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What Women Want: Patient Recommendations for Improving Access to Breast and Cervical Cancer Screening and Follow-up

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Abstract

BACKGROUND—The patient voice remains underrepresented in clinical and public health interventions. To inform interventions that strive to improve access to breast and cervical cancer screening and follow-up among low-income populations, we explored recommendations from low-income women pursuing health care in the safety net.

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METHODS—Semi-structured interviews were conducted among women receiving follow-up care for an abnormal breast or cervical cancer screening result or a positive cancer diagnosis in federally qualified health centers (FQHCs), free clinics, or an academic cancer center in the Chicago metropolitan area.

FINDINGS—Of the 138 women interviewed in the parent study, 52 women provided recommendations for improving access to screening and follow-up care. Most were between 41 and 65 years old (62%) and African American (60%) or White (25%). Recommendations included strengthening community-based health education with more urgent messaging, strategic partnerships, and active learning experiences to increase patient engagement, which women regarded as a key driver of access. Women also suggested increasing access by way of changes to health care delivery systems and policy, including more direct patient-provider and patient-clinic communications, addressing delays caused by high patient volume, combining preventive services, expanding insurance coverage, and adjusting screening guidelines.

CONCLUSIONS—This exploratory study demonstrates important insights from the patient lens that may help to increase the acceptability and efficacy of community and clinical interventions aimed at improving access to breast and cervical cancer screening and follow-up. Further research is needed to identify appropriate integration of patient input into interventions, practice, and policy change.

Introduction

Low-income and ethnic minority women are less likely to adhere to recommended breast and cervical cancer screening and follow-up care than non-minority and higher income counterparts (Elit et al., 2013; Goldman, Walker, Hubbard, & Kerlikowske, 2013; Swan et al., 2010). The need to address these cancer health disparities is pressing, given research linking higher cancer mortality rates with non-adherence to screening and timely follow-up (Hoerger et al., 2011). A large body of research has documented that low-income and minority women experience a multitude of barriers to receiving breast and cervical cancer screening and follow-up care (Ashing-Giwa et al., 2010; O'Malley & Mandelblatt, 2003).

Interventions that aim to improve patient engagement in health care have been largely based on policymakers' recommendations (Coulter & Ellins, 2007). While many studies have documented provider or systems-level evaluations and perspectives along the continuum of breast and cervical cancer-related care (Sabatino et al., 2008; Viadro, Farris, & Will, 2004), fewer focused studies have directly solicited patients' recommendations to address patient-reported barriers (Ashing-Giwa et al., 2013; Heisey et al., 2011; Mishra, DeForge, Barnett, Ntiri, & Grant, 2012). More formative research is needed to gather direct patient input for developing interventions for cancer screening and follow-up. Integrating patient input in the design of interventions encourages the benefits that could come from utilizing principles of community-based participatory research (Israel, Schulz, Parker, & Becker, 1998), whereby stakeholders – in this case, patients – contribute their knowledge and experience of a given phenomenon toward action to improve the health of community members.

Therefore, the purpose of this exploratory study was to help bridge the gap in patient-driven perspectives by gathering patients' recommendations for improving access to breast and

cervical cancer screening and follow-up care. We interviewed low-income women receiving follow-up care in the health care safety net for an abnormal screening result or diagnosis for breast or cervical cancer. This study adds to the literature by linking women's barriers to care with their own recommendations. Bridging the patient voice from this study with those of providers and policymakers may lead to the development of interventions that improve women's access to care and facilitate positive breast and cervical cancer-related care outcomes.

Methods

Setting and Participants

A purposive sample of women was recruited between March 2008 and December 2010 to participate in a qualitative study that investigated barriers and facilitators to breast and cervical cancer-related care among women receiving follow-up for an abnormality or positive cancer diagnosis from three clinic types in the Chicago metropolitan area: urban federally qualified health centers (FQHCs), suburban free primary care clinics, or an urban academic cancer center. We selected these sites because their patient populations mainly comprised low-income, uninsured or underinsured, and ethnic minority patients. Further, these clinic sites provided charity care, served publically insured patients, or provided women with access to free screening and diagnostic services through the Illinois Breast and Cervical Cancer Program (IBCCP) regardless of insurance status. Following a provider referral, trained research assistants approached women at the health clinic to recruit and enroll them into the study. Women were eligible if they received an abnormal breast or cervical cancer screening result or a positive cancer diagnosis. Women who were cognitively impaired, institutionalized, or under the age of 18 were ineligible for the study.

Data Collection

After obtaining written informed consent, bilingual research assistants collected demographic data and then conducted semi-structured, in-person interviews in English or Spanish. Interview questions were guided by the Chronic Care Model and elements of the Socio-ecological Model (Bronfenbrenner, 1977; Wagner, 1998); they assessed access to health care, follow-up, resources, social support, rationale for seeking care, and patient recommendations. Patients' recommendations to improve women's access to breast or cervical cancer screening and follow-up were specifically solicited with this question, asked of all participants, at the end of the interview: "How do you think we can improve women's access to breast exams and mammograms [or Pap tests and cancer care] and follow-up for them? Is there some obstacle that we could work on?" All interviews were audio-recorded and lasted approximately 45 minutes. This study was approved by the [names of IRBs blinded by *WHI* editors for peer review] Institutional Review Boards.

Analysis

Interviews were transcribed, and Spanish interviews were then translated into English and back-translated into Spanish for quality assurance. Only data from patients who provided recommendations to improve women's access to breast or cervical cancer screening and follow-up were included in the analyses presented in this report; patients were excluded if

they reported that they did not have any recommendations or chose not to provide a recommendation. A team of four data analysts ([blinded].) coded interviews following the inductive methodological approach of Hruschka et al. (2004) using ATLAS.ti 6.2 qualitative data analysis software. Team members independently reviewed the same four transcripts to generate initial codes, which were compared and reconciled through a consistent team consensus method to synthesize a standardized codebook of codes and code categories. To ensure consensus among coding schemes throughout the analysis, two teams of data analysts independently coded a subset of transcripts, and inter-coder reliability was measured with Cohen's kappa of 0.8 or greater (Hruschka et al., 2004). Following transcript coding, the research team systematically explored the data to identify consensus themes and sub-themes among patients' recommendations. Themes and sub-themes were rank-ordered by frequency, and thematic relationships were explored.

Results

Sample Characteristics

Of 138 women who participated in the parent study, 52 women (38%) provided recommendations when queried for suggestions for improving access to breast and cervical cancer screening and follow-up. As shown in Table 1, most (62%) of the 52 women in our sample were between 41 and 65 years old, African American (60%) or White (25%), and English-speaking (87%). All 52 respondents had an abnormal breast or cervical cancer screening result, and about half had a positive diagnosis for breast or cervical cancer.

Following the multi-stage coding process, we grouped predominant themes into two categories: (1) community-level recommendations and (2) institution- and policy-level recommendations. Table 2 provides a summary of the aggregated patient recommendations that we describe in detail below.

Community-Level Recommendations: Education & Dissemination

Heighten health messages—Overall, women regarded patient engagement as a facilitator of access, but the majority of participants expressed concern that breast and cervical cancer-related prevention and care is a neglected priority among women. Participants voiced that accentuating the quality-of-life and “life or death” implications associated with adherence to care should be a crucial element of preventive health education for women: “...let them know how important it is, that it is a life or death situation when it comes to your health and that your health is more important to you than anything” (African American; 55 y/o; breast; cancer). Feeling that neglect stems from lack of awareness about basic breast and cervical cancer screening and follow-up care, participants recommended that community health education initiatives use better strategies to clearly communicate the importance of adhering to recommended care and taking early action.

Strengthen community partnerships—Participants deemed canvassing the community, public health marketing, and tailoring the dissemination of health information to communities as essential components of cancer education. Women recommended that breast and cervical cancer education utilize a variety of non-health care settings to reach a wide

audience personally: “Catch [women] where you know they be, grocery stores, hair shops, anywhere...catch them to get them to go get checked out...” (African American; 31 y/o; breast; cancer).

Most women recommended enlisting local organizations to drive community education and information dissemination. They identified trusted community educational and faith-based settings as ideal venues to educate women of all ages about breast and cervical cancer screening processes and the importance of adhering to follow-up care. Women voiced that educational seminars and health fairs should be routinely held on college campuses to provide young women with age-appropriate information about Pap tests and follow-up care, as well as early education about breast cancer screening. African American participants, in particular, identified community churches as opportune venues for educating women: “I think every church should have a hookup with a hospital or their community health department so they can go out, especially in the black neighborhoods” (African American; 52 y/o; breast; non-cancer).

Educate proactively—Participants from all racial/ethnic groups stressed that women must be actively educated about accessing and navigating the health care system. Disseminating print materials, publicly advertising in high-traffic areas, and holding well-publicized events were methods recommended to reach women in the community. Participants suggested that educational materials should provide basic information on breast and cervical cancer, detail step-by-step screening processes, list local screening sites and describe how to access care, and list and explain how to access state and local screening programs. They recommended distributing print materials to residents by mail or in schools in addition to health care clinics, and rather than online:

...it’s not out there, it’s just not out there...And people who don’t know or people who haven’t gotten it by word of mouth, just don’t know that these things are available...Access to care. Most people who don’t have a way of accessing a computer or accessing the information from a Doctor, or who don’t follow up regularly with Doctors, will not have the access to know that these [local screening] places exist (White; 49 y/o; breast; non-cancer)

Study participants also recommended employing public health initiatives that promote women’s body awareness to facilitate access and adherence to screening and follow-up. They desired women-centered education that includes experiential learning opportunities. Women suggested that community centers or clinics offer educational workshops and demonstrations for self-breast examination, as hands-on learning could help a woman to become more comfortable and confident in knowing her own body and identifying abnormalities.

I think they need to teach people more about how to do self-breast exams. I am 47 years old and prior to me finding [the lump], I didn’t ever do self-breast exams and when I did try I didn’t know what to look for. So I think when they teach you they should have something where ‘okay you see this is what abnormal feels like’...Just so that they know and let them know it’s okay to touch yourself because you know culturally it’s like taboo... (African American; 47 y/o; breast; cancer)

Notably, study participants reported widespread lack of knowledge in the community about the breadth of public aid coverage and state and local cancer screening programs such as IBCCP. Suggestions for better informing the community about available screening programs included providing information via community health fairs, billboards, brochures distributed at clinics and churches, mailings, and notices published in town newsletters. Participants recommended providing women with practical guidance on *where* and *how* to access care. They added that structured interpersonal support is needed throughout the screening and follow-up process: “I mean, your flyers are there...But it’s hard, unless you know somebody and they can help you walk the path...” (White; 42 y/o; cervical; non-cancer).

Institution- and Policy-Level Recommendations: Health Care Delivery Systems

Enhance patient-centered care—Overall, women suggested that considering patients’ values and needs may facilitate access to screening and follow-up while increasing patient comfort with the care process. Many women suggested that patient-provider communication regarding screening and follow-up care stands to be improved. For example, they felt that health care providers should take a more proactive role in educating patients about preventive care and its health implications. As described by a young woman with a cervical screening abnormality: “...doctors and nurses should be able to tell you ‘well hey you’re at this age and you need to get this checked out’ and things like that. No matter what type of doctor you need they need to instruct their patient about their health and how important it is” (African American; 30 y/o; cervical; non-cancer). Participants also wanted providers to relay information about their diagnosis and prognosis more honestly: “... just make information more clear. People suffer and [it] probably hurts the people who you’re telling but they need to know. You need to be specific and let them actually know for sure if they are actually sick or not” (African American; 26 y/o; cervical; cancer).

On an administrative level, participants wanted health care clinics to provide phone calls or mailed postcards to remind women to schedule their yearly screening tests. In addition, women recommended that clinics provide patients with print materials detailing timelines and guidelines for screening and follow-up care, supplemented with verbal reinforcement from providers. In particular, women wanted to receive printed hand-outs directly from their provider that detail screening and diagnostic procedures or information about their diagnosis. Some women expressed feeling overwhelmed during clinic visits and wanted to access written information at a later point in time:

...they [should] give you more information. For example, some papers so you can later read about the problem. That’s what I think is missing a little bit, because the doctor can talk to you and sometimes you are nervous, sometimes you forget to ask the doctor something. And you are left there with questions. And if you get out of there with your information, when you have time – you read it, get well informed step by step what is it exactly, the disease that they are treating...I think that that would help a lot (Hispanic; 32 y/o; cervical; cancer)

Optimize system capacity and resources—Women provided many recommendations for improving access to clinical care and psychosocial support. They noted that larger health care facilities, more clinic sites, and more flexible clinic hours would help to facilitate access

and encourage adherence to care, by reducing delayed appointments related to patients' work conflicts and high patient volume:

I think some people are dismayed from doing [mammograms] because when they call for an appointment, the appointment is six or seven months down the line... so many facilities are just booked right now. And you can't get an appointment in some places very quickly. And something that you've scheduled six or seven months down the line, by the time it comes, you may or may not decide to go [...] so I think increasing the facilities, maybe increasing the hours, so there are evening hours for people who work during the day, so they can do it on the evening and on weekends may help... (African American; 45 y/o; breast; cancer)

Other women suggested that clinical preventive services should provide concurrent breast and cervical cancer screening in a single visit for increased efficiency:

Every time we women come and get a pap smear make sure that they get a breast exam, a thorough breast exam so that if they find something or they feel something that may be a little suspicious they can send them to go and get a mammogram or an ultrasound so that they can catch it before it gets out of hand (African American; 36 y/o, breast, cancer)

Several women reported that a shortage of providers in high-volume clinics serving uninsured or underinsured patients is a significant barrier to care and recommended hiring more clinic staff – and particularly more minority clinicians - as one potential solution. Improvements in staffing were further recommended to foster provider “patience” and cultural connection, bridge communication between patients and providers, and optimize connections to resources. One patient aptly described: “There’s only two doctors trying to serve the whole community up here you know and that’s a lot of pressure on them and then there’s a lot of pressure on us because I feel like they don’t have enough time or patience to be able to deal with everyone” (African American; 26 y/o; cervical; cancer). Hispanic women also noted that a greater presence of minority clinicians and staff may improve cancer screening uptake and follow-up among minority women: “Maybe there should be more Hispanic doctors, so that more people want to go and get their mammograms” (Hispanic; 33 y/o; cervical; non-cancer).

Women recommended that patients be connected with social workers and patient navigators or community health workers early and frequently in the follow-up process. As one woman expressed, “you have no idea all the programs and all the help that is available to you [...] at least a social worker could know some pinpoint questions to ask to get the patient thinking (African American; 41 y/o; breast; cancer). Participants also recommended offering patients psychosocial support resources like special support groups for young adult, middle-aged, and elderly women, clinic hotlines for those seeking immediate support and information, and a patient-tailored “buddy system”:

...say that some woman came in and she doesn't have anybody. If there was maybe a buddy system where [the clinic] can call and say 'we have this certain lady. If you're not busy would you be able to bring her here?' ...And maybe, you know, women would volunteer to help that way (White; 49 y/o; breast; non-cancer)

Change policy—Many women noted the need for policy changes involving screening guidelines, cost, and health insurance. Citing personal experiences as breast cancer survivors, several African American participants recommended adjusting screening guidelines to call for more frequent breast cancer screening.

In four months my tumor grew six centimeters so you just think if you've got a tumor and you wait a year. I think women should get more mammograms in less time than a year, like every six months instead of once every year [...] and if you catch it early you probably can save a whole lot of lives, a whole lot. So I think that they should give mammograms more frequent than less (African American; 46 y/o; breast; cancer)

Participants discussed cost as an obstacle to care and many supported the expansion of insurance coverage. One patient urged, "Try to get everybody in the country on insurance of some kind. I don't have the how. I think everybody needs insurance that will pay for at least minimal care" (White; 65 y/o; breast; cancer). Participants also recommended free screening services to improve access to preventive care. As one breast cancer survivor adamantly noted, "I think they should be free. I really truly do. And I think that's a lot of reason why people don't get them because they don't have the money or any means of getting them" (African American; 65 y/o; breast; cancer).

Discussion

This qualitative study showcases patients' recommendations for improving access to breast and cervical cancer screening and follow-up care, from the unique perspectives of low-income women seeking health care in the safety net system. Women regarded patient engagement as a driver of access and provided recommendations for community-, institution-, and policy-level changes. Their community-level recommendations demonstrated a demand for heightened health messaging, stronger community partnerships, and more engaging health education instructional practices. Women's institution- and policy-level recommendations focused on enhancing patient-centered care, optimizing system capacity and resources, and supporting health policies that increase access to care.

Community-level recommendations demonstrated a need for intensified and clearer health messaging, supporting similar findings of Heisey et al. (2011), as well as a grassroots approach to health education and information dissemination. Women shared ideas that included partnering with schools, churches, and other central community venues. African American women particularly touted churches as trusted and promising venues for delivering breast and cervical health information to women in their communities, paralleling the large body of literature supporting faith-based screening and preventive health interventions (Campbell et al., 2007; Matthews, Berrios, Darnell, & Calhoun, 2006). Women in our study suggested a range of community partnership types. Although some systematic reviews have been published synthesizing cancer prevention and screening interventions in particular community settings, such as barbershops (Linnan, D'Angelo, & Harrington, 2014), churches (Campbell et al., 2007), and worksites (Hutchinson & Wilson, 2012; Sorensen, Linnan, & Hunt, 2004), more rigorous research and evaluation is needed to

compare intervention effects among settings to identify those settings most appropriate and efficacious for specific audiences.

Women recommended implementing interactive and interpersonal health education strategies in communities to empower women to take initiative in their care. Interestingly, study participants made no mention of expanding the role of the Internet in facilitating health education or access to care – despite the growing use of social media and web-based platforms for health marketing and dissemination of health information (Househ, Borycki, & Kushniruk, 2014; Madathil, Rivera-Rodriguez, Greenstein, & Gramopadhye, 2014). Participants' concerns about the inaccessibility of web-based information echo documented health communications disparities, whereby some populations are persistently left behind due to limited access to technology (Viswanath et al., 2012). Moreover, women's desire for more traditional print media in health education suggests that existing outreach materials may not be reaching their intended targets. These findings support the ongoing need for community-based health education and interventions that are appropriately tailored for underserved women (Roman et al., 2014; Russell, Monahan, Wagle, & Champion, 2007).

Findings further demonstrate that women preferred to be actively taught, rather than merely told, how to engage in proper self-care and how to access and navigate the health care system, supporting health education instructional practices guided by principles of empowerment (Wallerstein, 1998; Freire, 1996) and adult learning (Vella, 2008). In addition, participants felt that women must be encouraged to be comfortable with their bodies. They believed that clinicians and community health workers could encourage women's body awareness, for example, by employing programs that provide hands-on instruction for breast self-exam. However, suggestions such as these may conflict with state-of-the-science public health guidelines set by the U.S. Preventive Services Task Force (USPSTF) which recommend against clinicians teaching women how to perform breast self-exams (US Preventive Services Task Force, 2009).

Not surprisingly, breast cancer survivors endorsed more frequent breast cancer screening. Mammography screening intervals are an intensely debated topic among health professionals, although patients have demonstrated disapproval of USPSTF guidelines that recommend less frequent screening (Kiviniemi & Hay, 2012; Squiers et al., 2011). Mixed messaging may leave women confused and suspicious about preventive care guidelines and processes (Allen et al., 2013). Continued efforts toward appropriate health messaging are imperative, and additional research and interventions may be needed to help women become informed consumers of health information and engage participants in evidence-based, shared-decision making processes with providers (Carman et al., 2010).

Enhancing patient-centered care was a core theme of institution-level recommendations to improve health care delivery. Women advocated for providers and clinics to take a proactive, clear, and honest role in informing patients. Perhaps due to their experiences with an abnormal screening result or cancer diagnosis, participants noted the importance of conveying to women the "life or death implications" of care. Although previous research suggested shying away from using language that could raise anxiety (Cameron & Leventhal, 1995), recent studies have indicated the importance of communicating honestly and using

words such as “cancer” in conversations about abnormal screening results with patients (Simon et al., 2010). Women’s desire for improved communication and understanding may further benefit from in-person psychosocial support via patient navigators, social workers, support groups, or a “buddy” or health care “sister” to intimately guide women through their care (Phillips et al., 2014; Yosha et al., 2011).

Related to patient-centered care, participants emphasized the need for optimizing health care system capacity and resources. Shortage of linguistically and culturally diverse providers was cited as a barrier to screening and follow-up, highlighting the pressing need to increase the pipeline of minorities in health care (Smith, Nsiah-Kumi, Jones, & Pamies, 2009), from physicians, nurses, and allied health professionals to administrative staff and support persons, like technicians and patient navigators. Increasing the pipeline may also address in the long-term high demand associated with a health care talent shortage (Harris, Lewis, & Calloway, 2012; Smith et al., 2009). Notwithstanding is the concurrent need for improving cultural competence within the health care system (Betancourt, Corbett, & Bondaryk, 2014; Harris, 2010), possibly by integrating support staff (e.g., social workers, navigators) earlier and more frequently in the care trajectory. Together, these strategies may increase women’s comfort with the health care system and facilitate access and adherence to screening and follow-up.

Although study participants had access to free or low-cost screening and diagnostic services, they still discussed health care cost and health insurance barriers to breast and cervical cancer screening and follow-up. They lamented that so few women knew about the availability of free screening programs such as IBCCP. This finding is important in light of the Affordable Care Act, which expands insurance coverage and preventive care. For women newly insured, efforts are required to increase awareness of preventive services made available to them. Because some women will remain uninsured, however, access to and awareness of free screening programs will continue to benefit this segment.

Before discussing practice and policy implications, we must acknowledge the limitations of this study. First, results may be subject to recall bias, demand characteristics, or variations in interviewing style. Second, the study sample included only seven Hispanic and one Asian woman, making it difficult to explore differences among the four racial/ethnic groups included in the study. Third, the generalizability of our findings may be limited. It is possible that results disproportionately reflect recommendations from participants who had especially negative or positive medical care experiences, those with limited knowledge of the health care system who may have had difficulty articulating suggestions, or groups demonstrating extreme response tendencies. Nevertheless, we accomplished our goal of giving voice to low-income women receiving breast and cervical cancer-related care in the safety net system. Additional research with a representative sample and that systematically collects patients’ suggestions or lack of suggestions for improving access to screening and follow-up care may be needed to corroborate the results of this qualitative study.

Implications for Practice and Policy

Specific implications for practice included strengthening community-based health education with heightened health messaging, strategic partnerships, and active learning experiences to

increase patient engagement, which women regarded as a key driver of access to screening and follow-up. These qualitative findings further highlight a need for coordinated support and interventions throughout low-income and underserved communities, as women also made recommendations for increasing access by way of changes to health care delivery systems, including more direct patient-provider and patient-clinic communications, addressing delays caused by high patient volume, combining preventive services, and expanding insurance coverage. While enhancing patient-centered communication may be achievable through coordinated care, reducing clinic delays and combining preventive services may be less attainable given that safety net clinics will likely remain under-resourced. All women in this study received screening and some level of follow-up care in the health care safety net, but they still described significant barriers, nonetheless, which were reflected in their recommendations. Patients' recommendations mirror some that researchers, clinicians, and institutions have strived to implement, although existing interventions are generally short-term and incomprehensive (Community Preventive Services Task Force, 2014). Women in this study collectively desired a comprehensive approach to promoting women's health – which current efforts to engage low-income communities and implement medical home models lack, often due to inconsistent funding for sustained research and interventions.

This exploratory study gives voice to the oft-forgotten patient in the modification of clinical practice and research while highlighting a need for true patient-informed interventions to guide more relevant and appropriate care for populations. It is among the first studies to seek the patient's input in improving access to breast and cervical cancer screening and follow-up care, contributing to patient-centered care, research, and quality improvement initiatives that recognize the patient as an equal-share stakeholder in health care. Our findings demonstrate important insights from the patient lens that could help improve the acceptability and efficacy of community and clinical interventions for improving access to breast and cervical cancer screening and follow-up. Findings additionally corroborate the need for patient input in intervention design and health care systems redesign, although further research may be needed to identify appropriate integration of patient input.

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Table 1

Sample Characteristics (N=52)

	<i>n</i>	(%)
Age		
21–40	18	(35)
41–65	32	(62)
> 65	2	(4)
Race/Ethnicity		
African American	31	(60)
Asian	1	(2)
Hispanic	7	(13)
White	13	(25)
Diagnosis		
Breast Cancer	20	(38)
Breast Non-cancer	16	(31)
Cervical Cancer	7	(13)
Cervical Non-cancer	9	(17)
Language Preference		
English	45	(87)
Spanish	6	(12)
Unreported	1	(2)
Clinic Type		
Academic Cancer Center	20	(38)
FQHC	18	(35)
Free Clinic	14	(27)

Table 2**Major Themes and Recommendations**

Themes	Patients' Recommendations
Community-level recommendations: education & dissemination	
Heighten health messages	<ul style="list-style-type: none"> Health education initiatives should emphasize quality-of-life implications of early detection and follow-up
Strengthen community partnerships	<ul style="list-style-type: none"> Health education and information dissemination should be tailored to communities Community organizations and institutions should help drive health education (schools, churches, etc.)
Educate proactively	<ul style="list-style-type: none"> Disseminate educational/informational materials in print Provide detailed instruction for breast self-exam to help elevate women's body awareness Increase community awareness for state and local screening programs Provide women with practical guidance on where and how to access care
Institution- and policy-level recommendations: health care delivery systems	
Enhance patient-centered care	<ul style="list-style-type: none"> Providers should take a proactive role in educating patients about recommended care and health implications Providers should communicate diagnoses and prognoses clearly and honestly Clinics should provide yearly reminders for breast and cervical cancer screening Clinics should supplement patient visits, test results, and diagnoses with informational print materials
Optimize system capacity & resources	<ul style="list-style-type: none"> Expand care facilities, clinic sites, clinic hours, and clinic staff size Increase the pipeline of racial/ethnic minority clinicians Connect patients with social workers and patient navigators early and frequently Provide women with stronger psychosocial support throughout the care continuum
Change policy	<ul style="list-style-type: none"> Women should be encouraged to screen more frequently for breast cancer Breast and cervical cancer screening should be provided concurrently Insurance coverage should be expanded/universal Women should have access to free breast and cervical cancer screening