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WELL WOMEN SERVICES:

A PROGRESS REPORT

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C O N T E N T S

WELL WOMEN SERVICES

A PROGRESS REPORT

INTRODUCTION

Since the late 1960s and early 1970s women have been increasingly critical of the type and quality of health care offered to them, whilst seeking to raise their own awareness about their health. By highlighting the fact that women's health needs have been historically neglected and by proposing a positive approach to health, the emerging women's health movement provided the catalyst for the development of the idea of "well woman services". More recently, those concerned with the effectiveness of national screening programmes for breast cancer and cervical cancer have acknowledged the importance of well women services in improving preventive services so that women at risk, who might not otherwise come forward for screening, can be encouraged to participate.,

Women's health needs should be addressed in their own right, as a matter of concern regardless of general assumptions about women's varied caring, working and reproductive roles. It is widely acknowledged that women experience inequalities in health: the Black report commented on working class women's failure to use preventive services, such as cervical cytology, and highlighted the fact that morbidity and mortality rates are higher for working class people than for the rest of the population [1].

Women's health is affected by their cultural or religious background as well as by the economic and social conditions in which they live. For example, many women from black and minority ethnic communities experience health services which are inaccessible and insensitive to their particular needs as a result of institutional racism and ignorance. Older women and lesbians often find that their particular needs are given a low priority by purchasers and providers of health services, or overlooked altogether.

The introduction in 1988 of national screening programmes for breast cancer and cervical cancer was a step towards a strategy of preventive women's health. The recent publication of the Department of Health booklet, "Your Health: a Guide to Services for Women", is intended to be part of a planned initiative to promote women's rights and prioritise their health needs [2].

However, such initiatives seem less positive when viewed within the overall context of an underfunded health service which has been experiencing fundamental changes since the National Health Service and Community Care Act 1990, and against the background of health authorities which are making swingeing cuts to services. It is feared that women's health services could bear the brunt of the cutbacks as health authorities attempt to balance their books. Indeed, evidence of such cuts already exists: the Family Planning Association's campaign against family

planning clinic closures estimates that one in four district health authorities nationwide have made cuts or are proposing to make cuts to their family planning provision [3]; London Health Emergency has shown that well women services have been under the axe in many of London's health districts [4]; and ACHCEW's recent annual report shows that many CHCs are concerned that women are one of the many groups in the community affected by cuts in health service funding [5]. The operation of contracts has exacerbated these reductions in service as some health authorities are already refusing to pay for infertility treatment, contraception or pregnancy testing [6 7].

Clearly, concerns about the inadequate and insensitive provision of health services for women are as widespread and valid now as they were back in 1981, when the Association of Community Health Councils held a seminar in Manchester on well women centres. Following the seminar, national guidelines for well women centres were produced, looking at their function and working [8]. In 1983 ACHCEW passed a resolution at its Annual General Meeting which urged the then DHSS "to encourage Regional Health Authorities to set up a Well Woman Clinic in each Health District in order to promote good health generally and to try to give women alternatives to using drugs such as sleeping tablets, tranquillisers and anti-depressants."

The variety of subsequent developments in the provision of local services for women have reflected both the debate and confusion over what constitutes a well women centre or clinic and the exigencies of local circumstances, such as available funding, support and demand. Community Health Councils (CHCs), along with women's health groups, have played their part in collecting women's views and pressing for improvements in local provision, some being very closely involved in the establishment and management of centres.

Whilst local initiatives have taken a number of different approaches, there is no co-ordinated comprehensive national overview of the current state of well women services. Information on existing provision is patchy and incomplete. To some well women centres this very autonomy is a positive indication of their distance from conventional health services. However, there must be few centres or clinics that would not welcome more information about practice in other areas and the opportunity to share experiences, both positive and negative.

This report does not set out to fill the information gap in an exhaustive sense; the transient nature of many well women services makes such a task virtually impossible. However, it aims to assess the extent to which ACHCEW's guidelines have been adopted and adapted at a local level and to consider the reasons underlying obstructions or delays in progress towards the development of well women centres in certain health districts, particularly in the light of demonstrable demand from local women. Where centres and clinics have been set up, the report examines whether services are appropriate to the whole range of women's needs or whether some women are still effectively excluded.

The specific focus on the effectiveness or otherwise of well women services also serves as a particularly cogent example of the chasm between Government policy, which claims to put the "consumer" paramount, and the reality. The vagaries of the internal market in health care may not prove the most conducive environment in which to develop flexible and sensitive services for women. A more direct impact on well women services has been effected by the introduction of the GPs' Contract in April 1990, which encourages GPs to provide well women clinics as part of services within general practice.

Whilst developments such as these, compounded by cuts in existing services, threaten to undermine the achievement of comprehensive well women services, it is still heartening to see examples of activity where lay and professional women are working together to provide sensitive, accessible and empowering services for local women. This report seeks, first, to highlight the key characteristics of the current state of well women services and secondly, to make recommendations for maintaining and improving existing services whilst ensuring that demand, in areas where provision is poor or non-existent, is acted upon by NHS authorities, according to the needs and wishes of local women.

1. ACHCEW NATIONAL GUIDELINES 1982

Following the seminar held by ACHCEW in Manchester in 1981 on well women centres, national guidelines were produced [9]. These were intended to be fairly broad, with room for modification according to local circumstances and it was recognised that they represented an ideal description of a well women centre.

The philosophy underpinning the guidelines was, "the promotion of health and well-being of the whole person" and the centres were to provide an "excellent opportunity for the early detection of disease or malfunction, as well as arresting the onset of psychosocial problems". The emphasis was placed on prevention rather than cure, with women being encouraged to take responsibility for their own well-being. For this reason, the word "centre" was chosen in preference to "clinic", which has associations with medicine and ill-health.

Aims and objectives

A key objective of the proposed well women centres was "to reach women who may otherwise stay away from their doctor because of class, cultural or religious difference. Many women do not wish to attend Family Planning clinics on religious grounds, are afraid of attending Cervical Cytology clinics or are unwilling to be examined by male GPs. Frequently GPs do not have the time or the skills with which to deal with women's health needs."

The main aims of well women centres were put forward as follows:

- to provide a service specifically for women which meets all their health care needs;

- to provide this comprehensive service in a relaxed and friendly atmosphere;

- to provide an accessible service available to all women;

- to provide a service run for and by women.

However, it was stated that well women centres would not seek to treat, but would instead refer women to their own GP, or to a specialist if the GP agreed. The intention was for well women centres to be complementary to other primary care services.

Services provided

The guidelines suggested that centres would provide a variety of medical screening, such as cervical cytology, breast examination, vaginal examination, blood pressure, rubella, urine, sickle cell, thalassaemia and weight, including the opportunity for women to learn self-examination techniques. Family planning advice, sensitive to the needs of all types of women, would be available, based on both medical expertise and information provided by lay staff.

Counselling was seen as an integral feature of centres as a way

of enabling women to help themselves. Counselling was defined in this context as "helping a woman define her own problems and responding to her needs in an empathic and/or sympathetic way, enabling her to make informed choices." Counselling could cover a range of problems, such as trauma following a major surgical operation (mastectomy, hysterectomy), cystitis, the menopause, pre-menstrual tension, miscarriage, abortion, rape, sexual relationships, depression, unemployment, smoking, alcoholism and housing and financial difficulties. By looking at the emotional well-being of the individual, counselling would extend, "the medical model of health to incorporate the social model."

It was envisaged that self-help groups would be set up in centres as "an invaluable source of mutual support for and by women themselves" on a range of topics that would be determined by the women attending. Women would have access to any relevant information at the centre. Another plank of the preventive health approach was that of health education/promotion whereby each woman would be encouraged by the health care team to enhance her health awareness. In addition to plenty of written information (in appropriate languages) and videos on health issues and patients' rights, women's health courses were also suggested by the guidelines. In particular, it was felt that each woman, together with members of the health care team, could draw up a health profile as a result of a straightforward but comprehensive questionnaire covering medical history, lifestyle and quality of life. This would be used as the basis of a programme for the woman to take steps to improve her health and emotional well-being.

Client groups

The guidelines advocated that well woman centres should try to meet the health needs of a comprehensive range of different types of women by providing appropriate services, thus attracting, for example, older women, women under 16, women from minority ethnic communities, single women, lesbians and disabled women.

Premises and opening hours

The emphasis was placed on flexibility: premises were to reflect local circumstances (such as a shop front in the high street in urban areas and a mobile service in rural areas) and opening hours were to make the centres as accessible as possible, for example providing evening and weekend as well as weekday sessions. Informality was another aim, with drop-in arrangements running alongside an appointment system, where possible, with tea and coffee available to women attending. The provision of creche facilities was seen as a fundamental requirement of any flexible and accessible service.

Staffing

The guidelines envisaged that centres would have both female health care staff as well as lay helpers. The health care team would include a health visitor, receptionist, counsellor, doctor and community health worker, all trained in counselling skills.

Setting up the service

Various strategies for identifying the needs of local women, putting forward proposals for funding and gaining the support of other interested parties are suggested. The guidelines state that, "a merger between, for example, a cervical cytology clinic and family planning clinic does not comprise a Well Women Centre but it is a starting point."

2. DIFFERENT MODELS OF WELL WOMAN CARE

This last statement provides a useful perspective from which to assess the debate around definitions of what exactly comprises a "well women centre" or "well women clinic". There are no universally agreed definitions, although some commentators have attempted to produce them [10 11]. To a large extent, the terms used to define a service can be rather misleading unless the actual service provided is examined, for example, a health authority might rename a "cytology clinic" a "well women clinic" although the services have not changed. In terms of the ACHCEW guidelines, a holistic model including considerable medical input was advocated.

It is perhaps more useful to look at the two ends of the spectrum between purely medical and purely holistic services to identify the key elements that characterise the different type of services that can be provided. Most NHS well women services are clinics organised around a medical model of health, offering free contraceptive services and screening services, cervical cytology screening [12]. Whilst some of these clinics have more recently begun to offer additional advice on weight, smoking and breast examination, the approach is still very much a medical one. Staffing usually comprises a doctor (usually female) and a nurse or health visitor. Any attempt to undertake a more holistic approach to women coming to the clinic is difficult to achieve other than in a piecemeal fashion.

In contrast, a more radical approach has been developed in some areas, notably the North West of England, towards well women centres which are in fact outside the NHS and have little or no medical input. The emphasis is very much on equal participation by women working in and attending the centres, with lay women playing interchangeable roles in terms of advice-giving, counselling, self-help, health promotion and information provision. Centres are often of a drop-in nature and encourage informality and a relaxed atmosphere. Funding is sought from sources outside the NHS and the use of volunteers is usually key to the success of such centres.

The report will later attempt to look at why different approaches have been adopted and their various degrees of success in terms of providing an accessible and sensitive service.

3. DEMAND AND CONSUMER FEEDBACK

Firstly, it is important to note that whilst the debate about the most appropriate type of service continues, local women are very clear that they want, and would use, some kind of well women service. There is undoubtedly a demonstrable level of unmet need which is not being addressed in anything other than an ad hoc manner. Whilst the range and extent of well women services has varied so widely in different parts of the country between the radical holistic model and the very limited medical model, what has remained remarkably consistent throughout is the high level of demand by local women for more services altogether, whether limited or more progressive. Both national studies and local surveys by CHCs provide ample evidence of this.

For example, Leathard's study showed overwhelming evidence that most CHCs, prompted by consumer demand and local pressure, would like women's health care to be developed along the lines of well women centres and clinics [13]. Similarly, the results of a national survey of women in Britain by the National Council of Women in 1990 [14] showed that when asked which facilities they would use if they were available at their GP's practice, 68% said they would use a well women clinic. Among those women aged 25-34 the figure was 80% and for those aged 35-44 it was 79%.

Many CHCs have identified the need for well women centres and have carried out local surveys to assess the demand for and satisfaction with well women services. Some of those involved include North Tyneside, Macclesfield, Swindon, Scunthorpe, South Birmingham, North Tees and South Tees, Newcastle, South Cumbria, North Lincolnshire, Bath, Norwich, Torbay, Waltham Forest, Sheffield, Grimsby, East Cumbria, Basildon & Thurrock, Great Yarmouth & Waveney, Manchester North, South & Central.

Examples of some of the findings can be seen in Table 1 on p. 8. It can be seen that, whilst the demand from local women for some form of well women service is clear, CHCs have taken different approaches to the question of whether the service required is the more medical model in a health or GP clinic or whether there is a need for the more holistic type of centre.

These varying approaches are illustrated further by a more detailed look at a sample from Table 1.

TABLE 1

Demand for well women services: some CHC findings

Name of CHC	Date	Method	Type of service favoured
East Cumbria[17]	1982	survey	well woman service
N. & S. Tees[15]	1983	survey	clinic
South Cumbria[16]	1983	survey	clinic, esp. mobile service for rural areas
North Lincs[18]	1983	survey	clinics
Waltham Forest[19]	1983	survey	centre
Grimsby[20]	1985	interviews	well woman service
North Beds	1986	survey	clinics
Bath[21]	1986	survey	clinics (see below)
Great Yarmouth	1987	public meeting	mobile service and centre
Scunthorpe[22]	1988	survey	centre
S. Birmingham[23]	1990	survey	clinics (see below)
Sheffield	1990	conference	clinics, centres, mobile service (see below)
C. Manchester	1991	campaign	clinics (see below)

South Birmingham CHC, whilst conducting a survey of recently delivered mothers resident in the district, asked mothers about the level of awareness of and opinions on well women clinics. Most women said they would find the service useful if it was available, although the CHC found that there was a need for greater publicity about the location and type of service available - about a third of the women asked had no idea what well woman clinics were and of those who thought they knew, many had very limited perceptions as to the type of service provided.

Bath CHC's investigation of well women clinics followed the redesignation of the existing cytology clinics with a wider screening and counselling remit. Whilst there was general satisfaction with the service, the overall level of knowledge of the clinic facilities was fairly low, and the take-up levels showed that there was a need for more sessions. The survey also highlighted the need for more, targeted publicity, particularly for women who do not normally go to their GP for advice or screening. The CHC felt that the clinics were geared more towards gynaecological issues rather than the "whole" woman and that the needs of older women were not fully addressed, for example, with the provision of counselling on the menopause.

Central Manchester CHC is currently involved in drawing together women from different agencies and from local communities in grassroots activity, including a series of women's health information days, to co-ordinate support for well women services. Both South and North Manchester have well women clinics, but at present women in Central Manchester do not have a service.

Milton Keynes CHC's ethnic minorities working group has urged the DHA to provide well women centres with particular attention to opening hours when women from minority ethnic communities would be able to attend, as well as a mobile service.

Sheffield CHC was recently involved in a "Health for All" conference in Sheffield for community and voluntary groups. Two workshops on women's health needs run by the CHC identified, among other things, the mismatch between needs and resources, the lack of respect for women's needs and the enthusiasm for a women's health centre/well woman centre/mobile service.

4. AN OVERALL PICTURE?

The variety of provision makes comparisons very difficult and this is partly why evaluation of the overall picture is not being given sufficient attention. However, a number of studies have attempted to look at provision on a regional or nationwide basis and have revealed wide variations in practice. For example, Jo Richardson carried out a survey of District Health Authorities (and health boards in Scotland) in 1987 for the Labour Party [24], and of the DHAs which responded, 52% stated that they had some form of well women clinic or centre, whilst 47% had none. The survey identified a total of 381 clinics/centres varying from those providing family planning and smear tests to those providing extensive screening and counselling. Overall, it seemed that many were inaccessible, unprogressive and lacking in publicity: only five centres were open on Saturdays and only three of this five were open every Saturday; less than a quarter offered evening sessions on any day of the week and many opened irregularly; only one in five were based on a holistic or semi-holistic model; and lack of advertising and awareness of the service was often a bigger problem than lack of funding.

Although CHCs have often played a positive role in encouraging the establishment of new services, the survey pointed out that in some cases, clinics or centres were set up as part of a negotiation between the CHC and DHA and were not necessarily in line with the original wishes of local women. Negative attitudes on the part of DHAs were also encountered - half of the DHAs which had no clinics or centres felt that such services were "unnecessary".

The survey report by Audrey Leathard, also in 1987, for the Family Planning Association, looking at CHCs' assessment of local family planning needs included a question on well women clinics and centres [25]. The report noted some difficulties assessing levels of provision because of the confusion surrounding the terminology and definition. This said, 85 out of the 120 DHAs returning questionnaires provided some facilities, although mainly only family planning and cytology services. It is interesting, if not surprising, to see that the perceptions of CHCs varied widely; some were looking specifically at holistic well women centres, whilst others considered cytology clinics roughly equivalent to well women clinics. Differences in perceptions still exist amongst CHCs as will be shown later in this report.

More specifically, as part of a project on self-help and health in 1988, Tina Posner looked at self-help groups associated with well women centres [26]. From 31 centres which replied, this study found "evidence of considerable support for self-help activity based in the centres and of a lay/professional partnership which helped to provide for women's health needs". Only four centres replied that they had no links with the health authority, whilst the remainder received a variety of support in terms of finance, staffing, premises and members on the management/steering committee. Seven of the centres were directly run by the DHA.

These attempts to piece together a national picture highlight the range of local services. This review looks more closely at this variation in order to find out why developments have differed so widely in their approach. The reasons are often more complex than a simple question of whether funding and support are available and are substantially influenced by the underlying ideology about the best method of providing a well women service. It is also important to look at the factors which make well women centres so popular and different from other women's health services.

Although very few have been subject to independent evaluation, many centres and clinics recognise that they are still not fully meeting the needs of all women locally and that some groups of women do not find the services accessible. There are also some commentators who consider that the development of less progressive forms of service are actually undermining efforts to provide more radical and holistic services [27].

The following information has been gathered from both CHCs and women working in centres and clinics. The different types of provision looked at are: well woman centres with little or no medical input, on the periphery of the NHS; well woman centres with some medical input; health authority well women clinics; and well women clinics run as part of general practice. In practice, some of the examples do not fit neatly into these categories and it should be noted that the rather artificial demarcations are intended as a tool towards examination rather than over-simplification. The perceived advantages and disadvantages of the various types of service are also explored.

5. TYPES OF WELL WOMAN PROVISION

a) Well Woman Centres - on the periphery of the NHS

This type of centre has generally been set up by women frustrated with efforts to establish a comprehensive well women service within the NHS. Some examples of well woman centres with little or no medical input are as follows:

North Tyneside Well Woman Centre is run by local women volunteers of all ages and is completely independent of the NHS. There is no professional input at all in the running of the centre - all the work is done by volunteers, including three nurses who currently come to help at the sessions as volunteers and because of their belief in the work of the centre. The centre offers a different topic each week on some aspect of women's health and well being. Recent examples include relaxation, addictions, anxiety and depression, breast screening and menopause support. The centre also offers listening and counselling on a one-to-one basis, for which all its members have received some training. In terms of information, the centre also has a good library of books to lend out and leaflets to give away. The centre received a one-off grant payment from North Tyneside Inner Areas Department in 1985 and have free use of the clinic premises. The centre works closely with the CHC.

Wakefield Well Woman Centre provides mainly advice, support and counselling services, with no medical work except for pregnancy testing. Run by volunteers with no paid workers, the centre has free premises independent of the health authority. A creche is available and the centre is fairly accessible, with one morning and one afternoon session a week. The CHC was involved in setting up the centre. Attempts to publicise the centre more effectively are under way.

Chorley & South Ribble Well Woman Centre, set up with the involvement of the CHC, is again run mainly by volunteers on a sessional basis and is independent of the health authority. **Bolton** has a very similar centre, although its afternoon sessions are held at a housing advice centre and its morning sessions are held in an old church hall.

Blackburn Well Woman Centre has no medical facilities bar those for taking blood pressure and pregnancy testing. The centre used to have a rota of doctors who came in once a week, but now has a health visitor for one session a week provided by the health authority. In addition to the volunteers who undergo training courses, the centre currently has an outreach worker with funding for four years and funding for a development worker to undertake fundraising work. The centre is particularly interested in attracting Asian women and the outreach worker, who is Asian, hopes to be able to address this. The centre also has listeners and provides advice and information as well as self-help groups, particularly on the menopause and pre-menstrual syndrome. Funding sources have been the Inner Area Programme and DHSS Opportunities for Volunteers, so the centre is not dependent on

health authority funding.

Lancaster Well Woman Centre is run mainly by volunteers and was set up with the help of the CHC. It has both pre-arranged sessions and drop-in sessions, providing a creche, counselling and information on various topics.

Discussion

Arguments in favour of these types of centres focus on their "independence" from the health service and the absence of a medical presence, which can often leave women feeling disempowered. By providing no or few medical services, the centres can enable women to see their health within a more holistic context rather than in terms of a collection of symptoms relating to their reproductive roles and biological make-up. In positive terms, the centres provide relaxed, informal surroundings in which women are given as much time as they need to discuss and learn more about their particular needs which often extend beyond their direct health concerns. Women are encouraged and given the support to take more control over their health and therefore in other areas of their lives too. The use of volunteers and high levels of lay involvement are seen as a positive step towards challenging the medical hierarchy; an understanding of the philosophy underpinning the notion of empowerment in the centres is as important as any formal qualifications.

However, several drawbacks have been highlighted by women involved with this particular approach. Firstly, the heavy reliance on volunteer staff has meant that many of the centres experience difficulties in ensuring continuity of provision and stability of services. One volunteer pointed out that the opening times of sessions are dependent upon the number of volunteers available and a rota is used to try to ensure these are as frequent as possible. Secondly, it is not clear to what extent volunteers receive the support and training needed to ensure a good quality service. Moreover, the use of volunteers could also be seen as yet another way in which women's work is unpaid and their commitment exploited.

Another concern is that of centres' perceived independence from the mainstream health service. In some cases, this independence is not a conscious choice, rather the centres could not get funding from the health authority approached. For those which positively choose to work outside the apparent bureacracy of the NHS, it can be argued that they are not addressing change and tackling the root of the problem within health service, where the real power lies. Whilst centres in this position are not tied to the priorities of the health authority, security of funding is often more precarious and they may have to spend much precious time fundraising just to survive on a shoestring budget. Women able to spend time and perhaps some of their own money in fundraising activities are usually the more articulate, well informed middle class women, rather than those who have the greatest need.

Most of the centres admit the need to publicise their services more widely and appropriately if they are to be successful in attracting women with the most pressing health needs, such as older women, women from minority ethnic groups and working class women. The use of interpreting services, for example, would be one way of providing a more accessible service for women whose first language is not English. A further criticism of this type of centre has been that some women feel inconvenienced when they discover that there are no screening services available; for example, some of the women attending the Chorley and South Ribble centre want a smear test and choose to go to the Preston Well Woman Centre which provides this service. Whilst some centres have chosen not to provide screening services, others would be willing to expand if the resources were forthcoming.

b) **Well Woman Centres - linked to the NHS**

Other centres achieve a combination of a holistic approach to women's health, whilst retaining some link with the NHS, whether by providing some medical services, such as screening for cervical cancer and breast cancer, or by receiving funding from the local health authority. Although relatively few such centres have been developed within the NHS, they come closer to the model proposed by ACHCEW's national guidelines. Some examples are as follows:

Rochdale Wellwoman Centre offers pregnancy testing, counselling and confidential information and advice during one evening session per week. The centre is based in the Health Education Unit and receives a grant from the DHA.

Southampton Well Woman Centre runs two drop-in centres, each open for one four-hour session per week. Whilst one centre has a doctor working voluntarily once a month, it does not have the facilities for taking smears. The other centre previously used health visitors but now has no medical input. This is more because of circumstances (lack of resources and insurance cover) than ideology. The health authority has recently withdrawn funding from the centre, leaving the future rather precarious, but the centre is constantly struggling to achieve permanent funding - the CHC has tried to persuade the DHA in this direction so that the centre can concentrate on more long-term planning. The centre provides a wide range of services, including advice on social security benefits and assertiveness training. It works closely with Asian groups in the community and has plans to produce a video with local Asian women on the menopause

Preston Well Woman Centre has premises provided free by the Borough Council and receives a health authority grant, although previous funding for the centre's part-time link workers is no longer available. The centre is more accessible than some, being open from Monday to Friday, 10am -4pm. Appointments are needed to see the medical staff (doctor, health visitor, community psychiatric nurse and clinical psychologist) whilst for women coming to the centre for counselling, advice or information, no

appointment is necessary. The centre has undertaken a considerable amount of outreach work, with a portable couch which can be taken to other organisations where smears can be carried out - the centre also has a mobile caravan which can be used to advertise the centre's activities and hold screening sessions. The centre's services can also be taken to disadvantaged wards of the town. The centre's development worker is particularly trying to consolidate contacts with women in the Asian community.

Thamesdown Area Well Woman Centre is run mainly by volunteers, supported by two part-time paid workers, with medical services provided free by the NHS. The centre has positively addressed the issue of accessibility: it has disabled access; can provide interpreters by request; provides an Asian health worker once a month; and produces leaflets in Urdu, Punjabi, Gujarati, Polish and Italian.

In the same district, Swindon CHC was recently involved with a rural well women initiative aimed at assessing the need for well women services in rural areas. Meetings were held at venues in six rural villages in and around Marlborough and whilst considerable interest was expressed for well women services, there has not yet been any positive action from the health authority.

Sheffield Women's Health Bus is an example of a mobile well women service. It provides screening and health education for women most at risk from preventable diseases and death and those who are least likely to make use of the conventional services, whether because of their class, culture or the lack of a female doctor. The bus targets women between the ages of 35 and 65 and women who live in areas of socio-economic deprivation where there are high levels of morbidity and mortality. The mobile service also helps to contact women in minority ethnic communities.

Grimsby Well Woman Centre operates on premises provided free by the local authority. Although fairly successful, the local CHC considers that more development is required in terms of health profiles and that there should be more involvement by the health authority, particularly the female clinicians. Another centre has opened in Immingham - a much needed resource in a deprived area of the district, although women attending meetings and courses have to contribute to the costs. This centre is not, however, known as a well woman centre because of objections from local GPs who said it could detract from GP well woman clinics.

Calderdale Well Woman Centre was established following a CHC report and recommendations to the health authority - one year's funding from the DHA was achieved and whilst this has gradually been cut altogether, the local authority now contributes a small sum. The lack of funding prevents the centre from being open continually. Plans are underway to obtain a bus to provide a mobile service.

Salisbury Well Woman Centre is run from health authority premises provided free, even though the grant has been withdrawn. The centre provides full medical services in addition to counselling and self-help groups.

Stockport Well Woman Centre is open during one evening session a week on a drop-in and appointment basis. Both medical and non-medical staff assist in facilitating self-help and discussion groups.

Southend Well Woman Clinic was originally set up by a group of women volunteers and now has premises provided by the health authority. Voluntary funding for the clinic is raised by the women themselves and another branch of the clinic has been set up in what is considered a socially disadvantaged area to the east of the district.

The well woman clinics in **Wythenshawe** and **Withington** in Manchester are further examples of services which closely follow the ACHCEW guidelines. Wythenshawe Well Woman Clinic, set up in 1981, was the first of its kind in the North West, where lay women were encouraged to participate alongside the medically experienced workers. Many women's health groups soon adopted it as the model of the sort of service that they would like to see available in their own communities [28]. Funding is very much on a shoestring and the clinic is run largely by volunteers. Ironically, the success of the clinics has made them less accessible; there is a waiting time of six weeks for an appointment although initially the clinics operated a drop-in policy and women wishing to use the clinics must also live within the district.

In North Manchester, the **Women's Health Team**, set up by the health authority as a resource and information centre, has been running successfully for over five years. The team provides some direct well women services, such as a drop-in session with creche facilities, women's discussion groups, an advice telephone line and training for women's health workers and local well women centres and clinics. It also acts as a central reference point for well women centres and refers women to their nearest centre. In addition to these services, the team liaises with other agencies and women's groups in the district and helps to identify the health needs of local women. The team has made particular efforts to attract women with children, carers, Asian women and black women, older women and young women.

A new development in well women services in North Manchester for young women is the Young Women's Advice Information and Time to Talk Project (**Y-WAIT**), which was set up in 1990 [29]. Run from a community centre by girls and young women aged between 14 and 25, and open from 4-8pm one evening a week, the well women clinic hopes to provide a confidential service to girls and young women who do not like using the existing clinics because they cater for "adult" women and are too formal.

In Liverpool, there is a telephone helpline, **"Healthwise"**, from which women can get general non-medical advice. A woman doctor

is also available for callers to speak to if they so wish. This is not intended as an alternative to a consultation with a GP, but is intended to encourage women to take such matters up with their GP. The phone-line is open Monday-Friday, 10am-10pm on 0800 223322.

Finally, but perhaps most interestingly, an exciting new development in well women services is taking shape in the form of the **Women's Health Centre, Hammersmith**, London. Capital from the Department of Health AIDS Support Grant has been approved for the centre to be developed along social/medical lines, with family planning, genito-urinary and ante-natal services running alongside one another. Key to the development of the centre is the fact that HIV services will be integrated at every level of the centre's work as part of a comprehensive preventive strategy within a primary health care model. Negotiations over staffing levels and premises are ongoing, although Riverside Health Authority will provide clinical staff and it is hoped that a key post will be jointly funded by the health authority/local authority to foster maximum collaboration. The centre also hopes to involve HIV women's organisations and women from the local community in the planning of services for the centre.

Discussion

Whilst the problems of securing funding and stability in staffing are as pertinent for many of the above centres as for those with few or no links with the NHS, they are seen by some women in the field to have distinct advantages over centres which do not provide any medical services. For example, the availability of cervical cytology screening is welcomed by many of the women attending and is particularly important for those women who, for a variety of reasons, normally stay away from conventional health services. The mobile screening and advice centres are of benefit to women in remote rural areas, women with disabilities and women from minority ethnic communities.

The centres' relationships with their health authorities vary considerably: some have a very positive relationship, with stable support in terms of the provision of premises, staff and funding, while others are more wary of interference by the health authority in the running of the centre. It is unlikely that health authorities will provide more services or funding while some centres and clinics manage to survive on voluntary funding.

c) Health Authority Well Woman Clinics

The two other main forms of well woman service provision are either in a health authority health centre or clinic or based in a GP practice. The first example of an "experimental" clinic in Glasgow is considered in some detail, because it is a rare example of a community well woman clinic within the NHS that has undergone a transformation from a medical model to a social model providing a comprehensive service [30].

The Ballantay Project was, "an attempt to alter a well woman clinic based on paternalistic values into one which reflects those of the women's health movement" [31]. The project tried to follow ACHCEW's guidelines to widen the scope of existing well woman clinics within Glasgow, which were not attracting the women most in need, that is, older women, women from minority ethnic groups and socially and economically deprived women. With three years' funding from the Scottish Home and Health Department, the project team was comprised of two doctors, a sociologist and a health education officer.

The clinic where the project took place was in a large council estate in the south east of Glasgow, where there was a multiple level of deprivation and many single-parent families living in the area adjacent to the clinic. The clinic was typical of its kind in a working class area; poorly attended and vulnerable to closure.

The "experiment" mainly involved, "altering the appearance and atmosphere of the clinic, introducing nonmedical services, providing health education in a novel manner and restructuring the clinic routine to increase consumer responsibility" [32]. The project highlighted some of the problems which the project team workers encountered in trying to transform the service. For example, attempts to reduce bureaucracy in the clinic by making the waiting area more homely, with posters, plants, curtains, free tea and coffee and chairs informally grouped were resisted by staff. The more informal setting, with the use of "services sheets" for women attending, self-help groups, leaving doors open, the lack of appointments and enabling women to use the staff kitchen were also initially opposed by the staff. Other changes resisted at first were the fact that women were allowed access to their records and that staff had little privacy because of the open access approach. However, following a staff change in doctors and over a period of time, the staff became more receptive to this approach.

Another difficulty experienced during the research was that the very popularity of the clinic meant that women experienced delays in the waiting room and the atmosphere was chaotic and noisy, particularly as the creche was not used as much as expected and many women preferred to keep their children with them. Eventually, it was agreed to hold an extra morning session to cater for the extra demand. In the evaluation, the project team felt the project did not really reveal the extent to which women felt responsible for their own health, as the evaluation did not have the optimum amount of consumer input.

In spite of these drawbacks and hurdles, the project was viewed as a notable success, both in the eyes of the Health Board in terms of providing a more efficient service (number of attenders and services used) and by the women attenders who were interviewed. The project team felt that they had succeeded in fulfilling the majority of ACHCEW's guidelines; a new and more positive health environment had been created in the clinic and expert knowledge was more broadly spread across the staff at the clinic. It was acknowledged that the staff had had to work against the system they were used to working within, but that the four keys to success were: training for staff; the clinic co-ordinator; counselling; and the "services sheet" for women enabling informed choice. This model has since been adopted elsewhere, both locally and in other parts of Scotland and serves as an excellent example of the innovations that are possible within the existing system.

A snapshot of the provision of well woman clinics by health authorities in England and Wales is as follows:

Ealing - the CHC would like to see a well woman clinic developed in each locality, but at present there is just one which has been re-established, open once a month in Southall, where there is a large proportion of Asian women.

Barnet CHC reported in 1988 on the effect of the recent amalgamation of well women and family planning services in the district. Whilst most of the women interviewed were happy with the services, staff were less satisfied, particularly as the amalgamation meant a cut in the number of sessions and therefore remaining sessions were much busier.

Macclesfield - following the CHC's survey in 1985 on the need for well woman clinics, a number of clinics were opened throughout the district in 1987, based on the existing cytology clinics. Despite being well attended, funding for the clinics was withdrawn less than a year later. Interim money was raised by a local trust fund and in 1989/90 well women services were reinstated into the health authority short term programme, but the trust fund still supplements health authority funding.

Bexley has a series of well women clinics run in health authority clinics by health visitors. Lack of publicity has meant a low take-up in some of the clinics, although to some extent a low profile has been sought to avoid any negative interference by the health authority.

South Glamorgan health authority organises a number of well woman clinics in a mixture of clinics and health centres, whilst in **West Glamorgan**, there is only one NHS well woman clinic, held weekly by appointment only, where women are allocated a twenty minute consultation period and tests such as blood pressure, weight and cervical smears may be taken.

Since the CHC's proposals for a well woman centre in 1985, **Torbay** health authority has set up a number of well person clinics, which, according to the CHC, include all aspects of care for women.

Norwich health authority has just one well woman clinic, operating two sessions per week. Open since 1985, the clinics success is indicated by the current four week waiting list and the age range (16-80+) of women attending, which includes some from outside the district. The all women staff include two doctors, a health visitor and a receptionist. Women are seen on a one-off appointment only basis which allows them a confidential and unhurried consultation with both the doctor and health visitor. Women are referred to their own GP if any further medical treatment is necessary. The atmosphere is relaxed and women have access to much health-related literature - free tea and coffee are provided by a volunteer group. However, it appears that this clinic could be under threat (see p.26).

Waltham Forest health authority now provides three women's health clinics, which include counselling services as well as screening. According to the CHC, these are well attended and quite well publicised, but still fall short of the original demand by the CHC for services under one roof in the form of a well woman centre.

East Cumbria District Health Education Department have, over the last couple of years, been undertaking a well woman clinic initiative. An evaluation report in March 1990 of a pilot clinic in Botcherby recommends that: with more involvement of lay women in the running of the clinics, with more extensive and effective advertising, with the possible inclusion of a needle exchange scheme and with a shift in the availability of the service to a more accessible time, the pilot clinics should be extended in the form of satellite clinics throughout Carlisle.

Basildon & Thurrock health authority runs three well woman clinics, which the CHC has helped to publicise. Due to the demand, well woman support clinics were set up throughout the district, financed by the borough council with staff provided and paid for by the DHA. Numerous sessions held, usually in the evening, included the menopause, smoking and women's health and some sessions provided creche facilities. However, due to lack of local authority funding, the support clinics closed at the end of March 1991.

Burnley, Pendle & Rossendale DHA set up eleven women's health clinics in 1985, run from health centres by community doctors and district nurses. The counselling service is not actively publicised and there have been suggestions from women attenders that the clinics could provide more of this.

Bristol & Weston Health Authority undertook a very interesting pilot project in the form of four new well woman drop in centres in Bristol, reported in 1989 [33]. A nursing sister, health visitor, physiotherapist, social worker and clerk/co-ordinator travelled to four different centres each week, only one of which

was a health clinic. The centres were held in areas of high unemployment where the women were known to carry heavy burdens associated with low incomes and poor housing. Cytology screening was not offered, but counselling was a key element in the service. Advice on relaxation techniques, diet and excercise were particularly welcomed by attenders in addition to other health promotion advice. The centres were fairly successful in attracting women over the age of forty - they accounted for 41% of all clients. However, funding has not been renewed for the pilot centres.

Islington health authority appears to have been the first to set up a well woman clinic in 1973, at Highbury Grange Health Centre, expanding the existing cervical cytology clinics to embrace a more holistic approach. Four more health centres now also provide sessions, excluding those held in GP practices. However, there is no dedicated well woman centre in Islington.

In **South East Kent** the health authority has set up well woman clinics, largely as a result of pressure from the CHC. However, the CHC is concerned that these are not as well attended as they should be and are still not attracting women who would not normally go to their GP.

Due to demand from local pressure groups and the CHC, Wirral health authority set up the **Seacombe Well Woman Clinic** in 1983. There are plans to rename it a well woman centre to reflect a broadening out of service. The clinic attempts to integrate a service approach with a self-help model, combining input from both voluntary and professional workers. In an evaluation report in 1989 of the clinic's success, the following constructive criticisms were included among wider recommendations about expanding the well woman service in the district: there was a need for more sessions and more time during sessions (women were experiencing long waits for appointments); the location should be more accessible in terms of getting there and for women with a disability; the clinic needed to set specific objectives in order to meet the needs of women who are socially and economically disadvantaged, women with disabilities, black and minority ethnic women, young women and older women. In addition to the Seacombe clinic, there has since been the development of a well women centre at St Catherine's Hospital, Birkenhead.

Liverpool DHA is currently looking at its well woman services provision, in the light of some underuse of the service and in particular, is considering the integration of family planning with well woman services. The health authority previously funded a study into the awareness and use of well woman services in Liverpool that was reported in 1989, making interesting comparisons between DHA and GP clinics by examining the rate and type of women attending and their satisfaction with the service[34]. The DHA and GP clinics were attended by less than 6% of the Liverpool female population aged between 15 and 64. Demand for the clinics was found to be high, although it would be higher if more evening sessions were held. The report points out that there needs to be effective liaison and collaboration between health authority clinics and general practice without

jeopardising confidentiality or threatening the continuity of primary care.

In particular, the fourteen health authority clinics studied were found to be very popular, despite long waiting lists, waiting times and the somewhat inconvenient opening hours. Aspects of the service which were particularly welcome were that all the staff were women, staff attitudes were welcoming and relaxed and there was plenty of time during the appointment to ask questions.

Although the clinics were particularly well attended by women aged 25 to 44 and reached some of the women who normally have little contact with preventive health services, it was noted that they do not reach many women over the age of 55. The report also found that , "women in poorer parts of the inner-city and outer-estates, who are in semi-skilled and unskilled occupations and households, are particularly poorly represented amongst well woman clinic users", in spite of the fact that they are at the greatest risk of ill health. The report suggests that this could be partly explained by the lack of walk-in facilities, as forward planning, telephone access and tranpsort are needed to make and keep an appointment. Moreover, as the report states, "For many women in difficult circumstances and with family commitments, their own health may be low on a long list of competing demands and externally-determined priorities, particularly when clinic waiting lists are long, and treatment cannot be given when a problem is identified."

In the eleven GP clinics examined, attenders seemed to value the continuity of care which their own GP gave and the familiarity with their background and medical history. GP clinics appeared to address a wider range of health issues, although there was a greater prevalence of gynaecological and physical problems in the records of GP clinics in comparison to DHA appointments. GPs in clinics also had the advantage of being able to take immediate action if any problems were identified.

The Liverpool study is a useful starting point for a discussion on the relative merits of different types of well woman provision, particularly in terms of provision within a general practice setting.

d) Well Woman Services in a GP Setting

Since the introduction of the GPs' contract in April 1990, many GPs have set up "well woman clinics" (see next section on the GPs' Contract). To some extent, the debate prior to this has therefore been somewhat overtaken by events. However, one of the strongest proponents of general practice based well woman care was Dr Katy Gardner [35]. As part of a report of the findings from a three-year review of a well woman clinic within an inner-city general practice in Liverpool, she argues that, "The well woman clinic functions both as a screening service and a self-referral service, a combination possible only within general practice. The advantage is that prevention and treatment are not separated." Gardner states that, although it would be

interesting to see well woman clinics run by the DHA in inner-city areas, the ultimate goal is an extension of general practice in terms of time and facilities available in order to provide this kind of service.

What is not addressed is the fact that such a service tends to attract only those women who already go to their GP. The article concedes that the practice failed to achieve its aim of attracting more women from social classes IV and V. Moreover, it does not tackle the question of choice; some women welcome the anonymity of a health clinic or centre and would still feel awkward or embarrassed discussing some matters with their GP. As Craddock et al have pointed out, not all GPs regard counselling within their remit and many still see well woman services purely in medical terms.

Jessop et al [36] have also put the case that if joint well woman sessions are held in general practice with a woman clinical medical officer and counsellor, and a general practitioner available to consult and to prescribe when necessary, the benefits to the women clients would be considerable. This service is envisaged as being complementary to existing family planning clinics and general practitioner consultations and would encourage a more integrated approach to primary care.

In fact these proposals formed the basis of what became the **Well Woman Project at Shoreditch Health Centre** in City and Hackney Health Authority. It is worth examining this very positive example of well woman provision taking a holistic approach within the NHS structure, as the experience illustrates both the drawbacks and benefits of this approach. The well woman sessions were established in 1985 to provide a service targetted at women over the age of 40. The project's three aims were to develop a model for offering this type of preventative service, to explore ways of working collaboratively with GPs and to integrate research and evaluation into service development. Using both local research and ACHCEW's guidelines as background, it aimed to meet the psycho-social needs of local women.

Originally, the project was aligned to the GP practice, but eventually the disparity in philosophy between the project workers and the GPs was such that formal links were severed. However, since then, the clinic has continued to be mainline funded as part of the Directorate of Maternity, Obstetrics and Gynaecology. Staffing now comprises a nurse practitioner, a health worker, a clerk and a counsellor. The staff also have a close working relationship with a community gynaecologist who works outside the clinic, but to whom referrals are made when necessary. Whilst the project targets women over forty, it also attracts younger women. There is approximately a two week wait for appointments, which are held twice a week, once in the afternoon and once in the evening.

The interests of the women coming to the sessions have led to the formation of a number of groups running for several weeks on subjects such as the menopause, eating disorders, stress and relaxation. As most of the women who come to the groups are

workers, the project recognises the need to target women who do not work, but who would benefit from such groups, although they may at first lack the confidence and energy to attend.
The project's outreach work, in addition to building links with community groups, involves the use of a health mobile provided by the DHA. This provides a well woman clinic once a week and is taken out to venues of the project's choice, in addition to being used for health promotion work. For example, a group of Asian and Turkish women took the mobile to their own meeting and provided interpreting services, as the project itself does not have this service. The project has good links with the local CHC, with whom it organised a public meeting on the menopause.

Another branch of the project is due to open in the north of the borough where there is a large homeless population, with many people living in bed and breakfast accommodation. Few are registered with a GP and many cannot find a GP with the appropriate language. The well woman project is exploring the possibility of funding for an advocacy worker in this regard.

Whilst it is recognised by project workers that there are restrictions working within the bureaucracy of the NHS, it is felt that this varies enormously according to the health authority's commitment and available funding. It is felt that by developing a new and positive model of how well woman care can be organised within the NHS (although outside a general practice setting) it is possible to influence current policy and practice within the health authority.

6. LACK OF PROGRESS

It is important to stress that the above examples of radical and more limited provision are not representative of the general level of development in well women services. It is more common for little progress to have been made and for local women's groups and the CHC to see their demands fall on stony ground. Below are some examples of the type of difficulties being experienced in areas where little or no progress has been made in spite of CHC activity and evidence of demand from local women. Some obstruction finds its roots in arguments that funding is not available whilst some health authorities still refuse to recognise that the services are necessary.

For example, in South Gwent, the DHA has consistently refused to consider the idea of establishing comprehensive well woman clinics. Similarly, East Suffolk CHC is concerned that no further progress has been made with regard to well women services. In Cambridge, the current climate with regard to women's health services generally is so bleak that, in its annual report last year, the CHC wrote that, "the high hopes of the Well Women movement seem rather naive - like asking for jam when there is no bread." In North Lincolnshire, consistent pressure was placed on the CHC to tone down its demands by the managers and professionals following the CHC survey which called for well women clinics. Unfortunately, this was an example of CHC weakness rather than strength and the CHC compromised its

original aims by agreeing that the DHA should undertake a pilot scheme for a Well Persons Advisory Centre - hardly a well woman clinic.

Two years ago, Hastings CHC asked their health authority to consider developing a well women's centre. However, the DHA felt that this would be a duplication of the family planning services and services offered by GPs and were not, therefore, prepared to devote any scarce resources to developing services for women any further. This indicates the extent to which the DHA lacked an understanding of the fundamental differences between the two sources of provision.

Bath also has negative news; since the CHC's survey into well women services in 1986, family planning and well woman services have suffered a reduction, the former having sessions reduced by over 30% throughout the district and specifically designated well woman sessions have been withdrawn altogether. Women attending the family planning clinics can book specific appointments for "well women services", but these only include cervical smear tests and breast cancer screening.

Most recently, Central Manchester CHC's campaign proposals for a well women service were turned down by the health authority.

7. EFFECTS OF THE GPS' CONTRACT 1990

In April 1990 the new General Practitioners' Contract was introduced, which, as part of a thrust towards more preventive health, included the financial incentive for GPs to set up their own health promotion clinics. It appears that in many areas GPs are running well woman (and well man/well person) clinics under this arrangement. Ironically, whilst encouraging GPs to undertake a wider role in promoting the wellbeing of users, the contract has arguably resulted in a restriction of choice for some women and the introduction of clinics which fall far short of the genuine well woman service envisaged by ACHCEW's guidelines. Of equal concern is the effect of the growth of GP well woman clinics on any health authority plans to develop more comprehensive well woman services in the community.

Financial incentives

There is little doubt that the financial incentive of £45 per clinic is one that many GPs have been swift to take advantage of. It is clearly in the GP's interest to refer a patient to a clinic rather than to offer free advice in surgery time. Indeed one GP has admitted that she cannot help regarding her patients for their financial potential [37]. The huge earning possibilities of health promotion clinics is illustrated by a two-partner practice in Coventry, which earned more than £6,000 from clinics in one quarter [38].

This has particular relevance when looking at well woman services, because GPs can profit from encouraging as many women as possible to attend a well woman clinic. Not only will the GP

make money from holding the clinic, but there is the added bonus that women attending might agree to a cervical smear test, therefore boosting the GP's chances of reaching her or his screening targets for cervical cancer for which she or he will receive further payment.

Aside from the drive to persuade women to attend a GP's well woman clinic, there have been examples of women who have felt pressurised into having a smear test by the GP, or even being threatened with removal from the GP's list if they do not comply. This is a blatant threat to a woman's choice about whether or where she has a cervical smear test, and largely stems from the inflexible screening targets which have led some GPs to such over-zealous and cynical measures.

Whilst it is a welcome fact that more GPs are beginning to recognise the importance of providing more well woman services, the current growth in GP well woman clinics should, nevertheless, be viewed with caution. The motives behind this development stem more from the opportunity for financial gain than a philosophical commitment to the priniciple of a comprehensive well woman service that enables women to take control of their own health.

Monitoring

Not only can the contract encourage some GPs to exert undue pressure on women to attend well woman clinics, but there is also an alarming lack of evidence that the clinics are being effectively monitored for the quality and effectiveness of service. A recent study by the Centre for Health Economics argues that there is little evidence to support the cost-effectiveness of many of the procedures for which extra payment is made [39]. Although the authors concede there may be value in some of the health promotion clinics which some GPs choose to run, they criticise the lack of regulation of such clinics. FHSAs are able to determine whether or not a GP is eligible for remuneration for a particular clinic and whether or not it meets the specifications laid down by the Department of Health. For example, in some areas, GPs had been allowed by the FHSA to see patients on an opportunistic basis, rather than all at one session. In November 1990 the Government issued a directive to demand tighter protocols and ban aggregated sessions. However, the Department of Health announced that from July 1st GPs will be able to earn health promotion fees by aggregating smaller sessions with as few as three patients. However, opportunistic screening will still not be valid in terms of remuneration.

Whilst tighter protocols are to be welcomed, it is still not clear whether regulations will apply to the quality of service provided, or simply to the number of attenders and length of time spent at a clinic. The disqualification of aggregated sessions was of particular concern to GPs in rural areas, where it has proved difficult to succeed in attracting enough people at one time to a clinic, because of transport difficulties and the inaccessibility of some practices. For example, North Bedfordshire CHC wrote to the Secretary of State for Health,

William Waldegrave, asking him to allow local FHSAs the maximum flexibility in the way they fund and arrange such clinics. Comments from local practices in the district illustrated problems experienced:

"Very difficult to arrange ten patients per session, particularly with well-woman clinics - patients frequently cancel appointments due to menstruation etc."

"I have not applied for health promotion clinic status, because it would be impossible to get ten women per week in a single-handed practice."

It was also pointed out that the stricter regulations would deny some people choice as to when they could attend for well woman clinics. This runs completely counter to the ACHCEW guidelines which recommend that centres are run on a drop-in basis as well as by appointment.

ACHCEW would welcome the development of national guidelines which set out the key elements that a comprehensive well woman service by GPs should provide. This should include guidelines on how the clinics could be more accessible, attract women who do not normally go to their GP, provide counselling as well as screening services, offer the opportunity for women to participate in discussion groups and learn more about their own health. CHCs could play a role here in questioning their FHSA about protocols for such clinics and pressing for tighter monitoring of the well woman service being provided. For example, West Glamorgan FHSA will be undertaking a patient survey of GP services with regard to the views of women on this type of provision and other CHCs may wish to encourage their FHSAs to undertake similar work.

Staff training

The use of practice nurses has been greatly increased by many GPs to enable them to provide the wider range of services encouraged by the new contract. In relation to well woman clinics, it is important that staff are suitably trained to provide this particular service, for example in counselling skills. An integral element in a comprehensive well woman service is the opportunity women attenders have to join self-help and discussion groups and it is not apparent that GP well woman clinics are providing this aspect of the service, particularly if women are seen on an individual basis for a limited amount of time. Indeed, it is questionable whether some GPs have the necessary training in group skills to facilitate this process. Similarly, there is a gap in GPs' training with regard to the broader aspects of women's health that go beyond physical checks such as screening of the breast and cervix.

Women GPs

One of the main criticisms that many women make about existing health services is that they would prefer to see a female doctor. In 1988 only 21.8 per cent of GPs were women, even though equal numbers of men and women qualify from medical school [40].

Although the Government claimed that the new contract would attract more women to general practice, there are others who claim the opposite.

For example, the Medical Women's Federation conducted a survey to find out how FHSAs were interpreting the new rules in relation to GPs' terms of service and their hours of availability [41]. Under the contract, full-time and part-time GPs have to be available to patients for a minimum number of hours a week, varying from 13 to 26. However, some FHSAs have specified that all GPs should hold evening surgeries. For some women GPs, domestic commitments are such that it is very difficult for them to hold evening surgeries and, as a consequence, some have resigned from general practice. Similarly, the inflexible way in which targets for cervical cytology screening and child immunisations are organised has meant that some women working part-time are at a disadvantage in trying to meet their targets and therefore lose out in terms of payment. These are clearly disincentives to women GPs and do not signpost a dramatic increase in the numbers of women who will be entering general practice.

Effect on wider provision of well woman services

Whilst it is a step forward in one sense for GPs to provide more well woman services in the form of well woman clinics, it could also be a step backwards in terms of the longer term development of comprehensive well woman provision in the community. Not only are the clinics being set up by many GPs a far cry from the guidelines produced by ACHCEW, but they have also provided health authorities with a rationale, though fundamentally flawed, for postponing any further progress towards establishing local well woman centres.

For example, West Essex CHC stated, "the health authority does not provide any well woman centres, preferring to advise women to attend either family planning clinics or their GP." Whilst Harlow Council does fund a well woman centre in the district, and there is currently an application for joint funding for the centre being considered, it is expected that it will be considered a low priority because the FHSA states that GPs are already providing well woman clinics. In Bexley, some under-use of existing health authority well woman clinics is thought by the CHC to have some connection to the increase in clinics run by GPs.

In Norwich, the Director of Community Services told the CHC that since the introduction of the GP contract, well woman services are available within general practice and a health authority well woman clinic would be a duplication of services. Moreover, it was claimed that the growing number of women GPs meant that a women only needed to change to another practice to avail herself of the services of a female doctor. Apart from the fact that in such a district with a large rural element it is sometimes impossible to change to another practice, there are only 33 out of 81 practices with a female GP and the geographical spread is unlikely to make them accessible to all women.

This example alone shows that the growth of GP well woman clinics does not satisfy the need that women have expressed for a local centre where a comprehensive range of services under one roof is provided by women staff. To reiterate an earlier point, there are some women who do not wish to see their GP about particular problems and who prefer the anonymity of a health centre. Many GP well woman clinics rely on the existing call-up cervical screening programme to invite women to attend and therefore fail to reach women who do not normally go to their GP, often those who are more at risk of ill-health. Similarly, a time-limited appointment system deters women who might otherwise drop in to a well woman centre at their own convenience.

8. CONTEXT OF GOVERNMENT POLICY AND LEGISLATION

The current focus on the "consumer" perspective, as put forward in the National Health Service and Community Care Act 1990 and corresponding white papers, twinned with the role of health authorities in assessing the health needs of the local community before purchasing the necessary services, should provide a powerful springboard for the development of a more comprehensive well woman service. If users' needs and demands are to provide the rationale for service provision, health authorities should be paying very serious attention to the expressed needs of local women.

In practice, the more overt process of "rationing" services which has been a by-product of the internal market of health care has made it clear that this type of service for women is seen by many health authorities as a low priority in the scramble for scarce resources. Exacerbating this lack of priority is the fact that the self-help philosophy of women's health, as the bedrock of many of the well woman centres, has dovetailed neatly with the Government's emphasis on the individual taking responsibility for her or his own health. This provides a convenient rationale for those in charge of the pursestrings to cut funding to services which can apparently survive by their own efforts. This vicious circle needs to be broken if well women services are to become more widely accessible within the NHS.

Government commitment to the provision of well women services is questionable. The Department of Health's recent guide to women's health services, in booklet form, made no specific reference to well women services other than to the possibility that GPs may provide well woman clinics [42]. No mention is made of well women centres which provide a more holistic service. One of the key aims of a comprehensive well woman service is to try to attract women who stay away from the health services available to them, for example women from black and minority ethnic communities. It is notable that the Department of Health booklet, despite including a section on women from minority ethnic communities, has not been made available in any languages other than English.

CONCLUSIONS

The main features of this review of well women services may be summarised as follows:

** WIDE VARIATION in the type of well woman services being developed continues with no central co-ordination or overview.

** INNOVATIONS WITHIN THE NHS are possible, as the Ballantay Project and the Shoreditch Well Woman Project aptly illustrate. Centres operating on the fringes of the NHS with little or no health authority funding continually face an uncertain future, usually relying on the unpaid work and commitment of local women.

** NEED FOR MORE ACCESSIBLE AND BETTER PUBLICISED SERVICES is recognised, even within those well-established centres and clinics. Women who tend to stay away from their GP are still not sufficiently aware of and involved in the running of well women services.

** DEMAND for well woman services on a larger scale and on a more comprehensive basis is as strong as ever, but there is a poor response to this demand by health authorities.

** CUTS IN WOMEN'S HEALTH SERVICES AND THE GPS' CONTRACT are undermining women's health choices. Health authorities are reducing provision (eg family planning clinics, pregnancy testing and infertility treatment) in attempts to balance their books. They commonly claim that separate well women centres are superfluous, as GPs provide a similar service, even though this falls far short of ACHCEW's guidelines for well women services.

This review has highlighted the current diversity of well women services, whilst looking at the relative merits of the various types of provision. There are clear examples of positive developments taking place, within the structures of the NHS, that signal the possibilities for future provision. The demand for a more accessible and comprehensive service is clear, as are the benefits accrued from a preventative approach; these cannot continue to be ignored if health authorities wish to avoid making shallow promises about assessing the needs of their local populations and buying services appropriately.

The argument, eagerly picked up by health authorities, that GP well woman clinics have usurped the need for any wider health authority provision fails to grasp the fundamental functions of well woman centres: a holistic service for women, by women, under one roof, that aims to attract women who do not normally go to their GPs. GP well woman clinics will continue to flourish in quantity if not quality as long as there is a financial incentive for GPs.

RECOMMENDATIONS

In order for progress to be consolidated and the threats to a comprehensive well women service to be challenged, **ACHCEW makes the following recommendations with regard to both community-based and GP-based services:**

** NHS purchasing authorities should seek the views of local women on existing or potential well women services and assess their needs and preferences, taking into account any relevant information already gathered by local CHCs;

** NHS purchasing authorities should provide the necessary funding and support for the development of accessible and comprehensive well women services, according to the needs and preferences of local women;

** NHS purchasing authorities should also provide sufficient resources to enable more effective promotion and publicity of existing well women services, particularly to target women who are less likely to visit their GP;

** CHCs should continue to highlight to purchasers the need for a comprehensive well women service where little or no progress has been made to date, and should challenge, where appropriate, attempts by NHS purchasing authorities to reduce the level of existing services

** Volunteers should receive some form of training and support, perhaps by "shadowing" an experienced worker for a period of time.

Specifically in relation to GP-based well women services, ACHCEW recommends that:

** National guidelines should be developed by the Department of Health, in keeping with the philosophy behind ACHCEW's guidelines, setting out the essential elements of a comprehensive GP well woman service that goes beyond a basic screening service, including the provision of counselling, self-help groups and an opportunity for women to participate in discussion groups;

** GPs and practice nurses should receive training in counselling and group work skills in order to provide a comprehensive well woman service;

** FHSAs should examine the protocols put forward by GPs for well woman clinics in the light of the national guidelines and monitor the satisfaction of women using the service;

** CHCs should monitor and comment on the effectiveness and consistency with which FHSAs apply the national guidelines.

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