Phase V: Media

Following the launch, the focus for media will be local, with minimal mass media being achieved through unpaid means. Later in the project mass media may be utilised if recruitment figures warrant wider promotion.

1. **Unpaid media**
   - newspapers. Press releases and articles explaining/inviting women to attend.
   - Direct contact with journalists to develop stories.
   - radio interviews
   - community service announcements
   - sponsored articles
   - provide articles to specialist newsletters and journals: Pharmaceutical Council, Headway, Community nurses, Australian Nurses Federation, etc.
   - "Women's pages" eg "What's on for Women" in Sunday Times, etc.

2. **Paid media**
   - paid advertising: papers, magazines, radios TV guide, insert into papers, etc.
   - taxis
   - local papers
   - on merchandise likely for women to purchase
   - billboards, and other signage

Phase VI: Invitations

1. **Personalised invitations**
   To be used as necessary to recruit women.

2. **Non-personalised invitations**
   To be used as necessary to recruit women.

Evaluation

1. Base-line data: knowledge, attitudes, and behaviour of target women and General Practitioners.
2. Point of service questionnaire: source of recruitment and reason for attending.
3. Process evaluation: attendance numbers following promotional strategies.
4. Post data: knowledge, attitudes, and behaviour of target women and General Practitioners after 12 months.
5. Statistics: number of attendees, seminars, pamphlets out, etc.
6. Non-attenders sample survey re knowledge, attitudes, beliefs, and factors which have/would influence them to attend for screening.
7. Test materials for appropriateness of message.
8. Client satisfaction survey: satisfaction at initial screening and follow-up.
9. Booked non-attenders: reasons for not attending.

2.3 Resource distribution to:

- Community health centres
- supermarkets
- Department of Social Security
- Community groups
- Department of Community Services
- Pharmacists
- local councils
- Church groups
- Aboriginal Medical Service
- HBF
- Commonwealth Employment Service
- Medicare
- Country Women's Association
- Hairdressers
- Community Education Centres
- Service Clubs - rotary, Lions, etc
- Women's Health Associations
- Shops.

Visit to representatives of each venue/group to assess willingness to become involved. Mail distribution to remainder.

2.4 Local personality/celebrity to support scheme, and promote project, preferably as a personal testimonial.

2.5 Promotional displays in prominent places within target area. Resource distribution and one to one information giving.

2.6 Groups with special needs will be identified. In consultation with those groups resources and strategies will be developed which are culturally and linguistically appropriate

Aboriginal Groups:

- flip charts for Aboriginal Health Workers to assist them with carrying out education
- posters and simple written material for semi-illiterate Aboriginal women

Non-English speaking groups

- ethnic radio
- material in other languages
- education with translator

2.7 Breast Care Clinics.

Set up breast care clinics for groups of women, incorporating:

- workshop on breast self examination (Cancer Foundation)
- workshop on the role of mammography (Regional Health Education Officer and Women's Cancer Prevention Unit)
- Mammography (appointments set up in advance)

2.8 Workplace education.

Identify workplaces where target women work, and conduct workplace education about mammography.

3. **Community Development**

3.1 Women who have either experienced community education as above, or attended the clinic will act as peer educators within the community, motivating other women to attend for screening.

3.2 Explore the possibility of training women to act as peer educators within the community.

5. **Aboriginal Health Workers**
   5.1 Education via Staff Development in-services.
   5.2 Ongoing liaison and resource distribution

6. **Local hospitals**
   6.1 Staff education of facilities available.
   6.2 Resource distribution and ongoing liaison

7. **Regional Directors Conferences (Health Department of WA)**
   7.1 Talk about pilot at regional directors conference in October 1989
   7.2 Give regular articles to the Regional Directors information newsletter

8. **Other health professionals**
   Other relevant health professionals, such as occupational health staff, physiotherapists, community health centres etc were invited to the 12.8.89 talk by Prof Armstrong.
   These health professionals will be identified and targeted as needed during the pilot.

Phase IV: Community education and development

In the south-west area the active co-operation of health professionals and community groups will be essential in effectively promoting this project.

1. **Community Networking**
   1.1 Begun with 12.8.88 visit to Bunbury, and liaison with women's groups and community groups about the project.
   1.2 On an ongoing basis, groups and individuals will be identified who are concerned with issues such as women, women's health, health, local affairs, senior citizens, etc. These groups impact on the target community, and will be kept informed about the project. Through them information is acquired, discussion stimulated and awareness of the subject will be identified.

2. **Community Education**
   2.1 Offer education: Contact with local groups and activity clubs, and women's groups and organisations. Explain pilot project, offer to discuss further. Specific targeting: bowling clubs, women's health centres, community houses, P&C's, churches, learning centres, TAFE, weight watchers/easy slim, CWA, etc.
   Educational strategies will need to include: information delivery, group work to deal with personal fears, concerns, and issues, values clarification exercises, role plays, self-responsibility and empowerment.
   2.2 Respond to requests to provide information, literature, presentations, etc.

invitations:

- by registry invitation offering appointment time.

Professional and Community development and education:

- see details in Phase II and IV below for implementation strategies.
- in country areas, community education will be primarily accomplished by the regional health professionals.

Phase III: Professional education August 1988 to November 1990

It is envisaged that these health professionals will promote the project to their communities, and facilitate women to attend for screening.

1. **General Practitioners**
   1.1 12.8.88. Invitational seminar at Bunbury Health and Development Centre by Professor B. Armstrong and Mrs D. Moore. Purpose: to advise of project and answer questions.
   1.2 September 1988 onwards. One-to-one liaison and information dissemination.
   1.3 Questionnaire to all GP's to assess their base-line knowledge attitudes and behaviour about mammography screening. Accompanied by covering letter from Dr Armstrong advising them about project.
   1.4 Information kit for General Practitioners. To be distributed.
   1.5 Ongoing liaison, assistance, and education between the unit's senior medical officer and General Practitioners. March 1989 onwards.

2. **Community Nurses**
   2.1 12.8.89. Community Health Staff invited to public talk by Prof Armstrong.
   2.2 January 1989: liaison with Regional Nursing Director. 20.3.89 Address to all community nurses in area at their district meetings to outline project and explore joint implementation of promotional strategies.
   2.3 Ongoing personal liaison and resource provision.
   2.4 Follow-up assistance and education as required.

3. **Regional Health Education Officers**
   3.1 Two day in-service October 1988 on all aspects of pilot projects by Women's Cancer Prevention Unit.
   3.2 Update in-service February 1989, May 1989.
   3.3 Ongoing personal liaison and resource provision.
   3.4 Joint development and implementation of promotional strategies with Women's Cancer Prevention Unit.

4. **Pharmacists**
   4.1 Resource distribution for display, and ongoing liaison.

Phase II: Recruitment strategy trials August-October 1989

Objective: To assess the impact of difference recruitment strategies upon attendance figures.

Method: Three different areas have been chosen to assess the impact of the following strategies: Publicity, Community and Professional Education, and Invitations.

Area 1 will receive publicity alone. Area 2 will receive publicity and personalised invitations. Area 3 will receive publicity and community education and development.

Afterwards, each area will be assessed in terms of the corresponding percentage response of target women screened.

This process will provide an indication of the relative merits of the various strategies.

Area 1 **Waroona**	**Area 2** **Collie**	**Area 3** **Harvey**
Time: 4 weeks Numbers: 200 Strategy: ↓	Time: 7 weeks Numbers: 700 Strategies: ↓	Time: 4 weeks Numbers: 240 Strategies: ↓
	plus invitations	**plus community education**
publicity	**publicity**	**publicity**

Publicity:

- launch
- the presence of the van
- local media:articles,
- radio, community service
- advertisements, etc.
- posters, pamphlets, etc.

Recruitment strategies:

Note: timescales are subject to the readiness of bus, staff etc, to proceed on schedule.

Phase I:	Programme launch	August 1989
Phase II:	Recruitment Strategy Trial	September/October 1989
Phase III:	Professional education and networking	August 1988 to November 1990
Phase IV:	Community networking, education, development	March 1989 to November 1990
Phase V:	Media	As required
Phase VI:	Personalised and non-personalised invitations	As required

It is envisaged that the promotion will need to be responsive both to:

- local needs and events
- the impact upon service delivery

It is also clear that regional health professionals such as regional health education officers, community nurses, General Practitioners, etc will be vital in undertaking local promotion, education, and referral.

Because of the mobile nature of the bus, promotion will be regionally based, focussing on the areas being currently serviced, and next on the timetable.

Records will be kept of this implementation.

Phase I: Programme launch July 1989

Programme launch will be promoted jointly by the Women's Cancer Prevention Unit and the Public Affairs Branch of the Health Department of W.A. Activities focus on unpaid publicity:

- press release
- Health Minister's speech
- TV and radio at launch of bus
- local celebrity to act as role model for area at launch
- newspaper articles, local and general press
- TV and radio interviews about the project
- Headway article, local media, articles
- photographer

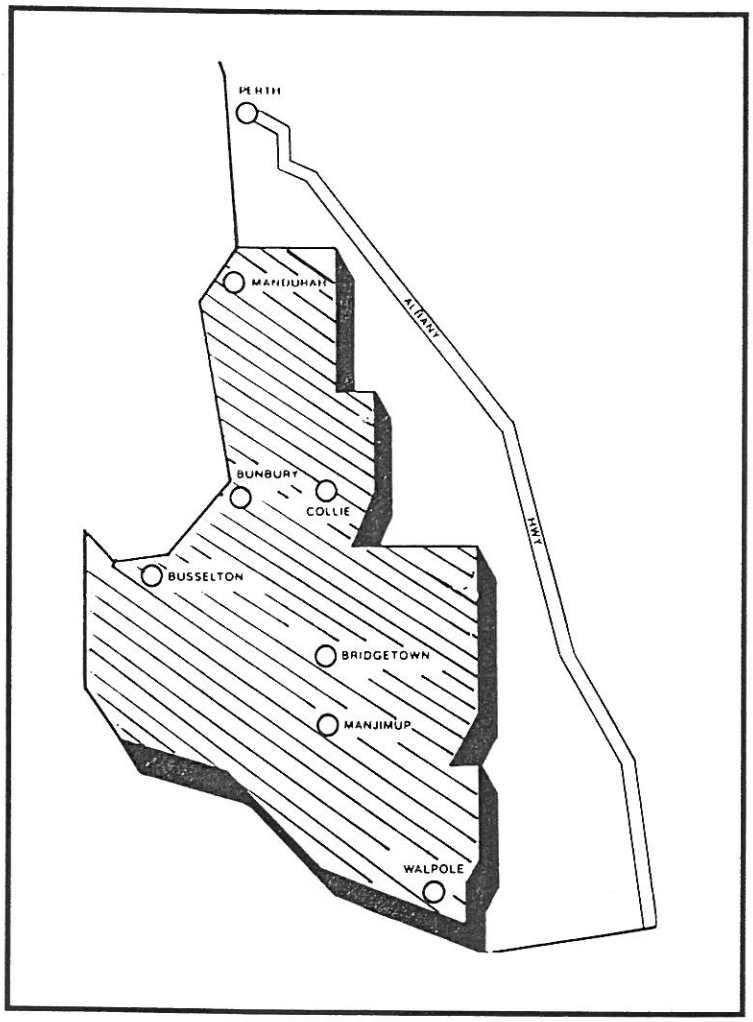
Part 3 - Breast X-ray Services South-west mobile pilot project

Target Group:

Women between 45 and 69 years of age resident in the target area.

Target Area:

Women resident in the area marked on this map: the south-west statistical division.



2. **Paid media**
   - paid advertising: papers, magazines, radios TV guide, insert into papers, etc.
   - taxis
   - local papers
   - on merchandise likely for women to purchase
   - billboards, and other signage

Invitations - Personalised and non-personalised

1. **Personalised invitations**
   According to other trials, the distribution of personalised invitations has a good response rate.
   Personalised invitations will be utilisated for non-attenders at the clinic, but if, when and where is unsure. At this stage use before late 1989 or 1990 is not envisaged.
   Electoral roll listing of women in target age and area. Personal letters to women by postcode, inviting them to attend for screening. Letter to contain appointment date. Includes pamphlet.

2. **Non-personalised invitations**
   Non personalised invitations via letterbox drop or newspaper insert has not achieved great success interstate. Also requires evaluation in view of the plethora of unsolicited mail in the metropolitan area. However, in surveys this has been a strategy recommended by women in the target age. Therefore, it may be used if required.

Evaluation

1. Base-line data: knowledge attitudes and behaviour of target women and General Practitioners.
2. Point of service questionnaire: source of recruitment and reason for attending.
3. Process evaluation: attendance numbers following promotional strategies.
4. Post data: knowledge attitudes and behaviour of target women and General Practitioners after 12 months.
5. Statistics: number of attendees, seminars, pamphlets out, etc.
6. Non-attenders sample survey re knowledge, attitudes, beliefs, and factors which have/would influence them to attend for screening.
7. Test materials for appropriateness of message.
8. Client satisfaction survey: satisfaction at initial screening and follow-up.
9. Booked non-attenders: reasons for not attending.

2.6 Groups with special needs will be identified. In consultation with those groups resources and strategies will be developed which are culturally and linguistically appropriate

Aboriginal Groups:

- community networking

Non-English speaking groups

- ethnic radio
- material in other languages
- education with translator

2.7 Breast Care Clinics.

Initiate breast care clinics for groups of women, incorporating:

- workshop on breast self examination (Cancer Foundation)
- workshop on the role of mammography (Regional Health Education Officer and Women's Cancer Prevention Unit)
- mammography (appointments set up in advance)

2.8 Workplace education.

Identify workplaces where target women work, and conduct workplace education about mammography screening.

3. **Community Development**

3.1 Women who have either experienced community education as above, or attended the clinic will act as peer educators within the community, motivating other women to attend for screening.

3.2 Explore the possibility of training women to act as peer educators within the community, particularly within sub-groups.

Media

Following the launch, the focus for media will be local, with minimal mass media being achieved through unpaid means. Later in the project mass media may be utilised if recruitment figures warrant wider promotion.

1. **Unpaid media**

- newspapers. Press releases and articles explaining/inviting women to attend.
- Direct contact with journalists to develop stories.
- radio interviews
- community service announcements
- sponsored articles
- provide articles to specialist newsletters and journals: Pharmaceutical Council, Headway, Community nurses, Australian Nurses Federation, etc.
- "Women's pages" eg "What's on for Women" in Sunday Times, etc.

7. **Other health professionals**
Other relevant health professionals, such as occupational health staff, physiotherapists, community health centres etc will be identified and targeted as needed during the pilot.

Phase IV: Community education and development

1. **Community Networking**
1.1 On an ongoing basis, groups and individuals will be identified who are concerned with issues such as women, women's health, health, local affairs, senior citizens, etc. These groups impact on the target community, and will be kept informed about the project. Through them information is acquired, discussion stimulated and awareness of the subject will be identified.

2. **Community Education**
2.1 Offer education: Contact with local groups and activity clubs, women's groups and organisations. Explain pilot project, offer to discuss further. Specific targeting: bowling clubs, women's health centres, community houses, P&C's, churches, learning centres, TAFE, weight watchers/easy slim, CWA, etc.
Educational strategies may need to include: information delivery, group work to deal with personal fears, concerns, and issues, values clarification exercises, role plays, self-responsibility and empowerment.
2.2 Respond to requests to provide information, literature, presentations, etc.
2.3 Resource distribution to:
- Community health centres
- supermarkets
- Department of Social Security
- community groups
- Department of Community Services
- Pharmacists
- local councils
- Church Groups
- Aboriginal Medical Service
- HBF
- Commonwealth Employment Service
- Medicare
- Country Women's Association
- Hairdressers
- Community Education Centres
- Service Clubs - Rotary, Lions, etc
- Women's Health Associations
- Shops.

Visit to representatives of each venue/group to assess willingness to become involved. Mail distribution to remainder.
2.4 Local personality/celebrity to support scheme, and promote project, preferably as a personal testimonial.
2.5 Promotional displays in prominent places within target area. Resource distribution and one to one information giving.

1.2 September 1988 onwards. One-to-one liaison and information dissemination by Prof. Armstrong.
1.3 February 1989. Questionnaire to all GP's to assess their base-line knowledge attitudes and behaviour about mammography screening. Accompanied by covering letter from Dr Armstrong advising them about project.
1.4 March to May 1989. Visit to selected surgeries by Dr Erica Luke, to discuss project. Prioritised:

- contact with Dr Luke over project, expressing either interest or concern
- practises run by women GP's
- big group practices
- personal contacts
- remainder.

1.5 March to May 1989 Information kit for General Practitioners. To be distributed by Dr Luke during visits above.
1.6 March 1989 onwards. Follow-up assistance and education as required, e.g. As part of Family Medicine Programme.
1.7 Dr Luke will contact women with abnormal results and the GP. This will impact on GP education.

2. **Community Nurses**
2.1 January 1989 Contact with Regional Directors of Nursing.
2.2 17.2.89 and 14.4.89 Address to all community nurses in area at the 2 District meetings to outline project and explore joint implementation of promotional strategies.
2.3 Ongoing personal liaison and resource provision.
2.4 Follow-up assistance and education as required.

3. **Regional Health Education Officers**
3.1 Two day in-service October 1988 on all aspects of pilot projects by Women's Cancer Prevention Unit.
3.2 Update in-service February 1989, May 1989.
3.3 Ongoing personal liaison and resource provision.
3.4 Joint development and implementation of promotional strategies with Women's Cancer Prevention Unit.

4. **Pharmacists**
4.1 March 1989. Visit to sample pharmacists to assess willingness to become involved in project.
4.2 March 1989 onwards. Resource distribution for display, and ongoing liaison.

5. **Aboriginal Health Workers**
5.1 Education via Staff Development in-services.
5.2 Ongoing liaison and resource distribution

6. **Local hospitals**
6.1 Staff education of facilities available.
6.2 Resource distribution and ongoing liaison.

these strategies implemented to ensure service delivery is fully utilised, but not over-stretched.

Where possible, the proactive implementation of recruitment strategies will be by area. Each area, beginning with the local government area of Canning, will be saturated before moving on to the next area. This will enable early evaluation to identify non-attenders, and the reasons for non-attendance, after all education strategies have been implemented.

It is difficult to confine promotional activities to a particular area. The effects of media, community networking, professional education, and especially peer education will result in requests from throughout the target area gradually, either by postcode area at a time or by group designation. This will result in reactive promotional/educational activity.

Detailed records will be kept of this implementation (see attached forms).

Phase I: Programme Launch Mid March 1989

Programme launch will be promoted jointly by the Women's Cancer Prevention Unit and the Public Affairs Branch of the Health Department of W.A. Activities include:

- unpaid publicity:
- press release
- speeches by Minister and Commissioner of Health.
- media launch: 10.30am 17.3.89.
- viewing by invitation, pm 17.3.89
- local celebrity to act as role model for area at media launch
- generated newspaper articles, local and general press
- TV and radio interviews about the project
- Headway article, local media, articles
- photographer

Phase II: Invitations to self-selected group. March 1989

Objective: To assess effectiveness of letter appointments vs no appointments as recruitment strategy.

Method: Approximately sixty women have expressed interest in the project. They will receive early invitations to attend the clinic. Half the women will receive appointment times, the other half will receive a phone number. Their attendance will be monitored.

Phase III: Professional education and networking September 1988 to November 1990

It is envisaged that these health professionals will promote the project to their communities, and facilitate women to attend for screening.

1. **General Practitioners**
   1.1 8.9.88. Invitational seminar at Bentley Hospital by Professor B. Armstrong and Mrs D. Moore. Purpose: to advise of project and answer questions.

Part 2 - Breast X-ray Services Cannington pilot project

Target Group:

Women between 45 and 69 years of age resident in the target area.

Target Area:

Women resident in these suburbs:

Beckenham
Belmont
Bentley
Canning Vale
Cannington
Carlisle
Cloverdale
East Cannington
Ferndale
Gosnells
Huntingdale
Kenwick
Kewdale
Langford
Lynwood
Maddington
Martin
Newburn
Orange Grove
Queens Park
Redcliffe
Riverton
Rivervale
Rossmoyne
Shelley
Southern River
St James
Thornlie
Victoria Park
Welshpool
Willeton
Wilson

Recruitment strategies:

Phase I:	Programme launch	March 17 1989
Phase II:	Invitations to self-selected sample	March 1989
Phase III:	Professional education and networking	September 1988 to November 1990
Phase IV:	Community networking, education, and development	March 1989 to November 1990
Phase V:	Media	As required
Phase VI:	Personalised and non-personalised invitations.	As required

It is envisaged that the promotion will need to be responsive both to:

- local needs and events
- the impact upon service delivery

For these reasons, it is not intended to set precise timelines for Phases V and VI. Instead, recruitment numbers at the service point will be monitored, and

Evaluation

1. Base-line data: knowledge attitudes and behaviour of target women (Caucasian and Aboriginal) and General Practitioners.
2. Point of service questionnaire: source of recruitment and reason for attending.
3. Process evaluation: attendance numbers following promotional strategies.
4. Post data: knowledge attitudes and behaviour of target women and General Practitioners after 12 months.
5. Statistics: number of attendees, seminars, pamphlets out, etc.
6. Non-attenders sample survey re knowledge, attitudes, beliefs, and factors which have/would influence them to attend for screening.
7. Test materials for appropriateness of message.
8. Client satisfaction survey: satisfaction at initial screening and follow-up.
9. Booked non-attenders: reasons for not attending.

2.7 Workplace education.
Identify workplaces where target women work, and conduct workplace education about Pap smears.

3. **Community Development**
3.1 Women who have either experienced community education as above, or attended a clinic will act as peer educators within the community, motivating other women to attend for screening.
3.2 Explore the possibility of training women to act as peer educators within the community.

Media

The focus for media will be local, with minimal mass media being achieved through unpaid means. Later in the project mass media may be utilised if recruitment figures warrant wider promotion.

1. **Unpaid media**
   - newspapers. Press releases and articles explaining/inviting women to attend.
   - Direct contact with journalists to develop stories.
   - radio interviews
   - community service announcements
   - sponsored articles
   - provide articles to specialist newsletters and journals: Pharmaceutical Council, Headway, Community nurses, Australia Nurses Federation, etc.
   - "Women's pages" eg "What's on for Women" in Sunday Times, etc.

2. **Paid media**
   - paid advertising: papers, magazines, radio, TV guide, insert into papers, etc.
   - taxis
   - local papers
   - on merchandise likely for women to purchase
   - billboards, and other signage

Invitations - Personalised and non-personalised

1. **Personalised invitations**
The goldfields area is perceived by local health professions to have very transient population, with many women in our target group absent from electoral rolls. Many Aboriginal women, who make up approximately 10% of our population, have no fixed address.
This advise suggests that personalised invitations from the electoral roll may not achieve the desired blanked coverage. Therefore, this strategy will be withheld pending further investigation of it's viability.

2 **Non-personalised invitations**
Non personalised invitations via letterbox drop or newspaper insert.

women's health groups and organisations. Explain pilot project, offer to discuss further. Specific targeting: bowling clubs, women's health centres, community houses, P&C's, churches, learning centres, TAFE, weight watchers/easy slim, CWA, etc.
Educational strategies may need to include: information delivery, group work to deal with personal fears, concerns, and issues, values clarification exercises, role plays, self-responsibility and empowerment.
2.2 Respond to requests to provide information, literature, presentations, etc.
2.3 Resource distribution to:

- Community health centres
- supermarkets
- Department of Social Security
- community groups
- Department of Community Services
- Pharmacists
- local councils
- Church groups
- Aboriginal Medical Service
- HBF
- Commonwealth Employment Service
- Medicare
- Country Women's Association
- Hairdressers
- Community Education Centres
- Service Clubs - rotary, Lions, etc
- Women's Health Associations
- Shops

Visit to representatives from each venue/group to assess willingness to become involved. Mail distribution to remainder.
2.4 Local personality/celebrity to support scheme, and promote project, preferably as a personal testimonial.
2.5 Promotional displays in prominent places within target area. Resource distribution and one to one information giving.
2.6 Groups with special needs will be identified. In consultation with those groups resources and strategies will be developed which are culturally and linguistically appropriate
Aboriginal Groups:

- flip charts for Aboriginal Health Workers to assist them with carrying out education
- posters and simple written material for semi-illiterate Aboriginal women

Non-English speaking groups

- ethnic radio
- material in other languages
- education with translator

2.2 December 1988 Questionnaire to all GP's to assess their base-line knowledge attitudes and behaviour about Pap smear cervical cytology screening.
2.3 Follow up contribution as required.

3. **Community Nurses**
3.1 January 1989 Contact with Regional Directors of Nursing.
3.2 20.3.89 Address to some community nurses Regional Health Education Officer in area at their District meetings to outline project and explore joint implementation of promotional strategies.
3.3 Ongoing personal liaison and resource provision.
3.4 Follow-up assistance and education as required.

4. **Regional Health Education Officers**
4.1 Two day in-service October 1988 on all aspects of pilot projects by Women's Cancer Prevention Unit.
4.2 Update in-service February 1989, May 1989.
4.3 Ongoing personal liaison and resource provision.
4.4 Joint development and implementation of promotional strategies with Women's Cancer Prevention Unit.

5. **Pharmacists**
5.1 Resource distribution for display, and hand out to community and ongoing liaison.

6. **Local Hospitals**
7.1 Staff education of facilities available.
7.2 Resource distribution and ongoing liaison

7. **Aboriginal Health Workers**
8.1 Aboriginal Health Workers will be closely involved in resource development
8.2 Education with Aboriginal women in urban fringe and remote community situations
8.3 inservicing on issues and education processes

8. **Other health professionals**
Other relevant health professionals, such as occupational health staff, physiotherapists, community health centre staff etc will be identified and targeted as needed during the pilot.

Phase III: Community education and development

1. **Community Networking**
1.1 On an ongoing basis, groups and individuals will be identified who are concerned with issues such as women's welfare, women's health, local affairs, senior citizens, etc. These groups impact on the target community, and will be kept informed about the project. Through them information is acquired, discussion stimulated and awareness of the subject will be identified.

2. **Community Education**
2.1 Offer education: Contact with local groups/activity clubs,

For these reasons, it is not intended to set precise timelines for Phases V and VI. Instead, recruitment numbers at the service point will be monitored, and these strategies implemented to ensure service delivery is fully utilised, but not over-stretched.

Promotion for the cervical project is to be handled locally. primary responsibility will be with the regional staff of Women's Cancer Prevention Unit, and the Regional Health Education Officer of the Health Promotions Service Branch.

Co-ordination and monitoring of promotion will be handled by the Promotions Officer at Women's Cancer Prevention Unit Co-ordination Unit with Media and invitations with the assistance of the Public Affairs Branch of Health Department of WA.

Detailed records will be kept of this implementation (see attached forms).

Phase I: Programme Launch December 1988

Programme launch promoted jointly by the Women's Cancer Prevention Unit and the Public Affairs Branch of the Health Department of W.A. Activities focus on unpaid publicity:

- press release
- Health Minister's speech
- media launch
- launch
- generated newspaper articles, local and general press
- TV and radio interviews about the project
- Headway article, local media, articles

Phase II: Professional networking

Because pap smears are traditionally the domain of GP's, extensive networking is required to ensure the co-operation of GP's in the areas, and to ensure their professional rights are not endangered.

It is envisaged that these health professionals will promote the project to their communities, and facilitate women to attend for screening.

1. **Professional Groups from Area**
   1.1 August 1988 Professor B Armstrong talked to Community Health Staff, Community Leaders, GP's and other medical staff from region area and women's groups.
   1.2 Sept-Oct 1988 Talk by Women's Cancer Prevention Unit Manager to Eastern Goldfields Medical Executives, GP's and Aboriginal Medical Service
   1.3 Dec 88 Letter to all General Medical Units and Community Health Units advising about service.
   1.4 January 89 Visit by Promotions Officer and Senior Medical Officer with related professionals.
   1.5 Ongoing liaison and information distribution by Senior Medical Officer and Pap Services Co-ordinator

2. **General Practitioners**
   2.1 Visit by Senior Medical Officer to majority of GP's in target area

Part 1 - Pap Smear Services Goldfields pilot project

Target Group:

Women between 18 and 69 years of age resident in the target area who have not have a Pap smear within the last three years.

Target Area:

Women resident in these places:

Adeline
Agnew
Albion Downs
Boulder
Broad Arrow
Condingup
Coolgardie
Esperance
Fimiston
Forrest
Gibson
Golden Ridge
Goongarrie
Grass Patch
Hopetoun
Kalgoorlie
Kambalda
Kambalda West
Kookynie
Lake Lefroy
Laverton
Leinster
Leonora
Menzies
Murrin Murrin
Neridup
Norseman
Ora Banda
Parkeston
Ravensthorpe
Rawlinna
Reid
Salmon Gums
Scadden
Southern Cross
Teutonic
Warburton Range
Widgimooltha
Windarra
Yeelirrie
Zanthus

Recruitment strategies:

Phase I:	Programme launch	December 1988
Phase II:	Professional education and networking	August 1988 to November 1990
Phase III:	Community education and development	August 1988 to November 1990
Phase IV:	Media	August 1988 to November 1990
Phase V:	Non personalised invitations	As required

It is envisaged that the promotion will need to be responsive both to:

- local needs and events
- the impact upon service delivery

Objectives:

1. To provide the target groups and relevant organisations with information about the service/s being provided.
2. To provide the target women with information about breast/cervix cancer, and the necessity for screening to enable early management of any abnormalities.
3. To reduce these women's fear about cancer.
4. To motivate women to attend for regular screening.

The target groups and strategies to achieve these aims and objectives will differ with each pilot project. These strategies are outlined in the subsequent sections.

However, it is important to recognise that one of the most important strategies operating in this pilot will be the needs of women themselves to overcome their fear and protect their health, particularly amongst sub-groups such as women from differing cultures and economic backgrounds. Consequently, it is perceived that networking and peer education by women within the community will be a significant contribution to the effectiveness of recruitment.

Introduction

This document outlines the promotion strategies which are proposed to recruit women to attend for mammography and cervical cytology screening, as part of the Women's Cancer Prevention Unit's pilot programmes for the prevention of cervix and breast cancer.

Recruitment strategies need to allow for a number of factors which may inhibit women from presenting for screening. Research indicates that these include:

- ignorance of the need to present for screening.
- a belief that screening is not personally relevant, often due to age.
- lack of trust in the efficacy of screening as a mode of prevention.
- conflicting medical opinions about the efficacy of screening as a mode of prevention.
- fear of cancer, resulting in a negative attitude towards discovery and early intervention. This is often expressed as denial or fatalism.
- a low commitment to measures for improving personal health.
- fear or experience of pain.
- socio-sexual attitudes associated with the screening process. These can result in embarrassment, and may be influenced by the health care provider's gender.
- other commitments, family and work, which women often prioritise over self-care and self-health.
- terminology which may alienate or confuse women.
- concerns about: confidentiality, accessibility, time lag before receiving results, accuracy, empathetic service etc.

There are also factors associated with this programme which will act in favour of women attending for screening. These include:

- a service which is free and available locally
- female health care providers
- the promise of professional, "high tech" treatment, with the authority of the Health Department of W.A.
- accessibility of the service
- existing fears of and knowledge (often personal) of the effect of cervix and/or breast cancer.
- the promise of reassurance

With these factors in mind, the promotional strategies for each of the pilot projects share similar aims and objectives.

Aims:

1. To motivate women within the target areas to attend for cancer screening
2. To identify which recruitment strategies used during the pilot programme proved the most effective in encouraging women to present for cancer screening.
3. To subsequently increase the likelihood of early identification and management of pre-cancer or cancer and reduce the mortality rate of cancer amongst women in W.A.

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Women's Cancer Prevention Unit
Health Department of W.A.

Promotion Plan

Recruiting Women

into pilot screening programmes for breast and cervix cancer 1988–1990

Genevieve Lyon
Promotions Officer
May 1989

PERCENTAGE DISTRIBUTION OF ENGLISH PROFICIENCY BY LGAs: 1986

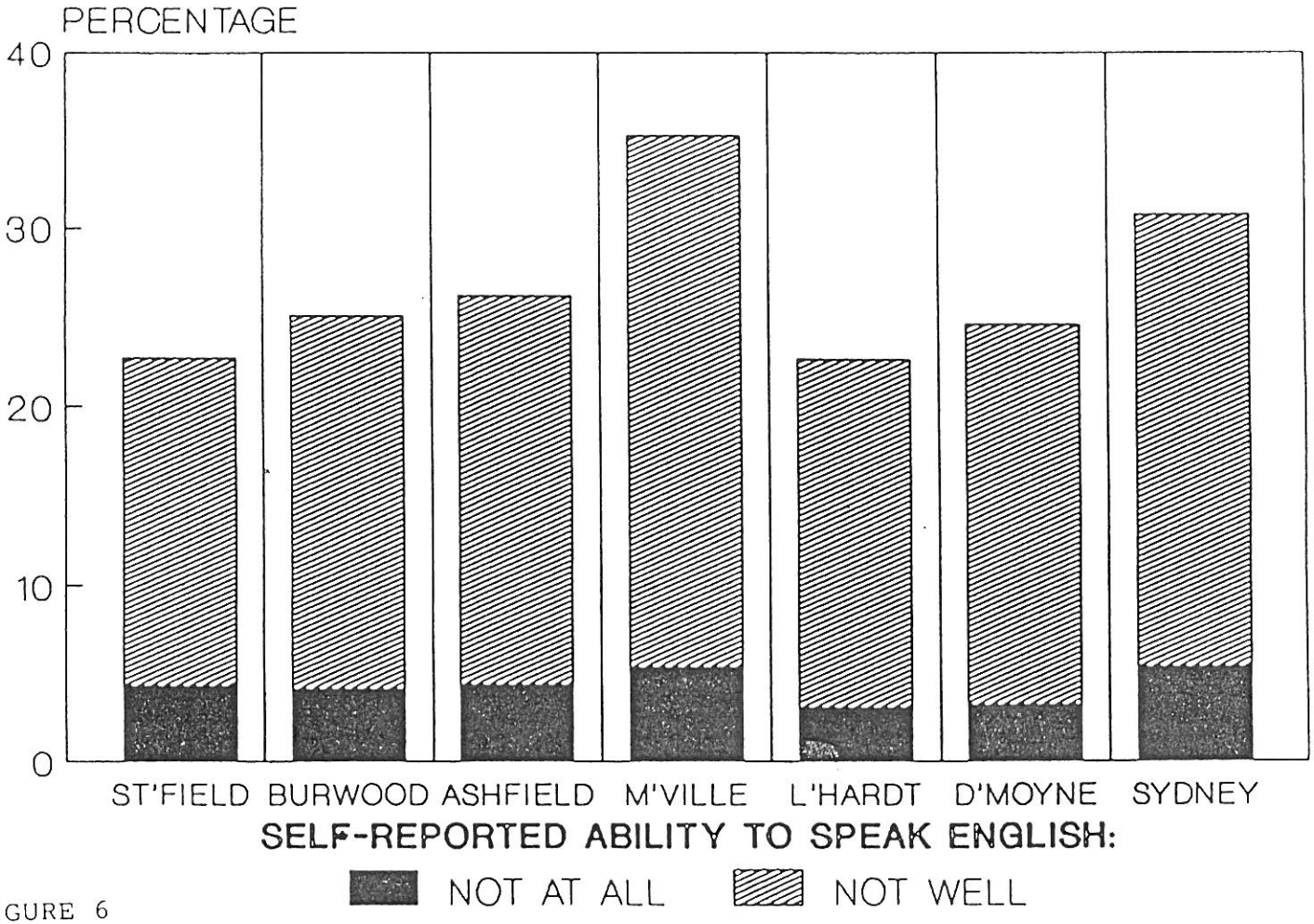


FIGURE 6

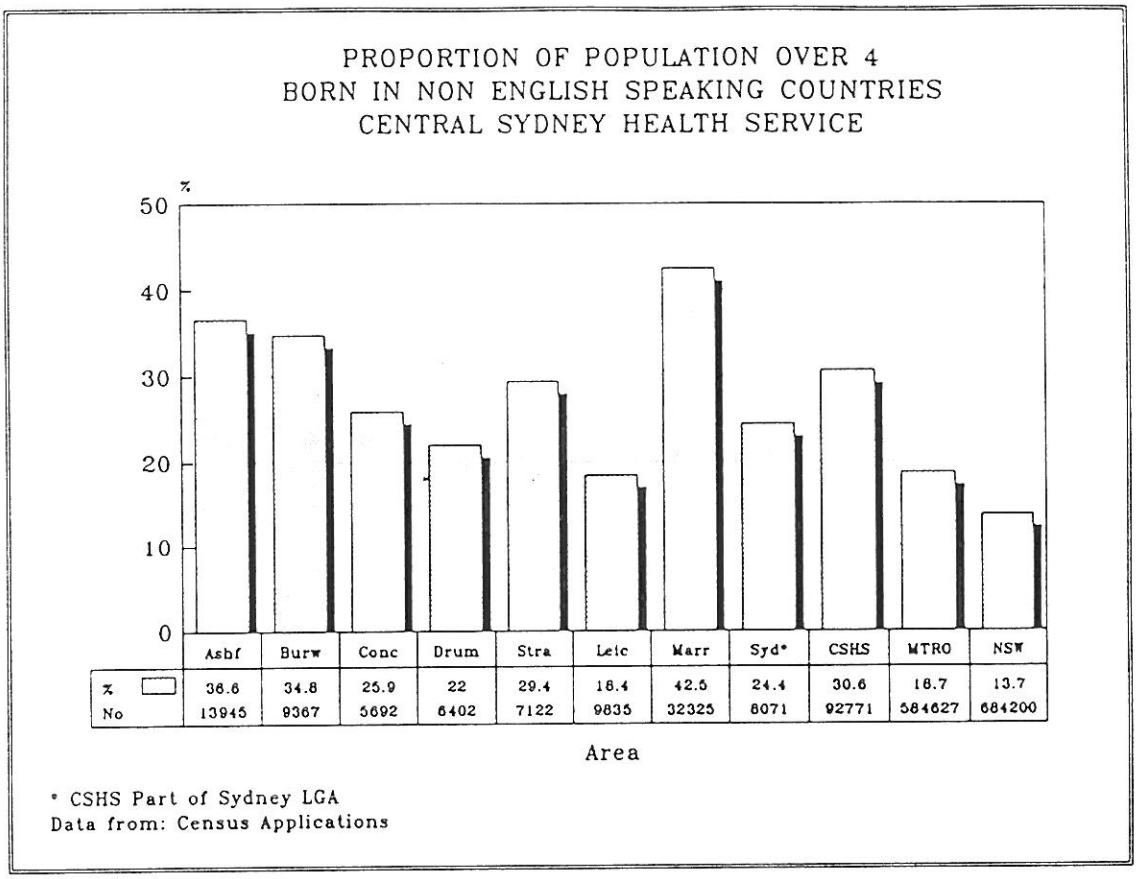

PROPORTION OF POPULATION OVER 4
BORN IN NON ENGLISH SPEAKING COUNTRIES
CENTRAL SYDNEY HEALTH SERVICE
%
50
40
30
20
10
0
Asbf Burw Conc Drum Stra Leic Marr Syd* CSHS MTRO NSW
% 36.6 34.8 25.9 22 29.4 18.4 42.5 24.4 30.6 18.7 13.7
No 13945 9367 5692 6402 7122 9835 32325 6071 92771 584627 684200
Area
* CSHS Part of Sydney LGA
Data from: Census Applications

FIGURE 5

CENTRAL SYDNEY HEALTH SERVICE

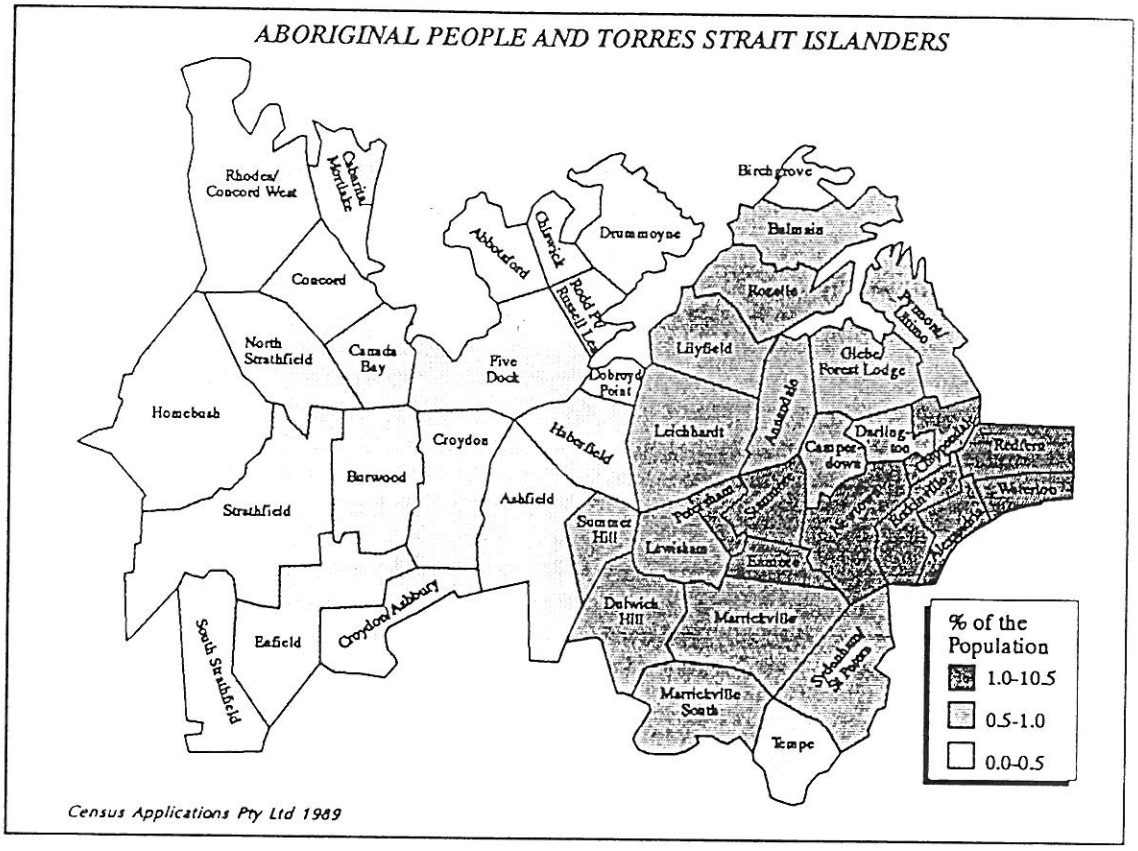
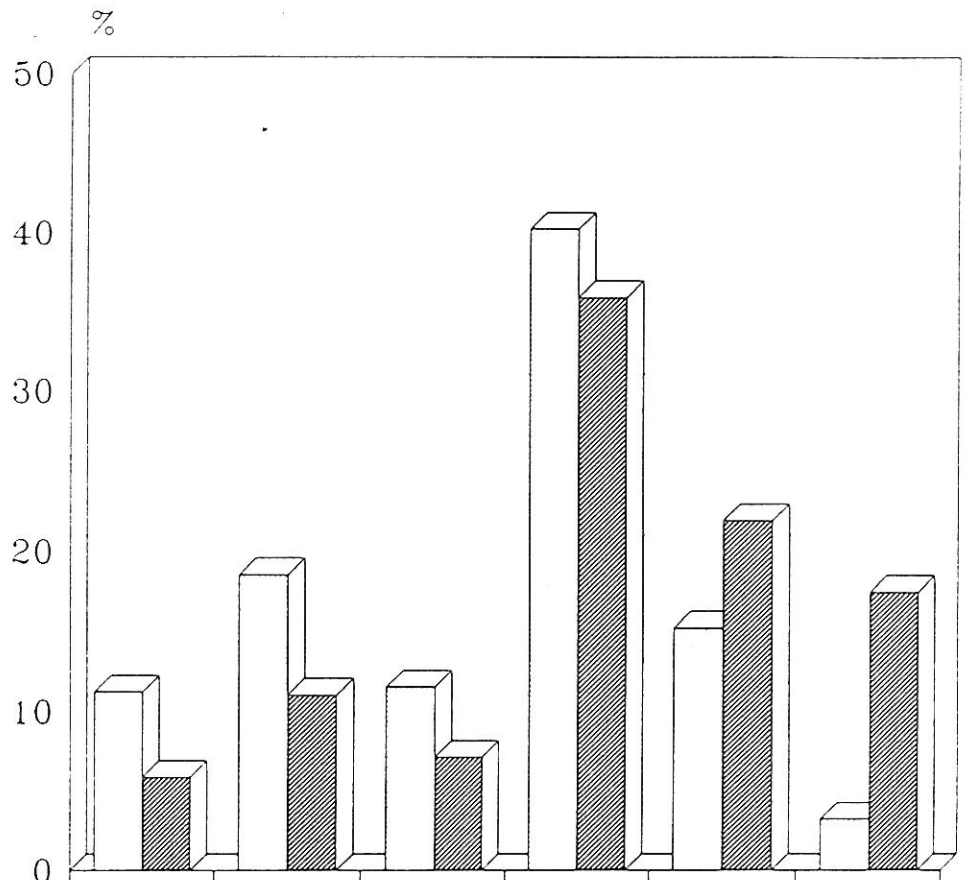


FIGURE 4

COMPARISON OF AGE GROUPS ABORIGINAL AND REST OF POPULATION IN CENTRAL SYDNEY HEALTH SERVICE



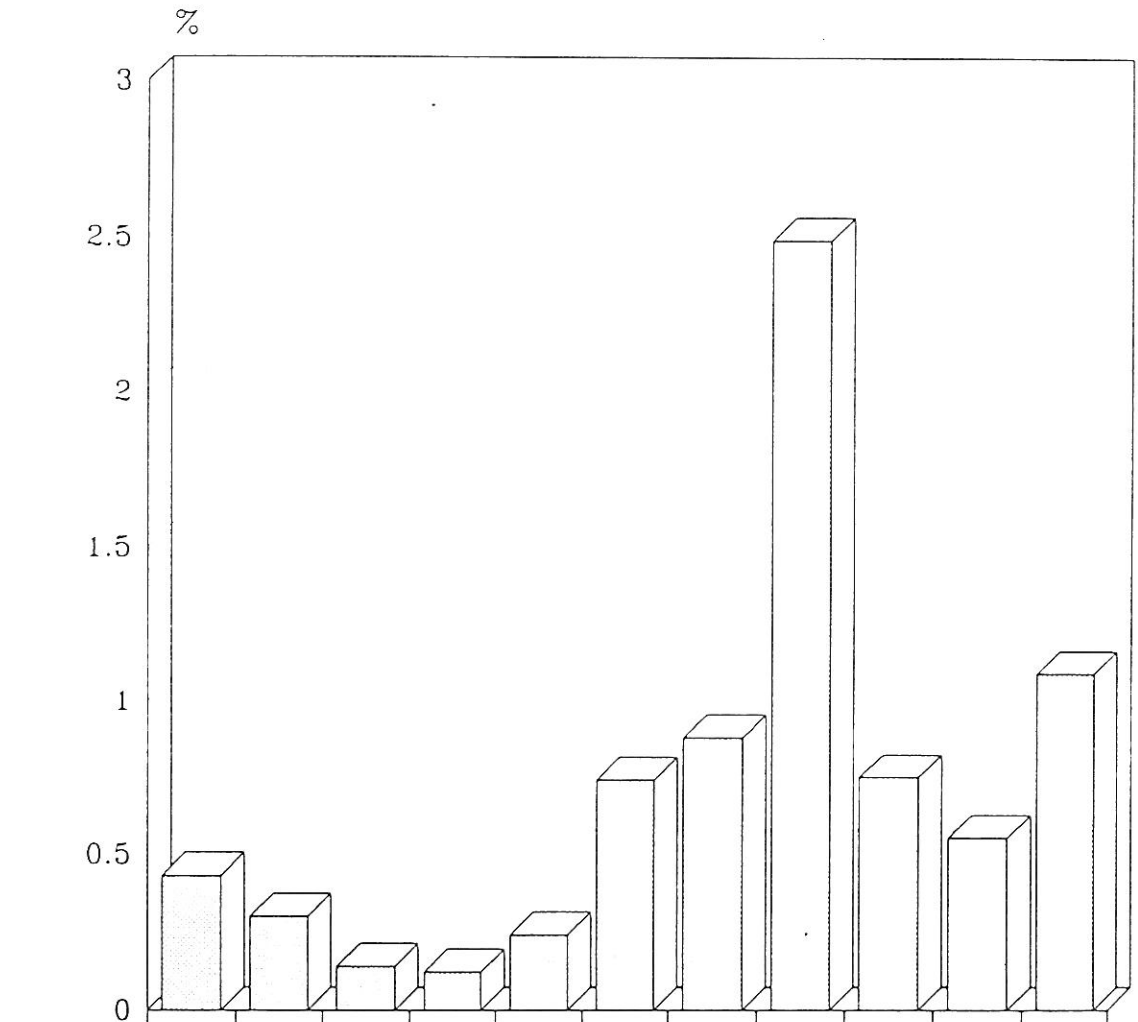
	0–4	5–14	15–19	20–39	40–59	60+
Ab. No.	273	451	281	978	370	78
Abor %	11	19	12	40	15	3
Oth No.	18858	35470	22955	115054	70508	56192
Oth %	6	11	7	36	22	17

Age Groups

NOTE: Area populations represented are 1986 ABS Census counts
Data from: ABS and Census Applications

FIGURE 3

CENTRAL SYDNEY HEALTH SERVICE ABORIGINAL POPULATION BY LGA AS PERCENTAGE OF POPULATION

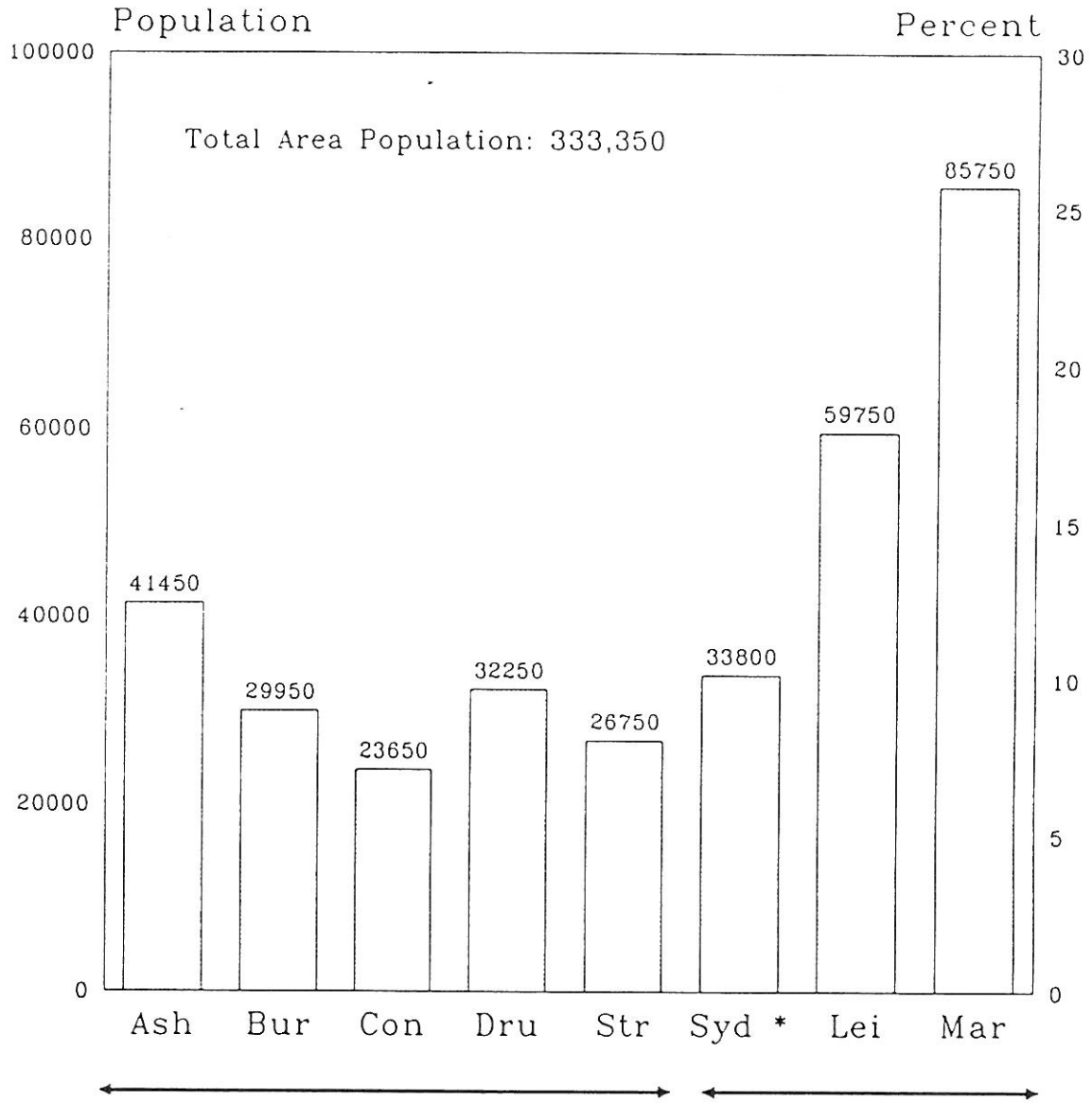


	Ash	Bur	Con	Dru	Str	Lei	Mar	Syd*	CSHS	SYD+	NSW
No.	174	87	34	39	63	421	725	870	2413	18593	59018
%	0.43	0.3	0.14	0.12	0.24	0.74	0.88	2.49	0.75	0.55	1.09

Data from: Census Applications 1989
* Indicates Cent Syd part of Sydney SLA
\+ All of Greater Sydney Metro Area

FIGURE 2

ESTIMATED RESIDENT POPULATION, 1988
CENTRAL SYDNEY HEALTH SERVICE
BY LOCAL GOVERNMENT AREA



SOURCE: Australian Bureau of Statistics
1988 Preliminary Population Estimates

FIGURE 1

5. English Proficiency by LGA as was measured by 1986 Census

* Marrickville has the highest proportion of residents who are unable to speak English "at all", Approximately 4%. Whilst Leichhardt has the lowest proportion, approximately 2%.

* Marrickville has the highest percentage who are able to speak English but not well 30%, followed by Sydney 25%, Ashfield 22%, Drummoyne 21%, Burwood 21%, Leichhardt 20% and Strathfield 18% (Figure 6).

I have to emphasise at the end of this document the following basic facts about good promotion.

* Promotion must get the attention of the target audience and comunicate effectively. Much promotion doesn't really communicate-you might listen to the radio for hours without really being aware of the advertisements.

* Different audiences may see the same message in different ways or interpret the same words differently.

* The communication process means a source trying to reach a receiver with a message. The receiver evaluates not only the message but also the source of the message in terms of trustworthiness and credibility.

* The communication process is further complicated as the receiver is also aware that the message is coming through some message channel - the carrier of the message.

* The receiver may attach more value to the service if the message comes not only from a well-respected source, but also through a well-respected channel.

4.2 SYDNEY WESTERN SECTOR

LANGUAGE SPOKEN AT HOME	CENSUS 1986	%
English	5897	73%
Greek	490	6%
Chinese	273	3%
Others	1420	18%
TOTAL	8080	100%

4.3 MARRICKVILLE LOCAL GOVERNMENT AREA

LANGUAGE SPOKEN AT HOME	CENSUS 1986	%
English	4274	50%
Greek	1468	17%
Italian	449	6%
Others	2288	27%
TOTAL	8479	100%

3.2 The proportion of NES residents varies among LGAs - from 42.5% in Marrickville, 36.6% in Ashfield and 34.8% in Burwood to 18.4% in Leichhardt.

But without exception every LGA in Central Sydney has a higher proportion of NES residents than NSW as a whole, 13.7% (Figure 5).

3.3 Marrickville has a high proportions of Vietnamese (Vietnamese-speaking), Portuguese, Latin Americans and Pacific Islanders.

3.4 Chinese-speaking Vietnamese have gravitated to the Homebush area, another group of Chinese-speaking migrants are found in Pyrmont/Ultimo, where 37% of migrants are new arrivals.

3.5 In the western LGSs, Italian-born residents predominate. Greek-born migrants are the most numerous group in Marrickville. Lebanese are concentrated along the southern boundary of the Area adjacent to Canterbury, where they are found in higher proportions.

4. The relative language distribution for some LGAs for CSAHS is:

4.1 DRUMMOYNE LOCAL GOVERNMENT AREA

LANGUAGE SPOKEN AT HOME	CENSUS 1986	%
English	3026	69%
Italian	835	19%
Greek	197	5%
Others	296	7%
TOTAL	4354	100%

SUPPORTIVE INFORMATION

This information is a basic tool for identifying health issues and strategies and can be used as a basic building block for the planning process.

1. Population

The total population of Central Sydney Area Health Service is 333,350 (1988 preliminary estimate).

There is considerable disparity in size among the area's larger Local Government Areas LGAs - Marrickville and Leichhardt - and the smaller LGAs - Concord, Burwood, Strathfield, Drummoyne and the western part of Sydney LGA.

One quarter of the Area's population lives in Marrickville, particularly important in view of the low socio-economic status and poor health indicators for Marrickville (Figure 1).

2. Aboriginal and Torres Straits Islanders

2.1 Aboriginal people have historically been concentrated in Central Sydney. The Area's Aboriginal and Torres Straits Islanders population totalled 2,413 at the time of the 1986 Census (Figure 2).

2.2 Aboriginal and Torres Straits Islander residents are much younger on average than the general Area population (Figure 3). Their communities are found in Redfern, Chippendale and Alexandria and to a lesser extent Glebe/Forest Lodge (Figure 4).

3. Migrants from Non-English Speaking Countries

3.1 Migrants from non-English speaking countries (NESC's) constitute more than one-third of Central Sydney Area's population and they are a very significant minority. They require special consideration for numerous reasons:

* Their health status may be relatively poor.

* Their health behaviour may be undermined by lack of formal schooling, inability to comprehend or communicate in English, or a clash between traditional and Australian health beliefs and services.

3.2.4 Feedback and Evaluation

* Women attending the van should be asked whether a volunteer told them about the service.

* Give volunteers feedback as results come in.

* Get suggestions on how we can improve our promotional strategies.

4. GROUPS WITH SPECIAL NEEDS

A. Non-English speaking groups

B. Aboriginal groups

In consultation with these groups, resources and strategies have to be developed appropriately in relation to cultures and languages.

A Non-English Speaking Groups

* Opening up communication with bi/multilingual GPs - (Individualised invitation strategy).

* Promoting use of the Programme at times when an interpreter is available.

* Ethnic radio and newspapers.

* Materials in major languages.

* Presentation with a translator to women's ethnic groups.

B Aboriginal Groups

* Liaison with Aboriginal health workers to assist them in carrying out education.

* Posters and simple written material for semi-literate Aboriginal women to be distributed to Aboriginal medical centres and community.

3.2.2 Arrange a Meeting of Volunteers

There are a number of objectives that could be met in a meeting of volunteers.

* It would give them an opportunity to meet each other and to start forming a cohesive mutually supportive group.

* Opportunity to give the volunteers more information about Breast Care and its aims.

* To tell them about some of the ideas we have about their role.

* To ask them to come up with further suggestions on what can be done to encourage more women to attend.

* To give them a resource kit.

The meeting would be run by the Programme's Health Promotion Officer and any other staff, as necessary.

3.2.3 When the Van Moves to a New Site

* Contact all volunteers two weeks prior to moving.

* Arrange a meeting where volunteers can:

  . Nominate which clubs or associates they will speak to (if any).

  . State what other activities they feel they could do to encourage other women to attend.

  . Discuss with the group any support they would like from the rest of the group, or from the Health Promotions Officer.

* Health Promotions Officer will be available for all volunteers to contact while activities are underway and if invited, will attend talks.

2.4 Resource distribution to:

* Community Health Centres
* Department of Social Security
* Church groups
* Aboriginal Medical Centres
* Hairdressers
* Rotary, Lions and Service clubs

2.5 One day campaign at high schools and universities to promote the idea of the Programme to the students, inviting them to act as ambassadors within their communities.

* The medium they would use is word of mouth - supported by brochures and posters which can carry all the detailed information.
* Students from different ethnic groups can spread the word of mouth effectively among their communities through their bi-lingual ability.

3. COMMUNITY DEVELOPMENT

3.1 Encouraging women who have either experienced community education or attended the van to act as peer educators or ambassadors within the Community, motivating other women to attend for screening.

3.2 Volunteers Groups

3.2.1 Strategy for Volunteer Recruitment

* People and relative organisations who have already been helpful could be approached.
* An advert could be placed in the local paper asking women if any are interested in forming a special group to assist in promoting the Programme through the community.

PHASE IV : COMMUNITY EDUCATION AND DEVELOPMENT

1. COMMUNITY NETWORKING

1.1 Liaison with women's groups and community groups about the Programme.

1.2 Invitation to visit the Breast X-Ray Programme Assessment Centre and van.

1.3 On-going information about the Programme.

1.4 On an on-going basis, groups and individuals who are concerned with issues such as women, women's health, local affairs and senior citizens will be identified.

2. COMMUNITY EDUCATION

2.1 The Programme has to contact:

* Local groups
* Women's groups and organisations
* Bowling Clubs
* Women's Health Centres

2.2 Educational strategies will need to include:

* Explanation of the Programme
* Information delivery
* Group work to deal with personal fears and concerns

2.3 On-going activities to provide information, literature and requests for presentation.

3. AREA HEALTH EDUCATION OFFICERS

3.1 Joint development and implementation of promotional strategies with the Programme.

3.2 Personal liaison and resource provision.

4. COMMUNITY NURSES

4.1 To address all community nurses in the area, at their district meetings, to outline the Programme and explore joint implementation of promotional strategies.

5. ABORIGINAL HEALTH WORKERS

5.1 Education via staff development in services.

5.2 On-going liaison and resource distribution.

PHASE III : PROFESSIONAL EDUCATION AND NETWORKING

OBJECTIVE

To develop communication between the Breast X-Ray Programme and health professionals who will promote the Service to their communities and facilitate the attendance of women for screening.

1. GENERAL PRACTITIONERS

1.1 Invitation Seminar:

To present the Programme's up to date results, and to discuss all medical aspects related to breast cancer.

1.2 Developing a New Information Kit for GPs:

To improve their knowledge regarding breast cancer and mammography .

* Central Sydney Area Health Service Breast X-Ray Programme's aims and objectives.
* Screening versus diagnostic mammography.
* How the Programme works.
* Answering questions such as. Does mammography work? (Australian and overseas results).
* Role of the general practitioner in the Programme.
* Questions women may ask about mammography screening.

2. COMMUNITY BASED CENTRAL SYDNEY AREA HEALTH SERVICE STAFF

2.1 Establishing and maintaining communication, at an appropriate level, with Community Health Services.

2.2 Consulting with Community Health team leaders regarding selection of van sites once a general area/suburb has been decided upon.

PHASE II : INVITATIONS

OBJECTIVES

1. PERSONALISED INVITATIONS

1.1 General Practitioner Invitations

Outline

* General practitioners will be visited by a Breast X-Ray Programme staff member to request their agreement to send letters of advice or letters with appointments to their patients.

* General practitioners' clerical staff will draw up a list of eligible women.

* Breast X-Ray Programme staff will check the list to exclude those who have recently attended the Programme.

* Women will be mailed an appointment time or simply advice to attend for screening, as agreed to by the general practitioner.

1.2 Electoral Listing Invitations

Outline

* The State Electoral Office will supply the Breast X-Ray Programme with a listing of the women in the target population.

* This listing will be checked by Breast X-Ray Programme staff to exclude those women who have recently attended.

* Letters with appointment times will be mailed to eligible women.

2. NON PERSONALISED INVITATIONS

* Invitation letter attached to mail box drop.

* Letters to women who have attended the Programme asking them to act as ambassadors for the Programme; to commission them to spread the word about the Service through peer groups, or in some cases, through their clubs and associations.

* The development of volunteer groups to assist in encouraging "target" women to attend for screening.

6.2 Multi-language material has to be considered when developing letterbox-drop-material (see attached Supportive Information).

6.3 A mailbox drop has to be one week before the van moves to the new site.

7. BREAST X-RAY PROGRAMME SECOND VAN

It is necessary that the Programme launch its second van in the near future.

7.1 Publicity recommended in this respect.

* Press releases
* Health Minister's speech
* Media launch
* Newspaper articles
* TV and Radio interviews

7.2 Ideas about new van.

* Attractive external colour
* Using the word "Service" instead of Programme to eliminate any suggestion of research.
* Use of attractive stand and signs.

3.4 Recommended sites to distribute posters and pamphlets:

* Health Centres
* Supermarkets
* Department of Social Security
* Pharmacies
* Local Councils
* Church groups
* Medicare
* Hairdressers
* Train stations

4. BREAST X-RAY PROGRAMME INFORMATION CENTRE

To be based near the van to answer queries and promote the Programme.

This Centre can be operated by the Programme's staff or by volunteer groups.

5. DIRECT MAIL (USING MAILING LISTS)

Letters and supporting material should be sent to doctors, organisations and communities in the region. Advance publicity will enable the Programme's staff to plan other local modifications which will enhance the promotion strategies.

6. MAILBOX DROPS

6.1 Mailbox drop material has to cover:

* Information about breast cancer and the advantage of having mammography.
* Information about the van site.
* Interpreter facilities at van (if available).
* Invitation to ask friends or relatives to attend for screening.

2.2 Paid Media

* Advertising in local and ethnic newspapers one week before van arrives on site, and every week during the period of stay.

* Advertising on merchandise likely to be purchased by Women.

3. POSTERS AND PAMPHLETS

3.1 Developing new posters and pamphlets (March - June 1990) to cover:

* Different languages (See attached Supportive Information).

* New message emphasizing well-being:

"You are enjoying perfect health now make sure you stay that way"

"It is your health we care about, shouldn't you care too?"

"It is a life of someone you care about; you can protect it, shouldn't you?"

"Screen your breasts and enjoy your life to the fullest".

"Thousands of women already have peace of mind, shouldn't you?"

"You always care about others, shouldn't you care about yourself".

3.2 The basic information can be carried in a pamphlet. It would answer the questions most likely to be asked and address some of the worries known to most trouble women.

3.3 Posters (outdoors and indoors), which present the message, should be designed and be available for both direct placement and for distribution. They must have visual appeal as well as containing the message.

PHASE I : PUBLICITY

1. OBJECTIVES

1.1. Short term massive publicity to cover target area (March 1990 to June 1990).

Message:

What do you know about Breast Cancer and Mammography?
What do you know about CSAHS Breast X-Ray Screening Programme?
Breast X-Ray Programme up-to-date results

1.2. Regular local publicity in relation to van site which needs a three month projection siting plan with a further three month plan agreed in broadterms.

2. MEDIA

2.1 Unpaid Media

* Public service radio announcements

  . By targeting particular stations such as 2GB and 2BL and their announcers, 90% of primary target audience can be reached.

  . Selective use of ethnic radio would extend the reach of strategy to non-English speaking women.

  . Advantages of using public announcement radio are:

    - It is free

    - It has news value and as such has credibility

    - It can be controlled - run the message - measure the response - repeat when necessary

* Newspaper press release and articles explaining and inviting women to attend.

* Community Service Announcements.

* Sponsored articles.

* Direct contact with journalists to develop stories.

* Provide articles to professional newsletters and journals e.g. pharmacists, community nurses.

RECRUITMENT STRATEGIES

PHASE I	Publicity	March 1990 to December 1990
PHASE II	Personalised and Non-Personalised Invitations	March 1990 to December 1990
PHASE III	Professional Education and Networking	March 1990 to December 1990
PHASE IV	Community Networking, Education and Development	March 1990 to December 1990

BREAST CARE

BREAST X RAY PROGRAMME

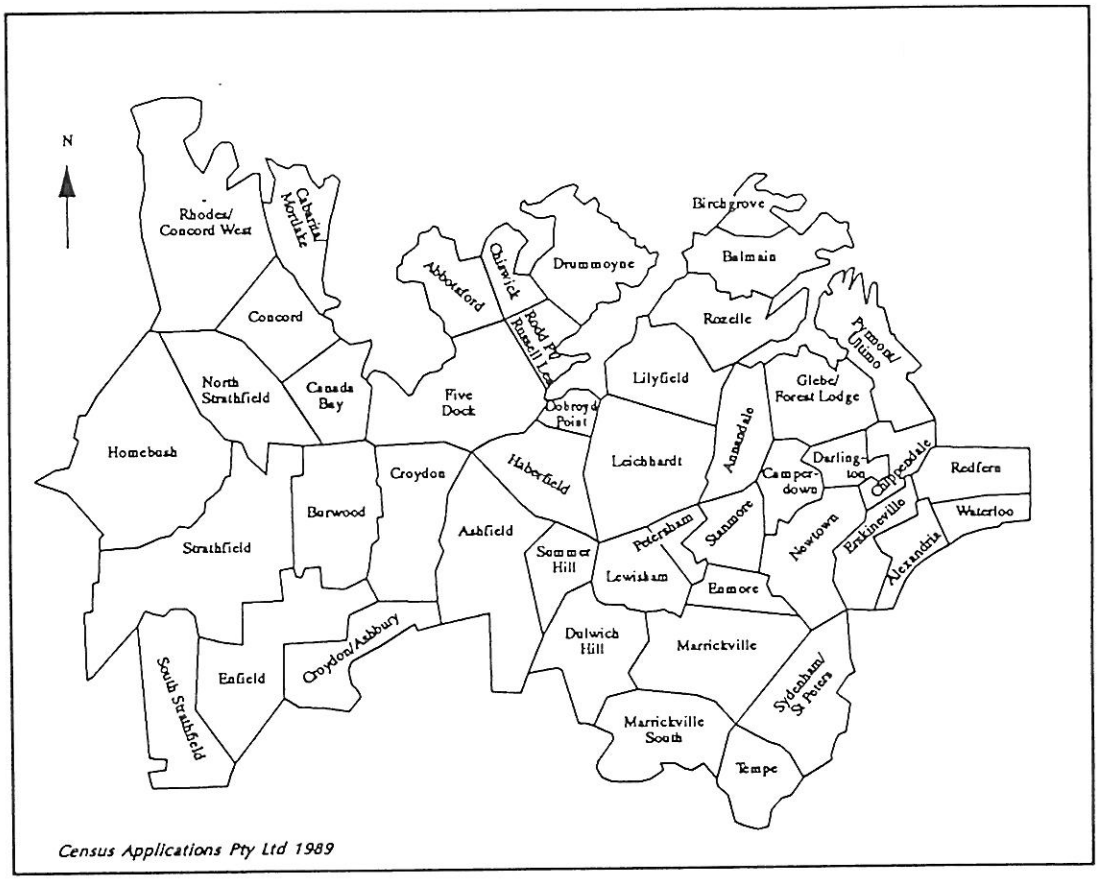
TARGET AREA

Suburbs of the Central Sydney Area Health Service.

TARGET GROUP

Women aged 45 years and over living in the target area.

CENTRAL SYDNEY HEALTH SERVICE



At the same time some factors can be considered as encouraging factors.

These include:

* Free service which is available locally

* The promise of high quality service

* Easy accessibility to the service

* The promise of reassurance and confidentiality

With these factors in mind, aim and objectives of the promotional strategies for the CSAHS Breast X-Ray Programme can be easily identified.

AIM

To motivate women within the target area and specified age group to attend for mammography.

OBJECTIVES

1. To provide the "target" women with information about breast cancer and the effectiveness of mammography as a mode for early breast cancer detection.

2. To provide the target group, professionals, relevant organisations and community groups with information about the service through effective networking and education.

3. Informative communication regarding the Programme results to date, which can help the target women overcome their fear and protect their health by attending for screening.

4. To pay a special attention to sub groups such as women from different cultures and economic backgrounds.

INTRODUCTION

There is often a tendency when thinking about the Communication Strategy Plan for a service to focus on the functional aspects of the service; That is to begin listing the benefits of the service as seen from the provider's perspective and then to examine ways of making sure the clients hear of these benefits.

While the functional benefits of mammography are obviously of great importance, focusing on them alone will expose us to the risk of seeing the communication task as simply one of making sure that all of the appropriate women hear about the benefits of screening.

In fact we have to be aware that mammography screening will be defined for a woman by the composite of messages she receives about it from all sources and her own perceptions of its relevance to her. Thus the net result of our Communication Strategic Plan will depend not only on what we say about the Programme, but also on what others say about it. The Programme also has to take into account the likely impact of a wider discussion of breast screening.

This document is to outline the recommended Communication Strategic Plan whereby women aged 45 years and over, living in the Central Sydney Area Health Service, can be encouraged to attend for mammographic screening.

Developing the recommended promotion plan needs to take into consideration a number of factors which may affect women within target group.

From experience to date, it has been noticed that certain factors can inhibit women from attending for screening.

These include:

* Fear of cancer which may result in negative attitude
* Terminology which may arise in confusion towards the service
* Ignorance of the need for screening
* Lack of information or trust regarding mammography as an effective mode of early breast cancer detection
* Fear of pain
* Negative attitude towards self-care and self-health
* Conflicting medical opinions about the efficiency of screening mammography

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PROMOTIONAL PLAN

For

CENTRAL SYDNEY AREA HEALTH SERVICE

BREAST X-RAY PROGRAMME

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February 1990