave among staff.

Waikato Women's hospital ran an extra colposcopy and laser clinic in December.

1992

Information on follow-up services such as colposcopy clinics, was not available to the programme.

12.5 General Comments

Other points were made by the manager:

- there was no carry over of tagged funding which had implications for the provision of low cost screening;
- the larger the practice, the more resistance there was to the Register among GPs;
- the close involvement of a number of staff in the mammography screening pilot had slowed down progress, as did some of the early difficulties with the Community Forum;
- there were gaps in communication between the Department and the regions, particularly when there were organisational and staff changes in the Department;
- changes in the Area Health Board at the end of 1991 undermined overall Board support of the programme; and
- the regional managers meetings were useful in developing the Waiora Waikato programme.
13 Wellington

13.1 Overview of the Wellington Programme

1991

Programme Objectives, Organisation and Management

The programme is based in Wellington. The main objectives of the programme were to promote the programme and Register to GPs, and to encourage older, Maori and Pacific Island women to have smears and enrol on the programme. The aim was to use a community development approach by having Maori and Pacific Island educators working with women from their communities, and public health nurses working with older women.

The aim of the programme was to integrate cervical screening services into existing services, and to build links with key service providers and ethnic communities.

Staffing Levels

The core staff consisted of the programme manager, the systems administrator.

In addition, two Pacific Island Initiatives coordinators and a liaison worker for the Primary Health Care Initiatives were employed. Part time and temporary staff included a health educator who was seconded until mid year, a person to set up workplace clinics, a public health nurse to organise education and training in a rural region, and a liaison person to work with GPs and community organisations in that same region.

In addition, the Pacific Island initiative had 10 educators, and the Maori Initiative had a number of extra support workers.

1992

The staff consisted of the programme manager, two systems administrators (1.25 FTE), one full-time data entry person, a liaison person for the Primary Health Care Initiatives (0.75), two full-time Pacific Island project coordinators, one full-time Maori coordinator, and a part-time workplace initiatives organiser.

In addition, three temporary administration clerical workers were employed, three community health workers were employed of a casual basis, and 15 community education workers (3.2 FTE) were contracted on a temporary basis. A casual lay smear taker was also in training.

13.2 Coverage

1991

Numbers of Smears

The number of smears peaked in October at 6374, compared with an average of 5339 for the remaining months.
Enrolments

The Register did not go live until 1992, so there was no information on enrolments before then.

Smear takers

A list of smear takers was compiled on database.

Community Consultation and Education

Community consultation was based on the areas programme initiatives, including local iwi, the Pacific Island Health Taskforce and Pacific Island organisations, unions and workplaces, Family Planning, the Cancer Society, General Practices, Union Health Services and the Wellington College of Education.

A wide range of Pacific Island groups were contacted about the programme, and a one day workshop was held mid-year with Pacific Island women to investigate requirements for resource material. Women from six island groups were involved in education.

Meetings were held with women from organisations with a large number of older women, and with a group of blind women, to discuss appropriate education strategies.

Pamphlets were developed for older women and workplace clinics.

A meeting was also held with lesbian women to discuss their information and service needs.

A liaison person was appointed to work with primary health care providers.

The Maori Audit Council, iwi and the Pacific Island Regional Health Taskforce were consulted about the use of ethnic data. Maori women in one district held education sessions in women's homes.

The Maori women involved in cervical screening formed a Committee to give support to initiatives across iwi and to liaise with the Area Health Board.

A meeting was held with about forty women to discuss ongoing training needs.

Publicity

The Smear takers Kit was launched at a Marae mid-year. Talks were given on two independent community radio stations. A two week publicity campaign was held in June and July, which focused on women over 50 years and emphasised the GPs role in inviting women to have smears.

There was an off air telephone line which received a good response.

Contributions were made by the programme to the Cancer Society's Network newsletter, and the newsletter of the Ministry of Pacific Island Development.
Services

Contracts were made with a number of community initiatives to provide a range of activities and services (see Community Consultation above).

Area Health Boards offered several low cost clinics, including clinics for low income women and workplace clinics in the one rural district, and a Marae clinic.

A list of low cost clinics was compiled and distributed across communities.

There were few areas without female smear takers.

The manager reported that workplace clinics were achieving good results with women with an outdated smear history.

Five local Marae provided clinics, which were initially run by GPs.

Monitoring and Evaluation

The evaluation of the older women's education programmes and the workplace clinics was carried out by using client questionnaires. An evaluation day was held to discuss future evaluation strategies.

The publicity campaign held mid-year was also evaluated.

Information on the GPs visits was compiled in Paradox.

1992

Comparisons of enrolments from the last quarter were not possible, as the Register only went live in January 1992. Approximately 12 percent of all enrolments were Maori, 40 percent were aged 35-70 years, and six percent were Pacific Islanders. The manager noted, however, that the number of Pacific Island enrolments were underestimated, as the software previously did not allow for women who did not specify their island group, and so they were classified as "other". That has now been changed.

Approximately 165, or just over 50 percent, of all GPs were participating in the programme. Six approved nurse smear takers were also participating.

Two education sessions were held for older women (17 in attendance), 30 for Maori women (317 in attendance), 40 for Pacific Island women (407 in attendance) and two general sessions in workplaces. The manager noted that much of the Maori education did not occur in sessions, but happened in one-to-one discussion. She also noted that the emphasis for Pacific Island women was on training new educators and expanding the education into rural regions. The details of the workplace initiatives were not available, as the organiser was ill at the time of writing this report.

In the first months of 1992, the manager was interviewed by Maori radio and a local community newspaper, an article was printed in another community newspaper, and media releases were made about the Te Whare Raupuora project.

A total of eight meetings were held with groups such as Mana Wahine, the Pacific Island Taskforce and GPs. A hui was held for Maori women on the Register and their need for cervical screening resources. Marae based clinics were also advertised.
Two community clinics sponsored by the programme were held in January-March 1992. There were also 25 services for Maori women, with 86 women screened. The manager noted that there were four services for Pacific Island women, with eleven women screened, but that the low number was because during March the Pacific Island smear takers were on a training programme. She also believed that many Pacific Island women went to GPs for smears.

The programme carried out a survey of eight workplaces that had had clinics provided by the programme. All reported that they were satisfied with the clinics, and suggestions for changes were incorporated into the 1992 programme.

13.3 Quality

1991

Service Provider Training and Quality Control

An educational flipchart was developed by the programme for smear takers to show to women when they were having a smear. The GPs also received a regular newsletter. Seminars for GPs on cervical screening were held in three different areas.

A small number of Maori and Pacific Island women were nominated for training as smear takers.

Discussions were held with Wellington Polytechnic about a smear takers course run jointly by Family Planning and the Area Health Board.

1992

Two education and training sessions were held for nurse smear takers: a Family Planning pelvic exam module and a Maori smear takers training hui. Five sessions were also held for community educators, including specific training courses for the Maori and Pacific Island educators. Eighteen educational visits were made to general practices, and two to obstetricians and gynaecologists.

13.4 Follow-up

1991

Results/Reminder Letters

The Primary Services Initiatives Liaison worker consulted with all GPs about their recall systems, and assisted them to develop age/sex registers. The programme also offered to audit existing recall systems.

Colposcopy, Biopsy and Treatment Services

Cost of referral was identified by the programme as an issue for low income women who needed follow-up treatment.
Options for developing a colposcopy database were developed and a project proposal drawn up.

1992

The programme was continuing to collect baseline data on referrals to the Wellington colposcopy clinic.

Otherwise, the manager noted that information about colposcopies and other follow-up procedures was difficult to obtain because of the change in contractual requirements with the Department meant that some information was no longer collected. The lack of coordination between cytology and histology data also made monitoring of follow-up difficult.

14 West Coast

14.1 Overview of the West Coast Programme

1991

Programme Objectives, Organisation and Management

The manager was appointed in February. To develop the approach of the programme, she examined the demographic, ethnic and social characteristics of the region.

The groups of women identified by the manager as priority groups on the West Coast were women with low incomes, women living in isolated areas, mid-life and older women, and Maori and Pacific Island women. Objectives were identified by the manager through community consultation. The emphasis of the programme was on providing education and publicity appropriate for the target groups, encouraging traditional providers to improve their existing services, and supplementing Area Health Board and other services to provide alternatives for those women who are not using traditional services.

Strategies were limited because of a low budget ($20,000) for expenses apart from salaries. The manager wanted to establish cervical screening as part of routine well-women's checks with an holistic focus.

Staffing Levels

Core staff consisted of the programme manager and the part time systems administrator. In addition, in 1991 a data entry operator/typist, a Maori Women's Health Coordinator, a training coordinator, a Well Women's Centre Nurse Educator and Public Health Nurse Educators were paid part time. A complementary Area Health Board non-medical smear taker was also employed part time.

1992

The manager remained the only full-time employee of the programme. In addition, there was a part time data entry person, one community educator/nurse smear taker
14.2 Coverage

1991

Numbers of Smears

The number of smears peaked in September at 584 smears, compared with an average of 315 smears for the remaining months.

Enrolments

The Register was installed in February, however due to installation of a new computer system in Medlab South, it did not become operational until early June.

The average number of enrolments in 1991 for each month (beginning April) was 174, with the smallest number in July (82 enrolments) and the most in October (293 enrolments).

Smear takers

A choice of smear taker was available to most women in the region. There were approximately 22-25 GPs in the region. Nine nurses were trained as smear takers.

Community Consultation and Education

The manager visited all GPs and Family Planning Services. Meetings were also held with practice receptionists in one area, and all others were contacted through the GP/Family Planning doctor. The manager met with all Public Health Nurses in September where they discussed a range of issues relating to the programme.

A public meeting was held by the manager in one district. The manager and the Nurse Educator also talked to six women's interest groups, all Community Health Committees in the region, all Maori Women's Welfare League groups in the region, and all other Maori groups that were identified (eg. Access groups). The manager also consulted with the Disabled Persons Association and Weightwatchers.

Publicity

The programme was launched in April. About that time the programme developed a flyer which was inserted in all local newspapers and most community newspapers. The Cancer Society leaflet was adapted to suit local needs, and was used as the primary information leaflet, along with the leaflet on smear takers.

Local radio stations provided free advertising of clinics and promotion days. There were also items about the programme on the local radio news, radio interviews, and items in the local newspaper.

An Enrolment Pack was developed by the programme which consisted of a leaflet, a list of smear takers, and a pre-enrolment form. Packs were distributed to practice receptionists and pharmacies.
Local projects coincided with the national advertising campaign (September-November), including promotion days, newspaper articles and displays at local Trust Banks.

In future, because of limited funds, the emphasis of the programme was to be on personal contact with service providers and women consumers.

Services

Contracts were made with several services, including a GP and a Family Planning Clinic, and a multicultural centre.

Free smear taking services were available in most areas, with an average of two Board cervical screening clinics per week. In the quarter June-September 26 clinics were held in seven different venues. The ten trained nurse smear takers offered low cost smears throughout the region.

The programme provided a home service for the disabled as required.

Monitoring and Evaluation

The manager reported some frustration in extracting information from the register. For example, smear numbers did not equate to individual women smeared.

The public health nurses participated in the evaluation of their utilisation of the Resource Kit by completing a questionnaire and attending a regional meeting. It was decided that further training was needed, and that the unused parts of the Kits should be redistributed.

All clinics and education sessions were monitored in terms of the number of attendances, and the characteristics of women. The manager reported that out of 367 women who had attended the clinics until October, 231 (over 60%) were aged 35 years and over, and 131 (over 35%) had an outdated smear history.

1992

Approximately 35 percent of all eligible women on the West Coast had enrolled in the programme. The average number of enrolments for the first few months of 1992 were 54 percent higher than for the last few months of 1991, whereas the average number of smears for the same period had decreased slightly.

Over 50 percent of women that enrolled between January and March 1992 were aged 35 years and over. Data on Maori enrolments were not available. Other details of coverage that were monitored by the programme included enrolments/pre-enrolments, and the screening histories, age and location of smear taker of enroled women.

Nineteen GPs were enroling women in the programme, with an adequacy rate of 90 percent. The seven nurse smear takers enroling women had an adequacy rate of 93 percent. Both GPs and nurse smear takers took an average of one smear per enroled woman.

The manager noted that much of the information on education sessions was not available from Area Health Board educators such as public health nurses and district nurses. Of the records that were kept, a total of eight sessions were held with a total
of 108 in attendance. The sessions included one for Maori men and five general sexual health sessions.

Ten publicity activities were recorded, including a staffed display at an Industrial Fair and ongoing advertisements of clinics.

Twenty one community clinics were held, with a total attendance of 100 women. The clinics were based in two districts and included a service for Maori women. A home visit service for women with disabilities was also newly established. Seven community clinics sponsored by the Cervical Screening Programme were held at a Well Women's Centre.

14.3 Quality

1991

Service Provider Training and Quality Control

A nurse smear taker training course was provided by the programme. A training video was circulated among the nurse smear takers.

Practice nurses were offered a training session about the programme and the register.

The programme educated smear takers to stop recycling disposable speculae.

Data Quality and Register Issues

The manager reported that generating the required statistics for contract management was not only difficult, but unhelpful to the programme.

1992

The programme carried out seven educational general practice visits, and four visits to the nurse smear takers while processing their certification.

14.4 Follow-up

1991

Result/Reminder Letters

The programme changed the wording of some of the letters.

Colposcopy, Biopsy and Treatment

The programme reported one incidence of a woman who was advised by the Register of an abnormal smear, but not by her GP.

1992

The number of abnormalities recorded by the Register and the number reported by the laboratory was different. Eight abnormalities were recorded by the Register, whereas
29 were recorded by the laboratory. There were 47 colposcopies performed, with no waiting list.

14.5 General Comments

The manager highlighted the following points:

- GPs reported that it was difficult to find "available time" during the course of their consultations to explain the programme and Register;

- the women that had enroled in the first year were the "easy" ones—different strategies needed to be developed for those women who were more difficult to access;

- GP resistance to the programme was related to their objections to the form filling, and the belief among some that the programme is a temporary initiative;

- the Board was not supportive of the programme in concept or financially, which accentuated the need for national support— the discontinuation of the provision of forms nationally had a negative impact on the West Coast programme; and

- again, because of limited resources, it would have been good if there had been some support with issues like training and evaluation from a national level.
National Overview of the Programme From January 1991 to March 1992

1 Introduction

This section summarises the review of each region in terms of the regional programme objectives, organisation and staffing levels; coverage indicators; quality indicators and follow-up indicators. The final part of the section summarises the monitoring, evaluation and reporting processes of the regions, including a summary of responses to the pilot of the quarterly report format.

2 Summary of the Regional Programme Objectives, Organisation, Management and Staffing Levels

The regional programmes ranged in their approaches to their organisation, priorities and management. While all identified that the focus of the programme was priority group women (ie. Maori and Pacific Island women, women aged 35 years and over, low income women) they varied in the way that the programme was organised to meet the needs of those women.

While the majority of programmes chose to support the existing services, some decided to emphasise the provision of alternative services.

The number of staff employed by the programme varied widely- from over 50 (including temporary/part time) in Auckland to 1 FTE in Northland.

3 Summary of Coverage

3.1 Numbers of Smears

A summary of smear numbers per region is presented in Table 1 below. Some of the information on some aspects of the regional programmes was not available to the author at the time of writing this report (June 1992).

Numbers of smears per month tended to increase in 1991, particularly in the months of September/November. There was an average increase of 27 percent for that period compared with the average smear rate for the remaining months. The increase in September-November 1991 corresponded with the national television advertising campaign.

Average numbers of smears per month decreased in the period January-March 1992 compared with the average number of smears per month in 1991. There was no consistent difference across regions, however, between smear rates for the period January-March 1991 and January-March 1992.
3.2 Enrolments

Table 1 presents a summary of enrolment and coverage information. There was no clear pattern in enrolments across the regions between 1991 and 1992, although there was generally an average increase in enrolments of seven percent.

The coverage rates varied widely, and tended to be highest in those regions where the Register had been operational for over ten months.

At this stage, the information that is available is too inconsistent to clearly indicate patterns. For those 12 regions where information was available, none had reached a 50 percent coverage rate, and less than one quarter had a coverage rate of 25 percent and over. The average coverage rate for the 12 regions was 18.5 percent.
Table 1 Summary of Regional Numbers of Enrolments and Smear Numbers, 1991 and January - May 1992

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<th>Region (Months live)</th>
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<th>Jan-Mar 1992</th>
<th>Percentage change</th>
<th>All</th>
<th>Percentage eligible&lt;sup&gt;b&lt;/sup&gt;</th>
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<sup>a</sup> Figures in brackets indicate average enrolments per month.
<sup>b</sup> Enrolments: Calculated from women aged 20-69 years, 1986 Census
<sup>c</sup> Enrolments: Calculated from women aged 35-69 years, 1986 Census

1. Up until mid-June 1992
3. Up until end March 1992
4. For May 1992 only
5. Excluding May 1992
7. Percentage of all enrolments up until December 1991
8. For January-March 1992 only
Table 1 (Cont)

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</tr>
<tr>
<td>Canterbury (15)</td>
<td>4,596</td>
<td>1,336</td>
</tr>
<tr>
<td>Hawkes Bay (9)</td>
<td>1,745</td>
<td>1,866</td>
</tr>
<tr>
<td>Nelson (20)</td>
<td>984</td>
<td>941&lt;sup&gt;4&lt;/sup&gt;</td>
</tr>
<tr>
<td>Manawatu (20)</td>
<td>3,620</td>
<td>1,283&lt;sup&gt;5&lt;/sup&gt;</td>
</tr>
<tr>
<td>Northland (11)</td>
<td>1,127&lt;sup&gt;2&lt;/sup&gt;</td>
<td>-</td>
</tr>
<tr>
<td>Otago (12)</td>
<td>2,018</td>
<td>758</td>
</tr>
<tr>
<td>Southland (13)</td>
<td>1,103&lt;sup&gt;2&lt;/sup&gt;</td>
<td>-</td>
</tr>
<tr>
<td>Tairawhiti (14)</td>
<td>456&lt;sup&gt;2&lt;/sup&gt;</td>
<td>-</td>
</tr>
<tr>
<td>Taranaki (15)</td>
<td>1,033</td>
<td>1,028&lt;sup&gt;5&lt;/sup&gt;</td>
</tr>
<tr>
<td>Waikato (9)</td>
<td>3,286&lt;sup&gt;6&lt;/sup&gt;</td>
<td>3,066&lt;sup&gt;5&lt;/sup&gt;</td>
</tr>
<tr>
<td>Wellington (5)</td>
<td>5,440</td>
<td>5,287</td>
</tr>
<tr>
<td>West Coast (15)</td>
<td>344</td>
<td>341</td>
</tr>
</tbody>
</table>
3.3 Smear Takers, Community Consultation and Education, Publicity and Services

Smear takers

Table 2 summarises the number of GPs and nurse smear takers in nine of the regions who were participating in the programme by enrolling women, and the number of eligible women per participating smear taker.

Where estimates were made, managers believed that approximately 50-60 percent of all GPs were enrolling at least some women.

<table>
<thead>
<tr>
<th>Region</th>
<th>Participating Smear Takers#</th>
<th>No Eligible Women per participating Smear Taker</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>GPs &amp; Specialists Nurses Other</td>
<td></td>
</tr>
<tr>
<td>Manawatu</td>
<td>146 (68%) 69 (32%) 1</td>
<td>303</td>
</tr>
<tr>
<td>Auckland</td>
<td>470 (61%) 331 (39%) 0</td>
<td>336</td>
</tr>
<tr>
<td>Nelson</td>
<td>51 (66%) 40 (44%) 0</td>
<td>336</td>
</tr>
<tr>
<td>West Coast</td>
<td>19 (73%) 7 (27%) 0</td>
<td>356</td>
</tr>
<tr>
<td>Hawkes Bay</td>
<td>60 (62%) 36 (38%) 0</td>
<td>393</td>
</tr>
<tr>
<td>Waikato</td>
<td>149 (85%) 26 (15%) 0</td>
<td>487</td>
</tr>
<tr>
<td>Southland</td>
<td>76 (88%) 10 (12%) 0</td>
<td>526</td>
</tr>
<tr>
<td>Wellington</td>
<td>165 (96%) 6 (4%) 0</td>
<td>679</td>
</tr>
<tr>
<td>Canterbury</td>
<td>193*</td>
<td>813</td>
</tr>
</tbody>
</table>

# Percent of total participating smear takers in that region in brackets
* All participating smear takers

The Manawatu region had the most participating smear takers per woman, and the Canterbury region had the least. Those four regions that had less than 360 eligible women per participating smear taker had a higher average enrolment rate of 23.5 percent, compared with the average rate for the remaining regions (average 11.6%) and the overall average rate of 19.5 percent.
The four regions with the greatest proportion of participating smear takers also had been live for a longer period (average 16 months) than the average regions (live an average of 12.5 months) and those with fewer participating smear takers (live an average 10 months).

Nelson had the largest proportion of nurse smear takers, and Wellington the smallest. In general, those regions where the proportion of nurse smear takers was greater than 25 percent again tended to have a higher coverage rate of all eligible women than the average for all regions, and for those where the proportion was less than 25 percent.

The average months live of those regions with a greater proportion of nurse smear takers (over 25 percent) also tended to be higher (14.6 months) than those regions with a smaller proportion of nurses (live 10.5 months).

Community Consultation and Education, Publicity, and Services

Table 3 presents a summary of the range of coverage strategies, coverage rates and months live of each regional programme. The aim of the summary is to emphasise the key strategies that emerged through the interviews with managers, rather than the strategies that were planned and not implemented, or that were a small part of the programme.

The most common strategies adopted by the regions included the use of free local media for promotion of the programme (12 regions), the use of health educators (11 regions), the support of GP services (along with promoting the Register to GPs) (10 regions), and the provision of alternative venues. The promotion and enhancement of alternative providers and Area Health Board services were also strategies used by the majority (9) of programmes.

No clear relationships between staffing levels, number and type of coverage strategies and coverage rates appears to emerge at this stage of the national programme. Those regions with higher coverage rates tended to be more likely to emphasise the provision of low cost services, and to enhance those services already available. Again, however, those regions tended to be more likely to have been live for an average of five months longer than the others.

It is generally difficult to make comparisons across the regions because of the demographic, cultural, geographic and organisational differences between them. The common link between the regions was an emphasis on community consultation and the facilitation of consumer involvement in decision making. And while all the regions had stated that the priority groups for their programme were women aged 35 and older, Maori and Pacific Island women and low income women, each had allocated different levels and types of resources to strategies designed to reach those women.

According to the information collected during the evaluation, the different strategies and priorities of the regions were influenced by a number of factors. The factors include the overall level of resources, which in turn affected the staffing levels and the level of service provision.

Those regions where the manager reported that resources were inadequate, for example, tended to have fewer staff employed by the programme and were less likely to be supported by their Area Health Board. Those programmes also tended to be located in areas of relative geographical isolation and high unemployment, such as the West Coast, Nelson, Southland and Tairawhiti. The strategies adopted by those programmes tended to be focused on developing low cost services, and enhancing
Table 3 Summary of Coverage Strategies, Coverage Rates, and Months Live

<table>
<thead>
<tr>
<th>Region</th>
<th>Staff(^a)</th>
<th>Coverage Strategies: Key Emphasis(^b) of the Programme</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>GP support</td>
</tr>
<tr>
<td>Nelson</td>
<td>2</td>
<td>X</td>
</tr>
<tr>
<td>West Coast</td>
<td>2</td>
<td>X</td>
</tr>
<tr>
<td>Otago</td>
<td>5</td>
<td>X</td>
</tr>
<tr>
<td>Taranaki</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Southland</td>
<td>3.5</td>
<td>X</td>
</tr>
<tr>
<td>Tairawhiti</td>
<td>1.5</td>
<td>X</td>
</tr>
<tr>
<td>Manawatu</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Hawkes Bay</td>
<td>3.5</td>
<td></td>
</tr>
<tr>
<td>Canterbury</td>
<td>8.5</td>
<td>X</td>
</tr>
<tr>
<td>Auckland</td>
<td>15</td>
<td>X</td>
</tr>
<tr>
<td>Waikato</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Wellington</td>
<td>9</td>
<td>X</td>
</tr>
<tr>
<td>Bay of Plenty</td>
<td>4</td>
<td>X</td>
</tr>
<tr>
<td>Northland</td>
<td>1.5</td>
<td></td>
</tr>
</tbody>
</table>

\(^a\) Includes an estimate of those staff on contract, employed part time etc. at any one time

\(^b\) Key emphasis = the focus of the programme's activities as according to manager's reports and interview data

\(^c\) Eg. women's health centres, Marae clinics, home visits, suitcase clinics, mobile units, polytechnics

\(^d\) Ie. alternatives to GPs, Family Planning services and specialists
<table>
<thead>
<tr>
<th>Region</th>
<th>Coverage Strategies: (cont)</th>
<th>Eligible Women Enroled (E)</th>
<th>Months Register Live (L)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AHB Services</td>
<td>Free local media</td>
<td>Paid advertising</td>
</tr>
<tr>
<td>Nelson</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>West Coast</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Otago</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Taranaki</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Southland</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Tairawhihi</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manawatu</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Hawkes Bay</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Canterbury</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Auckland</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Waikato</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Wellington</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Bay of Plenty</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Northland</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

E = Eligible women enroled aged 20-70 years, calculated from 1986 Census Data
L = Time Register live in months (ie. time in months Register operative and recording smears)
existing services, such as promoting community clinics, and encouraging participation by GPs and nurses.

Networking with women in geographically isolated areas was also reported to be problematic. Northland, Tairawhiti and Southland all reported that they had had some problems in generating the involvement of Maori women.

Programmes in those regions who reported a good resource level were more likely to be located in one of the main centres, such as Auckland, Wellington, Christchurch and Dunedin. The choice of strategy by those programmes was less likely to be hindered by the perception of a lack of resources, and included the use of paid advertising campaigns, devolution of resources to districts within the region, and the use of numerous health educators and community workers.

3.4 Monitoring of Coverage Strategies

The main source for programmes of information on coverage was information provided by the laboratories on overall smear rates, and information generated by the Register, as outlined in Table 1. Overall smear rates are only a crude estimate of the number of women having smears. There was also no information on ethnicity, age and smear status.

Managers reported that not all women that had pre-enroled had had their smear recorded on the Register, as the smear was not sent in with a Register form. Some managers also reported that all the information they wanted was not yet able to be generated by the Register.

Table 4 presents a summary of the availability of monitoring data on the number of education and smear taking clinics, the number attending those sessions, and the recording of smear history.

At the time of writing this report, limited data were available.

Current information on the number of education sessions and clinics held during each quarter was available from half of the programmes at the time of writing this report. Six also had information about the attendance rates and smear histories of women having smears at clinics and/or services under contract to the programme. Some managers noted that where services were contracted out, it was often difficult to ensure that they were monitored consistently, and that the monitoring information was passed on to the programme.

A further four programme managers have reported that certain information has been collated, but it was not available to include in this report. A total of eleven programmes, therefore, have been identified as collecting basic information about education and smear taking initiatives. The three remaining programmes have indicated that 1991 information has been collected. The status of that information and monitoring in 1992 was unknown to the author.

All programmes had kept some record of the number of meetings held with groups in the community. Managers often commented, however, that it was difficult to quantify the process of community consultation, and that much of it was not immediately visible. All programmes had involved key members of their community,
including service providers and consumers, in service planning. All held regular meetings.
Table 4 Summary of Monitoring of Education Sessions and Smear Clinics by Each Region

<table>
<thead>
<tr>
<th></th>
<th>Education Sessions</th>
<th></th>
<th>Smeartaking Clinics</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Community Workers</td>
<td>AHB Nurses</td>
<td>AHB Nurses</td>
</tr>
<tr>
<td>Hawkes Bay</td>
<td>Avail N N</td>
<td>? ? ?</td>
<td>Avail Avail Avail</td>
</tr>
<tr>
<td>Nelson</td>
<td>Avail N N</td>
<td>? ? ?</td>
<td>Avail Avail Avail</td>
</tr>
<tr>
<td>Northland</td>
<td>NYA NYA NYA N</td>
<td>N N N</td>
<td>? ? ?</td>
</tr>
<tr>
<td>Southland</td>
<td>Avail Avail Avail</td>
<td>Avail Avail ?</td>
<td>Avail Avail ?</td>
</tr>
<tr>
<td>Wellington</td>
<td>Avail Avail Avail</td>
<td>? ? ?</td>
<td>Avail Avail Avail</td>
</tr>
<tr>
<td>West Coast</td>
<td>Avail Avail Avail</td>
<td>N N N</td>
<td>Avail Avail Avail</td>
</tr>
</tbody>
</table>

**KEY**

- **No.** = Number of Sessions/Clinics
- **A** = Number attending
- **H** = Recording of smear history
- **Avail** = 1991 and 1992 information collected and collated by the programme
- **NYA** = Information reported as being collected by the programme but not yet collated/available to the author at the time of writing (June 1992)
- **N** = Information not collected
- **?** = Status unknown
- **1991** = 1991 information available only

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both formally and informally with a range of groups, and had groups advising the planning and implementation of the programme.

The processes of those meetings and consultations, and their effectiveness, are more difficult to measure. One manager, for example, believed that some of the "representatives" that had been elected to one group were not actually "representative" of their community. It was only after a period of several months and informal community feedback that the situation became apparent.

The processes of working with Maori groups were perceived by managers to be different to those of working with older Pakeha women; and the processes of working with Pacific Island women were different again. Different Maori tribes and island groups also had particular ways of working.

The issue of monitoring processes was investigated by independent researchers in Auckland. While they advised the district coordinators on ways that they could monitor their activities, the researchers believed that they had had limited success in ensuring regular and consistent recording. One measure that was suggested was to follow-up women who had attended education sessions, to monitor whether they had subsequent had a smear. This was believed to be too intrusive a measure by those in the programme.

Where effectiveness has been reported, however, a range of strategies appear to have been successful. Community consultation and publicity appears to have generated some demand for community based clinics, particularly in the smaller regions. Of the women attending Area Health Board clinics in Hawkes Bay, for example, over 65 percent were reported to have an outdated smear history, and were over 50 years of age. In Manawatu/Wanganui, 70-80 percent of women that attended AHB clinics were aged 35 years and over and had outdated smear histories, and in Nelson, over 20 percent of women that attended the free nurse smear taker clinic had an outdated history.

All managers perceived a need for the development of accurate and reliable consumer satisfaction measures.

4 Summary of Quality

4.1 Service Provider Training

All the programmes had sponsored nurse smear taker training courses with two exceptions. One had discontinued its course and subsequent had access to a course in another region; the other was planning a course. Several regions were involved in assisting general practices set up age/sex registers and had run training sessions about the Register for practice nurses. All programme had visited all GPs and provided them with information about the programme.

Five regions held training sessions for their community educators.

4.2 Quality of Smears and Smear Reading

The quality of smears varied between regions and across time, with an adequacy rate of 55 percent in Southland (almost 2% inadequate and over 40% non-optimal), a one
percent inadequate and 13 percent non-optimal rate in Canterbury, and a 0.1 percent inadequate rate in Otago. One region reported a range in quality of smears taken by GPs of 33-94 percent. Nurse smear takers had higher overall adequacy rates in all regions.

Reports of smear taking quality were sent out regularly to all service providers.

A variation in reporting by laboratories was reported by some regions. One manager believed that laboratories were under-reporting suboptimals; another believed that one laboratory was over-reporting. Several managers believed that there was a lack of uniform quality assurance measures across laboratories.

4.3 Data Quality and Register Issues

All programmes reported a variety of different problems including problems with enrolment forms; data entry; the interfaces between laboratories, the Register and PAXUS; and the generation of information from the Register, (eg. how many women had out of date smear histories, how many previous abnormal smears women have had). Problems with women moving to a different Area Health Board and subsequent no longer being tracked by the Register were also reported.

Correcting mistakes and ensuring good quality information was entered on the Register was reported to be time consuming. Most programme had changed the enrolment and others related forms, and some managers believed that forms should have been standardised and produced nationally.

The level of security of information was reported to be high by all regions, and all had obtained the approval of their Board Ethics Committee.

Some programmes had yet to obtain approval to use Maori data.

4.4 Overall Monitoring/Evaluation

At least eight of the programmes had quality assurance programmes in place, or were developing them. About half of the programmes held regular management meetings.

Three of the programmes were carrying out a review of the quality of colposcopy services.

5 Summary of Follow-up

5.1 Result/Reminder Letters

Many programmes had received complaints and enquiries from women and GPs, because the content of the letter generated by the Register and sent to women was different to what GPs had told women. This was particularly the case with inflammatory smear results. The majority of programmes had changed the wording of the letters generated by the Register. Several others believed that the wording should be changed, but that the letters should be standardised nationally. Some programmes reported that the Register had sometimes generated inappropriate letters.
Some managers reported cases where women had received treatment and had been "signed out" from the Register, but were not signed back on by the specialist or GP after the treatment had concluded, so that they were no longer recalled by the Register.

5.2 Colposcopy, Biopsy and Treatment Services

Programmes reported variations in referral patterns by GPs following an abnormal smear result, and a lack of communication from laboratories to smear takers about how to interpret results.

Regions are now required by the Department of Health to report on waiting lists for urgent and non urgent colposcopy. The regions were to collect information on the numbers of women with CIN 1 results that waited longer than six months, the numbers with CIN 3 that waited longer than four weeks, and the numbers of women with CIS results waiting longer than two weeks. The new requirements were released in June 1992, so the information was not available to the author at the time of writing this report.

Where information was available, in most regions waiting lists for colposcopy were lower than the period defined in the performance indicators, although three programmes reported a "backlog" in the numbers waiting for colposcopy services.

Table 5 below shows the numbers of women that did not attend their first and subsequent colposcopy appointment in some regions (information was not available for all regions). The numbers not attending for subsequent appointments were higher than those not attending first appointments. The numbers of non-attenders were highest in Auckland and Waikato, although the rate per all referrals was unknown. The numbers of subsequent colposcopy non-attenders were over twice as high as those for first colposcopy non-attenders.

Table 5 Numbers not Attending for First and Subsequent Colposcopy by Region, for the Period February-March 1992.

<table>
<thead>
<tr>
<th>Region</th>
<th>February</th>
<th>March</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>First</td>
<td>Subsequent</td>
</tr>
<tr>
<td>Auckland</td>
<td>26</td>
<td>91</td>
</tr>
<tr>
<td>Bay of Plenty</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Canterbury</td>
<td>DNA</td>
<td>DNA</td>
</tr>
<tr>
<td>Hawkes Bay</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Manawatu</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Northland</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Nelson(^1)</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Otago</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Southland</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Taranaki</td>
<td>11</td>
<td>13</td>
</tr>
<tr>
<td>Tairawhiti</td>
<td>5</td>
<td>DNA</td>
</tr>
<tr>
<td>Waikato(^2)</td>
<td>10</td>
<td>DNA</td>
</tr>
<tr>
<td>Wellington(^3)</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>West Coast</td>
<td>5</td>
<td>DNA</td>
</tr>
<tr>
<td>Total</td>
<td>56</td>
<td>131</td>
</tr>
</tbody>
</table>

DNA = data not available
1. Marlborough figures only
2. Figures for subsequent colposcopy only collected from 14 February only
3. For two districts only
The monitoring of follow-up services was reported by all programme managers as being extremely difficult because of the lack of coordination between cytology and histology information, and the reliance on other service areas to provide information. The lack of input by the programme into follow-up service provision also made it difficult to improve the quality and availability of the services. However, several programmes reported that they were attempting to establish their own monitoring and auditing of follow-up services.

6 Summary of General Comments

General comments related to the allocation of resources to each region, the relationship of the regional programme with the Department, the attitudes of GPs to the programme, and the difficulties in reaching risk groups, particularly Maori women. A summary of details of the comments is given below.

While four of the regional managers reported their programmes were well resourced, six reported that they believed their resources were not adequate and that they did not receive support (including extra staff) from the Area Health Board.

The relationship of the regional programmes with the Department was reported to have varied over time. Most managers stated that they did not receive as much direction and supervision from the Department as they would have liked in the early establishment phase of their programme. The majority believed that communication between the Advisory Group, the Department and the regions could be improved, along with the coordination of information.

Most managers thought that the performance indicators that they provided the Department on coverage were meaningless and often difficult and time consuming to generate.

At least half the regions reported resistance to the programme, and more particularly the Register, by some GPs. The main reasons given by GPs was the time consuming nature and "fiddliness" of filling in the Register forms, and that they already had their own recall system. Some managers believed that those were not the only reasons, and that some GPs felt threatened by the issues raised by the Cartwright report and the subsequent recommendations. Managers also thought that some GPs believed that the programme was created for political rather than health reasons.

At least three of the managers expressed concern at the level of difficulty they were having in reaching unscreened women, and encouraging them to have smears and enrol on the Register. In particular they reported difficulties in developing appropriate strategies for Maori women, and monitoring the effectiveness of approaches.

Finally, several managers were surprised that some of the difficulties relating to the enrolment forms, letters and other details had not been resolved as a result of the pilot projects. The two managers of the regions where the pilot projects had occurred believed that in some respects their task had been made more difficult because of the experiences that some GPs had had with the pilots.
Summary of Programme Monitoring, Evaluation and Reporting

7.1 Summary of Regional Monitoring and Evaluation in 1991

Monitoring and Evaluation of Coverage

Information was available from all regions on the numbers of smears processed by the regional laboratories.

There was some variation of recording of enrolments on the Register, including the reporting actual enrolments received, the enrolments recorded on the Register, the number of smears received at the Register, and the number of slides received at the Register. There were also differences in the availability of information about particular groups of women, including Maori.

All regions kept summaries of smear takers, and kept some record of meetings held with different groups. Managers also had information about the range and location of education sessions and smear taking services, and were able to summarise promotional and publicity activities.

Only one region had specifically set funds aside for formal evaluation to investigate the effectiveness of strategies involving GPs, and to monitor coverage and consumer satisfaction among Maori and Pacific Island women.

Monitoring and Evaluation of Quality

A limited amount of information on quality was collected by the regions because of problems of access to information. Smear taking quality was monitored by all programmes, as was the quality of training programmes that they sponsored or provided.

The quality of laboratory procedures and smear diagnosis was not monitored, and there was no formal monitoring of data accuracy and other Register issues.

Some regions reported that they were addressing overall quality assurance issues and looking at developing measures to monitor programme quality. At the time of writing this report the details of those quality assurance measures were not available.

Limited information was available on treatment quality because of the lack of coordination between histology and cytology information.

Monitoring and Evaluation of Follow-up

Limited information was also available on follow-up issues. Not all laboratories provided the programmes with regular reports on the number and type of abnormalities, and because of the relatively small proportion of enrolments in most regions in 1991, limited information on abnormalities was available from the Register.

Most regions monitored the time between smears being taken and results being received by the smear taker, and being entered onto the Register.
Managers collected information on the number of colposcopy services, and the waiting lists. Little or no information was available in 1991 about inappropriate follow-up, failure to follow-up, and non-attendance at colposcopy. Again, managers identified the lack of combined cytology and histology information as a large limitation in their ability to monitor follow-up.

7.2 Summary of Reporting

Regular reports of the regions to the Department included "Quarterly" reports to the NCSP manager and regular reports to the Contract Management Section of the Department on Performance targets relating to coverage and follow-up services.

Most managers believed that the information supplied to Contract Management as inappropriate and of little use to them for management purposes.

Managers also wanted changes in the quarterly report format. They wanted to ensure that the information that was collected was consistent across regions, and that the information could be easily summarised and analysed in a way that would provide feedback to the regions on aspects of their programme's effectiveness. The wide range and variation of information supplied by managers using the previous quarterly report format made it difficult to compare regions in terms of various key indicators. The "Quarterly" reports were also not supplied by all regions for the time period specified.

7.3 Summary of Responses to the Pilot of the Quarterly Report

Nine regions supplied information for the first months of the year using the revised Quarterly Report format (see Appendix E). Some managers reported that they found that gathering the information within the required timeframe was difficult, and limited the range of information that they could provide. Others required clarification of definitions.

A summary of amendments to the format suggested by the managers who responded is available on request to the author.

As shown in Table 5, not all regions had information available relating to the provision of education sessions and screening services at the time of this report. The majority of those that reported using the format were, however, able to provide some information on staffing levels, enrolments, number of smear takers, monitoring activities, publicity, smear taker training and quality of smears. Limited information was available on follow-up (eg. numbers requiring treatment) and some aspects of quality such as treatment failure and false positives.
Discussion and Conclusions

1 The NCSP and the Regional Programmes

As shown by the results from the regions, during the period January 1991-March 1992 the NCSP was not so much a "national" programme, as a set of regionally implemented programmes with a range of different resource levels, priorities, strategies, procedures and monitoring processes. The common link between the regional programmes was the Register and the overall policies regarding the range of women that should be screened, frequency of screening, and procedures for follow-up.

There appears to be several reasons for such diversity in the regions, including a perceived lack of guidance and direction from the Department of Health in the early formative stages of the regional development; the level of Area Health Board personnel available; the ethnic, demographic and geographic diversity of the regions themselves; and the background and focus of the regional managers.

Such diversity, and the variation in stages of development in the different regional programmes at the present time, makes it difficult to draw conclusions about the current regional difference in coverage rates. Both the number of participating smear takers and the level of enrolment of eligible women appears to be related to the length of the Register being live.

Levels of GP participation in the programme (i.e. those that were actively enrolling women) appeared to be particularly low. The low level of GP participation and the correspondingly low levels of enrolment after the first two years of operation of the programme are consistent with estimates that 40 percent of women would be enrolled on the Register with a voluntary opt in programme (Cox 1989).

On the other hand, estimates based on the experiences of programmes overseas with "opt out" Registers (i.e. women are automatically enroled unless they request not to be) indicate that an enrolment rate of approximately 98 percent of all women having smears could be expected here with a similar Register. The gatekeeping role by GPs and other health care providers appears to have been an important factor in determining the level of participation in the programme by women.

Legislation to make the Register an opt out one is scheduled to be introduced later in 1992. It will be important to monitor the impact of the legislation on rates of enrolment by women, particularly older, Maori and Pacific Island women. Maximum participation of eligible women in the programme is essential if it is to be effective, and if adequate data to monitor the programme are to be collected. While an opt off Register may more or less guarantee the latter, by ensuring that all women who have a smear are given the option to enrol, it will not necessarily guarantee that all eligible women will have regular smears. Regions need to continue to look at ways of increasing the availability, acceptability and accessibility of screening services.

The participation by eligible women by having smears and enroling is not the only factor that influences the effectiveness of the NCSP. While achieving maximum participation has been the main focus of the first stages of the programme, factors such as quality and follow-up will become increasingly important. At this stage, not enough is known about the different components that influence the overall quality and
follow-up, such as quality assurance measures in laboratories, referral patterns of GPs, and quality of treatment.

One New Zealand study has shown, for example, that some GPs are not following the recent Working Party guide-lines on screening intervals and treatment (Adams 1992). Some GPs, for example, are screening young women more frequently than recommended; some are referring women after their first abnormal smear; and a small proportion do not refer women who have had a CIN 2 or CIN 3 smear result. Over-screening of younger women, over-referral of minor abnormalities and failure to refer women for further investigation and treatment could mean that resources are not being allocated to those women that could potentially most benefit from screening, while increasing the overall cost of the programme and decreasing its effectiveness (Bonita & Paul 1991; Paul et al 1991).

Although the provision for opt off legislation may ensure that women are included on the register, and that they are recalled when advised, factors such as the lack of a link between colposcopy and histology, and the lack of coordination between primary and secondary services, may hinder the subsequent follow-up and monitoring of women who have had abnormal smears.

2 The Evaluation of the NCSP and the Regional Programmes

If the NCSP is to be evaluated on a national level, information needs to be collected regularly and consistently from the regions. To a certain extent, coverage information can be generated regularly by the Register. If a more complete picture of the regional programmes is to be gained, however, broader information needs to be provided on issues such as coverage strategies, quality of services and follow-up of women. Such information may give an indication of reasons for any regional variations in information from the Register relating to coverage, levels of inadequate smears, and rates of abnormality.

The pilot of the revised format indicated that not all regions were consistently collecting some of the information that the December 1991 Discussion Paper recommended should be collected by all programmes (see Appendix C).

Unfortunately, it will be difficult to collect the information retrospectively. However, the programme can still be regarded as being in its early stages, and some information on indicators such as coverage strategies could be collected in the 1992-1993 year that would be valuable in interpreting coverage rates. As discussed above, with opt off legislation, overall enrolment levels should be a more accurate indicator of all women that are having smears.

Other coverage information that would be relevant to collect in the 1992-93 year includes an evaluation of coverage strategies by measuring levels of awareness, the extent of screening, and consumer satisfaction among women. One way that such information could be collected is at a regional level, using such techniques as selected sampling and using contact with key representatives in the community to distribute questionnaires and carry out interviews.

Priority should also be given wherever possible to the piloting and evaluation of specific coverage strategies, such as GP-based interventions, and the use of pamphlet drops and other publicity.
As discussed above, factors such as quality and follow-up will become increasingly important as more women are screened regularly. At this stage, the information collected by the regions on both those factors is minimal. If the quality and follow-up aspects of the programme are to be monitored, Area Health Boards need to be required to ensure that the regional programme has access to the relevant information. Some information, such as quality assurance measures in laboratories, may be inaccessible in the short term.

It is recommended, then, that the quarterly report format is continued to be refined and developed in consultation with managers, so that monitoring of coverage, quality and follow-up issues is regular and consistent. The reporting format needs to be comprehensive enough to indicate areas where there are gaps in information collection, but also needs to be "user friendly", so that completion is regular and up to date, and that at least 90 percent of the required information is supplied.

3 Implications for Other Public Health Programmes

The results of the first evaluation year of the NCSP have implications for the future planning and monitoring of other large scale screening and public health initiatives. If monitoring and evaluation of such initiatives is to be consistent, ongoing and meaningful, then provision for the regular and reliable collection of minimum key information must be made at the beginning, and included in the programme planning. Those responsible for implementing the programme should ensure that key monitoring and evaluation milestones are clarified and linked to specific programme objectives, that indicators and sources of information are identified, and that methods and frequency of data collection and collation are explicit.
APPENDIX A

Evaluation Model and Relationships
**Figure 1**

**Diagram of the Evaluation Model**

Input

Process

Coverage

Quality

Followup

Costs

Detection

Incidence

Mortality
Figure 2
Model of Relationships between Resource Utilisation and NCSP Focus Areas

Resources

Inputs
Consumers
Providers

Process
Planning
Programme
and delivery

Outputs
Understanding
Attitudes
Coverage
Quality
Follow Up
Registration

Outcomes
Cervical Cancer Incidence
Cervical Cancer Mortality

NCSP Focus Areas
Coverage
Quality
Follow Up
Cost
APPENDIX B

Analysis of Potential Process and Output Indicators
a) Coverage

Coverage describes the proportion of eligible women (ie. aged 20-70 years) who have had a smear in the last X years. Indicators will include overall population rates, and rates for particular target groups.

Coverage is affected by accuracy of records and databases, and identification of eligible women; aspects of service provision (eg. women who attended but were not recorded; failed communication, lack of choice of time and venue) and knowledge, attitudes and behaviour of women.

Indicators

Process Indicators
* involvement of women as consumers in planning of smear taking services
* the extent to which women consumers from priority groups are involved in the planning of services and the monitoring of performance
* type and frequency of Health information, education and publicity
* coordination of screening initiatives
* number, location and type of screening services available
* completion of enrolment forms
* transcription onto the register
* completeness of the register
* call/recall procedures

Output Indicators
* knowledge and attitudes of women (of and to cervical screening and the NCSP)
* acceptability of NCSP to women (eg. cost, choice of service, cultural appropriateness, register)
* proportion of women declining smears and reasons
* knowledge of GPs and other potential smear takers (of and to cervical screening and the NCSP)
* proportion of GPs enrolling women
* percentage of women enrolling and/or registered
* time since last smear
* percentage of eligible women on the register in total and by priority group (eg. Maori women, women over 45 years, women with abnormalities that are untreated or inappropriately treated, Pacific Island women, and socially and economically disadvantaged women)
* percentage of women who have had a smear test in total and by priority group, and percentage of those who are enroled
* number of smears per 1,000 women
* percentage of women who have had at least one smear in the past three years
* percentage of women screened who had not had a smear within the last five years or who had never had a smear
* percentage of smear results according to stage
* coverage in terms of age, location, and ethnicity

Each of the indicators will be analysed by Area Health Board data and nationally.
Data Sources

**Existing Sources**
* information and regular reports from screening coordinators
* records kept by service providers
* census data (for demographic and ethnic profiles)

**New Sources**
* interview and observational data
* calculations from the national register
* sample survey of smear takers
* household survey

**Resources/Key People**
* AZIMUTH consultants (John Brakenbury)
* screening coordinators

**Action Required**
* access records held by the NCSP Section
* contact screening coordinators
* visit sites and access records
* develop interview instruments and observation methods for on site data collection
* contact AZIMUTH representatives
* develop questionnaires for surveys

Other Comments

b) Quality

**Indicators**

**Process Indicators**
* training opportunities and requirements for smear takers and readers
* percentage of smears for which spatula or spatula and cytobrush were used
* smear taker compliance with guidelines for quality smear taking
* meeting the requirements of minimum standards of competency for laboratories and cytologists which relate to the number of smears analysed
* number of smears done at TELARC laboratories
* number of laboratories registered with TELARC
* quality control procedures
* procedures for processing and accessing information

**Output Indicators**
* attendance at training sessions in the last 12 months/three years by smear takers and readers
* percentage of women screened by a smear taker who elect to be recalled by that smear taker or who return to that smear taker on recall
* percentage of smears which were categorised as satisfactory or less than satisfactory
* proportion of unreadable smears
* percentage of false negatives found histologically
* percentage of true positives found at biopsy
* specificity and sensitivity of screening procedures (calculated by proportion of women screened found to have abnormalities and their corresponding smear result)
* confidentiality of the register (eg. password procedures, systems for purging and updating, complaints about misuse of information, response to requests for information)

Data Sources

Existing Sources
* records kept relating to provision of training
* laboratory records relating to smear quality, cytology and histology (not for all laboratories?)
* information kept by Primary Services Contracts
* laboratory records
* cytology and histology registers

New Sources
* survey of laboratories
* survey of smear takers
* audit of data input and output sites

Resources / Key People
* laboratory staff

Action Required
* identify existing laboratories and their size
* contact laboratories about their willingness to be involved in the evaluation, their records keeping etc
* identify smear takers through coordinators
* develop survey instruments

Other Comments

c) Recall / Follow Up

Indicators

Process Indicators
* result notification procedures
* recall procedures
* record keeping (eg. form filling), storage and retrieval procedures
* availability of follow up services (eg. colposcopy)
Output Indicators

- percentage of women on the national register
- reliability of information kept on the register
- percentage of women on the register who are mailed smear results
- percentage of results received
- percentage of women who understand the smear results and follow-up requirements
- percentage of women who are satisfied with their result notification
- percentage of women who request recall reminders and who are sent reminder letters
- percentage of reminder letters received
- percentage of women who have not received a reminder letter
- recall response rate
- percentage of women with normal smears that had a repeat smear within three years
- percentage of reminder letters with incorrect recall dates
- percentage of women receiving "overdue recall reminder letters"
- time elapse between abnormal smear and follow up
- number of recalls not followed up
- average waiting time for colposcopy, biopsy and treatment
- percentage of late grade abnormalities following treatment
- number of women with CIS/invasive cancer who have a regular screening history
- proportion of women with invasive cancer assessed by multidisciplinary teams

Data Sources

Existing Sources
- National Register
- laboratory records-smear, cytology and histology records
- hospital records
- regional programme records

New Sources
- follow up letters to GPs
- "Case Studies" of women with invasive cancer

Resources/Key People

Action Required
- contact laboratories (see "Quality")
APPENDIX C

NCSP Evaluation Proposal
NATIONAL CERVICAL SCREENING PROGRAMME

NATIONAL EVALUATION

PROPOSAL FOR DISCUSSION

Prepared by Jo Adams
Health Research Services
December 1991
1) SUMMARY

Each regional cervical screening programme of the (former) Area Health Board region of New Zealand has been visited by the researcher responsible for the evaluation of the National Cervical Screening Programme (NCSP). The aim of the visits was to establish contact with the programme managers and to become familiar with each of their regional programmes. The researcher also wanted to investigate what information was being collected, and what monitoring and evaluation systems were being developed or were in place.

Although there were some common themes across the regions, the variations were also found to be great in terms of the kinds of strategies that had been developed, and the way that they were being monitored.

Concerns that were common to all programmes included the need for an opt off system, the problem of resistance by general practitioners, and problems relating to the inputs into and outputs from the register.

It is recommended that the current information collection and monitoring systems be addressed. There is a need for more consistent information collection and coordinated analysis of that information. It is suggested that Health Research Services (HRS) develop a way of making information collection more consistent. A suggested form for this is included in the report. HRS could be responsible for the collation and analysis of this data for the duration of the evaluation project.

2) INTRODUCTION

This report gives an overview of work on the National Cervical Screening Programme evaluation to date, summarises what has been found, and outlines future directions.

A detailed description of the National Cervical Screening Programme aims and objectives is given in the discussion paper attached.

3) AIMS OF THE NATIONAL EVALUATION

The main aim of the National Cervical Screening Programme evaluation is to examine whether the programme has met its objectives. On a national, long term level, the objectives are to reduce the cervical cancer incidence and mortality rates. In order to achieve those objectives, however, a number of intermediate steps need to occur. Five key issues relate to the potential success of the cervical screening programme:

1) **Coverage:** The programme needs to achieve maximum coverage in terms of the number of eligible women screened, particularly among those groups identified as being at risk (ie. older, low income, Maori and Pacific Island women). Coverage can
be effected by the availability, cost and types of services, and the amount and type of health education and publicity.

2) **Quality:** The programme needs to ensure that the components of the programme are of high quality. Quality of smear taking and reading, turn around time of smears, security of information, quality of information, and quality of smear taking services (ie. acceptability to women) are issues here.

3) **Follow Up:** It is important that women are adequately followed up following their smear. Factors relating to follow up include result notification procedures, accuracy of record keeping, and availability and accessibility of diagnosis and treatment services.

4) **Costs:** The costs of the various components of the programme need to be monitored to determine the most effective use of resources.

5) **Documentation/Monitoring/Evaluation:** By building in an evaluation component, we can learn "how we're doing" and base the decisions that we make on quality information.

As the national programme is regional implemented, monitoring of each of the above issues needs to occur at a regional level. This needs to be done in a way that is consistent and accurate, yet also need to be acceptable to all the consumers of the programme (ie. regional managers, their staff, laboratories, and all other programme participants). Programmes have also already been established for some time, so existing systems and procedures need to be taken into account. This was the first stage of the development of the evaluation strategy: all 14 regions were visited by the researcher to document the following areas in each programme:
- the aims and objectives
- the action taken
- the priorities
- the problems
- the documentation, monitoring and evaluation occurring and
- the overall use of funding.

The next section is a brief summary of what was discovered.
4) SUMMARY OF ACTIVITY IN THE REGIONAL CERVICAL SCREENING PROGRAMMES

Aims and Objectives

Each region has a main overall aim of achieving maximum participation of women in the programme. A range of strategies have been developed to achieve that aim, ranging from provision of free services to the improvement of quality of existing services.

Action

Community consultation is a main activity in many areas. Part of that process is the establishment of advisory groups formed by community representatives, and using key people from different groups as liaison points.

Developing contact with existing smear takers also appears to be a common activity. Contact with general practitioners in particular has been fostered by all regions. The use of alternative venues, such as womens health centres, is also promoted where they are available. Some regions have included other (former) Area Health Board staff (eg. Public Health Nurses, District Nurses) in their activities, with varying degrees of success.

Priorities

The priorities identified reflect the regional variations, but are based on the groups defined as being at risk by the national programme: Maori, Pacific Island and older women.

Problems

Although problems, like priorities, vary depending on the region and the stage that the programme is at, several common problems have been identified. These include the wording of the letters generated by the register, problems with information interfaces, inappropriate indicator requirements from Contracts Management, and resistance from general practitioners. The lack of interface between cytology and histology is an issue that inhibits ability to monitor follow up.

There was unanimous agreement that the lack of "opt off" legislation is a major barrier to the effectiveness of the programme. The follow up of women also appears to be an issue which would partially be addressed by the introduction of legislation.

Information collection/Monitoring/Evaluation

Again, there are regional variations that can be explained partially by budget differences (which appear to be large in some cases). There are two sets of information that are consistently being collected across each region: the information relating to performance indicators which is provided to Contracts Management; and
the quarterly reports provided to Gill Grew relating to process aspects of the programme.

The information provided to Contracts Management is generated by the register and some programmes had difficulty with this. The definitions used for the indicators and the actual indicators themselves appear to be a problem. Managers get little feedback on those indicators.

The information that is sent to the NCSP is summarised and sent back to managers. While this appears to be of some use, there was general agreement that the process could perhaps be addressed again and alternatives looked at.

Otherwise, the information collection and monitoring varied widely across regions. Some had clearly defined evaluation components included in their programme; others had systems for monitoring aspects such as education sessions, clinics etc. There was a general interest in developing ways of monitoring consumer satisfaction and overall coverage. The main task for this issue is to develop ways of: ensuring consistent information collection, coordinating that information, processing and feeding back the information in a way that is useful.

**Use of Funding**

The bulk of funding is used for the programme manager's salary and systems administration. The remaining funds (if any) are used for health educators, running smear taker training, developing education resources, buying newspaper and radio advertising space, and funding health educators/community workers. Each region had a different emphasis on particular strategies.

**Conclusion**

The visits to the regions were a valuable starting point for the evaluation. The support and warm reception given to the researcher were greatly appreciated.

There are clearly some issues that need to be addressed. The "opt off" legislation appears to be required urgently. For evaluation purposes, there is a need to develop a system where key "minimum" information is collected, compiled and analysed so it can be fed back to both regions and the national programme.
5) MINIMUM INFORMATION REQUIREMENTS TO EVALUATE THE PROGRAMME

Evaluation can only be carried out if there is a set of clear, measurable objectives. In addressing the effectiveness of their activities, programme managers need to be able to explicitly state what they are wanting to achieve, and develop a range of strategies designed to do this. The evaluation of each programme, therefore, should be closely based on the programme's aims and implementation plan.

The researcher has collected some of the information relating to past activities. What is needed is the development of a system to collect information on an ongoing basis in the future. Draft forms have been developed as a first stage of developing the system. A copy of the form is attached for your comment. Feedback on the form is invited from programme managers, the NCSP, the Advisory Group and others with an interest in the NCSP.

It is suggested that this form be developed to replace the current form used to report to Gill on a quarterly basis. It is also suggested that HRS be responsible for the collation and analysis of this and other information, including the performance indicator information.

Coverage Information Requirements

The range of information that can be collected to monitor coverage is outlined in the background paper attached. At this stage, focus should be on process indicators. Key indicators include: community consultation and involvement in planning, type and frequency of health information and publicity, services offered, and monitoring of strategies implemented. Consumer satisfaction should be monitored wherever possible. Selected sampling, using contact with key representatives in the community to distribute questionnaires/carry out interviews, is one way of doing this.

The researcher will look at the information generated by the register to ensure that all regions can generate the minimum information required.

Quality Information Requirements

This is an area where there is less access to information. Smear taking quality can and should be monitored regional. Laboratory quality can be monitored by collecting information relating to rates of atypical, low grade abnormal and high grade smears on a regional level. These rates can then be compared to a national standard. The information should be generated by the register, but until there is an opt off system, the information should be collected from laboratories wherever possible.

Programme managers should collect information relating to smear taker training-ie. numbers of training sessions, who attended and subsequent quality of smears.
Follow Up Information Requirements

This is another area where information is not readily available. Where possible, managers should manually monitor follow up and keep a record of "failures", along with reasons. The availability of follow up services should also be monitored.

Documentation/Monitoring/Evaluation Requirements

Records of regular documentation, monitoring and evaluation procedures should be kept. The use of this information should also be looked at.

Cost

The researcher will be liaising with managers to see what cost information it is possible to access from each region.

6) FUTURE INFORMATION REQUIREMENTS AND REPORTING PROCEDURES

At the end of the first evaluation year (June 1992), the researcher will write a report which will have three main sections:

1) Descriptive: This section will give a descriptive account of the activities and strategies of each region. It will give details of the aims, actions, priorities, problems, information collection/evaluations, and funding (where available).

2) Analytical: This section will analyse the information contained in the first section in terms of the areas of coverage, quality, follow up, evaluation and costs.

3) Future Directions: This section will outline the implications for future directions of both the NCSP and the evaluation in light of the above information. It will present recommendations for evaluation strategies for 1992-93, including details of what output/outcome measurements should be achieved.
APPENDIX D

Draft Quarterly Report
1) COVERAGE

Aims and Objectives

To:
To:

Action

Outcome: attach register generated information

Documentation/Monitoring/Evaluation

Problems

Other Comments/Future Action
2) QUALITY

Aims and Objectives

To:

To:

Action

Outcome: attach register generated information

Documentation/Monitoring/Evaluation

Problems

Other Comments/Future Action
3) FOLLOW UP

Aims and Objectives

To:
To:
To:

Action

Outcome

Documentation/Monitoring/Evaluation

Problems

Other Comments/Future Action
4) DOCUMENTATION/MONITORING/EVALUATION

Aims and Objectives

To:

To:

Action

Outcome

Documentation/Monitoring/Evaluation

Problems

Other Comments/Future Action
APPENDIX E

Final Quarterly Report Format
QUARTERLY REPORT

For the period:

Region:

Manager:

1 GENERAL PROGRAMME INFORMATION

1.1 Staff: Paid and Unpaid workers
(excluding overall programme manager)

<table>
<thead>
<tr>
<th>Position</th>
<th>Number</th>
<th>Status*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Register coordinator</td>
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<td></td>
</tr>
<tr>
<td>Administration/clerical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data entry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Health Workers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ie. nursing background)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Education Workers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lay Smear Takers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Please enter fulltime equivalent and whether permanent eg. half-time = 0.5, temporary = t

1.2 Key Objectives for this Quarter

TO:

TO:

TO:

TO:
## COVERAGE INFORMATION

### 2.1 Enrolments

<table>
<thead>
<tr>
<th></th>
<th>No.</th>
<th>% of this 1/4</th>
<th>% change from last 1/4</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enrolments this 1/4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maori</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ages 35-70</td>
<td></td>
<td></td>
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<tr>
<td>Other (specify)</td>
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### 2.2 Participating smear takers

<table>
<thead>
<tr>
<th>Number</th>
<th>Adequacy rate</th>
<th>Average no. smears per enroled woman</th>
<th>Comments</th>
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</thead>
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<tr>
<td>GPs</td>
<td></td>
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<tr>
<td>Nurses</td>
<td></td>
<td></td>
<td></td>
</tr>
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<td>Other</td>
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</table>
### 2.3 Community Education

<table>
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<tr>
<th>Session Type: For</th>
<th>Number of Sessions</th>
<th>Sessions Recording Screening History</th>
<th>Total Attendance</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Older women</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maori women</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pacific Island women</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Session</td>
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### 2.4 Publicity and Promotion

<table>
<thead>
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<th>Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Media Campaigns</td>
<td></td>
</tr>
<tr>
<td>Talks, seminars, meetings</td>
<td></td>
</tr>
<tr>
<td>Letter drops, advertising</td>
<td></td>
</tr>
</tbody>
</table>
### 2.5 Screening Services Provided by Area Health Boards

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Total no. of Sessions</th>
<th>Total no. of Services</th>
<th>Total Attendance</th>
<th>Comments</th>
</tr>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td></td>
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</tr>
<tr>
<td>Services for Maori</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services for Pacific Islanders</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services for women with disabilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 2.6 Other Screening Services

<table>
<thead>
<tr>
<th>Provider of Services</th>
<th>Type of Service</th>
<th>Total Number of Sessions</th>
<th>Total Number Attendance</th>
<th>Total</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervical Screening Programme</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Practitioners</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women's Health Centres</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
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<td></td>
<td></td>
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</tr>
</tbody>
</table>
## 2.7 Surveys and Other Monitoring Activities

<table>
<thead>
<tr>
<th>Target Population</th>
<th>Total no. of surveys</th>
<th>Total no. in samples</th>
<th>Key Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Practice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practice Nurses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational Health Nurses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All smear-takers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enroled women</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eligible women</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Target group women</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other surveys</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>(specify)</td>
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<td></td>
</tr>
<tr>
<td>Other monitoring activities</td>
<td></td>
<td></td>
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<tr>
<td>(specify)</td>
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</tbody>
</table>
3 QUALITY INFORMATION

3.1 Smear Quality, Diagnosis Quality and Treatment Quality

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Number</th>
<th>Percentage Change from last 1/4</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of poor quality smears</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Length of time to receive results (time in days)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>False Positives¹</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment failure²</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Women diagnosed as having CIS from the smear reading, subsequently diagnosed as negative following biopsy.
2. Women who have received treatment for CIN 1, 2 and 3 who subsequently develop CIS/invasive cancer.

3.2 Provider Education and Training

<table>
<thead>
<tr>
<th>Aim</th>
<th>Total Events</th>
<th>Total * Practitioners Involved</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Practice visits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse Smear Taker training</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lay Smear Taker training</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Educator training</td>
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<td></td>
</tr>
</tbody>
</table>

* "Practitioners" refers to the category named eg. general practitioners, community educators etc
4 FOLLOW UP INFORMATION

4.1 Abnormalities, Follow Up and Treatment

<table>
<thead>
<tr>
<th>Number</th>
<th>% change since last 1/4</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abnormalities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colposcopies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waiting time for colposcopy (time in weeks)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colposcopies resulting in treatment*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Not including the initial biopsy

5 SUMMARY AND FURTHER COMMENTS
References


