Cervical screening in the inner cities: is the opportunistic approach still worthwhile?

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Since the national call and recall cervical screening programme was set up in 1988, population coverage has improved.¹ Geographical differences persist, however, and many inner city areas have a 40-60% response rate.² Factors associated with low acceptance rates for screening include unemployment, overcrowding, ethnic minority, population mobility, and inaccuracy of the patient registers of family health services authorities.³ Also, women may not perceive themselves to be at risk or may not wish to attend their doctor's surgery or the local clinic.

The inner London Borough of Wandsworth has a multicultural population of all social classes. In 1992-3 the uptake of cervical screening was 60%. The Women's Nationwide Cancer Control Campaign (WNCCC) has over 25 years' experience in providing mobile units for both public and workplace screening, which have been shown to improve the response of high risk groups by 30-50%.^{4,5}

Subjects, methods, and results

The WNCCC mobile units provided "drop in" screening in car parks of major shops (public screening) and a workplace programme for employees of Wandsworth council (workplace screening). The results of these programmes were compared with information from Wandsworth Health Authority's screening programme (NHS screening) carried out in the same year. Publicity posters and information leaflets were distributed throughout the borough before the public screening, and fliers were translated into the main local ethnic languages. The council employees received a personal-

ised letter, WNCCC leaflets, and information about local "well women" services. The WNCCC screening sessions offered women blood pressure, breast, and pelvic examinations, and cervical smears were taken from those who had not been tested within the previous three years. Women were also asked to complete an anonymous questionnaire covering ethnicity, occupation, reasons for attending, screening history, and registration with a general practitioner.

Table 1 gives details of the women attending the screening programmes. Significantly fewer of the women who attended NHS screenings were aged 40 or over (37%) compared with those attending public screenings (52%) and workplace screenings (79%). Significantly more of the women attending public screenings were from social classes IV and V (39%) compared with those in the background population (16%) or attending workplace screenings (12%). The proportion of women attending public screening who were black (18%) was not significantly different from that in the background population (11%) and in those attending workplace screenings (12%).

The public screening programme attracted women who claimed never to have received an invitation to be screened (57%) and those who were not registered with a general practitioner (28%). Only 17% of the women attending public screenings and 22% of those attending workplace screenings had been screened within the previous three years—these women came for the other checks offered—so that these programmes did not seem to be attracting women who wanted more frequent testing.

Comment

The NHS screening programme gives every eligible woman the opportunity for a regular smear at her general practitioner's surgery or her local clinic, but there is inevitably a shortfall for various reasons. Additional screening programmes are justified if they are cost effective and attract women who are unlikely to use the routine programme. They also serve to increase local awareness of the benefits of screening, particularly among women who are difficult to reach through statutory organisations. We showed that significantly more older women attended the opportunistic (WNCCC) programmes and that women of lower social class were overrepresented in the public screening.

Some of our findings could be used to improve the NHS programme—such as a guarantee of seeing a female smear taker and more flexible sessional times. However, the informality and convenience of the public screenings and minimisation of time off work of the workplace programme cannot be matched easily by the routine NHS programme.

SC is now breast and cervical screening facilitator at City and East London Family Health Services Authority. KSR retired from WNCCC in 1994.

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Table 1—Details of women attending Women's Nationwide Cancer Control Campaign (WNCCC) cervical screening programmes compared with those attending NHS screening programme and characteristics of general population of Borough of Wandsworth. Values are numbers (percentages) unless stated otherwise

		WNCCC programmes	
	Comparison population	Public screening	Workplace screening
Women's age (years):	NHS screening programme (n = 6525)	(n = 130)	(n = 155)
<40	4123 (63)	62 (48)	32 (21)
≥40	2402 (37)	68 (52)	123 (79)
χ^2 Test (v comparison population)		$\chi^2 = 12.5$, df = 1, P<0.004	$\chi^2 = 114.8$, df = 1, P<0.0001
Social class*:	Borough population (n = 6712)	(n = 119)	(n = 295)
I and II	3477 (52)	21 (17)	142 (48)
III (manual and non-manual)	2159 (32)	40 (32)	107 (36)
IV and V	905 (16)	49 (39)	34 (12)
Not classified	171 (3)	9 (12)	12 (4)
χ^2 Test (v comparison population)		$\chi^2 = 102.1$, df = 3, P<0.0001	$\chi^2 = 59.4$, df = 3, P<0.0001
Ethnicity:	Borough population (n = 85 939)	(n = 125)	(n = 286)
White	68 847 (80)	93 (76)	228 (80)
Black	9 264 (11)	22 (18)	33 (12)
Asian	5 862 (7)	7 (6)	13 (4)
Other	1 966 (2)	3 (2)	12 (4)
χ^2 Test (v comparison population)		$\chi^2 = 6.2$, df = 3, P = 0.1	$\chi^2 = 7.0$, df = 3, P>0.05

*Based on occupation of woman or her partner, depending on who was in the higher social class.

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- 5 Thornton J, Chamberlain J. Cervical screening in the workplace. *Community Med* 1989;11:290-8.

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