CHAPTER 3

ACCESS TO SERVICES

3.1 A principal aim of the National Program is to ensure that all women in the eligible age group, regardless of their geographical location, ethnic background, Aboriginality or socio-economic status, have equal access to the Program. This chapter looks at the problems of implementing the Program in rural and remote areas. The chapter also looks at the problems associated with screening Aboriginal and Torres Strait Islander women, and women from non-English speaking backgrounds; and the extent to which these groups participate in the Program.

Rural and Remote Areas

3.2 Implementing the Program in rural and remote areas poses many problems, especially arising out of the difficulties created by distance, the lack of transport and the lack of medical facilities in these areas. One witness told the Committee that 'no-one should underestimate the difficulty in establishing a rural-based assessment and screening service ... '.[143]

3.3 In certain remote areas of the country, such as north-west Western Australia, Queensland and the Northern Territory (outside the main population centres) and the west coast of Tasmania, the problems of service delivery are often compounded by the problems of remoteness and isolation.

3.4 As noted above, the problems of service delivery in remote areas relate in part to the great distances involved. A witness, drawing on his experience in Western Australia, noted:

> The difficulties related to remoteness are enormous. It involves not just the actual distance and floods and 45 degree heat; it involves who you can hire to do the jobs, [and] transport for people from unbelievably remote areas into wherever the centre may be.[144]

3.5 The need for women to travel great distances for screening and assessment services may also result in personal (including financial), and social dislocation and family problems.

3.6 The lack of access in rural and remote areas was highlighted during the inquiry. One witness highlighted some of these concerns.

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143. *Transcript of Evidence*, p.353 (North West Health Service, Tamworth).

144. *Transcript of Evidence*, p.275 (Health Department of Western Australia).

> The way the screening is delivered is the first one. You are likely to need mobile facilities because you will have small populations which cannot justify a full-time fixed screening unit. Secondly, recruitment strategies are a little different and they are easier, in this sense. We have done our own studies and published randomised trials, looking at GP recruitment strategies ... compliance is in excess of 90 per cent if the GP is involved. So we have developed strategies which ultimately involve GPs in the process.[145]

3.7 One submission argued that there were considerable delays in implementing the Program in rural areas.[146] However, it needs to be noted that the Program aims to be progressively implemented over five years and often the provision of services is more difficult in rural and remote areas compared with urban settings. For example, the commissioning of mobile units to service rural and remote areas takes up to 12 months.[147] In addition, some States, especially Queensland, have adopted the strategy of introducing screening services initially in more populated areas, before rural services have been established.[148] A representative of DHS&H did, however, concede that more could be done to extend the program in rural areas, particularly in relation to the establishment of more screening and assessment centres in the larger provincial towns.[149]

Models of Service Delivery

3.8 There are basically two models of service delivery in rural and remote areas – one is to bring the service to the client, the other is to bring the client to the service. The first approach has involved the use of mobile units in rural areas.

1. Service to Client

3.9 One submission noted that mobile services represent an effective way to provide services in remote areas, such as north-west Western Australia, and parts of the Northern Territory and Queensland because the population density in these areas is too low to justify the cost of fixed units or any fixed radiological services.[150] Mobile units have been established in New South Wales (7 mobile units), Western Australia (3 units), Queensland (3 units) and South Australia and Tasmania (1 unit each).[151]

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145. *Transcript of Evidence*, pp.735-6 (Professor Forbes).

146. *Transcript of Evidence*, p.754 (RACS, Divisional Group of Rural Surgeons).

147. DHS&H, Progress Report, *op. cit.*, p.5.

148. *Transcript of Evidence*, p.923 (Queensland Department of Health).

149. *Transcript of Evidence*, p.1432 (DHS&H).

150. *Transcript of Evidence*, p.1340 (RACS, Section of Breast Surgery).

151. *Transcript of Evidence*, pp.1402-4 (DHS&H).

3.10 Western Australia has had considerably more experience of screening in rural and remote areas than any other program in Australia and now offers screening to all women outside the Perth metropolitan area. Approximately one quarter of the target population in Western Australia lives outside the Perth metropolitan area. To bring women to Perth from these remote areas could cost up to $1000 so it was decided to develop a screening system based on mobile units. Mobile units now operate on two-yearly cycles in the south-west, northern and south-eastern regions of the State. The system involves the use of vans, with trailers attached, each moved by a prime mover with the added facility of on-board processing of films. The availability of on-board processing has made it easier to monitor the original and the additional film views; and it also allows the radiographer to take additional views at the patient's first attendance if the need arises.[152]

3.11 Queensland faces similar problems to Western Australia in providing an effective screening program, especially in relation to the decentralised population and remoteness of the State. In relation to the remote north of the State, it is proposed to provide a screening service for the Cape York Peninsula & Torres Strait Islands by providing a relocatable mobile unit and an assessment team to travel to the isolated Aboriginal and Islander communities in that region.[153]

3.12 The largely decentralised population outside the south-east corner of Queensland also poses problems of access to assessment centres. In most instances, assessment services will be provided in conjunction with a fixed screening unit, but in the more remote areas, assessment services will be provided at larger centres that fly in an assessment team to the remote location.[154]

3.13 The Committee received evidence of problems in relation to the use of mobile units. In South Australia, it was noted that there is a problem with the high staff turnover for radiographers in the mobile unit in that State.[155] This also has led to concerns about the quality of the films due to the necessity to retrain radiographers to staff the mobile unit.[156]

2. Client to Service

3.14 In some remote areas it is neither feasible nor practicable to bring the screening service to the client via a mobile service. For example, in the far west of Queensland, it was noted that efforts will be made to provide transport for

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152. Submission No.41, p.2 (Dr Gibson); Supplementary submission No.41, pp.13-15 (Dr Gibson).

153. *Transcript of Evidence*, pp.985-6 (Queensland Department of Health).

154. *ibid.*, p.925.

155. *Transcript of Evidence*, pp.64,88 (SABXRS).

156. *Transcript of Evidence*, p.88 (SABXRS).

Aboriginal women, in particular, from outlying communities when mobile units are in the larger country towns to conduct screening services.[157]

3.15 One witness noted, in the Queensland context, that costs could be reduced by two-thirds by bringing patients to a major centre for screening, rather than providing a mobile service.[158] The high cost of providing a mobile screening service was raised during the inquiry. The Northern Territory decided against the introduction of a mobile screening service because of its high cost – up to $400,000 to set up the van (excluding running costs).[159]

3. Assistance for Travel Costs

3.16 Financial assistance for travel and accommodation expenses is currently provided by the States and the Northern Territory to assist people in rural areas to receive medical treatment.[160] The Committee was told that the eligibility criteria under these schemes varies considerably.[161] However, under the schemes women are generally eligible for assistance if recalled for assessment or treatment.

3.17 Patients are required to have been referred by a specialist for treatment. Assistance is payable for transport expenses, for example, the cost of travel by public transport from the point of referral to the treatment centre, travel by private motor vehicle (with a reimbursement for the distance travelled) and in some cases, by air travel, if the patients' medical condition requires it.

3.18 Under the Queensland and Western Australian schemes, patients are eligible for assistance if they reside more than 50 kilometres outside the metropolitan area. In South Australia and New South Wales patients are eligible if they are required to travel more than 200 kilometres from their place of residence for treatment, while in Victoria, eligibility is restricted to persons residing 100 kilometres from a treatment centre.

3.19 In Tasmania, if treatment is not available locally, patients are eligible for assistance to travel to Hobart or Launceston. Where specialist treatment is not available in Tasmania, patients may be eligible for assistance to receive treatment

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157. *Transcript of Evidence*, p.925 (Queensland Department of Health).

158. *Transcript of Evidence*, p.812 (Professor McCaffrey).

159. *Transcript of Evidence*, p.1799 (Northern Territory Department of Health and Community Services).

160. The Commonwealth scheme, the Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS) was abolished in 1987. The Commonwealth now provides funding directly to the States and Territories for their own travel assistance schemes. In NSW the scheme is called the Isolated Patients Travelling and Accommodation Assistance Scheme (IPTAAS). In the other States it is often called the Patients Assistance Travel Scheme (PATS) or an equivalent title.

161. *Transcript of Evidence*, p.513-4 (North Coast Breast Screening Program, Lismore).

on the mainland. In the Northern Territory, if treatment is not available in the local town, the scheme pays for the travel costs of women required to receive treatment in Darwin or Alice Springs. The scheme also pays for women to go interstate for radiotherapy treatment.[162]

3.20 The schemes also provide assistance for accommodation expenses if the specialist regards it as necessary for the patient to stay overnight for follow-up treatment. The rates for accommodation vary between States but are generally in the range of $30-35 per night. Provision also exists in many States for an escort or attendant to accompany the patient where this is necessary for medical reasons.

3.21 Some deficiencies with the operation of the schemes were noted during the inquiry. One witness argued that the rate of subsidy payable under the scheme in New South Wales was inadequate, especially for women living in country areas of New South Wales and requiring any extended period of treatment in Sydney.[163] It was also noted that the low rate of benefit payable for accommodation costs would make it especially difficult for women from lower socio-economic groups to afford treatment. It was also noted that problems exist for women that are excluded from eligibility under the schemes because they reside in country areas but just outside the distance limits imposed by the various schemes. One witness noted that in the case of New South Wales, patients requiring treatment yet living within a 200 kilometre radius of the treatment centre are excluded from benefits under the scheme and may not be able to afford the travel and accommodation costs required.[164]

3.22 Several witnesses raised the possibility of introducing a special travel allowance to encourage women in rural areas to present for assessment and treatment. One witness suggested that attention should be given to funding transport for women, for example, by using local service groups or local health services to organise transport for these women to attend a screening and assessment centre.[165] The Northern Territory Department of Health & Community Services indicated that in the Territory, access for women residing outside the main population centres could be improved by introducing a scheme that paid for the transport and accommodation costs for women to come to major centres for screening.[166] The Committee referred to the problem of ensuring that assessment would also be available within a reasonable time after screening. However, it was pointed out that in Darwin it is planned to schedule appointments so that screening

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162. *Transcript of Evidence*, p.1800 (Northern Territory Department of Health and Community Services).

163. *Transcript of Evidence*, p.1575 (RACR).

164. *Transcript of Evidence*, p.513 (North Coast Breast Screening Program, Lismore).

165. *Transcript of Evidence*, p.333 (Health Services Association of New South Wales).

166. *Transcript of Evidence*, p.1803 (NT Department of Health & Community Services).

and assessment occurred on the same day or screening on day one and assessment on the following day.[167]

3.23 Some witnesses did not support the introduction of travel allowances. One witness argued that such a scheme would be very costly to operate.[168] DHS&H indicated that the current approaches, especially the mobile services, are proving effective without the need for special transport allowances.[169]

Other Problems of Service Delivery

3.24 Other problems relating to the implementation of the Program in rural areas were raised during the inquiry. One submission noted a lack of liaison and co-ordination with many regional facilities and personnel competent to provide screening and assessment services; and a lack of use made of existing private sector facilities in some rural areas.[170]

3.25 Another witness noted that rural health services are often deficient in many areas of medical expertise.[171] Another submission, supporting this view, noted the limited number of medical consultants available in surgery, radiology and pathology in rural areas.[172] Other submissions highlighted the difficulties often experienced in attracting radiographers to work in rural areas.[173] One submission noted that it was particularly difficult to attract radiographers to work in mobile units as this often involved extended periods of time away from home.[174] There are also problems attracting radiological staff. The Committee was told that in rural areas, radiologists in private practice often have difficulty in providing reading services to screening centres.[175] (These issues are discussed further in Chapter 2).

3.26 Another witness argued that more formal links should be established between various country screening centres and central treatment centres.[176] This could be

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167. *ibid.*, p.1804.

168. *Transcript of Evidence*, p.762 (RACS, Divisional Group of Rural Surgeons).

169. *Transcript of Evidence*, p.1432 (DHS&H).

170. *Transcript of Evidence*, p.754 (RACS, Divisional Group of Rural Surgeons).

171. *Transcript of Evidence*, p.339 (Health Services Association of New South Wales).

172. *Transcript of Evidence*, p.497 (North Coast Breast Screening Program, Lismore).

173. *ibid.*, p.488; *Transcript of Evidence*, p.348 (North West Health Service, Tamworth).

174. *Transcript of Evidence*, p.488 (North Coast Breast Screening Program, Lismore).

175. *ibid.*, p.489.

176. *Transcript of Evidence*, p.775 (Dr Renwick).

facilitated by linking, for example, five country centres with a central treatment centre with data being exchanged between the centres.

3.27 The Committee believes that access to the Program for women in rural and remote areas needs to be improved. As noted, access to services in these areas often requires special and innovative strategies to ensure that adequate access is provided.

Recommendation

The Committee RECOMMENDS:

7. That strategies be implemented to improve access to the Program in rural and remote areas and that these strategies involve, where appropriate, the provision of financial assistance to encourage women to participate in the Program.

Aboriginal and Torres Strait Islander Women

1. Problems of Access

3.28 Aboriginal and Torres Strait Islander women often encounter problems in gaining access to the screening Program. Some of these problems are associated with living in rural and/or remote areas. These problems, such as distance and isolation, were noted in the previous section. During the inquiry, however, the Committee received considerable evidence to suggest that a major impediment to the successful implementation of the screening program among Aboriginal and Torres Strait Islander women lies in the cultural differences between them and the non-Aboriginal population and the very different health priorities of these women. The Committee believes that the Program needs to take account of these factors in delivering a screening service that is relevant and culturally appropriate for Aboriginal and Torres Strait Islander women. The Committee believes that it is important that the Program not be 'imposed' on Aboriginal and Torres Strait Islander women but that a suitably modified form of screening program be introduced in consultation with this group.

3.29 The Committee received evidence that, at least in the Northern Territory, a modified type of screening program will be introduced. The Northern Territory Department of Health and Community Services told the Committee that, during consultations with Aboriginal women, it was made clear to the Department that the conventional 'model' of a screening program was not appropriate to these women. The Department noted that:

> They also told us that they really were not keen on these organ based programs and they wanted a holistic screening program looking at the whole of the woman, rather than ... focusing on the cervix today and the breast tomorrow. Experience in other States has shown ... that

even where it is promoted very strongly to Aboriginal women, they are still not particularly interested in breast screening.[177]

3.30 In response to these concerns the Department noted that in the Northern Territory the Program will fund a holistic women's health promotion and screening program that incorporates breast examination and screening for cervical cancer.[178]

3.31 Other factors limiting Aboriginal and Torres Strait Islander acceptance of the Program were noted during the inquiry. One witness noted, for example, that Aboriginals are reluctant to present themselves for the type of breast examination required at the usual breast screening clinics. The witness stated that 'they [Aboriginals] tend not to report symptoms of breast lumps for a whole host of reasons. Therefore, they tend to present with rather late disease which patently is only open to palliative treatment.'[179] Another witness also noted that for Aboriginal and Torres Strait Islanders 'accepting a screening protocol ... that is quite formalised, with a lot of questions asked when you arrive and having to go through a routine are not very acceptable to the population as a group'.[180]

3.32 It was also noted during the inquiry that the health needs of Aboriginal women are different from non-Aboriginal women and there was a general lack of interest among Aboriginal women in the screening Program. The Northern Territory Department of Health and Community Services stated that:

> The health priorities of Aboriginal people are different from non-Aboriginal[s]. ... Aboriginal women have much higher death rates from much more common sorts of diseases that non-Aboriginal women never die of these days – or rarely die of these days. For example, respiratory diseases, circulatory diseases, diabetes, infection and all those types of things are really common causes of death amongst Aboriginal women. So they actually identified themselves that there are a whole lot of other things that they would like to address before breast cancer. So that was their priority.[181]

3.33 Another witness agreed that similar attitudes exist among urban Aboriginals. The witness noted that breast cancer is probably 'very low on their health needs

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177. *Transcript of Evidence*, pp.1808-7 (Northern Territory Department of Health and Community Services).

178. *ibid.*, p.1782.

179. *Transcript of Evidence*, p.780 (Dr Renwick).

180. *Transcript of Evidence*, p.793 (Dr Rickard).

181. *Transcript of Evidence*, p.1806 (Northern Territory Department of Health and Community Services).

list. They have social and economic problems that are of much more major significance to them'.[182]

3.34 Data indicate that cancers in general are a much more common cause of death among non-Aboriginal women than among Aboriginal women. Statistics show that in the Northern Territory cancers are the third most common cause of death for non-Aboriginal women, while they represent the fifth most common cause of death for Aboriginal and Torres Strait Islander women. Cancer mortality rates are also very different for non-Aboriginal and Aboriginal women. While breast cancer is the most common cause of death from cancer for non-Aboriginal women, cervical and lung cancer are much more common causes of death than breast cancer for Aboriginal women.[183]

3.35 One witness suggested that the incidence of breast cancer among Aboriginal women may be lower than for the general population. Data indicate that the incidence of breast cancer among Aboriginal women in the Northern Territory is 11 per 100,000, compared with an incidence of 36 per 100,000 for non-Aboriginal women.[184] One witness suggested that this may be related to their lower socio-economic status and diet. Research in the United States has found that breast cancer is more commonly found among women in the higher socio-economic groups.[185]

3.36 The lower life expectancy of Aboriginal women may also be a factor in the lower incidence rate of breast cancer among Aboriginal women. The life expectancy of Aboriginal and Torres Strait Islander women is 64 years, some 15 years less than for women generally. In addition, only about half of Aboriginal females can expect to live to 65 years, compared with almost nine out of ten of the female population generally.[186] One witness noted that, given their lower life expectancy, further consideration may need to be given to the appropriate age at which Aboriginal and Torres Strait Islander women should be screened.[187]

2. Numbers Screened

3.37 The proportion of Aboriginal women screened under the Program varies between States. In Western Australia, 1.72 per cent of Aboriginal women in the 40-

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182. *Transcript of Evidence*, p.793 (Dr Rickard).

183. Northern Territory Department of Health and Community Services, *Feasibility Study – Northern Territory Participation in the NPEDBC*, September 1991, p.14.

184. *ibid.*, p.13.

185. *Transcript of Evidence*, p.780 (Dr Renwick).

186. Australian Institute of Health & Welfare, *Australia's Health, 1992*, AGPS, Canberra, 1992, p.211.

187. *Transcript of Evidence*, p.355 (North West Health Service, Tamworth).

69 years age group have been screened (compared with their representation of 1.35 per cent of the target population).[188] In South Australia, 0.4 per cent of Aboriginal women in the age group 40-64 years have been screened (compared with their representation of 0.6 per cent of the target population).[189] In the Northern Territory, where screening will begin in June 1994, there are 1,100 Aboriginal women in the target age group of 50-69 years.[190]

3. *Recruitment Strategies*

3.38 Several different successful recruitment strategies for Aboriginal and Torres Strait Islander women were discussed during the inquiry. Most emphasised that close liaison with Aboriginal and Torres Strait Islander community organisations and other groups was essential in encouraging Aboriginal and Torres Strait Islander women to participate in the program. The Committee believes that the Program should liaise closely with the Aboriginal Health Services (AHSs) in particular. Some 92 AHSs now operate throughout the country and provide a range of services such as primary health care and health education and promotion. The Committee believes that the AHSs would be a useful means by which the screening program could be promoted throughout the Aboriginal and Torres Strait Islander community.

3.39 Several States indicated during the inquiry the importance of close liaison with local Aboriginal health workers, community nurses and community health groups in their recruitment strategies for Aboriginal women.[191] In South Australia a full-time promotions and education officer has been employed to develop strategies to improve access for Aboriginal and other minority groups.[192]

3.40 A witness representing the North Coast Breast Screening Program told the Committee that the Service spends a great deal of time speaking with local Aboriginals and Aboriginal health workers in the area. The Service also provides transport for Aboriginal women from outlying areas attending the mobile service.[193]

3.41 In the Northern Territory, rural women, including Aboriginals, will be specially targeted when the program is introduced. The Northern Territory Screening Service has recently employed several remote area women's health nurses

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188. *Transcript of Evidence*, p.162 (Health Department of Western Australia).

189. *Transcript of Evidence*, pp.21,79 (SABXRS).

190. Advice from the Northern Territory Department of Health and Community Services, 9 May 1994.

191. *Transcript of Evidence*, p.79 (SABXRS); p.180 (Health Department of Western Australia).

192. *Transcript of Evidence*, p.80 (SABXRS).

193. *Transcript of Evidence*, p.515 (North Coast Breast Screening Program, Lismore).

and they will have the role of informing Aboriginal women of the availability of the service and encouraging their attendance.[194] The Committee, however, believes that to avoid a possible duplication of resources, the NT Department of Health and Community Services should seek to use the AHSs in the Northern Territory to disseminate information about the Program.

3.42 The Committee believes that more should be done to improve the access of Aboriginal and Torres Strait Islander women to the Program especially through the involvement of Aboriginal and Torres Strait Islander community-based organisations, especially the AHSs. The Committee notes that in several States, strategies are in place to improve access for Aboriginals and Torres Strait Islanders – strategies that often involve close liaison with Aboriginal groups and communities and display a sensitivity to Aboriginal and Torres Strait Islander cultural values. The Committee also considers that more information should be disseminated to Aboriginal and Torres Strait Islander communities about the Program and that more should be done to educate Aboriginal and Torres Strait Islander women about the benefits of the Program.

Recommendation

The Committee RECOMMENDS:

8. That strategies, sensitive to Aboriginal and Torres Strait Islander cultural values, be implemented to increase the access of these women to the Program, and that these strategies involve:

   - close liaison with Aboriginal and Torres Strait Islander community-based health organisations, especially the Aboriginal Health Services; and

   - the dissemination of culturally appropriate information about the Program throughout the Aboriginal and Torres Strait Islander community.

Women from Non-English Speaking Backgrounds

3.43 Many witnesses suggested that more should be done to target women from non-English speaking backgrounds. A representative of DHS&H noted that the dissemination of information to women of non-English speaking backgrounds needs to be supplemented by culturally appropriate strategies.

> Certainly it is a very great problem to reach women of non-English speaking backgrounds, and the solution is much more than providing information in multiple languages, because it is not only a matter of language, it is a matter of culture as well. Most of these efforts have taken place at the state level, and a number of the programs have gone out of their way to try innovative approaches to get women from non-

194. *Transcript of Evidence*, p.1805 (NT Department of Health & Community Services).

> English speaking backgrounds. Efforts have been made to go into, say local factories, and some of the programs have women on their staff who accompany a woman of non-English speaking background through the program, a woman who speaks the same language and from the same culture. So there are varying approaches, and I think that, as the program develops and as we try to increase the amount of recruitment, there needs to be a great deal of discussion.[195]

3.44 Access to the program by women from non-English speaking backgrounds varies between the States and Territories. In Victoria, 22 per cent of women screened are of non-English speaking backgrounds, equal to their proportion in the population;[196] in the ACT the proportion screened is 13.7 per cent (compared with their representation of 18 to 20 per cent of the target population)[197]; and in Tasmania the numbers screened are equal to or slightly below their representation in the population.[198]

Targeting Ethnic Groups

3.45 Some witnesses suggested that more information needs to be provided to ethnic groups about the screening program. A member of the South Australian Multicultural & Ethnic Affairs Commission noted that:

> I would like to see more information given – be it written information, audio information such as audio-tapes or personal consultation with the communities. If that were done, those women would be enlightened about the danger of breast cancer.[199]

3.46 Translation of material into various ethnic languages is important in disseminating information about the screening program. Several States have developed strategies in relation to the use of translation services. In South Australia, brochures about the Program have been translated into 15 languages and distributed via the screening service and through the Ethnic Communities Council and other ethnic organisations.[200] In Victoria, information and promotional material has been translated into 10 of the most common community languages. The consent forms used for all women who are recalled for further investigation are also currently being translated into these 10 languages.[201]

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195. *Transcript of Evidence*, p.1441 (DHS&H).

196. *Transcript of Evidence*, p.1129 (BreastScreen).

197. *Transcript of Evidence*, p.1750 (Australian Capital Territory Department of Health).

198. *Transcript of Evidence*, p.1775 (Tasmanian Breast Screening Service).

199. *Transcript of Evidence*, p.81 (South Australian Multicultural and Ethnic Affairs Commission).

200. *Transcript of Evidence*, p.21 (SABXRS).

201. Additional information from BreastScreen to the Committee, dated 29 March 1994, p.1.

3.47 The Committee was told that certain ethnic groups, especially the more recently arrived groups need to be specifically targeted to encourage their participation in the Program. One witness noted that Vietnamese women are difficult to attract to a screening program. It was noted that 'it is more foreign to their background culture, and it is more difficult to communicate with them'[202]. Turkish and Arab women were also identified as difficult groups to recruit for screening.[203] The Committee was informed that well-established ethnic groups, such as Italians and Greeks were much less reluctant to attend for screening.

3.48 The Committee received evidence that it is important in some ethnic communities to target the male members of the household, so as to ensure that the women in these ethnic groups attend for screening.[204] The Women's Health Service for the West, Footscray, suggested that this is a particularly useful strategy in working with Arabic women. It was noted that in working with Arab women 'it would be difficult to access the women' without the cooperation of the Lebanese Welfare Council, which is composed of men.[205]

3.49 Several witnesses noted that close liaison with ethnic organisations, the ethnic media and migrant health services is also important in encouraging non-English speaking women to present for screening. The Women's Health Service for the West noted that the Service has developed strategies whereby staff work with key people in the ethnic communities and local women within these communities who are able to pass on the information about breast screening by word of mouth. It was noted that this strategy is particularly effective because women in the particular communities identify more closely with someone from their own community, especially someone who is not seen to be a 'health professional'.[206]

Recommendation

The Committee RECOMMENDS:

9. That strategies, sensitive to the cultural backgrounds and values of women of non-English speaking backgrounds be implemented to increase the access of women from these groups to the Program.

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202. *Transcript of Evidence*, p.793 (Dr Rickard).

203. *Transcript of Evidence*, pp.779 (Dr Rickard); p.1254 (Women's Health Service for the West).

204. *Transcript of Evidence*, pp.779 (Dr Rickard); p.1136 (BreastScreen).

205. *Transcript of Evidence*, p.1254 (Women's Health Service for the West).

206. *ibid.*