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TORONTO
Public Health



Engaging Seldom or Never Screened Women in Cancer Screening

*A compendium of pan-Canadian best
and promising practices*





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South Riverdale Community Health Centre
955 Queen St. E.
Toronto, ON M4M 3P3
Phone: (416) 461-1925
E-mail: srchc@srchc.com

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Funder

Public Health Agency of Canada

Advisory Committee Chair

Linda Muraca, Marvella Koffler Breast Centre, Mount Sinai Hospital

Advisory Committee

Carling Barry, Centre for Independent Living Toronto

Nancy Barry, Centre for Independent Living Toronto

Gillian Bromfield, Canadian Cancer Society

Margaret Fitch, Odette Cancer Centre, Sunnybrook Health Sciences Centre

Younglee Ha, KCWA Family and Social Services

Grace Ho, South Riverdale Community Health Centre

Roberta (Robbi) Howlett

Gina Ing, Toronto Public Health

Susan Larsh, Cancer Care Ontario

Maria Lee, South Riverdale Community Health Centre

Working Group

Grace Ho, South Riverdale Community Health Centre

Gina Ing, Toronto Public Health

Maria Lee, South Riverdale Community Health Centre

Linda Muraca, Marvella Koffler Breast Centre, Mount Sinai Hospital

Project Coordinator

Aggie Mazzucco

Research Coordinator

Felicia Tan



ACKNOWLEDGEMENTS	iii
EXECUTIVE SUMMARY	1
INTRODUCTION	3
METHODOLOGY	7
LITERATURE REVIEW	13
PROMISING PRACTICES BY PROVINCE	
Northwest Territories	
Northwest Territories Demonstration Program of the Integrated Strategy in Healthy Living and Chronic Disease Risk Factor Campaign	26
British Columbia	
Pap Screening Clinics with Aboriginal Women in Skidegate, Haida Gwaii	28
The Screening Mammography Program (SMP) of British Columbia	30
Self-Collection of Specimens for HPV Testing in Hard-to-Reach Women	32
Alberta	
Aboriginal Breast Cancer Screening Resource Toolkit.	34
The Vocational and Rehabilitation Research Institute (VRRRI) Simply Health: The Breast — Health for Women	36
Saskatchewan	
Connecting the Breast Cancer Community	38
Our Lives Through Our Eyes.	40
Promoting a Healthy Lifestyle in Your Community Resource Kit.	42
Manitoba	
Dr. W.C. Wiebe Clinic Reserved Booking Project	44
The Early Detection is Your Best Protection Recall Fact Sheet.	46
Improving Access to Breast Screening for First Nation Women from Small, Isolated Manitoba Communities	48
Multicultural Outreach: Cancer Education and Screening Project.	50
Reduce Your Cancer Risk Facilitator Tool Kit with DVD	52
Ontario	
50 Over 50 Challenge	54
Aboriginal Breast Health Train-the-Trainer Program	58
Be a Breast Friend Salon Project: Health Promotion in a Non-Traditional Setting.	60
“Because I Care...” Postcard and Incentive Campaign	62
Breast Health Informational Events and Bus Trips for Low German Speaking Mennonites in Southwestern Ontario.	64
Building Breast Healthy Neighbourhoods (BBHN)	66
CDP Cancer Prevention and Screening Program	68
Check It Out Guys: The Trans Men’s Pap Campaign.	70
Check It Out: Queer Women Need Paps Too!	72
A Community-Based Intervention to Increase Screening Mammography Among Disadvantaged Women at an Inner-City Drop-In Centre	74
Community Capacity Building Project	76
Consensus Guidelines for Primary Health Care of Adults with Developmental Disabilities	78
Developmental Disabilities Primary Care Initiative	80
Female Sexuality Education Program.	82

Gateways to Cancer Screening: A Participatory Needs Assessment of Women with Mobility Disabilities	84
Greater Toronto Area (GTA) Cancer Prevention and Screening Physician Campaign Strategy	86
Hand in Hand: Breast Cancer Prevention Project.	90
Immigrant Women’s Health Centre Mobile Health Clinic Program	92
Increasing Breast, Cervical and Colorectal Cancer Screening Awareness and Participation in the Arabic and Somali Communities	94
Joy Luck Women’s Project (Phase 1)	96
Joy Luck Women’s Project: Building Capacity (Phase 2)	98
The Lay Health Educator Breast Screening Program (LHEBSP)	100
Lay Health Educator Program aka Screening Saves Lives Program	102
Let’s Take a Stand Against ... Colorectal Cancer!	104
The Making of the <i>Fotonovelas</i>	106
The Making Us Visible Peer Education Program.	108
Northwestern Ontario Breast Screening Mobile Program	110
OMNI/Rogers Women’s Cancer Initiative for Multi-Ethnic Communities	112
Promoting Cancer Screening and Prevention in the Workplace (Toolkit)	114
Promoting Cancer Screening in Chinese Communities in Ontario	116
Scarborough Breast Health Community Action Project	118
Somali Community Breast Health Project.	122
South Riverdale Community Health Centre Women’s Screening Clinic	124
A Tailored Intervention to Promote Breast Cancer Screening among South Asian Immigrant Women	126
Women’s Health Educator Program	128
Your Health Matters: Ethno Cultural Project	130
Quebec	
The Use of Mobile Screening Units to Reach Women Living in Remote Areas	132
New Brunswick	
Over 40 Screening Program	134
Pink Parties	136
Stanley Health Centre Primary Care Practice	138
Well Woman Program	140
Nova Scotia	
Nova Scotia Breast Screening Program (NSBSP) Mobile Breast Screening Service.	142
Using Data and GIS Technology to Understand Uptake and Target Interventions	144
What Women Want: One Stop Team Based Cancer Screening	146
Prince Edward Island	
Screening Awareness Project Initiative: getscreenedpei.ca	148
Newfoundland and Labrador	
Site Specific Planning	150
Well Women’s Clinic	152
WORKING TOWARD BEST PRACTICES	155
CONCLUSION	161
REFERENCES.	163
INDEX	171



This compendium is a starting point in a new, national — and uniquely Canadian — conversation on improving both access to equitable healthcare and cancer screening participation across the country, for all women.

Most Canadian provinces and territories have programs to screen for breast, cervical and — to a lesser, but growing, extent — colorectal cancer. Despite such initiatives, however, some groups of women are less likely than others to participate in cancer screening, and are much more likely to experience unfavourable outcomes from these diseases. These populations may include, but are not limited to:

- Newcomers to Canada and immigrant women
- Older women
- Rural and geographically isolated women
- Disabled women
- Low-income women
- Aboriginal women
- Women of low literacy or whose first language is not English
- Women who self-identify as lesbian, bisexual, queer, questioning or two-spirit, and
- Trans women, trans men and intersex people (where screening may be indicated).


Across Canada, community and health agencies have developed a wide range of innovative and effective practices to reach seldom or never screened women. To the best of the project team's knowledge, however, there have been no organized, cross-country, attempts to document and share these practices, the majority of which occur at the grassroots level.

This project addresses this gap in knowledge.

The **Pan-Canadian Best and Promising Practices to Engage Seldom or Never Screened Women in Cancer Screening** project has collected and compiled a wealth of Canadian practices to increase awareness of and participation in cancer screening for underserved populations.

By creating a comprehensive overview of 61 such practices, this project's aim is to help community and health agencies and providers, health promoters, provincial/territorial cancer prevention and screening programs, researchers, educators, policymakers, government, decision-makers and funders in their efforts to engage seldom or never screened populations in cancer screening. Ideally, this compendium will:

- Facilitate national collaboration and sharing of resources
- Recognize and highlight the wealth of successful practices to improve awareness of and participation in cancer screening for underserved and often marginalized communities
- Allow agencies and researchers to make efficient use of their limited resources by harnessing and adapting the successes of their peers across the country, and
- Expand and strengthen a network of Canadian community and health agencies and researchers to further share experiences and best and promising practices.



The scope of this project was limited to women, but did include trans women, trans men and intersex people as recommended by stakeholders.

As a broader, longer-term goal, it is hoped that this compendium will eventually contribute to increased cancer screening participation, and to reductions in morbidity and mortality associated with breast, cervical and colorectal cancers for all Canadian women.

Two main **methodologies** were used for this project:

- A comprehensive **literature review** to identify practices aimed at increasing awareness, intention to screen and screening uptake for breast, cervical and/or colorectal cancer in underserved populations, and
- An **environmental scan** to identify Canadian practices to engage seldom or never screened women.

Taken together, the literature review and 61 practice descriptions provide rich information and insights on strategies and programs to engage seldom or never screened women in cancer screening. A comprehensive summary for **working towards best practices** is included, with specific suggestions and points on:

- Relationship building and community engagement
- Communications with target audiences, as well as between and among stakeholders
- Enhancing accessibility, self-efficacy, self-advocacy and empowerment in target populations
- Program design
- Program evaluation
- Engaging healthcare providers in programs to promote screening
- Integrating data and technology into program design and evaluation
- Managing human resources, and
- The role of funders and sustainability planning.

The Pan-Canadian Best and Promising Practices project has seen extraordinary support and buy-in from agencies with a mandate for engaging seldom and never screened women in cancer screening. In creating this resource, what has become evident is not only the remarkable breadth, diversity, commitment and creativity of Canadian programs that promote cancer awareness and screening participation for underserved populations, but also program providers' overwhelming eagerness to share and learn about their own and others' successes. Hopefully, this compendium will serve as a springboard for future efforts aimed at engaging seldom or never screened populations.



Introduction



Across Canada, community and health agencies have implemented a wide array of effective, tailored programs to increase awareness of and participation in cancer screening among women who seldom, if ever, engage in regular screening. To the best of the project team's knowledge, however, there have been no organized, cross-country attempts to document and share these successes, the majority of which occur at the grassroots level.

This project seeks to address this gap in knowledge.

The **Pan-Canadian Best and Promising Practices to Engage Seldom or Never Screened Women in Cancer Screening** project was conceived to collect and share effective strategies to increase awareness of and participation in cancer screening. By creating a comprehensive overview of such practices, our aim is to help community and health agencies and providers, health promoters, provincial/territorial cancer prevention and screening programs, researchers, educators, policymakers, government, decision-makers and funders in their efforts to engage seldom or never screened populations. Ideally, this project will:

- Facilitate national collaboration and sharing of resources
- Recognize and highlight the wealth of successful practices to improve awareness and cancer screening participation for underserved and often marginalized communities
- Allow agencies and researchers to make efficient use of their limited resources by harnessing and adapting the successes of their peers across the country, and
- Expand and strengthen a network of Canadian community and health agencies and researchers to further share experiences and best and promising practices.


The scope of this project was limited to women, but did include trans women, trans men and intersex people as recommended by stakeholders.

As a broader, longer-term goal, it is hoped that this compendium will eventually contribute to increased cancer screening participation, and to reductions in morbidity and mortality associated with breast, cervical and colorectal cancers for all Canadian women.

ABOUT THIS DOCUMENT

This compendium contains information on the need for the Pan-Canadian Best and Promising Practices project and the background events leading to its creation. It outlines the project's methodology, specifically, a literature review and environmental scan. The literature review provides a summary of evidence-based research on best and promising practices aimed at increasing awareness, intention to screen and screening uptake for breast, cervical and/or colorectal cancer. The environmental scan identified 61 successful, customized practices that agencies across Canada undertook to engage seldom or never screened populations in cancer screening. Descriptions of these promising Canadian practices make up the bulk of this document.

Each practice description provides detailed information on target audience, program focus and setting, theoretical background, goals and objectives, as well as program implementation steps, scope and



reach. Formal and informal evaluation results and key findings are included. Importantly, each description includes a list of critical factors for adaptation, as well as challenges and lessons learned. Where available, program links and contact information are provided to encourage the sharing of resources and the building of networks.

In the “Working towards best practices” section, a summary of key messages gleaned from the literature review and practice descriptions has been included to distill the collective wisdom and experience of the authors and program providers. This section can serve as a useful starting point or checklist for agencies as they plan and implement initiatives to engage seldom or never screened women in cancer screening programs.

This document is intended as a guide and is not an exhaustive representation of the practices across the country. Ideally, users of the document will consider the needs, values, attitudes and preferences of individuals and groups of women, use clinical judgment, and work with available human, financial and healthcare services and resources in their settings. While this compendium was developed using the best available evidence, it is incumbent upon program providers and implementers to stay current in this rapidly changing field.

BACKGROUND: THE NEED FOR THIS PROJECT


WHY PREPARE A COMPENDIUM OF BEST AND PROMISING PRACTICES?

From 2002 to 2006, the South Riverdale Community Health Centre (SRCHC)ⁱ (Toronto) and partner agencies implemented a series of projects to engage underserved women in cancer screening. This current initiative builds on the success of the Joy Luck Women’s Project (see page 96); Phase II of the Joy Luck’s Women’s Project (see page 98); and a third phase, Building Breast Healthy Neighbourhoods (see page 66).

As a result of the success of these projects, agencies in other provinces (including Alberta, Manitoba and Nova Scotia) approached SRCHC to share ideas, program resources and expertise to supplement their outreach efforts. Gaps in literature — as well as limited human and financial resources — mean that many program providers struggle to find the best strategies to reach underserved groups and to meet their diverse and challenging needs. Requests for assistance — and the agencies’ restricted capacity to develop and evaluate similar programs and materials — suggested that there was a strong need for a compendium of best and promising practices. Such a document would optimize the use of limited resources while capitalizing on the often untapped, and often unrecorded, wealth of excellent programs across the country.

In 2009, SRCHC, Mount Sinai Hospital’s Marvelle Koffler Breast Centre and Toronto Public Health partnered with key advisors from the Canadian Cancer Society, Cancer Care Ontario, Centre for Independent Living of Toronto, KCWA Family and Social Services and Odette Cancer Centre, Sunnybrook Health Sciences Centre, to put forward a proposal for funding to develop this project.

ⁱ As a community health centre, SRCHC prioritizes work with marginalized communities. It provides primary healthcare, offered from an equity and determinants of health approach.



This project has been realized thanks to funding received by the Public Health Agency of Canada.

INEQUITIES IN CANCER SCREENING AMONG MARGINALIZED POPULATIONS

Most provinces and territories in Canada have cervical and breast cancer screening programs. Colorectal cancer screening programs have recently been implemented in a few provinces, with more expected in coming years. Regular cancer screening can prevent and/or detect cancer at an early stage. If cancer is detected and successfully treated, morbidity and mortality can be significantly reduced.

Despite the availability of screening programs and the proven effectiveness of cancer screening, participation rates vary across the country. In recent years, breast and cervical screening rates in several provinces have reached a plateau, and there is room for higher screening participation for all three cancers.

Further, research indicates that, in Canada — and in many other countries — some groups of women are less likely to participate in cancer screening, and are much more likely to experience unfavourable outcomes if diagnosed with breast, cervical and colorectal cancer.¹⁻¹⁵ Seldom or never screened populations may include, but are not limited to:¹⁻¹⁶

- Newcomers to Canada and immigrant women
- Older women
- Rural and geographically isolated women
- Disabled women
- Low-income women
- Aboriginal women
- Women of low literacy or whose first language is not English
- Women who self-identify as lesbian, bisexual, queer, questioning or two-spirit, and
- Trans women, trans men and intersex people (where screening may be indicated).

Novel and targeted approaches are needed to further improve screening participation rates and to reach seldom or never screened populations. This document highlights dozens of such customized approaches, so that agencies across the country can learn about, draw on and, hopefully, replicate their peers' successes.

The Pan-Canadian Best and Promising Practices project has seen extraordinary support and buy-in from agencies with a mandate for engaging seldom and never screened women in cancer screening. In creating this resource, what has become evident is not only the remarkable breadth, diversity, commitment and creativity of these agencies and programs, but also program providers' overwhelming eagerness to share and learn about their own and others' successes. It is hoped that this compendium will serve as a springboard for future efforts aimed at engaging seldom or never screened populations.



Methodology



DEFINITIONS AND TERMINOLOGY

For both the literature review and the environmental scan, an assessment toolⁱ was used to distinguish between “best practices” and “promising practices.” A best practice is, in brief, a practice that has demonstrated effectiveness through the use of appropriate, well-documented research or evaluation methodologies and can be replicated, adapted and/or transferred. A promising practice is less rigorously evaluated than a best practice but still offers ideas about what may work well in a given situation.ⁱⁱ

Based on the assessment, all 61 practice descriptions included in this document have been classified as promising practices, mainly because they were not evaluated at the levels required for best practices. While best practices to engage seldom or never screened women in cancer screening may well exist in Canada, the methodology undertaken did not reveal them. The inclusion of promising practices captures a range of dynamic initiatives that may otherwise have gone unnoticed and that may be useful and relevant in a pan-Canadian context. As well, promising practices were included in an effort to address the dearth of Canadian published literature in this field and to recognize that many agencies have limited resources to allocate to evaluate program outcomes.

For the purposes of this project, “unscreened” and “never screened” both signify that a woman has never had a recommended screening test. “Seldom screened” or “underscreened” mean that a woman has been screened at least once, but not for the recommended duration and/or at intervals longer than recommended by evidence-based screening guidelines.

LITERATURE REVIEW

The literature review provides information about programs that have been comprehensively evaluated. It highlights trends apparent in the research that can both inform/guide the development of evidence-based practices and be translated into initiatives targeting seldom or never screened women across Canada.

SEARCH STRATEGY

A search of published articles was conducted using Scholars Portal, Academic Search Premier, Medline and PubMed. The databases were searched from the earliest record to 2009. To be included, studies needed to

- Be aimed at increasing screening uptake, intention to screen and/or knowledge of breast, cervical, and/or colorectal cancer
- Employ quantitative or qualitative methods
- Focus on women from underserved groups (including newcomers and immigrant women; older women; rural and geographically isolated women; disabled women; low-income women; Aboriginal women; women who self-identify as lesbian, bisexual, queer, questioning or two-spirit; and trans women, trans men and intersex people)
- Be applicable and relevant to public health practice in Canada
- Be published in a credible, peer-reviewed journal

ⁱ The Canadian Diabetes Association’s assessment tool can be accessed at: <http://www.diabetes.ca/files/NOV23Teleconference/AssessmentToolDec407.pdf>

ⁱⁱ The Canadian Best Practices Initiatives Background Methodology can be accessed at: <http://cbpp-pcpe.phac-aspc.gc.ca/pubs/CBPI-methodology.pdf>

- Be published in English or French
- Have been conducted in Canada, the United States and Australia, and
- Provide sufficient information in terms of population addressed, goals and objectives, methodology, results, study limitations and other pertinent data.

The studies' reference sections provided additional sources of articles. Out of 114 studies found, 68 were considered the most relevant.

CLASSIFICATION

The quality of each study was assessed based on six components: selection bias, study design, confounders, blinding, data collection methods, and withdrawals and dropouts. The assessment tool was adapted from the tool used by the Canadian Diabetes Association to identify "best" and "promising" practices in diabetes education.ⁱⁱⁱ These ratings were then used to categorize the published studies. For the purpose of this literature review, studies that received at least four strong component ratings and no weak rating were classified as "best" practices (i.e., strong study quality), while those that received fewer than four strong component ratings and no more than one weak rating were classified as "promising" practices (i.e., moderate study quality). This categorization was conducted to capture intervention studies (e.g., pilot studies or studies with innovative ideas) that might not possess the required qualities of a strong intervention study (e.g., having adequate statistical analysis and sample size and a randomized, controlled study design) but might provide valuable information for the development of health promotion strategies.

ENVIRONMENTAL SCAN

In order to be as comprehensive as possible in identifying past and current Canadian best and promising practices to engage seldom or never screened women in cancer screening, the Pan-Canadian Best and Promising Practices project researched unpublished "grey literature" that documented initiatives across the country, often at a grassroots level, and conducted outreach with national, provincial/territorial and community-level agencies with a mandate for outreach to seldom or never screened populations.

RECRUITMENT STRATEGIES

Numerous strategies were employed to inform this project and to ensure pan-Canadian recognition and participant recruitment, including:

- Conducting key informant interviews
- Distributing printed and electronic communications materials
- Establishing a toll-free project line
- Participating in pan-Canadian, provincial/territorial and regional conferences and meetings
- Recruiting national, provincial/territorial and community champions, and
- Other strategies, such as joining relevant listservs, attending program launches, etc.

ⁱⁱⁱ The Canadian Diabetes Association's assessment tool can be accessed at:
<http://www.diabetes.ca/files/NOV23Teleconference/AssessmentToolDec407.pdf>

Key informants

Key informant interviews were conducted with experienced and respected leaders in breast, cervical and/or colorectal cancer prevention and screening to:

- Inform our project protocol and recruitment strategies
- Identify pan-Canadian, provincial/territorial and community programs and contacts
- Endorse the project through personalized outreach to colleagues, and
- Maximize buy-in and participation across Canada.

As well, the project advisory committee consisted of representatives from a diverse group of reputable partners with mandates for outreach to seldom or never screened women and strong local and national networks. The advisory committee greatly enhanced the process, outreach capabilities and outcome of this project.

Project communications

Printed and electronic communications materials, such as a backgrounder, bilingual announcements and postcards, were developed. Overall, more than 500 postcards were distributed. Advertisements were placed in publications, newsletters, bulletins and websites (e.g., the Ontario Health Promotion E-Bulletin and GTA Cancer Prevention and Screening Network WebEx). Individual and agency contacts were identified based on their relevance to cancer screening and prevention (or related areas) and/or seldom or never screened populations. These included, but are not limited to, community and health agencies and researchers, funders, provincial/territorial cancer boards and screening programs, regional cancer centres, public health units, hospitals, non-profit organizations, community health centres, women's centres, disabled women's networks, independent living centres, immigrant service agencies and Aboriginal friendship centres from across the country.

Project messaging invited prospective participants to share and exchange knowledge and showcase the great work they were doing in the community. Participants were urged to respond by:

1. Filling out the project's online survey or contacting the project for a phone interview; and/or
2. Becoming a national, provincial/territorial or community champion by sharing their contacts and helping recruit survey participants.

Conference and meeting presentations

Presentations were made at national, provincial/territorial and regional conferences and meetings. Participation and personalized follow-up were essential to securing pan-Canadian recognition and representation for this project, as well as identifying champions from outside of Ontario. For example, presentations were made to:

- The Working Group of the Canadian Breast Cancer Screening Initiative (CBCSI) for Under-Served Populations
- An Echo^{iv}-sponsored discussion: "Conversations: Equity in Cancer Screening for Women in Ontario"

^{iv} Echo is an agency of the Ministry of Health and Long-Term Care, governed by a board of directors.

- The “Cancer Community Programming Stakeholders Meeting” of the Public Health Agency of Canada, and
- The “Cervical Screening Collaboration: Sharing Strategies to Maximize Participation in Cervical Screening in Canada” workshop, hosted by the Pan-Canadian Cervical Screening Initiative, Canadian Partnership Against Cancer.

Recommendations from these conferences also supported the Pan-Canadian Best and Promising Practices project’s conviction that a compendium of best and promising practices was needed.

National, provincial/territorial and community champions

To maximize this project’s outreach efforts, strategies were developed to recruit well known and highly regarded individuals in cancer prevention and screening (or related areas), and/or agencies with a mandate for outreach to seldom or never screened populations. Program contacts, key informants, and conference and meeting participants were used to identify prospective champions. Individuals were asked to endorse the project to their network of contacts and/or to identify best and promising practices targeted to seldom or never screened populations. Many of the identified contacts, in turn, shared additional leads. In effect, a snowball recruitment strategy emerged, promoting interest and participation in this project across all levels (i.e., national, provincial/territorial and community). Champions were critical to our efforts to securing a *pan-Canadian* reach for practices.

DATA COLLECTION

A bilingual online survey was developed to collect preliminary information from community and health agencies and researchers. Telephone interviews were conducted to garner more in-depth information from survey respondents. Prospective participants were also given the option of submitting grey literature (unpublished and/or internal written reports), complete a more detailed version of the survey at their convenience or schedule a more extensive one-time interview. All interviews were tape recorded with the permission of the interviewee.

In all, more than 1000 contacts were solicited from across Canada, 300 of which were either face-to-face or personalized email communications. Approximately 41 surveys (preliminary or full) were submitted and 31 interviews (follow-up or full) were conducted over an eight-month period. In some cases, grey literature was submitted to provide supplementary information.

In total, 61 practices were identified and summarized — five from the published literature and 56 from the environmental scan.

REPORT WRITING AND DATA VERIFICATION

Two-page practice descriptions were drafted using data obtained through grey literature, written surveys and telephone interviews. Completed descriptions were sent to the relevant source agency contact(s) or researcher(s) for approval.

Each description provides detailed information and insights from program providers and implementers. It is hoped that this information can help other agencies and researchers replicate and translate practices into their specific contexts.



Literature Review



STUDIES BY TARGET POPULATION

The literature review is organized by target population, followed by program strategy, so that readers can better view the types of strategies used for each population. The key themes that emerged from the studies are then highlighted for each strategy (see page 163 for references).

The majority of the studies reported were conducted in community settings. Common study designs reported included randomized controlled, quasi-experimental, matched comparison group, Solomon four-group, cohort analytic, as well as one group pre- and post-test. The theoretical frameworks commonly used included Health Belief Model, Transtheoretical Stages of Change Model, PRECEDE-PROCEED Model, and Social Support Theory. Several studies, however, did not indicate whether a theoretical concept underpinned their intervention programs. In the majority of the studies, the populations targeted by the intervention programs overlapped (e.g., immigrant and low-income women, or rural and immigrant women). In addition, most of the studies reported were conducted in the United States; only five were conducted in Canada (see pages 28, 32, 74, 116 and 126 for program descriptions)^{1,9,29,31,54} and two in Australia.^{27,50} Further, some of the studies might not have been able to measure actual screening behaviour because of time constraints.

LOW-INCOME WOMEN


Low rates of cancer screening have been observed among low-income women, and have been linked to several barriers, including daily life problems, lack of access to transportation for medical appointments and lack of knowledge about cancer screening.^{28,58} Studies cited in this literature review often identify low-income women based on their household income, the community in which they reside or the health centre they visit.

Printed communications and telephone calls

Six studies utilizing printed communications (e.g., letters and cards) and/or telephone calls were found. Four were best practices^{15,41,58,70} and two were promising practices.^{11,36} Three of the studies addressed breast and cervical cancer screening, two addressed breast cancer screening, and one addressed breast, cervical and colorectal cancer screening.

An invitation letter, sometimes followed by a reminder telephone call, may be an effective medium to engage low-income women in breast, cervical and/or colorectal screening, as demonstrated by various studies.^{41,58,70} Invitation letters typically contain information about the screening tests, address questions or concerns women may have about screening and explain how and where to get screened. Letters are signed by the physician or medical director, printed on the clinic's letterhead and written at appropriate literacy levels and using culturally accessible lay language.^{36,41} Follow-up calls are conducted by trained personnel who address barriers faced by the women and/or help schedule screening appointments. Follow-up calls are often conducted between seven and 14 days after sending letters, but there is no suggested "most appropriate" time.

Although tailored letters addressing risks, questions or barriers relevant to the individual may be more effective than non-tailored letters in increasing cancer screening attendance, there is no unified theory in terms of the standard for message tailoring. For example, Skinner, Strecher and Hospers (1994)



first conducted telephone interviews with 435 women to examine factors preventing them from having a mammogram (e.g., perceived risk factors and barriers to screening) and subsequently sent a tailored letter to these women, highlighting their individual risk factors for breast cancer and addressing their concerns. They found that among low-income women, those who received the tailored letter were more likely to have had a mammogram at follow-up than those who received a letter with standardized messages. However, Jibaja-Weiss, Volk, Kingery, Smith and Holcomb (2003), in their study with low-income and immigrant women, found that while it was important to tailor invitation letters, too much information on individual risk might decrease the likelihood of women receiving cancer screening. They found that women who received personalized, tailored letters containing specific risk factors extracted from their medical records were less likely to obtain breast and cervical cancer screening than those who received personalized, tailored letters containing general risk factors. The authors explained that too much individualized information might be alarming to the women, thus resulting in avoidant behavior. Further research is needed to explore what kind of information is sufficient and appropriate to motivate low-income women to attend screening.

Education

Three studies using video-based education were found. Two were best practices^{3,73} and one was a promising practice.⁵⁹ Two of the studies addressed breast cancer screening and one addressed cervical cancer screening.


Presenting culturally sensitive health education videos may be an effective way to prompt low-income, immigrant women to obtain a mammogram or Pap test.^{3,73} The videos used in these studies featured members of diverse ethnic groups to address beliefs, fears, misconceptions and benefits of screening tests. Message framing and ethnic targeting may play a role in the effectiveness of video-based education. Schneider et al. (2001) examined the effectiveness of different persuasive messages and ethnic group targeting on the mammography screening rates among low-income women of various ethnicities. They found that videos that emphasized the costs of not getting a mammogram and that were accompanied by photographs of multicultural women were the most effective in motivating mammography use among the low-income women. However, this effect held true for only certain ethnic groups and its relative advantage faded by 12-month follow-up. Hence, further exploration is needed to examine the differential impact of various message framing and ethnic group targeting.

Lay health educators

Lay health educators may be called by many names, such as community health workers, natural helpers, peer educators or community outreach workers (among others), and are either paid workers or volunteers. They are recruited mainly because they come from the target community and therefore possess knowledge of the community. Usually, they are not certified health professionals and do not have formal health education.²⁰

Eight studies using lay health educators were found, with five best practices^{5,22,47,55,62} and three promising practices.^{12,24,71} Three of the studies addressed breast and cervical cancer screening while five addressed breast cancer screening.

These studies demonstrated the value of using lay health educators to provide one-to-one or small-group educational programs to low-income women. Educators need to be indigenous to the community



and to educate the women within the context of the women's experiences, barriers and familiarity with local services. Educators deliver educational sessions during home visits or in community settings such as churches, health fairs, beauty parlours and public housing. Videos and/or printed materials are often used to reinforce health messages. Educators may follow up with telephone calls and/or mailings to provide women in their communities with further assistance. Other activities may include helping women to set up mammography appointments, providing transportation and/or childcare or accompanying women to screening.

Lay health educators can be used in various settings. In a clinic setting, for example, trained lay health educators can approach and educate female patients and offer them a visit to the screening clinic. This strategy may be an effective way to increase cervical cancer screening among low-income, immigrant women.⁴⁷ Another potentially effective strategy for low-income, immigrant women calls for recruiting and training hair salon stylists to provide their clients with breast health information and culturally sensitive counselling, and to encourage their clients to engage in screening.⁷¹

Multi-strategies

Three studies that were promising practices were found.^{4,21,37} One study addressed cervical cancer screening, one addressed colorectal cancer screening and one addressed breast and cervical cancer screening.

One common theme that arose from these studies was the use of in-reach and outreach activities to reach low-income women. In-reach activities, such as training and workshops, were targeted at healthcare providers or community outreach staff, while outreach activities such as educational classes, media campaigns, direct mailings and videos playing in clinic waiting rooms, were used with women in the target population. While two of the studies found some success in increasing screening rates,^{4,21} one study did not.³⁷ The latter study, however, differed from the former two in that no training was provided to the healthcare providers; instead, only posters and monthly examination room messages were provided. Although the independent effect of the different strategies used was not examined, training healthcare providers or outreach staff might help improve screening rates among low-income women. Further exploration is needed.

Healthcare providers

Two studies — both promising practices — targeting healthcare providers were found.^{10,49} One addressed breast cancer screening and the other addressed breast and cervical cancer screening.

While targeting healthcare providers to help engage low-income women in cancer screening may be a promising approach, further evaluation is needed. McGuire, Leypoldt, Narducci, and Ward (2007) conducted a demonstration project in which they recruited community pharmacists in medically underserved and low-income neighbourhoods to distribute mammography and Pap-test enrollment materials to eligible patients. Their preliminary findings suggest that community pharmacists may be a potential vehicle to recruit low-income women into cancer screening programs.

NEWCOMERS AND IMMIGRANT WOMENⁱ

Low screening rates among immigrant women have been well documented in the literature. While barriers to screening appear to be somewhat similar among various immigrant groups, it is crucial to note that each group is unique and may have distinct health beliefs and practices.^{45,48} These distinctions should not be disregarded; programs may need to be culturally tailored to each specific group.

Studies cited in this literature review focus on various immigrant women, including African, Vietnamese, Chinese, Cambodian, Korean, Hispanic, Latina, Hmong and native Hawaiian. The target women are often identified based on whether they speak and/or write the native language or based on self-identification. Recruitment of participants is often conducted in neighbourhoods with a large number of the target women, in health centres that serve a large number of the target women, or in places where the target women usually congregate (e.g., churches and community centres). In addition, some of the studies gather information about the women's length of residence in the country they migrated to. No definition, however, is given as to who is considered a "newcomer."

Mass media

Three studies using media-related education were found; one was a best practice⁵⁰ and two were promising practices.^{1,35} One study focused on breast cancer screening, one on cervical cancer screening, and one on breast and cervical cancer screening.


Media-led campaigns typically involve advertisements, articles, and/or discussions in ethnic newspapers, radio and/or television stations. Two of the studies, one focusing on South Asian women and one on Vietnamese women, found that media-led education has the potential to increase knowledge about breast and/or cervical cancer screening, as well as intention to screen. Media-led education, however, did not succeed in getting the women to go for screening. Although one of the three studies found a significant increase in screening rates, especially among women from the intervention areas, the focus was on non-English speaking women, not on a specific immigrant group.⁵⁰ In addition, the length of the media campaign and the media tools used varied among these studies.

Media-led campaigns may have the potential to encourage screening participation. Certain groups, however, may need additional interventions to improve compliance with screening guidelines. For example, Lam et al. (2003) randomly assigned a group of Vietnamese-American women into either a media-led education group or a media-led education group combined with lay health worker outreach group. They found that, following intervention, women in the combination group were significantly more likely to report obtaining a Pap test than those in the media-led education group. Mock et al. (2007), in their study of Vietnamese-American women, obtained similar results.

Church-based education

Six studies were found that used church-based education to promote screening. Four were best practices^{32,38,39,56} and two were promising practices.^{13,19} Five of the studies addressed breast cancer screening, and one addressed cervical cancer screening.

ⁱ Immigrant women are also referred to as "minority" women in several studies.



Conducting health education sessions in churches has been used successfully among African-American and Korean-American women. Such programs are usually led by indigenous educators who are cancer survivors or nurses. The education sessions generally include shared personal cancer experiences and address cultural beliefs and misconceptions about cancer prevention and screening. Other typical activities include video presentations, group discussions, breast self-examination demonstrations and mobile screening services.

Several studies examined whether full versus partial program activities (e.g., video presentation only, or mobile van services only) were needed to increase screening participation.^{32,39,56} Results varied, and may have depended on factors such as geographical location. Recruiting churches as partners in cancer prevention can be an effective method to engage women from certain immigrant groups to engage in cancer screening.

Lay health educatorsⁱⁱ

Fifteen studies were found that examined the use of lay health educators as the primary outreach to engage immigrant women in cancer screening. Five were best practices^{5,18,22,65,68} and 10 were promising practices.^{12,19,24-26,33,42,43,71,75} Seven studies addressed breast cancer screening, two addressed cervical cancer screening, two addressed colorectal cancer screening, three addressed breast and cervical cancer screening and one addressed breast, cervical and colorectal cancer screening.

Using indigenous lay health educators to deliver educational messages may be an effective method to encourage screening participation among various immigrant groups. Indigenous lay health educators are able to effectively promote health messages that reflect the cultural norms of their target audience because of their status as part of the cultural group and their ability to meet with women in person as and when necessary.

Incorporating the cultural elements of a targeted group into an intervention program may be one way to encourage its participation in screening. For example, Larkey, Lopez, Minnal and Gonzalez (2009) developed a pilot program using storytelling, which plays an important role in Latino culture, to encourage colorectal cancer screening among Latina women. In a face-to-face context, a *promotora* (community health advisor) read and acted out the dialogue in a story that reflected the values and themes of Latino culture. Preliminary findings indicate that women in the storytelling intervention had significantly higher intention to go for colorectal cancer screening and to recommend screening to others than those in the comparison group.

Multi-strategies

Seven studies using multi-component interventions were found. Three were best practices^{51,57,66} and four were promising practices.^{6,40,53,74} One of the studies addressed breast cancer screening, four addressed cervical cancer screening and two addressed breast, cervical and colorectal cancer screening.

Studies using multiple strategies to promote screening participation among immigrant women generally utilize mass media interventions in combination with other strategies. Or, they utilize a combination of

ⁱⁱ Please see pages 15 and 16 for details about some of the common activities conducted by lay health educators.

interventions targeted at various levels, such as individual, community and organizational levels. For example, several studies used mass media in combination with lay health educators,^{40,51,57} while some studies simultaneously provided training to healthcare providers, information programs for the community and individual education via lay health educators.^{66,74}

Although it is challenging to examine the contributions of each intervention component, studies using multi-strategies demonstrated that these more complex approaches are effective methods of improving screening participation among immigrant women.

Education

Four studies were found using education initiatives. Two studies were best practices^{64,73} and two were promising practices.^{60,69} Three of the studies focused on breast cancer screening while one focused on cervical cancer screening.

A noteworthy component of one of the studies was the inclusion of men in a breast health education program. Tanjasiri et al. (2007) developed the Hmong Breast Cancer Project, which included men and women in separate education sessions, with the intention of increasing the instrumental and emotional support that men gave to women in their families to engage in regular breast screening. The men were recruited by asking participating women to bring their spouses, partners or other male members of their households. Following the intervention, there was a significant increase in the men's beliefs that men in the family should support women not only in getting their breasts checked, but also through treatment if they had breast cancer. Enlisting the support of men in certain immigrant groups to capitalize on the cultural strengths of social support and decision-making styles may be one potential way to motivate women to go for screening. Further studies are needed to support the potential of using this method of health promotion in different immigrant groups.


OLDER WOMEN

Screening among older women is underutilized. Further, beliefs about and barriers to screening faced by older women may be different than those of younger women. Therefore, different strategies to increase screening rates may be required across the lifespan.⁸ Two studies — both best practices — were found that specifically focused on women aged 60 and older.

Printed communications and telephone calls

Janz et al. (1997) conducted a study with women between the ages of 65 and 85 using a two-step intervention. Women in the intervention group first received a personal letter from their primary care physician, which contained information about breast cancer screening and appointment scheduling. The letter was accompanied by a postcard for the women to complete after obtaining the screening in order to redeem a \$15 grocery coupon. Women who did not respond to the letter after two months received a call from a peer counsellor. Findings indicated that over a 12-month period, significantly more women in the intervention group than in the comparison group obtained a confirmed mammogram and the most dramatic difference occurred during the initial two months.

Although the independent effects of the peer counselling or the grocery coupon could not be determined, the authors suggested that a physician letter with a coupon incentive might be an effective initial way to



alert older women about obtaining a mammogram, while the peer counselling call could be reserved for women who required more intensive intervention.

Education

Wood and Duffy (2004) developed a self-instructional breast health kit and sent the kit to African-American and Caucasian women over age 60. The kit included a video that provided information on access and barriers to mammograms, the benefits of mammograms, the risk factors associated with specific ages and ethnicities, and step-by-step instructions on breast self-examination. The breast self-examination information included an interactive practice of the skills with print materials to encourage active drill and practice, as well as mini-lump models in black and white skin tones.

Results indicated that women who received the breast health kit had significantly higher knowledge scores and breast self-examination skills than women who did not receive the kit. However, in terms of obtaining mammography at eight-month follow-up, there were no significant differences between the intervention group and the comparison group. Hence, the authors suggested that self-instructional breast health kits could be use to increase older women's knowledge and breast self-examination skills but additional intervention was needed to overcome barriers to mammography.

RURAL AND GEOGRAPHICALLY ISOLATED WOMEN


Barriers — for example, difficulty accessing primary care services because of a lack of providers, geographic distance or terrain, or a lack of transportation — often preclude rural or geographically isolated women from cancer screening.^{23,44} Studies cited in this literature review recruit their target population from rural towns or farms.

Multi-strategies

Three studies — all classified as best practices — that utilized multiple strategies were found.^{2,23,27} Two of the studies focused on breast cancer screening while one focused on cervical cancer screening.

One of the themes that emerged from these studies was the recruitment of leaders and/or liaison personnel from the community to help develop and implement multifarious community-based activities to reach rural women. For example, Hancock et al. (2001) conducted "The Cancer Action in Rural Towns (CART)" project in several rural towns in Australia to increase cervical cancer screening rates. A facilitator and liaison worker from the community were hired to develop and implement various outreach activities, which included distributing pamphlets, displaying posters, personal visits and information sessions, cancer awareness seminars, media releases, invitations to Pap tests and provision of outreach Pap test clinics. Likewise, Flynn et al. (1997) recruited opinion leaders from the community to organize and host breast screening education sessions in the intervention area in rural New York State. Other activities in the program included providing breast screening mobile van services, mailing an information package about breast cancer screening to all households and offering a breast screening education program to healthcare providers.

Results from both studies indicated that, following intervention, women in the intervention areas were more likely to get screened than those in comparison areas. Additionally, Flynn et al. (1997) found that women who received the intervention activities along with the mobile van service had significantly higher mammography rates than women who were offered only the mobile van service. Therefore, besides



providing easy access to screening services, additional interventions may be required to encourage screening participation among rural women.

ABORIGINAL WOMEN

Screening rates among Aboriginal women are low. Barriers to screening participation include different cultural concepts of cancer and its prevention, lack of culturally suitable services, lack of knowledge about screening, and geographical location.^{52,63} Studies cited in this literature review identify eligible Aboriginal women from medical clinics on the reserve or who are official enrolled members of the target group/tribe.

Lay health educators

Two studies were found that utilized lay health educators to deliver educational programs to Aboriginal women from two tribes in North Carolina. Both were best practices and focused on cervical cancer screening.^{16,17}

In both studies, trained lay health educators from the Aboriginal community provided in-home, individualized education sessions. The educators conducted home visits to provide women with personalized information on cervical cancer and screening, and then maintained contact to reinforce the information provided during the home visits. Video presentations and printed materials were also used during the home visits to support the information provided.

The results of the studies showed clearly the value of using lay health educators in cancer education for Aboriginal women: significantly more women in the intervention group than the comparison group reported having had a Pap test at follow-up; women in the intervention group also had higher levels of change in knowledge.


Talking Circle format

Examining the community structure, values and lifestyles of a culture, and then developing culturally appropriate strategies to support cancer screening, may improve screening participation among Aboriginal women. The Talking Circle format is a well-known method of intragroup communication in many Aboriginal communities. Hodge, Fredericks and Rodriguez (1996) utilized the Talking Circle Format, combined with traditional Aboriginal stories, as a vehicle to provide cancer education and to improve cervical cancer screening rates among Aboriginal women.

A Talking Circle facilitator opened the session with a traditional story and discussion of the health topic, and then opened the floor to participants for discussion. While talking, the participant held a talisman and had total control of the floor as she discussed her fears, needs or concerns in an accepting environment. Although pending further evaluation at time of publication, this study indicated that the Aboriginal women responded favourably to the culturally framed education project.

WOMEN WHO SELF-IDENTIFY AS LESBIAN, BISEXUAL, QUEER, QUESTIONING OR TWO-SPIRIT

Research that examines cancer screening interventions targeting this population is scarce. Many screening programs do not have materials specifically designed for these audiences. As well, several factors, such as insensitive and unwelcoming experiences with the healthcare system, may keep this



population from seeking preventative healthcare services.^{7,67} Studies cited in this literature review identify lesbian and bisexual women based on self-identification.

Education

Two studies using education sessions were found; one was a best practice⁷ and one was promising practice.¹⁴ One study addressed breast cancer screening while the other addressed breast, cervical and colorectal cancer screening.

Both studies focused on group-format interventions that provided support and information to women who were lesbian or bisexual. Bowen, Powers and Greenlee (2006) suggested that group interventions that served as a combination of support, information, skills training and interaction with other lesbian and bisexual women could help this population to interpret health information and make health choices. They developed a weekly, two-hour group counselling intervention that, over four weeks, combined information dissemination, group discussion and skills training. In addition, each of the four sessions had a main theme: risk assessment and education, breast cancer screening, stress management and social support.

Results indicated that participants in the intervention group had significant reductions in their perceived risk of and anxieties and fears about breast cancer at six- and 24-month follow-up, as well as an increase in breast screening rates at 24 months, as compared with those in the comparison group. Group-based interventions delivered in a sensitive and supportive setting may help lesbian and bisexual women understand their personal cancer risk more accurately and improve their screening behaviours. More research is needed to address the cancer risks and behaviours of this population, as well as to examine potential strategies to improve screening rates for lesbian and bisexual women.

TRANS WOMEN, TRANS MEN AND INTERSEX PEOPLE


This literature review did not find any studies that focus on identifying strategies to facilitate cancer screening among trans women, trans men and intersex people. Evidently, studies that focus on this population are very much needed.

DISABLED WOMEN

Physically and/or intellectually disabled women are underserved for cancer screening. Very little research, however, provides information about the cancer screening behaviours and utilization of cancer screening tests among disabled women. This literature review briefly summarized a holistic health intervention developed for women with mild to moderate intellectual disabilities.

Education

The “Women Be Healthy” education program was an eight-week curriculum developed for women with mild to moderate intellectual disabilities to help them become more equal partners in their health care.⁴⁶ The curriculum included health education, coping skills training, exposure to the medical setting and assertiveness training. Some of the health topics covered included breast and pelvic care. Participants were also taught breast self-examination. In addition, they were instructed on relaxation techniques that they could adopt during a pelvic examination, watched videos of pelvic examination and manipulated some of the instruments used during the examination. A visit to a gynaecological clinic was also in the curriculum so that participants could role-play the procedures leading up to the examination.



Results indicated significant improvements in participants' health knowledge, beliefs and coping strategies following intervention; knowledge and coping strategies were maintained at 10-week follow-up. Although further evaluation with a larger sample is needed, the "Women Be Healthy" program is an example of the potential of a group-based intervention to help women with intellectual disabilities become more knowledgeable about and perhaps more comfortable with healthcare procedures. Further research is needed to identify strategies to support women with disabilities in health screening programs and to assist health professionals in implementing interventions directed at reducing cancer mortality among disabled women.

CONCLUSION

It is difficult to generalize conclusions regarding successful interventions, as virtually all major types of screening interventions have been found at least somewhat effective in some studies. In addition, no intervention works for all groups or individuals and in all settings. These caveats reinforce the importance of understanding the target population, tailoring intervention programs according to the target population's needs and the barriers they face, and taking into account the impact of other factors, such as individuals' readiness to adopt new health-related behaviours and experiences with the healthcare system.



Promising Practices

Northwest Territories Demonstration Program of the Integrated Strategy in Healthy Living and Chronic Disease Risk Factor Campaign



TARGET AUDIENCE: Women aged 20+ living in the North, including geographically isolated women and Aboriginal women

Program focus: Breast cancer (including other chronic diseases)

Challenges/risks faced by target population: Women living in the North have higher rates of breast cancer than women in the general population (for women aged 40–50) and are 1.5 times more likely to be diagnosed with colorectal cancer. Lifestyle factors that put women at increased risk include tobacco use, obesity and lack of physical activity. Geographical challenges include difficulties in accessing health and screening services (women are typically seen when they are already symptomatic) and language barriers (11 official languages).

Setting: Yellowknife and Hay River

Province: Northwest Territories

Theoretical background: None stated

Program status: 2009 to present

Funder: Public Health Agency of Canada

BRIEF OVERVIEW

- The Breast Screening Program (BSP) of Stanton Territorial Health Authority developed the Northwest Territories Demonstration Program based on the practice of a collaborative and coordinated approach to reducing non-communicable diseases by addressing their common risk factors.
- Pamphlets and posters that addressed breast cancer risk factors and prevention, as well as other chronic diseases with shared risk factors, were developed and distributed to nurse practitioners to disseminate to their patients.
- While evaluation of the program is underway, this practice demonstrates how information on more than one chronic disease can be integrated into educational materials on the early detection and prevention of breast cancer.

PROGRAM GOALS AND OBJECTIVES

- To foster collaboration and integration, promote healthy living and reduce chronic disease in the Northwest, focusing on primary and secondary prevention and using evidence-based approaches and best-practices interventions
- The objective of the BSP, as part of the integrated project, is to reduce the incidence of breast cancer in asymptomatic women, aged 50–79, by increasing participation rates for screening and reducing modifiable risk factors through health promotion activities targeted to specific lifestyle risk factors

PROGRAM IMPLEMENTATION STEPS

- The assistant chief health medical officer of the NWT developed the integrated strategy for chronic diseases, based partly on suggestions from the public about having an integrated approach to chronic disease education and prevention
- Funding was available for different programs throughout the NWT to adopt this integrated strategy
- The BSP of Stanton Territorial Health Authority created an integrated, chronic disease risk factor campaign that provided information not only on breast cancer risk factors and prevention but also on other chronic diseases such as diabetes, high blood pressure, heart disease, stroke and colorectal cancer
- The chronic diseases were selected based on the common risk factors they shared with breast cancer; the main message is that certain risk factors associated with breast cancer are also risk factors for other chronic diseases; therefore, reducing breast cancer risk factors may also reduce the risk of developing other chronic diseases
- Pamphlets and posters were created and translated into six of the 11 official languages of the NWT: English, French, Chipewyan, South Slavey, T'licho and Innuinaqtun

- Pamphlets were distributed to nurse practitioners, along with patient evaluation forms and a letter to nurses providing instructions on pamphlet distribution and evaluation

PROGRAM REACH

- To date, approximately 150 women have been reached

EVALUATION

Method

- Evaluation is in progress
- Patients who received the pamphlets were asked to complete an evaluation form assessing factors such as the readability of the information, whether they learned new information, whether any of the information would influence them to make changes in their lives, and their awareness of the risk factors for breast cancer and other chronic diseases

Key findings

- Not available

CRITICAL FACTORS FOR ADAPTATION

- Engage women as early as possible in initiatives to promote lifestyle changes in order to reduce future incidence of chronic disease
- Ensure information provided in pamphlets and posters is simple and easy to read; people generally do not want to have to read too much information
- Ensure the pamphlets and posters are culturally appropriate and relevant to the target population, and that they use images from the target population

- Frame the messages in a positive way (i.e., emphasize what women can do to reduce the likelihood of getting breast cancer rather than what women should not do to increase their chances of developing the disease)

CHALLENGES

- Ensure the languages and pictures used in the pamphlets and posters are appropriate to the target population and suitable for all literacy levels
- Many nurse practitioners were unclear about how to distribute the evaluation forms and how to get patients to complete and return them
- It was difficult to create a program that showed accurately the number of chronic diseases associated with high-risk lifestyle factors known to be prevalent in the NWT

LESSONS LEARNED

- Face-to-face meetings versus phone and letter instruction may have helped clarify the evaluation process and objectives to nurse practitioners, and to address their questions

ADAPTATION FROM OTHER PROGRAMS

None

program links

www.srhhb.org/services/function_statement.php?id=10&PHPSESSID=4a36af8a271742e1833e18f662eead44

program contact

Marcia Campbell, RTR ACR
 Program Coordinator
 Breast Screening Program
 Stanton Territorial Health Authority
 PO Box 10, 550 Byrne Road
 Yellowknife, NWT X1A 2N1
 Phone: (867) 873-0452
 E-mail: marcia_campbell@gov.nt.ca

Pap Screening Clinics with Aboriginal Women in Skidegate, Haida Gwaii



TARGET AUDIENCE: Aboriginal women, aged 40+ years, living on a rural reserve in British Columbia

Program focus: Cervical cancer

Challenges/risks faced by target population: Aboriginal women in British Columbia, especially Elders, are underscreened for cervical cancer compared with the general population. Barriers to screening identified by Aboriginal women include lack of continuity of care, feelings of embarrassment, inadequate follow-up and recall systems and insufficient information on reasons for Pap tests.

Setting: Rural reserve in Skidegate, Haida Gwaii (formerly Queen Charlotte Islands)

Province: British Columbia

Theoretical background: None stated

Program status: Completed in 1992

Funder: 1992 British Columbia Health Research Foundation's special demonstration project in community development; research collaboration with the University of British Columbia's department of family practice

BRIEF OVERVIEW

- A pilot Pap screening outreach initiative, which marked a departure from the usual screening approach offered to the Aboriginal community, was developed to address the cervical cancer screening needs of Aboriginal women in Skidegate, a rural reserve on Haida Gwaii.
- Eligible underscreened women aged 40+ years were invited, via letters and home visits, to screening at two Pap test clinics in the community.
- Results indicated a participation rate of 48% of invitees, an increase of 15% over the previously recorded screening rate for this population.

PROGRAM GOALS AND OBJECTIVES

- To design, implement and evaluate a pilot program, in consultation with community representatives, to address the cervical cancer screening needs of Aboriginal women, aged 40+ years, on a rural reserve in British Columbia

PROGRAM IMPLEMENTATION STEPS

- Key links to the population, including family physicians, community health representatives (CHRs), nurses and other support personnel, were identified
- The community was consulted to design an outreach process
- CHRs (trained and certified through the Department of Indian Affairs Medical Services branch) were identified as key individuals who could help address the issue of cervical cancer screening in a respectful and sensitive

manner; they played a central liaison role among local physicians, band representatives and other members of the Haida community

- CHRs approached women, aged 40+ years, on the Skidegate Reserve for informal interviews to obtain suggestions for improving Pap screening rates and services in their community; these women were chosen based on their willingness to participate and their status as respected opinion leaders and Elders in their community
- Based on the women's suggestions, two half-day Pap clinics were planned; eligible women overdue for cervical screening were mailed a formal invitation, letter of information and consent form six weeks before the clinic days
- CHRs then made home visits to the women to discuss the project and reasons for regular Pap screening, as well as to obtain consent, book appointment times and administer a questionnaire
- The eligible women were later reminded of their appointments by telephone
- Pap clinics were held at the Skidegate Health Centre, with Pap tests and age-appropriate well-woman examinations conducted by two female physicians
- Refreshments and educational materials on cervical cancer were provided
- A semi-structured exit interview was conducted to obtain feedback on the perceived success of this style of clinic

PROGRAM REACH

- Of 27 women identified as overdue for Pap screening, 11 women received a Pap test

EVALUATION

Method

- Women eligible for screening were identified through a chart review at the main medical clinic and the Skidegate band list
- Information on cervical screening status and gynaecologic history was abstracted from each woman's medical chart and compared for accuracy with the British Columbia Cancer Agency's central cytology registry
- Associations between Pap status and other variables were calculated using χ^2 or Fisher's exact tests
- Qualitative information from informal interviews and questionnaires was synthesized by identifying central themes and extracting key statements

Key findings

- 27 of 74 women residing in Skidegate met inclusion criteria and were identified as overdue for cervical screening
- 23 of these 27 women could be contacted and were invited for screening; 12 women agreed to participate and 11 kept appointments at the Pap clinic, for a participation rate of 48%, which was an increase of 15% over the previously recorded screening rate
- All participants indicated that the outreach clinic was a better venue than individual appointments at the main clinic
- All participants said they would have a Pap test done again when it was next recommended or when the next Pap clinic was held, and most wanted to be notified by the physician of test results and be reminded by telephone or mail when their next Pap test was due

CRITICAL FACTORS FOR ADAPTATION

- Obtain endorsement for the project from local organizations involved in healthcare
- Ensure that the design, implementation and evaluation of health programs on reserve are directed by Aboriginal health professionals and the people they serve
- Choose clinic dates that avoid conflict with seasonal food-gathering activities
- Have personal contact by staff who are well known and respected in the community (e.g., CHRs acted as

liaisons)

- Provide adequate time for visiting, tea and socialization; these activities show respect and are critical to the consultation process and participation in the outreach program
- Have female physicians known to the community conduct the screening tests

CHALLENGES

- Identifying all eligible Aboriginal women in a specific population for screening was challenging, and might be more so in large communities or for "non-Status" women without band affiliation
- 52% of women visited by CHRs still did not participate: other barriers to screening remain to be identified and addressed

LESSONS LEARNED

- Written materials (e.g., pamphlets) were not well received by the women; visual materials were helpful to the physicians for illustrating basic anatomy
- Next steps include more screening clinics of this type and evaluation for sustainability

ADAPTATION FROM OTHER PROGRAMS

None

reference

Calam, B., Norgrove, L., Brown, D., & Wilson, M. A. (1999). Pap screening clinics with native women in Skidegate, Haida Gwaii: Need for innovation. *Canadian Family Physician, 45*, 355-360.

program contacts

Betty Calam, MD CCFP, MCISc, FCFP
Associate Professor/Site Director
St. Paul's Site, UBC Family Practice Residency Program
St. Paul's Hospital
1081 Burrard St.
Vancouver, BC V6Z 1Y6
Phone: (604) 806-8462
E-mail: bcalam@providencehealth.bc.ca

Mary Ann Wilson, CHR
Skidegate Health Centre
Skidegate, BC VOT 1S1
Phone: (250) 559-4610

The Screening Mammography Program (SMP) of British Columbia



TARGET AUDIENCE: Aboriginal women; minority women

Program focus: Breast cancer

Challenges/risks faced by target population: The target audience is often less inclined than the general population to access screening services due to lack of understanding, awareness and/or geographic, cultural or socio-economic barriers.

Setting: Communities across British Columbia

Province: British Columbia

Theoretical background: None stated

Program status: 1988 to present

Funder: British Columbia Cancer Agency

BRIEF OVERVIEW

- In collaboration with Aboriginal groups and leaders, the Screening Mammography Program (SMP) of BC developed Aboriginal-specific educational materials about breast health and screening; various initiatives were also carried out to improve screening participation in Aboriginal communities.
- As well, cancer prevention coordinators from the British Columbia Cancer Agency were recruited from across the province to provide education about breast health and screening to both Aboriginal and minority groups.
- The 2008/2009 SMP Annual Report revealed that nearly 300,000 mammograms were conducted in 2008, an increase of approximately 8000 over 2007; 14% of these mammograms were performed for women attending the SMP for the first time.

PROGRAM GOALS AND OBJECTIVES

- To reduce the death rate from breast cancer in all BC women, aged 40–79

PROGRAM IMPLEMENTATION STEPS

- A partnership was formed between the SMP and Aboriginal groups and leaders to develop customized education and promotion materials that reflect the Aboriginal groups' unique cultures, and to develop various initiatives to improve regular screening mammography rates for Aboriginal women
- An Aboriginal Women's Health Workshop, a joint project with the BC Cervical Cancer Screening Program, was piloted at the Vancouver Aboriginal Friendship Centre;

the session also functioned as a focus group, where women were:

- ♦ Provided with information about breast and cervical cancer and the importance of screening
- ♦ Given opportunities to share their experiences with the healthcare system and discuss barriers to accessing services
- ♦ Asked for their ideas about improving the healthcare system
- Results of the sessions were transmitted to healthcare providers to help them improve services to Aboriginal women
- A Women's Wellness Champions project was developed through the Community Grants Fund, a funding initiative maintained by the BC Cancer Agency to support local initiatives that support efforts to increase screening participation in communities across the province:
 - ♦ Women from several reserves in and around Victoria were trained about breast health and screening
 - ♦ These women in turn provided support and education to other women on the reserves
 - ♦ The outreach could be as simple as going to a neighbour to talk about screening; the notion is to integrate screening into everyday thinking and practice
 - ♦ The program's nurse and lay women met once a month for updates and to discuss any emerging issues

- Other initiatives were conducted to reach other minority women:
 - Cancer prevention coordinators across BC were recruited to network with and conduct community-based programs on breast health and screening to the women in their communities
 - Core educational materials (e.g., pamphlets and PowerPoint presentations) were developed and translated into various languages, (e.g., Chinese and Punjabi) to support British Columbia Cancer Agency prevention coordinators in breast screening outreach efforts
- SMP mobile van services also visit approximately 120 communities throughout BC once or twice a year

PROGRAM REACH

- To date, approximately 300,000 women have been reached

EVALUATION

Method

- Data are collected and analyzed on an ongoing basis to monitor the SMP's effectiveness; the following results are based on the 2008/2009 Annual Report

Key findings

- 286,993 breast screening examinations were conducted in 2008 (nearly 8000 more than in 2007), of which 14% (40,439) were performed for women attending the SMP for the first time
- The overall participation rate for women aged 50–69 was 51%; the rate increased by 3–5% in several areas as a result of the expansion of screening services
- Participation rates by selected ethnic groups were generally lower than that those of the overall population: 40.7% for Aboriginal women; 47.9% for East/South Asian women; and 42% for South Asian women
- Note: The individual contributions of each initiative described above to the overall increase in screening rates cannot be determined in this report

CRITICAL FACTORS FOR ADAPTATION

- Understand the target audience, including cultural beliefs, life experiences and attitudes towards healthcare
- Know the barriers to screening services for the target population and develop strategies to eliminate the barriers

- With community involvement, develop educational materials customized to the target population
- Obtain support from credible members of the target community to help reach out to underscreened women
- Have a genuine desire to provide service to the target population
- Customized programs and dedicated groups of people working in communities throughout the province are essential to improving screening participation among the target population

CHALLENGES

- Finding the right people at the local level to help connect with the communities
- Determining the gathering places for women from each particular community and how best to reach out to them; community-based health events that work for one ethnic group may not necessarily work for all ethnic groups

LESSONS LEARNED

- The commitment of local advocates and leaders, as well as promotion and education by first-line influencers, are essential for the ongoing success of the programs

ADAPTATION FROM OTHER PROGRAMS

None

program link

www.smpbc.ca

program contact

Ann MacDonald
 Promotion and Education Specialist
 Screening Mammography Program
 BC Cancer Agency
 801–686 W. Broadway
 Vancouver, BC V5Z 1G1
 Phone: (604) 707-5927
 E-mail: amacdonald4@bccancer.bc.ca

Self-Collection of Specimens for HPV Testing in Hard-to-Reach Women



TARGET AUDIENCE: Hard-to-reach women in Vancouver's Downtown Eastside, including women with no fixed address, low-income women, women of low literacy, sex trade workers or women with a history of alcohol or drug abuse

Program focus: Cervical cancer

Challenges/risks faced by target population: Women of lower socioeconomic status may not make full use of available cytology screening programs. As a result, these women experience higher rates of cervical cancer than women in the general population.

Setting: Vancouver's Downtown Eastside

Province: British Columbia

Theoretical background: None stated

Program status: 2004–2005

Funder: Reducing Health Disparities Strategic Initiative of the Canadian Institutes of Health Research

BRIEF OVERVIEW

- This study was conducted to examine the feasibility of self-collection of specimens for human papillomavirus (HPV) testing as a part of cervical cancer screening for women in Vancouver's Downtown Eastside.
- Study participants were significantly less likely than women in the BC general population to have ever had a Pap test or to have had a Pap test in the three years before study recruitment.
- Study findings suggest that women who do not participate in cervical cancer screening programs, and who are at high risk of cervical cancer, may be willing to provide a self-collected specimen.

PROGRAM GOALS AND OBJECTIVES

- To study the feasibility of using self-collected specimens for testing HPV status among hard-to-reach women

PROGRAM IMPLEMENTATION STEPS

- Ethical approval for the study was obtained from the University of British Columbia
- Women were recruited to the study from November 2004 to October 2005 by outreach nurses using a standardized recruitment statement in women's centres, shelters and alleys
- Self-collection of specimens for HPV testing is not a standard part of cervical cancer screening; thus, all women were advised to have a Pap test within one year
- Participants were given a diagram that illustrated how to obtain a cervicovaginal specimen

- They were instructed to insert a Dacron swab intravaginally, rotate it three times and place it in a specimen tube containing specimen transport medium (Digene Corporation)
- Women were asked to collect the specimen immediately at the closest washroom or private location and to return it to the nurse
- Samples were transported to the British Columbia Centre for Disease Control within 24 hours of collection and analyzed for the presence of high-risk HPV DNA using the Digene HPV test, as per manufacturer's instructions

PROGRAM REACH

- 296 women were invited to participate in the study.
- Of these, 152 (51.4%) women agreed to participate; this is similar to the participation rate of other studies in Vancouver's Downtown Eastside
- One specimen was lost, leaving 151 specimens for analysis

EVALUATION

Method

- The Pap testing rates among study participants was compared to rates of the BC general population
- The prevalence of high-risk HPV among participants was determined

Key findings

- Participants had a median age of 39 years as compared with a median age of 40 years for women who participated in the provincial cervical cancer screening program
- Compared with the general population, significantly more women in the study group had never had a Pap test in BC (13.9% v. 8.3%, $p < 0.05$)
- Of the study participants, 53.6% had received a Pap test within the 36 months before study recruitment, which was significantly lower than the BC general population (68.4%)
- These results suggest that self-collection of specimens for HPV testing is a feasible way to reach women who do not receive routine cervical cancer screening
- The prevalence of high-risk HPV was more than double that of the general BC population, as recently reported by the Cervical Cancer Screening Program (28.3% v. 13.9%), despite the fact that median age in the two groups was similar. This suggests that self-collection of specimens is feasible for women who are at high risk for cervical cancer
- After HPV status was determined, the outreach team was able to recontact 81.4% (35/43) of the participants who tested positive for high-risk HPV; these women were referred for further testing

CRITICAL FACTORS FOR ADAPTATION

- Build an experienced outreach team that knows the population and the location
- An organized screening program is critical to ensure that the intervention accesses women who have not received screening
- Excellent colposcopic follow-up for women who are HPV positive is essential

CHALLENGES

- Street-involved women often do not know their screening status
- Ensuring that women found to be positive for high-risk HPV went for follow-up testing

LESSONS LEARNED

- Future studies should include an examination of the rate of follow-up testing among women found to be positive for high-risk HPV
- Improved methods are necessary to enhance uptake of follow-up interventions
- Given the high incidence of this preventable cancer in developing countries, self-collection of specimens for HPV screening could be offered as a component of reproductive health programs and could be administered by healthcare workers to improve access to cervical cancer screening
- Follow-up using screen-and-treat methods could then be used to offer definitive treatment for women at risk of cervical cancer

ADAPTATION FROM OTHER PROGRAMS

None

reference

Ogilvie, G., Krajden, M., Maginley, J., Isaac-Renton, J., Hislop, G., Elwood-Martin, R., Sherlock, C., Taylor, D., and Rekart, M. (2007). Feasibility of self-collection of specimens for human papillomavirus testing in hard-to-reach women, *Canadian Medical Association Journal*, 177, 480–483.

program contact

Dr. Gina Ogilvie, Assistant Professor
University of British Columbia
Associate Director, Division of
STI/HIV Prevention and Control
British Columbia Centre for Disease Control
655 W. 12th Ave.
Vancouver, BC V5Z 4R4
E-mail: gina.ogilvie@bccdc.ca

Aboriginal Breast Cancer Screening Resource Toolkit



TARGET AUDIENCE: Healthcare providers who work with Aboriginal women

Program focus: Breast cancer

Challenges/risks faced by target population: It is difficult to find Aboriginal-specific information related to breast cancer in Canada. The incidence of breast cancer among Aboriginal women is increasing, and Aboriginal women are more likely to be diagnosed with breast cancer at a later stage than non-Aboriginal women.

Setting: First Nations, Métis and urban Aboriginal communities

Province: Alberta

Theoretical background: None stated

Program status: 2007 to present

Funder: Alberta Health Services, Screening Programs (formerly Alberta Cancer Board)

BRIEF OVERVIEW

- The Aboriginal Breast Cancer Screening Resource Toolkit was specifically designed by the Alberta Health Services Screening Programs to help healthcare providers working in Aboriginal communities increase breast cancer knowledge, awareness and screening rates among Aboriginal women.
- Healthcare providers viewed the toolkits as a valuable resource; further evaluation of the effectiveness of the toolkit is being finalized.

PROGRAM GOALS AND OBJECTIVES

Short-term objectives

- To develop a culturally appropriate Aboriginal breast cancer screening educational resource toolkit
- To educate healthcare providers in Aboriginal communities on breast cancer screening and how to use the toolkit
- To distribute the toolkit to Aboriginal health settings in Alberta

Long-term objective

- To increase breast cancer knowledge, awareness and screening rates among Aboriginal women in Alberta

PROGRAM IMPLEMENTATION STEPS

- An advisory committee was formed with representatives from the (former) Alberta Cancer Board staff, First Nations and Inuit Health — Health Canada, Métis Nation of Alberta and (former) regional health authorities, as well as an Aboriginal Elder woman (Note: The Alberta

Cancer Board and regional health authorities were amalgamated into the Alberta Health Services in 2008)

- Culturally appropriate educational resources, including brochures, a breast health wheel, PowerPoint presentations and posters were developed; photo models for the brochures were recruited from the target Aboriginal communities
- Toolkits were pilot-tested with on-reserve and urban Aboriginal healthcare providers
- Final toolkits were distributed to healthcare providers in First Nations, Métis and urban Aboriginal communities
- Healthcare providers targeted included community health representatives, registered nurses, community health nurses, health promotion coordinators and Aboriginal liaisons
- Educational sessions were provided to healthcare providers, and included updates on colorectal and cervical cancer; screening in Alberta; breast cancer and screening; healthy living; and ideas on how to use the toolkits
- The usefulness of the toolkits and educational sessions was evaluated using focus groups and surveys

PROGRAM REACH

- 150 resource toolkits were distributed across Alberta
- Educational sessions were delivered to 130 healthcare providers in eight locations

EVALUATION

Method

- Healthcare providers who attended the educational sessions completed surveys
- Focus groups were subsequently conducted to evaluate the usability and quality of the toolkit
- An online qualitative survey was given to advisory committee members to evaluate the process of developing the kits
- An evaluation of the toolkit's usability and quality is in progress

Key findings

- 93.6% of the participants who completed the surveys at the educational sessions ($N = 63$) rated the presentations as very good or excellent and 98.4% rated the usefulness of the information as very good or excellent
- 98.5% of the participants felt somewhat confident or very confident about using the toolkit in their community after the training

CRITICAL FACTORS FOR ADAPTATION

- Take time to build relationships with the communities
- Take time to develop resources, and make sure they are culturally appropriate and easy to use
- Ensure regular, ongoing communication with clinical content experts as well as community representatives and leaders

CHALLENGES

- It took a significant amount of time to build relationships with the communities
- Involving multiple stakeholders is recommended but requires a greater investment in time
- 150 toolkits were distributed but only 30% were known to be used in the communities

LESSONS LEARNED

- Terms of reference for the advisory committee defining its role would have been useful at the start of the program
- A better dissemination plan was needed to ensure the toolkits got used in the communities
- Development of brochures and other resources can be expensive; having them online might be more feasible if resources are limited
- Travelling to remote Aboriginal communities can be difficult; having educational sessions online might be a good alternative, and might enable more healthcare providers to attend training sessions

ADAPTATION FROM OTHER PROGRAMS

The concept for the toolkit and resources were adapted from the Aboriginal Cervical Cancer Screening Resource Toolkit, developed in 2006 by the (former) Alberta Cancer board (now Alberta Health Services)

Note: In spring 2010, an Aboriginal Colorectal Cancer Screening Toolkit, along with an updated Aboriginal Cervical Cancer Screening Toolkit, will be distributed throughout Alberta

program link

www.screeningforlife.ca

program contact

Melissa Hyman, MSc
Health Promotion Coordinator
Cancer Screening Programs
Health Promotion, Disease and Injury
Prevention
Population and Public Health —
Alberta Health Services
2nd Floor, #2202 – 2nd St. SW
Calgary, AB T2S 3C1
Phone: (403) 355-3244
E-mail: melissa.hyman@albertahealthservices.ca

The Vocational and Rehabilitation Research Institute (VRRRI)

Simply Health: The Breast — Health for Women



TARGET AUDIENCE: Women with developmental disabilities

SECONDARY AUDIENCE: Women of low literacy or whose first language is not English

Program focus: Breast cancer

Challenges/risks faced by target population: Breast screening rates for women with developmental disabilities are lower than that of the general Canadian population. People with developmental disabilities are typically marginalized and treated as a secondary audience in the healthcare system. Access to information is a necessary step in empowering people with developmental disabilities to increase control over and improve their health.

Setting: Mostly urban centres

Province: Alberta

Theoretical background: None stated

Program status: 2004–2006

Funder: Calgary Region Community Board Persons with Developmental Disabilities Community Capacity Initiative

BRIEF OVERVIEW

- Simply Health plain-language documents, videos and workshops were developed in partnership with Alberta Health Services' (AHS) Grace Women's Outreach Program to enhance the ability of people with developmental disabilities to be full participants in making informed decisions about their own healthcare and to interact with healthcare staff.
- Continued interest in VRRRI's online and print resources indicate that demand for understandable information is high, especially given that the population with English literacy challenges is increasing.

PROGRAM GOALS AND OBJECTIVES

- The Simply Health series is meant to enhance the accessibility of health prevention information; it helps people with developmental disabilities learn more about healthcare and provides them with the information they need to talk to their doctors
- Simply Health: The Breast — Health for Women helps women learn about their breasts, shows some problems women can develop with their breasts, tells women what to look for and shows women what they can do to try to keep their breasts healthy

PROGRAM IMPLEMENTATION STEPS

- A series of plain-language videos and booklets was created on topics identified as priorities by healthcare professionals
- It took approximately 1.5 years to develop the Simply Health series

- VRRRI used women with developmental disabilities as translators when creating the plain-language documents and video
- The breast video shows a physician, nurse and patient during a breast exam
- The narrative:
 - ♦ Explains why the doctor is doing what she is doing
 - ♦ Explains clinical breast exam and provides a rationale for it
 - ♦ Lets women know what they can do at home
 - ♦ Walks women through a mammogram, including what the machine and image look like and the purpose of the screening/diagnostic tool
- In order to reach their target populations, VRRRI partnered with the AHS Grace Women's Outreach Program, which runs community outreach services with marginalized populations, to develop and implement the Simply Health workshops
- The program and resources were developed on the premise that when women know what to expect, they will be less fearful and better prepared to ask questions
- The added benefit of reaching people with low literacy was realized when Literacy Alberta agreed to distribute the print resources to their target populations
- Knowledge translation activities included building and maintaining a plain-language dissemination network and presenting at literacy and disability conferences

PROGRAM REACH

- In 2005, more than 200 workshops were delivered to an estimated 3000 adults with developmental disabilities, newcomers and immigrants
- Thousands more have been reached locally and internationally through conferences and distribution of free online and hard-copy resources by VRRRI and literacy groups such as Literacy Alberta

EVALUATION

While a formal outcome evaluation has not been conducted, the following measures indicate that VRRRI is on track:

- Women with developmental disabilities helped to develop the materials, thus helping to ensure that the information is accessible to its target audience
- The project uses dissemination channels with partners already connected to their target audiences
- The project receives continued requests for reprints

CRITICAL FACTORS FOR ADAPTATION

- Grade 3–4 level English was used, which is lower than the commonly understood level for plain language; written information is supplemented with pictures to reach audiences with cognitive limitations who need information to be presented concretely
- The work must be directed by the target audience's needs
- Participatory approaches should be used to meaningfully engage members (e.g., as translators) in the design, development and delivery of the program and resources
- When working with adults with developmental disabilities, ensure that processes and approaches are sensitive to physical and systemic barriers (e.g., women with developmental disabilities may feel that their bodies are lesser than those of able-bodied women, which can make it difficult to find a volunteer actor for the video who is comfortable having her breasts exposed; video takes should consider physical barriers and not exceed 40 minutes or so)
- Involve frontline workers who have established trusted working relationships with project participants
- Consider investing the staff, time and money to create resources and keep them current

CHALLENGES

- Funders give money for a time-limited project versus ongoing programming
- It is difficult to attract funds for ongoing content edits and to translate the material into different languages; while existing videos can be dubbed, it would be preferable to create videos for each target population, using volunteer actors from each community
- Print materials are updated as funding allows; no ongoing funding is available to do so on a regular basis
- Videos are especially costly to produce and have not been updated since they were created in 2005; the main information, however, is still valid and useful

LESSONS LEARNED

- Keep information presented in more costly formats, such as video, more general to ensure a longer shelf life
- A special team in the VRRRI research department is devoted to developing plain-language materials on topics of interest to people with developmental disabilities; these materials will be easily translatable to the larger population
- While VRRRI is not involved in direct health prevention, it is responding to high demand for understandable health information, especially given that the population with English literacy challenges is increasing

ADAPTATION FROM OTHER PROGRAMS

None

program link

www.vrri.org/Research/Health-and-Disabilities/Simply-Health-A-Series-of-Plain-Language-Documents-Videos-and-Workshops-on-Preventative-Personal.html

program contact

Donovan Tymchyshyn
Director of Research
The Vocational and Rehabilitation Research
Institute
3304 – 33rd St. NW
Calgary, AB T2L 2A6
Phone: (403) 284-1121 ext. 430
E-mail: dtymchyshyn@vrri.org

Connecting the Breast Cancer Community



TARGET AUDIENCE: Rural and geographically isolated women; Aboriginal women; younger women; older women; breast cancer survivors; healthcare providers, organizations and agencies

Program focus: Breast cancer

Challenges/risks faced by target population: Aboriginal and rural women are often at great disadvantage in Saskatchewan when it comes to awareness and understanding of the array of breast cancer services and resources available in the province. For this reason, they may not know about or hesitate to participate in available screening or support programs, and may misunderstand or mistrust programs and providers.

Setting: Urban and rural communities, including Aboriginal communities

Province: Saskatchewan

Theoretical background: None stated

Program status: Ongoing

Funder: Saskatchewan Breast Cancer Network

BRIEF OVERVIEW

- Connecting the Breast Cancer Community (CBCC) is a day-long event that brings together women in the general community — with a particular focus on rural and urban Aboriginal women — to learn about and interact with a wide variety of breast cancer agencies.
- Participants learn about activities, services and resources for breast health and breast cancer in Saskatchewan.
- The event has been very well received and attended, with anecdotal evidence of message uptake; evaluation results indicate high participant satisfaction and enthusiasm, improved relationships and trust and increased understanding, as well as strong support to make this an annual event.

PROGRAM GOALS AND OBJECTIVES

- To increase awareness of and access to activities, services and resources for breast health and breast cancer in Saskatchewan
- To facilitate collaboration among stakeholders within the breast cancer community

PROGRAM IMPLEMENTATION STEPS

- The Saskatchewan Breast Cancer Network (SBCN) compiled a comprehensive list of breast cancer resources and services with key contacts/representatives in the province
- Agencies and speakers were invited to participate
- Participating presentations included (but were not limited to) Our Lives Through Our Eyes (Aboriginal photovoice exhibit), the Canadian Cancer Society,

- breast cancer survivors, a genetic counsellor from the Royal University Hospital department of genetics, HOPE Cancer Health Centre Inc., Breast Cancer Action Saskatchewan, Lymphedema Services in Saskatchewan, Saskatchewan Cancer Agency, Regina Qu'Appelle Health Region's Breast Assessment Centre and Palliative Care Services, the University of Saskatchewan's department of community health & epidemiology, the Saskatchewan Cancer Action Network, Breast Cancer Action Saskatchewan, the Saskatchewan Cancer Agency, and Living with Hope: Developing a Psychosocial Support Program for Male Spouses of Women with Breast Cancer
- The venue (i.e., the Delta Regina Hotel) was selected and finalized
- The agenda was finalized
- The event was publicized through SBCN and participating/related agencies:
 - ♦ Invitations and marketing specified that the event was free, that meals would be provided, and that travel would be funded for rural/Aboriginal women
- During the first part of the event, each presenter made a short presentation, followed by a 5–10 minute question-and-answer session
- Handouts with backup information, contact information (including toll-free numbers), suggested resources and other information were provided by presenters
- During the rest of the day, participants could talk with presenters to get more information, develop relationships and network

- Display tables at the venue enhanced access and awareness
- Participants could also register for upcoming events and activities

PROGRAM REACH

- The SBCN has held three, day-long CBCC events, with more planned
- Each event attracted approximately 95 participants and approximately 14 presenters

EVALUATION

Method

- Participants' and presenters' evaluation forms were collected and summarized

Key findings

- Participants and presenters generally responded very positively to the event and requested that it be an annual event
- CBCC provided increased knowledge about and increased understanding of breast cancer issues and related services
- The event built trust and reduced barriers to services by putting a public face to healthcare providers (potentially making contact easier), as well as showcasing their dedication and passion
- Participants' attendance was influenced by the variety of the themes and topics at the event, as well as the comfort that came from easy registration, no admission fee and funded travel
- The event allowed participants to familiarize themselves with relevant community resources and agencies
- 95% of presenters attended the entire event because they were interested in other presentations
- Presenters are interested in participating because:
 - The event does not require too much preparation
 - They are attracted to a venue that creates awareness and understanding of their programs
 - The timing and agenda are flexible enough to fit their schedules

CRITICAL FACTORS FOR ADAPTATION

- Start and end on time and hold presenters to their allotted time
- Provide free meals and ensure that registration is easy and straightforward
- Subsidize travel for Aboriginal and rural women

- Identify and reach out to women who would not ordinarily attend by establishing trust and encouraging them to attend; arrange for more than one woman to attend from her community so that she does not feel alone

CHALLENGES

- Coordinating this event requires:
 - Knowledge of the breast cancer community, including key players and organizations
 - Established relationships within the breast cancer community
 - Creating a varied agenda that appeals to a wide audience

LESSONS LEARNED

- It is crucial to present a variety of themes and topics
- Challenging registration forms, as well as paying for and choosing sessions, can deter senior and Aboriginal women from attending
- Targeting younger women, before they are old enough to attend recommended screening programs, can familiarize women with the idea of screening in the hopes that they will be open to it in the future
- Participants, including younger women, can also pass on messages about screening and resources to older and younger women in their communities

ADAPTATION FROM OTHER PROGRAMS

None

program links

None currently available

program contact

Peg Schmidt, Coordinator
 Saskatchewan Breast Cancer
 Network
 458 Wakabayashi Cres.
 Saskatoon, SK S7K 7L7
 Phone: (306) 931-9632
 E-mail: pjschmidt@sasktel.net

Our Lives Through Our Eyes



TARGET AUDIENCE: Aboriginal women and cancer survivors living in Saskatchewan, including rural and geographically isolated women and low-income women

Program focus: Breast cancer

Challenges/risks faced by target population: Cancer rates among Aboriginal women are increasing dramatically in some regions for various cancers, particularly breast cancer. Aboriginal women have a higher chance of being diagnosed with breast cancer and lower survival rates than Canadian women in the general population.

Setting: Aboriginal communities (rural and urban)

Province: Saskatchewan

Theoretical background: Cross-cultural research; participatory action research

Program status: 2006 to present

Funder: Saskatchewan Breast Cancer Network; Canadian Cancer Society; Public Health Agency of Canada

BRIEF OVERVIEW

- Visualizing Breast Cancer (VBC), a research project out of the University of Saskatchewan, department of sociology, engaged 12 Aboriginal breast cancer survivors in a photovoice project
- Building on the success of that project, the Saskatchewan Breast Cancer Network (SBCN) facilitated Our Lives Through Our Eyes, a travelling exhibit of the women's images and stories.
- The SBCN further expanded on VBC, bringing together the women in an ongoing series of meetings and workshops to form the SBCN Aboriginal Women and Breast Cancer working group.
- Participants continue to be connected to the breast cancer community and are motivated to act as ambassadors to improve understanding and access to education about early detection within their communities.

PROGRAM GOALS AND OBJECTIVES

- To develop an understanding of the meaning of breast cancer for Aboriginal women and the resources available to them in SK
- To evaluate the use of photovoice
- To improve the breast cancer community's awareness of the education, information and support needs of Aboriginal women in SK
- To allow participants to reach policymakers and enhance community health

PROGRAM IMPLEMENTATION STEPS

- Photovoice is based on a participatory action research methodology in which participants document their lives through their own images and stories, in the

process engaging in critical reflection and advocating community and policy change

- SK Aboriginal women aged 19+ who had completed treatment for breast cancer were recruited to participate in VBC via articles in Saskatoon and First Nations newspapers and breast cancer support groups
- Participants took part in interviews with researchers about their experiences, and used digital cameras to document the meaning of breast cancer to them; they then selected particularly meaningful photographs and discussed them in depth
- On February 8–9, 2008, a Sharing Circle/Community Workshop was held for participants (with an Elder) to meet each other, share photographs and stories, and establish relationships
- During the second part of the workshop, participants met with invested community members and relevant policymakers, including The Saskatoon Health Region, Breast Health Centre in Saskatoon, Breast Cancer Action Saskatchewan, Breast Cancer Community of Stakeholders and Indigenous Peoples Health Research Centre to discuss the research findings and services that may better meet the needs of the Aboriginal women breast cancer survivors
- The SBCN developed and funded Our Lives through Our Eyes, an exhibit of participants' photos and stories
- Three exhibits are made available at no cost for any community, organization or survivor to borrow; access has been made available at screening sites, national and provincial health centres, conferences, Aboriginal workshops and Aboriginal community centres; whenever possible, a survivor is present
- Building on the strengths of VBC and the connections established during the project, SBCN reunited

participants to discuss ways to more appropriately represent Aboriginal women in SK

- An Aboriginal Women's Breast Cancer working group for SK was formed
- In response to Aboriginal women's desire to see their own images in screening literature ("I want to see a brown face"), committee members created a poster and pamphlets about support services and screening, with a photograph of participants and First Nations imagery and the slogan, "We want you to know"

PROGRAM REACH

- 10 Aboriginal women from Saskatchewan completed the photovoice project
- The approximate viewing audience is difficult to estimate as the display has at times spent a week or more in some centres

EVALUATION

Method

- Qualitative data analysis, ongoing

Key findings (both VBC + SBCN project)

- VBC provided an essential first step in supporting Aboriginal breast cancer survivors in SK, affirming their experiences, privileging their own wisdom and indigenous knowledge, validating their diversity, building collaborative relationships between the women and community partners and raising awareness of survivors' experiences
- Providing opportunities for Aboriginal women to identify and document their perspectives is essential to improve knowledge about Aboriginal women's wellness, and to develop practices, programs and policies geared toward empowering marginalized groups and improving health and community
- Participants continue to be connected to the breast cancer community and are motivated and committed to act as ambassadors to improve understanding and access to education and information about early detection within their communities

CRITICAL FACTORS FOR ADAPTATION

- Photovoice and other dialogues must be participatory and participant directed
- It is crucial for Aboriginal women to take the lead in engaging members of their own communities and in telling their own stories around breast health issues; this is similarly important when developing educational resources and activities
- Engage Aboriginal cancer survivors to relay the importance and relevance of breast cancer awareness and screening to Aboriginal women in their communities

CHALLENGES

- Participants took longer than anticipated to collect photographs for the VBC
- Connecting photovoice to social policy
- Coordinating reunions for participants was complicated by several factors, including difficulty tracking down more transient women, participants' inconsistent access to telephones, financial circumstances, concerns about solo or winter travel, and choosing dates that did not interfere with trapping, family care and/or employment

LESSONS LEARNED

- Allow several months for participants to take photographs and be flexible with deadlines
- Photovoice projects in Aboriginal communities must take into account that certain aspects of the culture (e.g., some natural medicines, Sweat Lodges, Sun Dances and other ceremonies) cannot be photographed because they are sacred
- Participants did not want to remain anonymous and preferred to be credited openly for their contributions
- Policymakers who participate in the community workshop should be chosen in consultation with the participants
- Arrange for prepaid bus tickets, direct billing of hotel and meals, etc., and consider including travel funding for a driver or companion

ADAPTATION FROM OTHER PROGRAMS

None

program contacts

Visualizing Breast Cancer

Carolyn Brooks, MA, PhD
Assistant Professor, Department of Sociology
University of Saskatchewan
1019 - 9 Campus Dr.
Saskatoon, SK S7N 5A5
Phone: (306) 966-5814
E-mail: carolyn.brooks@usask.ca

Our Lives Through Our Eyes

Doreen Callander, Advisory Committee Chair
Saskatchewan Breast Cancer Network
Coordinator, Cancer Control
Canadian Cancer Society
Saskatchewan Division
1036 College Dr.
Saskatoon, SK S7N 0W1
Phone: (306) 244-7600
E-mail: dcallander@sk.cancer.ca

Promoting a Healthy Lifestyle in Your Community Resource Kit



TARGET AUDIENCE: Aboriginal women living in communities across Saskatchewan

Program focus: All cancers, including breast, cervical and colorectal cancer

Challenges/risks faced by target population: Women in the target population have limited access to, awareness of and participation in screening programs. There is a lack of culturally appropriate resources, education and information delivery methods for Aboriginal communities to improve knowledge and understanding of risk reduction and healthy lifestyle choices.

Setting: Aboriginal communities

Province: Saskatchewan

Theoretical background: None stated

Program status: 2005 to present

Funder: Public Health Agency of Canada (2005 pilot); Canadian Cancer Society (2006 to present)

BRIEF OVERVIEW

- The Promoting a Healthy Lifestyle in Your Community Resource Kit was specifically designed for Aboriginal communities and contains information on a variety of topics under the heading “living a healthy lifestyle,” including prevention, early detection and risk factors related to certain types of cancers, including breast, cervical and colorectal cancer.
- The kit was distributed to community health leaders and representatives, who can tailor individual presentations to audiences, enabling groups to assert their own priorities.
- To date, responses to presentations and the kit indicate that they are effective means of promoting cancer awareness and screening among Aboriginal women.

PROGRAM GOALS AND OBJECTIVES

- To improve the health of Aboriginal communities
- To provide healthcare providers and community health leaders and representatives with a model for planning and implementing public events focused on living a healthy lifestyle, including prevention, early detection and risk factors related to certain types of cancers

PROGRAM IMPLEMENTATION STEPS

- The Saskatchewan Breast Cancer Network (SBCN) identified the need for a flexible, comprehensive resource kit that Aboriginal community health representatives and other lay health leaders could use to create “healthy living” presentations to members of their community

- With community consultation that included Aboriginal community members, healthcare providers and cancer survivors, the kit was assembled with the following components:
 - ♦ A planning and presentation binder, divided into easy-to-use sections for quick reference, which provides background information on promoting cancer awareness, risk reduction and “living a healthy lifestyle in your community”
 - ♦ A complete, step-by-step checklist is included to help facilitators plan, promote and implement education presentations in their communities
 - ♦ Reproducible master copies of handouts and forms for event planning and the education presentation
 - ♦ The education PowerPoint presentation “Living a Healthy Lifestyle,” which provides the facilitator/presenter with key points and questions for discussion; it is also available in electronic or CD format
 - ♦ A list of contacts, websites and resources for more information on living a healthy lifestyle
 - ♦ Additional resources can be accessed upon request, and include *Nanakatawithimiso: Take Care of Yourself*, a video about keeping Aboriginal women healthy, produced by the Peter Ballantyne Cree Nations Health Services, Saskatchewan, in 2007; the video asks the questions: Why should I have a Pap test? Why should I have a mammogram?

- The kit was publicized through local survivors' connections, community health representatives and the SBCN

PROGRAM REACH

- 76 kits have been distributed

EVALUATION

Method

- Participants completed evaluations forms, which were included in the kit

Key findings

- Not enough completed evaluation forms have been returned to draw conclusions

CRITICAL FACTORS FOR ADAPTATION

- Ensure that the kit allows for a variety of presentation formats and that it is flexible enough to let facilitators tailor presentations to individual audiences
- Market the health promotion messaging to make it palatable to the audience: invite participants for a social gathering with refreshments, and make the "healthy lifestyles" discussion the secondary draw; conversely, "healthy lifestyles" is potentially more appealing than "cancer screening"
- Always provide contact information for more resources or assistance
- Involve community health representatives, Aboriginal leaders and Elders in program development to ensure that the resource is appropriate, respected and accepted

CHALLENGES

- Developing the resource required several on-site discussions and pilot tests of the kit; review by e-mail was not a successful method with the Aboriginal representatives
- Only a limited number of comments and evaluations have been received

LESSONS LEARNED

- Be flexible: A community's priorities do not necessarily always mesh with organizers'
- Take advantage of an engaged audience to introduce topics, such as cancer screening, that may be less appealing to audiences
- Accessible, community-specific resources — like a video or DVD that can easily be screened to a living room full of people — are relatively simple, non-threatening and effective means of getting out messages about the importance of cancer screening

ADAPTATION FROM OTHER PROGRAMS

None

program links

www.cancer.ca/saskatchewan/about%20cancer/types%20of%20cancer/saskatchewan%20breast%20cancer%20network.aspx?sc_lang=en

program contact

Doreen Callander
 Advisory Committee Chair
 Saskatchewan Breast Cancer Network
 Coordinator, Cancer Control
 Canadian Cancer Society
 Saskatchewan Division
 1036 College Dr.
 Saskatoon, SK S7N 0W1
 Phone: (306) 244-7600
 E-mail: dcallander@sk.cancer.ca

Dr. W.C. Wiebe Clinic Reserved Booking Project



TARGET AUDIENCE: Underscreened women in Winkler, Manitoba

Program focus: Breast cancer

Challenges/risks faced by target population: Underscreened women are at increased risk for poorer health outcomes.

Setting: City of Winkler

Province: Manitoba

Theoretical background: Community capacity building

Program status: 2009 to present

Funder: Manitoba Health Initiatives/Manitoba Breast Screening Program

BRIEF OVERVIEW

- The Reserved Booking project is a joint initiative between the Manitoba Breast Screening Program (MBSP) and the Dr. W.C. Wiebe Medical Centre in Winkler, which has a database system that can identify women aged 50+ who have not had a mammogram in the previous two years.
- The MBSP provides reserved appointments at the W.C. Wiebe Medical Centre for women who have never come or who are overdue for a mammogram, thereby enabling them to make an appointment as soon as they are identified during a clinic visit.
- Data from the first year indicate that reserved booking can be an effective way for provincial screening program sites to work with primary care physicians to improve screening rates among underscreened women.

PROGRAM GOALS AND OBJECTIVES

- To improve screening attendance among women who have never come or are overdue for a mammogram and to provide them with easy access to mammography screening

PROGRAM IMPLEMENTATION STEPS

- The W.C. Wiebe Medical Centre was one of the first clinics in the province to become a demonstration site for the Physician Integrated Network (PIN) project, whose goal is to facilitate systemic improvements in the delivery of primary care in Manitoba

- Clinics that participate in the PIN project choose an area of concentration as part of the demonstration; the Wiebe Centre concentrates its efforts on preventative practices
- The Wiebe Centre asked the MBSP to partner with it to boost screening rates among underscreened women
- The clinic has a reminder system that can flag the physician's attention if a screening test is outstanding
- The clinic manager contacts the MBSP and arranges block appointments (i.e., designated times have been reserved specifically for the medical centre) so that clinic staff are able to book mammograms
- When a patient who is overdue for a mammogram sees the physician, a pop-up screen will appear, signalling to the physician that the woman is due/overdue for a mammogram
- The physician then sends the patient to the receptionist, who will book a mammogram appointment immediately

PROGRAM REACH

- From January 1, 2009, to December 31, 2009, 171 mammogram appointments were booked

EVALUATION

Method

Data was compiled on characteristic information and mammography history

Key findings

- 68 of the 171 women (40%) had not had a mammogram in the previous three or more years
- 105 women (61%) who had a mammogram were new to the MBSP, compared to the MBSP provincewide rate of about 21% for first appointments
- 25 women (15%) did not show up for their appointment; the MBSP provincial no-show rate was about 8%
- 55 women (32%) were born outside of Canada; the MBSP provincial rate was about 15%

CRITICAL FACTORS FOR ADAPTATION

- Clinics must have electronic medical records (EMR) software that is capable of tracking information such as mammography history, as well as a reminder system that can prompt physicians if a patient is overdue for a test

CHALLENGES

- It takes a significant investment of time and resources to transfer patient records from a paper and filing system to an EMR system, which may not be feasible for smaller clinics

- Even if a clinic has the necessary database system, it may not choose to focus its efforts on preventive/early detection practices such as breast cancer screening
- It can be difficult to convince other clinics to take the initiative to put the process in place

LESSONS LEARNED

- It is worth collaborating and building a relationship with a primary care clinic(s); this strategy is an effective way to encourage women who are overdue for mammograms to get screened
- Although EMR is very helpful in this direct-booking process, physicians without access to the software can still help to improve local screening rates by talking with their patients about screening and offering appointments for direct booking

ADAPTATION FROM OTHER PROGRAMS

Community group bookings used by the MBSP with First Nations and immigrant communities

program links

www.cancercare.mb.ca/mbsp
PIN project: www.gov.mb.ca/health/phc/pin/index.html

program contact

Brandy Pantel, Health Educator
Manitoba Breast Screening Program
25 Sherbrook St., Unit 5
Winnipeg, MB R3C 2B1
Phone: (204) 788-8353
E-mail: Brandy.Pantel@cancercare.mb.ca

The Early Detection is Your Best Protection Recall Fact Sheet



TARGET AUDIENCE: Underscreened women living in the north end of Winnipeg

Program focus: Breast cancer

Challenges/risks faced by target population: Many women living in the north-end area of Winnipeg are members of at-risk populations, including low-income, low-education, Aboriginal and immigrant groups. These groups are among those who are less likely to participate in regular cancer screening and shown to be at increased risk for poorer health outcomes.

Setting: Two postal code areas in the north end of Winnipeg

Province: Manitoba

Theoretical background: Population health; adult education principles

Program status: 2009 to present

Funder: Manitoba Breast Screening Program

BRIEF OVERVIEW

- The Early Detection is Your Best Protection recall fact sheet was created to educate and inform women being recalled to the Manitoba Breast Screening Program (MBSP) with the intention of encouraging them to book an appointment.
- A pilot test was conducted comparing the effectiveness of sending a standard recall letter plus educational fact sheet (N=398) with the current practice of a recall letter alone (N=404).
- Results indicated a 6% difference between the two groups, suggesting that the addition of the educational fact sheet to the recall letter may be an effective means of increasing screening rates in an underscreened community; comparisons are being planned for other postal code areas and in rural areas.

PROGRAM GOALS AND OBJECTIVES

- To examine if the practice of adding an educational fact sheet to a standard recall letter is effective at increasing breast cancer screening rates among women being recalled to the MBSP
- To provide women with accurate and up-to-date information about the benefits and limitations of mammography to help them make more informed decisions about returning for screening

PROGRAM IMPLEMENTATION STEPS

- An educational fact sheet was developed to accompany the standard letter sent to women who were being recalled to the MBSP; typically a pamphlet is included only when women are first invited for screening at the MBSP

- In response to criticisms of many breast screening programs, the fact sheet included both information about the advantages of mammography (i.e., why women should get screened) as well as its limitations; the aim was to help empower women to make more informed decisions about returning for screening
- The fact sheet also addressed misconceptions about mammography screening (e.g., once a woman gets a mammogram, she will not get breast cancer)
- Several drafts of the fact sheet were created
- Informal feedback was solicited from MBSP management and screening staff, and changes were made
- A revised draft of the resource was vetted by women in the clinic's waiting room and by members of the general public, who may have been more representative of women not getting re-screened
- Development of the fact sheet took about one year
- Two postal code areas were selected to pilot test the new fact sheet

PROGRAM REACH

- 398 of 802 recalled women were sent the educational fact sheet

EVALUATION

Method

- 802 recalled women were divided into two groups (N = 398 and 404, respectively) based on the first letter of their last name

- The first group received the standard recall letter plus the educational fact sheet
- The second group received the recall letter only
- 98% of women in both groups were due for a two-year recall letter

Key findings

- 67% of two-year recall women (i.e., women who should have mammograms every two years according to clinical guidelines) from the first postal code who received the fact sheet plus recall letter booked a mammogram appointment, compared to 57% of women who received the letter only
- 71% of two-year recall women from the second postal code who received the fact sheet plus recall letter booked a mammogram appointment, compared to 70% of the women who received the letter only
- Overall, 69% of the women (one- and two-year recall) who received the fact sheet plus recall letter booked a mammogram appointment, compared to 63% of the women in the letter-only group

CRITICAL FACTORS FOR ADAPTATION

- Consider the target audience, the purpose of the resource and what the agency hopes to achieve when creating the resource
- Gather as much feedback as possible
- Tailor the reading level of the resource to the target audience(s)

CHALLENGES

- Clarifying the main purpose of the resource (e.g., to educate and inform women about mammography or to increase screening rates)
- Deciding and agreeing on what information to include in the resource; for example:
 - Understanding the limitations of mammograms may empower women to trust themselves when they notice changes in their breasts

- Knowing that women’s breasts change over the lifetime may encourage women whose last screening experience was painful to reconsider getting re-screened
- While communicating information about the average lump size is common, not all cancers are lumps and it is important for women to be aware of other conditions such as inflammatory breast disease; it is also hard to relay this information effectively in print form

LESSONS LEARNED

- Be more focused and targeted when gathering feedback about draft versions of the brochure (e.g., open-ended questions can be helpful in generating feedback, but may generate a lot of irrelevant information)

ADAPTATION FROM OTHER PROGRAMS

Facts were gathered from various sources such as the Canadian Cancer Society

program links

None currently available

program contact

Brandy Pantel, Health Educator
 Manitoba Breast Screening Program
 25 Sherbrook St., Unit 5
 Winnipeg, MB R3C 2B1
 Phone: (204) 788-8353
 E-mail: Brandy.Pantel@cancercare.mb.ca

Improving Access to Breast Screening for First Nation Women from Small, Isolated Manitoba Communities



TARGET AUDIENCE: Geographically isolated First Nation women, including low-income women, older women and women of low literacy or whose first language is not English

Program focus: Breast cancer

Challenges/risks faced by target population: Some First Nation women in Manitoba live in very isolated communities without mobile access or reasonable winter road access to the closest breast screening site.

Setting: 10 northern First Nation communities

Province: Manitoba

Theoretical background: Determinants of health

Program status: 2006 to present

Funder: CancerCare Manitoba Foundation (pilot); CancerCare Manitoba (ongoing)

BRIEF OVERVIEW

- The project covers costs to fly women via charter flights from 10 remote communities without screening access to the closest fixed or mobile screening site.
- The project coordinates ground transportation, flights, refreshments and mammograms.
- Results indicate that directly addressing transportation barriers to screening by involving community health workers and providing transportation greatly improves screening attendance.

PROGRAM GOALS AND OBJECTIVES

- To increase the number of women attending breast screening in 10 northern communities
- To determine the logistics of arranging flights to the nearest screening site
- To determine the feasibility of transporting mammography equipment by plane
- To develop a business case for ongoing funding

PROGRAM IMPLEMENTATION STEPS

- Health workers such as nurses or community health representatives from the communities contacted eligible women by telephone or home visits
- Ground transportation was arranged to bring women to and from the airport and the nearest screening site; return flights were also arranged
- Refreshments were provided in the host community
- A cost analysis was conducted to determine the type of plane to use for each community

PROGRAM REACH

- 128 of the 282 women in the age-eligible population (50–69 years) were reached in the pilot project

EVALUATION

Method

- Participation rates, abnormal results and breast cancer detection were measured

Key findings

- Screening participation rates rose from 17% to 53% in the 10 target communities combined, compared to the provincial rate of 52% at the time
- 82 (64%) women had their first visit with the Manitoba Breast Screening Program; almost all the remaining women were overdue for a mammogram
- 10 women had abnormal results; two women were diagnosed with breast cancer

CRITICAL FACTORS FOR ADAPTATION

- Obtain active support from the health staff in the community and from the health centre hosting the mobile sites
- Have a single event that focuses on breast cancer screening and make the trip pleasant for the women by having some refreshments and making it an outing; attempts to bring women in for a mammogram while they were in the clinic for other health issues were not successful
- Have sufficient funding, as flights are expensive

CHALLENGES

- Weather is an issue when transporting screening staff, participants and equipment by air
- In small communities, situational events such as funerals or forest fires can cause a carefully planned screening day to fall through with little notice

LESSONS LEARNED

- It took years to obtain funding for this project; agency needs to be persistent
- Building relationships with people in the community is crucial (e.g., health workers in the communities often have busy schedules and competing priorities)
- It is necessary to send women to a screening site with the requisite resources to take on the responsibilities of a host site (e.g., mobile sites in small health centres may not have the capacity to pick up women at the airport and provide refreshments)

ADAPTATION FROM OTHER PROGRAMS

None

program links

None currently available

program contact

Katie Watters, Manager
Program Development and Education
Manitoba Screening Programs
CancerCare Manitoba
25 Sherbrook St., Unit 5
Winnipeg, MB R3C 2B1
Phone: (204) 788-8630
E-mail: katie.watters@cancercare.mb.ca

Multicultural Outreach: Cancer Education and Screening Project



TARGET AUDIENCE: Chinese, Vietnamese, Spanish, Filipino and Portuguese women

Program focus: Breast and cervical cancer

Challenges/risks faced by target population: Figures from Statistics Canada and advice from the Sexuality Education Resource Centre (SERC) in Manitoba indicated that immigrant women aged 50–69 were less likely to be screened; the target ethnic groups had the largest population sizes.

Setting: Community level

Province: Manitoba

Theoretical background: Population health; community capacity building; determinants of health

Program status: 2005–2007; 2008 to present

Funder: Public Health Agency of Canada (pilot); CancerCare Manitoba (ongoing)

BRIEF OVERVIEW

- This two-year, multicultural outreach project was developed to improve breast and cervical cancer screening rates among women from five immigrant communities in Manitoba by addressing barriers related to culture, access, transportation and language.
- Evaluation of the project indicated that immigrant women appreciated receiving information in their own language and many were not aware of the information or services available.
- Funding has been secured to keep the program active.

PROGRAM GOALS AND OBJECTIVES

- To increase the number of Chinese, Vietnamese, Spanish, Filipino and Portuguese women getting screened for breast and cervical cancer
- To increase awareness about breast and cervical cancer
- To determine whether the underserved women were reached

PROGRAM IMPLEMENTATION STEPS

- Manitoba's breast and cervical cancer screening programs formed a partnership with the Sexuality Education Resource Centre, Klinik, Mount Carmel Clinic, Breast Cancer Centre of Hope and Manitoba Breast Cancer Network
- The project group established an advisory committee in each of the five targeted communities to provide direction and guidance on project activities (e.g., places to hold presentations and ideas about promoting the presentations)

- With assistance from the advisory committees, five facilitators (one from each cultural group) were hired and trained
- Each facilitator was then asked to expand community capacity by engaging five community support people to seek out women in the community and coordinate presentation opportunities
- The facilitators were first given a one-day training on community outreach and later joined the support people in a two-day training
- Training covered an overview of breast and cervical cancer, risk factors, information on screening and where to go, lesson plans and presentation kits that included translated videos and brochures
- Presentations were held in places of worship, homes, cultural centres, language schools and apartment blocks
- The facilitators and support people also identified underscreened women and organized group trips for women who needed support to get screened

PROGRAM REACH

- 892 women, including those hired to deliver the program, have been reached through 57 presentations and group trips

EVALUATION

Method

- Using translated project evaluation forms, participants were asked to provide demographic information and to comment about the importance of translated

information, as well as their knowledge of screening and cancer services

- Two focus groups were also conducted with the facilitators and community support people to gather feedback about women's experiences with the project

Key findings

- 71% of the women said it was very important to receive information in their own language; all the information was new to 64–81% of the women; 15–37% were not aware of the healthcare centres
- 57 women participated in breast screening group trips and 124 women participated in Pap screening group trips
- 53% of the women in the Pap screening group trips had not had a Pap test in more than five years; one woman was diagnosed with a high-grade cervical abnormality
- 61% of the women in the breast screening group trips were new to the screening program; one woman was diagnosed with breast cancer
- Overall, the facilitators and community support people reported that the objectives of the project had been met; the breadth of its success, however, was limited by insufficient time and resources

CRITICAL FACTORS FOR ADAPTATION

- Have translated resources (e.g., videos and brochures) to make it easier to get information to diverse groups of women
- Work in partnership with an organization that has ample experience working with immigrant populations and has strong connections in the communities; this will help facilitate the recruitment of suitable candidates from the targeted communities
- Maintain strong and continuous relationships with the working partners
- Secure sustainable funding

CHALLENGES

- It proved difficult to coordinate transportation for group trips (e.g., sometimes facilitators had to call CancerCare Manitoba several times to find a date when a van and volunteer were available)
- The short-term nature of the project was challenging; grant funding is time limited and there is no guarantee of additional funding to continue or expand the work
- Some segments of the communities were not reached (e.g., the Mandarin-speaking and Brazilian communities)

LESSONS LEARNED

- The large variation within and between cultural communities with respect to knowledge levels, learning styles and group trip needs, required facilitators to use different approaches with each community
- An integrated approach (e.g., one that covers prevention and screening programs for several cancers) may be a good strategy for presenting cancer topics to immigrant communities
- A comprehensive video is a valuable tool to accompany the presentation because it ensures accurate and consistent content
- Refresher training sessions can be offered to the facilitators and community support people to keep them up to date
- Translated cancer treatment information is essential
- Managing five communities on top of other work duties is difficult; recruiting a project coordinator or reducing the communities to three may be more manageable
- To address some of the challenges, a comprehensive Reduce Your Cancer Risk video (see page 52) was produced with voiceover translations to form the basis of presentations with other cultural groups

ADAPTATION FROM OTHER PROGRAMS

This project was an expansion of a pilot project in the Indo-Canadian community

program links

Translated pamphlets:
www.cancercare.mb.ca/breasthealthresources
www.cancercare.mb.ca/index.cfm?pageid=276

program contact

Katie Watters, Manager
Program Development and Education
Manitoba Screening Programs
CancerCare Manitoba
25 Sherbrook St., Unit 5
Winnipeg, MB R3C 2B1
Phone: (204) 788-8630
E-mail: katie.watters@cancercare.mb.ca

Reduce Your Cancer Risk Facilitator Tool Kit with DVD



TARGET AUDIENCE: Community health facilitators, Aboriginal women, immigrant women, women whose first language is not English and the general public

Program focus: Breast, cervical and colorectal cancer

Challenges/risks faced by target population: With the implementation of the ColonCheck Manitoba program, and an increased focus on prevention messages, a general screening and risk reduction resource was required to empower health professionals to provide consistent, reliable and up-to-date health information to Manitobans about reducing their cancer risk.

Setting: Diverse communities across Manitoba

Province: Manitoba

Theoretical background: Social marketing strategy; positive reinforcement theory; community development approach

Program status: 2008 to present

Funder: Merck; Glaxo Smith Kline; Artificial Intelligence in Medicine; CancerCare Manitoba Foundation; Public Health Agency of Canada; Manitoba breast, cervical and colorectal cancer screening programs

BRIEF OVERVIEW

- The Reduce Your Cancer Risk Facilitator Tool Kit with DVD was developed for community health facilitators such as multicultural outreach workers, community health representatives, public health nurses and volunteers to use in their communities.
- The comprehensive resource toolkit can be used in multicultural outreach projects and has the potential to reach many people in the community.

PROGRAM GOALS AND OBJECTIVES

- To increase awareness of cancer risk reduction strategies and increase screening rates among underscreened individuals

PROGRAM IMPLEMENTATION STEPS

- The Manitoba breast, cervical and colorectal cancer screening programs and the CancerCare Manitoba Foundation team identified the need, secured funding and consulted with stakeholders from various multicultural groups to develop a comprehensive resource
- The team applied a multi-pronged social marketing strategy to ensure that the toolkit reached a broad range of communities provincially
- The Reduce Your Cancer Risk Facilitator Tool Kit includes a presentation outline, recruitment activities, a comprehensive frequently asked questions list, sample resources and an order form; it also includes a 25-minute, multi-language Reduce Your Cancer Risk DVD

- A facilitator training session was conducted to distribute the toolkit to health facilitators and to train them on how to deliver the kit and to facilitate group sessions on risk reduction for breast, cervical and colorectal cancers
- Beat Cancer Drum Café, a free, public event involving an interactive drumming session, was hosted to promote awareness about screening and risk reduction for cancer
- Ensuring that the healthy messages reached Manitobans from diverse backgrounds and communities, in particular Aboriginal communities and immigrants, was a priority; as such, educators from inner-city, multicultural and northern communities were invited to the facilitator training workshop, and the DVD was dubbed into 16 languages
- “Pass it on” copies of the DVD were created to encourage community members to pass on the DVD to interested friends and family
- To track the reach of the pass-it-on DVDs, a prepaid postcard was attached to each copy; each viewer signed the postcard after watching the DVD and passed it on; once the card was full, the viewers were asked to mail the postcard to CancerCare Manitoba
- Looped versions of the DVD were distributed to doctor’s offices throughout the province to be played in waiting rooms
- The DVD and related resources were made available online on the CancerCare Manitoba website, and

in binder form in various community networks and Manitoba libraries

- Information in the toolkit and DVD focuses on positive messaging such as informing individuals about what they can and should do instead of what they cannot or should not do; this helps get people thinking about how they can change their lifestyles

PROGRAM REACH

- More than 60 community health facilitators attended the facilitator training session
- Approximately 1000 copies of the DVD were distributed across the province
- The looped version of the DVD was played at MBSP fixed and mobile sites, where 45,000 women get screened yearly
- 173 facilitator toolkits were distributed

EVALUATION

Method (Evaluation in progress)

- Evaluation forms were gathered from health educators using the toolkit, an e-mail survey was sent to individuals who received a DVD, and web activity was monitored to evaluate online viewing
- Results were also based on number of DVDs distributed, "pass it on" postcards and completed presentation evaluation forms

Key findings

- As of January 2010, the toolkit was used to deliver 105 multilingual presentations in communities from six different regional health authorities, reaching more than 1600 people; an average of 15 people attended each presentation; eight groups of women were motivated to go for a mammogram or Pap test
- Women also picked up fecal occult blood test (FOBT) kits (for colorectal cancer screening) after seeing the DVD in the breast screening waiting area

CRITICAL FACTORS FOR ADAPTATION

- Collaborate with other organizations to increase program reach and funding sources (e.g., the Breast and Women's Cancer Network helped increase program reach, while other partners helped access new funding sources)
- Take the time to develop the messages in the DVD and make the messages general enough so that small changes will not make DVD content obsolete
- Make the toolkit as easy as possible to use (e.g., by

providing health facilitators with all the materials needed to educate the public)

- Consult with multicultural groups to get their feedback about the type of resources they want and to develop the type of risk-reduction messages that work for that particular group

CHALLENGES

- Finding new ways to promote the toolkit and DVD in different communities
- Keeping the resources up to date and evidence based in response to changes in health guidelines, practices and messaging

LESSONS LEARNED

- By working together as part of a joint initiative, the three Manitoba screening programs and CancerCare Manitoba Foundation became a strong force and were able to accomplish a great deal
- The resource included messaging related to risk reduction and prevention across all three screening programs, as well as general risk reduction for all cancers; this approach, rather than separating the programs, makes information easier for educators to access and distribute to the public

ADAPTATION FROM OTHER PROGRAMS

The tool kit was adapted from Ovarian Cancer Canada's "Listen to the Whispers" program

program links

[www.cancercare.mb.ca/
breasthealthresources](http://www.cancercare.mb.ca/breasthealthresources)

program contact

Kimberly Templeton
Program Manager
Manitoba Cervical Cancer Screening
Program
25 Sherbrook St., Unit 5
Winnipeg, MB R3C 2B1
Phone: (204) 788-8648
E-mail: [kimberly.templeton@
cancercare.mb.ca](mailto:kimberly.templeton@cancercare.mb.ca)

50 Over 50 Challenge



TARGET AUDIENCE: Never screened women aged 50+

Program focus: Breast cancer

Challenges/risks faced by target population: The Ontario Breast Screening Program, Northeast Region, covers a 115,000-square-mile radius and faces some of the greatest geographical barriers in the province. Two barriers known to discourage women from participating in breast screening are fear it will be painful and time (i.e., “I haven’t gotten around to it”).

Setting: North Bay, Sudbury (two sites), Moose Factory, Kapuskasing, Timmons and Sturgeon Falls

Province: Ontario

Theoretical background: None stated

Program status: 2007 to present

Funder: Ontario Breast Screening Program, Northeast Region; North Bay Hospital Foundation; community corporate and media sponsors

BRIEF OVERVIEW

- The 50 Over 50 Challenge is a one-day event to screen 50 or more women who have never had a mammogram in a 12-hour period; this idea originated from the Ontario Breast Screening Program (OBSP) in London, Ontario.
- Expanding each year, the event has been shown to be an effective way of increasing breast cancer awareness and screening rates among never- and underscreened women in Northern Ontario.

PROGRAM GOALS AND OBJECTIVES

- To reduce breast cancer mortality by screening 70% of eligible women by 2010 and 90% by 2020
- To screen 50 unscreened women in a 12-hour period (with more sites added each year, the goal has grown to 250 over 50)

PROGRAM IMPLEMENTATION STEPS

- A consultation process was conducted with screening staff (primarily nurses and technicians) and public health to gain internal buy-in, identify challenges, problem-solve and get recommendations
- A steering group was formed consisting of OBSP staff and community partners (e.g., Canadian Cancer Society lay health educators; see page 102) from underscreened communities or a local coalition
- The annual event date was confirmed for the last Monday of October from 8 a.m. to 8 p.m.
- A budget was established
- Community corporate sponsors were solicited for door prizes and incentives such as mugs filled with health

information and educational tools

- Media sponsors were solicited; some also offered points for loyalty club listeners and free advertising on their websites
- Radio stations were identified based on their reach to women in the 50+ target age group (e.g., easy rock, adult contemporary)
- Four-hour radio remotes were purchased for each of the OBSP sites
- Some interview subjects were pre-selected to highlight personal stories and key messages
- A schedule was created to ensure that enough staff were on hand to meet the demands of the day and to accommodate regular breaks (e.g., having a dedicated staff member taking clinical histories can save valuable time)
- Strategies to address overflow and wait times of up to two hours were created (e.g., displays on healthy living or volunteers doing pink braids)
- Each site was provided with an event kit that included the 50 Over 50 logo; sponsorship letter; advance flyer; customizable event poster; event PSAs; suggested event sponsors, key messages and radio interviews; and a sample press release, thank you letter, and letter to the editor
- A shuttle service was coordinated to transport women to the screening site
- Post-event requirements, including press releases, letters to the editor and thank-you letters highlighting the number of women screened were drafted and sent to relevant sponsors and supporters

PROGRAM REACH

- In 2007, a total of 88 women were screened at one site; in 2008, with two sites participating in competition, a total of 182 women were screened; in 2009, 276 women were screened at seven sites

EVALUATION

Method

- OBSP database screening statistics were cross-referenced with the number of eligible women by postal codes
- Qualitative interviews with women
- Survey questions were printed on the back of hourly prize draw cards asking women how they heard about the Challenge and what brought them in the door

Key findings

- At least 75% of women were never screened
- At least 20% of women were from underscreened communities
- Most women liked the event because they had fun and didn't have time to become anxious
- Messaging on the radio remotes was a motivating factor for women to get screened

CRITICAL FACTORS FOR ADAPTATION

- Create a sense of urgency around the issue of breast screening (e.g., "Do women in the northeast have what it takes to show the northwest they are serious about early detection in the battle against breast cancer in a 12-hour period?")
- Offer tangible incentives for women to participate in a specific timeframe, such as draw prizes, small gifts and refreshments
- Provide opportunities for women to overcome procrastination provoked by anxiety about the process or simply the lack of time (e.g., "If you are a woman 50 or over and you haven't crossed 'breast screening' off of your to-do list, today is the day to make time for you!")
- The program requires the capability to screen 50 women or more within a 12-hour period; hub sites can support smaller communities by sending clerical staff
- Support from key stakeholders and partners is key, as is support from the business community for incentives
- A small amount of funding is required to have a four-hour radio remote during the course of the day; competitive disc jockey chat between well-known radio personalities and personal testimonials (e.g., that

- having a mammogram wasn't nearly as bad as feared) were critical to getting women in the door
- Need to be able to handle overflow and wait times of up to two hours in ways that enable women to have fun, access valuable information and have qualified staff to answer their questions

CHALLENGES

- Be able to anticipate and be prepared to respond to rushes and lulls
- Weather (e.g., a snowstorm in Sudbury severely affected the ability of women to participate)
- Making sure staff had access to nutritious meals to keep them fueled and to demonstrate appreciation for their hard work

LESSONS LEARNED

- Competition between communities is a great way to promote a sense of urgency and motivate women to get screened today
- The event is a huge undertaking for one day; the momentum, however, is long lasting, resulting in numerous spinoff appointments
- The event generated great momentum coming out of breast cancer month and into November
- The event is flexible enough that each site can reflect the unique personality of its community and planning committee partners

ADAPTATION FROM OTHER PROGRAMS

Based on the marathon concept conceived by the Regional OBSP Centre in London, Ontario

program links

None currently available

program contact

Sharon Bowes, Health Promotion Coordinator
Ontario Breast Screening Program —
Northeast Region
4 Waldford Rd.
Sudbury, ON P3E 2H4
Phone: (705) 675-2294
E-mail: sbowes@hrsrh.on.ca



Breast Cancer Risk Factors: What You Can Do About Them!

Some factors you **cannot** change.



Being a woman



Your age



Your family history

Some factors you **can** change.



Lose a few pounds



Exercise more



Limit your alcohol



Stop smoking

If you make these changes you can **also** reduce the risk of...



Diabetes



High blood pressure



Heart attack and stroke



Colon or bowel cancer

Three things you **can** do for good breast health.



Know your own breasts and check for any changes.



Women age 40 and over should have a breast exam done by a nurse or doctor at least every two years.



All women over the age of 50 should have a mammogram – a special x-ray of the breasts – every two years.



For more information, talk to your doctor or nurse, or call the Breast Screening Program in Yellowknife (867) 873-0452 in Hay River (867) 874-7223.

Sponsored by:



NORTHWEST TERRITORIES DEMONSTRATION PROGRAM OF THE INTEGRATED STRATEGY IN HEALTHY LIVING AND CHRONIC DISEASE RISK FACTOR CAMPAIGN, PAGE 26



GATEWAYS TO CANCER SCREENING: A PARTICIPATORY NEEDS ASSESSMENT OF WOMEN WITH MOBILITY DISABILITIES, PAGE 84



THE USE OF MOBILE SCREENING UNITS TO REACH WOMEN LIVING IN REMOTE AREAS, PAGE 132

When was your last Mammogram?



Women aged 50 to 69 should have regular screening mammograms.
Women 40–49 should talk to their health care provider about their breast cancer risk and their need for screening mammograms.

To book a mammogram or learn more call 1.866.727.3926 or visit www.screeningforlife.ca



ABORIGINAL BREAST CANCER SCREENING RESOURCE TOOLKIT, PAGE 34



BE A BREAST FRIEND SALON PROJECT: HEALTH PROMOTION IN A NON-TRADITIONAL SETTING, PAGE 60

Don't forget to order your **FREE** resources today and fill out our online survey to win **great prizes!**

Stylists save lives. Be a breast friend.

www.beabreastfriend.ca

FREE

Squeeze

BE A BREAST FRIEND

Meet A Mammogram Technician

5 Things EVERY WOMAN NEEDS TO KNOW ABOUT MAMMOGRAMS

Reducing Your Risk of BREAST PROBLEMS

My First Mammogram

Kimmy Phuong Hoang's inspiring story about... by conquering fear and... regular breast screenings are so important.

One early detection... three generations of women

Thanks to breast screening, this grandmother is here to share her wisdom and guidance because her breast cancer was detected early.

Grâce au dépistage du cancer du sein, cette grand-mère est présente pour partager sa sagesse et ses conseils puisque son cancer du sein a été dépisté tôt.

Canadian Cancer Society / Société canadienne du cancer

Have a Pink Party!

WHAT

Throwing a Pink Party is a great way to get your friends or colleagues together **AND** raise awareness about breast health and cervical cancer prevention. Pink Parties are similar to other home parties, except that nothing is being sold at a Pink Party. We've added an educational component to something that is already fun!

Your Pink Party could be held over lunch with the women at your office, as part of a potluck at your place ("Pink Potluck") or with a group of your girlfriends on a Saturday Night. Be creative...let's get people talking!

WHEN

Any day, anytime, any month of the year.

HOW

Once you have picked a date and invited your guests (less than 20 is ideal, the maximum is 25) please contact the Canadian Cancer Society and ask for a free Pink Party Kit.

Phone: 1-800-455-9090 or Email: ccsnb@nb.cancer.ca

Your kit includes everything you need:

- Breast Trivia Game (the ultimate conversation starter)
- Cervical Cancer Quiz and brochure
- "Thingamaboobs" for everyone!
- Early detection and screening pamphlets, shower cards, pledge cards
- Pink themed decorating, food and drink ideas

Let's Get People Talking!

Join us on [facebook](https://www.facebook.com/cancer.ca)

PINK PARTIES, PAGE 136

"BECAUSE I CARE..." POSTCARD AND INCENTIVE CAMPAIGN, PAGE 62

Aboriginal Breast Health Train-the-Trainer Program



TARGET AUDIENCE: Frontline workers who work with Aboriginal women

Program focus: Breast cancer

Challenges/risks faced by target population: Aboriginal women have lower cancer screening rates compared to the general population, and those with breast cancer have the poorest five-year survival rate in North America.

Setting: City of Hamilton; Aboriginal communities in Hamilton, Brantford, Six Nations and New Credit

Province: Ontario

Theoretical background: Campinha-Bacote's model of cultural competence; community development

Program status: 2006–2008

Funder: Canadian Breast Cancer Foundation, Ontario Region

BRIEF OVERVIEW

- The Aboriginal Breast Health Train-the-Trainer program was designed to impart breast health knowledge to frontline workers who work with the Aboriginal population. In turn, the workers provided breast health education workshops to Aboriginal women in their communities.
- An Aboriginal-specific breast health workshop manual and resource kit were developed to train the frontline workers; an Aboriginal-specific cultural awareness training series was delivered to staff from the Ontario Breast Screening Program (OBSP).
- Evaluation of the training programs indicated an increase in knowledge about breast health and screening among frontline workers; this initiative resulted in a substantial increase in the number of Aboriginal women participating in mammography screening at local OBSP sites.

PROGRAM GOALS AND OBJECTIVES

- To reduce breast cancer mortality among Aboriginal women through increased breast health education and routine mammography
- To increase education and awareness about breast health and cancer screening among Aboriginal women living in the target regions
- To increase levels of education and awareness about breast health and cancer among frontline workers, healthcare providers and caregivers who provide services to Aboriginal women
- To provide culturally appropriate breast health education
- To provide capacity and skill building opportunities for Aboriginal women to engage in breast health education

training and to share their expertise, thus reaching greater numbers of Aboriginal women

- To increase the number of Aboriginal women who use early detection methods
- To clarify misconceptions about breast cancer and reduce fear and denial
- To provide cultural awareness training to OBSP staff

PROGRAM IMPLEMENTATION STEPS

- A steering committee was established with membership from the De dwa da dehs nye>s Aboriginal Health Centre, OBSP, Juravinski Cancer Centre and City of Hamilton Public Health Services
- A project coordinator was recruited; program activities (i.e., train-the-trainer and cultural awareness training) were identified and a project launch was organized
- An OBSP tracking system was developed to identify women who attended the OBSP as a result of project activities
- Networking meetings and events with Aboriginal frontline workers were held to raise awareness of the program and recruit members for the advisory committee
- After reviewing existing breast health education manuals and materials, content for the train-the-trainer workshop manual's modules were identified; a culturally appropriate training manual and resource kit were developed, reviewed and edited with input from the advisory committee and Aboriginal community
- The course was subsequently promoted to Aboriginal frontline workers

- Other materials were developed (e.g., evaluation tools, Aboriginal-specific OBSP resource materials (brochure and poster), and media package)
- A two-day train-the-trainer workshop was offered twice; the second workshop was revised based on feedback from the first workshop; a group facilitation workshop on Aboriginal adult learning principles was offered, based on needs identified during the second workshop
- A four-part Aboriginal cultural awareness training series was offered to OBSP staff at various OBSP sites within the region
- Project data was collected and analyzed

PROGRAM REACH

- 34 women participated in the train-the trainer program; the number of women they reached in their communities is difficult to determine

EVALUATION

Method

- Pre- and post-training knowledge surveys, telephone interviews and anecdotal comments

Key findings

- Participants in the Aboriginal Breast Health Train-the-Trainer program demonstrated an average 30% knowledge increase from pre- to post-surveys in breast health, breast cancer, early detection practices and healthy lifestyle choices
- Several months following the program, all graduates contacted had shared their new knowledge with coworkers, friends, family and clients of their respective agencies
- Continued evaluation of program outcomes showed a substantial increase in the number of women participating in mammography screening at local OBSP sites as the result of this initiative
- Participants in the cultural awareness training series displayed greater knowledge of Aboriginal culture and issues (e.g., impact of residential schools) and rated the sessions as highly interesting and relevant

CRITICAL FACTORS FOR ADAPTATION

- Secure adequate funding, preferably ongoing, for a full-time project coordinator, development of resource materials, project promotion, etc.
- Have members from the Aboriginal community deliver the train-the-trainer workshop modules

CHALLENGES

- Community engagement
- Securing funds to disseminate the final report to the community and celebrate project accomplishments

LESSONS LEARNED

- A permanent project chair and a full-time, Aboriginal project coordinator should be recruited at the beginning of the project
- It would be beneficial to have more Aboriginal representation on the steering committee
- More incentives could be offered for membership on the advisory committee
- More realistic time frames for project completion should be set (i.e., this should have been a three-year project, which would have allowed for a more complete dissemination plan)
- Ongoing funding is necessary to maintain the program and ongoing support should be provided to program graduates
- Social events are necessary for promoting the project in the Aboriginal community
- Regularly scheduled meetings would ensure ongoing communication and meeting of timelines

ADAPTATION FROM OTHER PROGRAMS

The City of Hamilton Women’s Health Educator Program (see page 128)

program links

www.hamilton.ca/NR/rdonlyres/05E3832D-E002-4817-8C4E-25CC469D8823/0/AboriginalBreastHealthProjectReport.pdf

program contact

Cindy Mutch
 Regional Health Promotion Coordinator, OBSP
 Hamilton, Niagara, Haldimand and Brant (LHIN 4)
 Sir William Osler Health Institute
 565 Sanatorium Rd., Suite 207
 Hamilton, ON L9C 7N4
 Phone: (905) 521-2100 ext. 79283
 E-mail: Cindy.Mutch@jcc.hhsc.ca

Be a Breast Friend Salon Project: Health Promotion in a Non-Traditional Setting



TARGET AUDIENCE: All women, including underserved and hard-to-reach women

Program focus: Breast cancer

Challenges/risks faced by target population: Although breast cancer is the most common type of cancer among women in Ontario, currently, only about 60% of women in the province aged 50–69 have regular mammograms. Innovative practices that reach out to women in familiar, non-traditional settings may play a role in boosting awareness and screening rates among underserved and hard-to-reach populations.

Setting: Regions of Hamilton, Halton, Niagara, Brant and Haldimand-Norfolk

Province: Ontario

Theoretical background: PRECEDE-PROCEED model

Program status: 2008 to present

Funder: Canadian Breast Cancer Foundation, Ontario Region

BRIEF OVERVIEW

- The Be a Breast Friend Salon Project capitalized on the unique, intimate relationship women have with their hair stylists; stylists were empowered to talk with their clients about breast health and the importance of regular breast cancer screening for women aged 50+ years.
- Women who visited participating salons reported an increase in awareness of breast health and intention to participate in breast cancer screening after speaking to their hair stylists and reading project resources.

PROGRAM GOALS AND OBJECTIVES

- To build community capacity by engaging hair stylists to act as lay health educators to promote regular breast cancer screening
- To increase awareness of four key breast health messages:
 - ♦ Mammograms can save lives
 - ♦ Women 50+ need regular mammograms
 - ♦ All women should know how their breasts look and feel
 - ♦ Women aged 50+ can book their own mammograms at the Ontario Breast Screening Program (OBSP)
- To increase the number of women planning to attend the OBSP in the Hamilton, Halton, Niagara, Brant and Haldimand-Norfolk regions of Ontario

PROGRAM IMPLEMENTATION STEPS

- A joint initiative was formed with representation from

Hamilton, Halton, Niagara, Brant and Haldimand-Norfolk public health units

- A pilot project, conducted in partnership with the Canadian Cancer Society, the OBSP and hairstylists, guided the development and implementation of the present, larger-scale project
- A recruitment package was launched and mailed to 980 salons, asking them to engage in conversations with their clients and to promote the project's four key breast health messages
- The salon recruitment package contained: a brochure outlining project details; copies of *Squeeze*, a glossy, full-colour breast health magazine; a "Stylists saves lives. Ask me how." workstation mirror decal to prompt conversation; emery boards with the OBSP's toll-free number and the project's website address; and Canadian Cancer Society "Thingamaboobs," educational keychains that help stylists to show clients the different lump sizes that can be detected through a variety of breast screening methods
- Stylists and clients were directed to the project's website to learn more about the project, to read *Squeeze* magazine online and to complete a survey
- A reminder postcard was sent after three months to all salons in the region, encouraging them to take part in the project
- Incentive prizes were offered to salons that encouraged stylists and clients to complete and return the evaluation surveys

PROGRAM REACH

- 980 salons received recruitment packages and 5360 people visited the website

EVALUATION

Method

- Hair stylists and their clients completed surveys

Key findings

Client survey results (N = 630)

- 51% of the clients were 50+ years
- 71% reported having a conversation about breast health with their stylists and 30% of eligible clients reported that they planned to book a mammogram because of the conversation
- 65% felt encouraged to get regular mammograms
- 96% were interested in having their stylists talk about breast screening and thought salons were an appropriate place to do so
- 97% reported that *Squeeze* magazine was an informative resource
- 98% felt that the Thingamaboob was an informative visual tool
- 94% planned to tell other women about the importance of mammography
- 75% responded accurately to knowing that they could book their own mammogram

Stylist survey results (N = 62)

- 68% reported speaking to five or more clients per week about breast screening
- 96% thought the four key messages about breast screening were easy to remember
- 98% felt comfortable talking to their female clients about the importance of regular breast screening; 74% felt comfortable talking to their male clients about the importance of regular breast screening
- 100% thought the project was easy to implement and that the salon was an appropriate venue to discuss health topics
- 95% reported they would continue to promote breast screening to their clients

CRITICAL FACTORS FOR ADAPTATION

- Get support and reduce costs by soliciting project stakeholders and partners
- Create professional-looking educational tools to promote salon buy-in
- Have a champion at each salon to increase the commitment and sustainability of the project, and engage champions in planning

- Be flexible to salons' needs and abilities to adopt all aspects of the project into their business setting and operations (e.g., some salons could not accommodate the mirror decal)
- Build a strong brand image and keep the messaging consistent so that people instantly recognize the project
- Keep the messages simple and easy to remember

CHALLENGES

- Obtaining up-to-date mailing lists; some salons had moved or gone out of business, resulting in wasted packages
- Having enough stylists and clients complete the online survey
- Evaluating whether women are booking mammogram appointments at the OBSP as a result of speaking with their stylists, especially within a short period of time

LESSONS LEARNED

- Providing hard copies of the surveys and offering instant incentives upon return of the surveys helped to increase response rates
- Sharing the *Squeeze* magazine with other organizations and partners such as doctors' offices helped increase project reach
- Create a sustainability plan at the beginning to encourage project continuity

ADAPTATION FROM OTHER PROGRAMS

Based on the "Be a Breast Friend" campaign originally developed by the Alberta Breast Screening Program

program links

www.beabreastfriend.ca

program contact

Sonya Muntwyler, RN, BScN
Public Health Nurse
Heart Health & Cancer Prevention
Health Department
The Regional Municipality of Halton
1151 Bronte Rd.
Oakville, ON L6M 3L1
Phone: (905) 825-6000 ext. 7829
E-mail: Sonya.Muntwyler@halton.ca

“Because I Care...” Postcard and Incentive Campaign



TARGET AUDIENCE: Women 50+ who are eligible for screening at the OBSP; underscreened and hard-to-reach women

Program focus: Breast cancer

Challenges/risks faced by target population: International studies have clearly demonstrated that breast screening can significantly reduce breast cancer deaths in women aged 50+. The Ontario Breast Screening Program (OBSP), Northeast Region, is reaching 51.5% of eligible women; a recent review identified several underscreened areas in the Sudbury district.

Setting: Underscreened communities across Sudbury and Manitoulin Island

Province: Ontario

Theoretical background: None stated

Program status: 2007 to present

Funder: Ontario Breast Screening Program

BRIEF OVERVIEW

- The “Because I Care...” postcard and incentive campaign was developed around a prominent city councillor who posed with three generations of her family to raise awareness about the OBSP in the greater Sudbury area.
- The campaign launch was very successful. While subsequent campaigns using the postcards did not bring in as many women as was hoped, organizers believe this concept has the potential to increase awareness and screening rates among underscreened women.

PROGRAM GOALS AND OBJECTIVES

- To increase screening in hard-to-reach populations and to reduce deaths from breast and cervical cancer

PROGRAM IMPLEMENTATION STEPS

- A prominent city councillor from Greater Sudbury was approaching her 50th birthday; as the daughter of a breast cancer survivor, she decided she wanted to celebrate her birthday by helping to raise awareness about the OBSP
- The councillor worked with staff from the OBSP, Sudbury and District Health Unit, and the Canadian Cancer Society (CCS)
- Building on the success of the Tell Two Friends campaign, a decision was made to launch a similar campaign in Sudbury

- The “Because I Care...” awareness campaign was about women communicating the importance of early detection to other women
- A photographer volunteered her services and developed the creative vision (“Three generations of women — One early detection”)
- Three generations of women from the councillor’s family were featured in a dramatic and beautiful postcard, where the members bared all, with a caption that shared their family story
- Early focus testing demonstrated that this would be a highly effective tool in motivating women to encourage other women they cared about to get screened
- The councillor celebrated her 50th and her mother’s 80th birthday by inviting friends, colleagues, and all women born in 1957 and earlier to join her for a 50th birthday celebration at the OBSP; a second invitation was designed for this initiative
- The postcards were printed
- An unveiling of the postcard campaign and media launch were coordinated
- Campaign messaging was personal and emphasized the intergenerational impact of breast cancer (e.g., “As the daughter of a breast cancer survivor, I am acutely aware of the potential impact on my chances of developing the disease, but more important, my daughters’ chances”; “I wanted to celebrate my 50th in a meaningful way...”; “The time to be proactive is now!”)

- The city councillor’s long affiliation with the city’s social planning council and many community-based organizations, and her role as an elected official, helped the OBSP get the message to hard-to-reach sectors of the community (e.g., lesbian women, women of low income and low education, and survivors of assault)
- The OBSP ultimately partnered with the Canadian Cancer Society Lay Health Educator Program (see page 102) in order to target its outreach to underscreened communities
- Incentives were offered to women who booked an appointment for a mammogram and brought in the postcard as a means of encouraging screening uptake

PROGRAM REACH

- Thousands of women in Northeastern Ontario were touched by this campaign; more than 100 women attended the birthday celebration and hundreds more were reached through the partnership with the CCS Lay Health Educator Program

EVALUATION

Method

- Statistical data was obtained using OBSP database records

Key findings

- Through the Lay Health Educator Program referrals, 90 women have been screened to date
- 18 (20%) were first-time screens, 65 (72%) were recalls and seven had unknown screening status

CRITICAL FACTORS FOR ADAPTATION

- Requires a very high profile, well-liked and respected woman who is willing to share her personal story and has a long-term, trusted relationship with underserved women
- Keep the campaign time-limited; only so many women will respond to any approach, and every strategy has a lifespan
- Confirm partnership/incentive campaigns that will use postcards to determine print quantities
- Maintain control over the campaign (i.e., do not hand over the postcards to another organization to create their own campaign); instead, work collaboratively to ensure the best potential for success
- Ensure consistent messaging and collaboration with partner groups and key stakeholders in the community

- Offer incentives; they serve as a significant motivator to getting women overdue for screening in the door

CHALLENGES

- Ethical issues were raised by the medical community about whether the use of incentives could be considered coercion depending on the population of women; although more attractive incentives could have promoted greater response rates, it was determined that incentives of nominal value such as gift certificates for a free coffee and nail files with OBSP toll-free number would not compromise the integrity of the campaign

LESSONS LEARNED

- Too many postcards were printed
- Once the OBSP handed over the postcards to another organization, it lost input over the campaign, including how the postcards were being distributed, what was said when they were distributed, and whether OBSP pamphlets were being handed out along with the cards; this was especially concerning given that the postcard was being distributed by lay health educators

ADAPTATION FROM OTHER PROGRAMS

The campaign was built on the successful “Tell Two Friends” concept from the OBSP Regional Centre in London, Ontario

program links

None currently available

program contact

Sharon Bowes
 Health Promotion Coordinator
 Ontario Breast Screening Program
 — Northeast Region
 4 Walford Rd.
 Sudbury, ON P3E 2H4
 Phone: (705) 675-2294
 E-mail: sbowes@hrsrh.on.ca

Breast Health Informational Events and Bus Trips for Low German Speaking Mennonites in Southwestern Ontario



TARGET AUDIENCE: Low German (LG) speaking Mennonite women living in Southwestern Ontario and their healthcare providers

Program focus: Breast cancer

Challenges/risks faced by target population: The proportion of LG speaking Mennonite women who practise cancer-screening behaviours is lower than that of the general population in Elgin County; this population and their healthcare providers lack specifically developed educational materials.

Setting: Rural and small LG Mennonite communities in East Elgin, Aylmer

Province: Ontario

Theoretical background: None stated

Program status: 2002 to present; informational events and group screening since 2007

Funder: Elgin St. Thomas Public Health (ESTPH) and South West Cancer Prevention and Screening Network for informational events and group screenings/bus trips; financial support for bus trips from Ontario Breast Screening Program (OBSP)

BRIEF OVERVIEW

- Three culturally tailored pamphlets were developed to address the lack of plain-language information and education about health issues available to LG speaking Mennonite women in Elgin County.
- The new promising practice — informational events and bus trips (group screenings) — was designed to increase awareness and screening rates among this community.
- To date, approximately 90 LG speaking women have attended the two educational events, and 34 eligible women had had a mammogram at the OBSP; many more women, and their healthcare providers, have been reached through the low-literacy pamphlets and radio ads.

PROGRAM GOALS AND OBJECTIVES

- To increase breast health awareness among LG speaking Mennonite women
- To increase the breast screening rate of LG speaking Mennonite women aged 50+ years, through the OBSP

PROGRAM IMPLEMENTATION STEPS

- The three culturally tailored pamphlets were initiated by ESTPH; a partnership was formed with various organizations, including Oxford County Board of Health, the Tricounty LG speaking Health Promotion Committee, Mennonite Central Committee in Aylmer and Family Education Support Program Aylmer
- A needs assessment, "Healthcare Needs of Mennonite Women Living in Elgin County," was completed in 2001
- Based on the identified needs, three pamphlets were developed and focus-tested with LG speaking Mennonite

- women: "Breast and Cervical Health: What Should Women Do?"; "Breast Health: What Should Women Do?" and "Mammograms: What Should Women Do?"
- The pamphlets were disseminated throughout Southwestern Ontario (e.g., at public health units and doctors' offices) and on the ESTPH's website
- To further address identified needs, several intervention activities were conducted from 2004 to 2006: transportation to screening; face-to-face meetings with women influential within their community; educational group meetings in the homes of influential women; and displays and presentations at public health fairs held in church halls
- Two educational events (2007, 2010) called "Women's Health — It Matters!" and two OBSP group screenings (bus trips) were coordinated in 2007 and 2008
- The first group of women was recruited through a fully translated information event and the second through advertisements on a local LG radio station; both group screening trips were held on Saturday; were exclusive to LG speaking women; and included snacks, lunch, cancer-screening health promotion/education activities and a shopping trip
- Two translators were secured; one to assist with filling out forms and the other with the mammography technologist
- A bus trip is planned for 2010 in cooperation with the local OBSP

PROGRAM REACH

- To date, approximately 90 LG Mennonite women have attended the educational events and 34 women have

been screened through the group screenings; many more were reached through the low-literacy pamphlets and radio ads

EVALUATION

Method

- 80 LG speaking Mennonite women, aged 18+ years, completed a Cancer Screening Awareness and Behaviours (CSAB) survey to evaluate the pamphlets in 2002; women completed the survey by themselves or through an interpreter
- Informational events and bus trips (group screenings) are evaluated by attendance rates and informal participant evaluations

Key findings

The CSAB Survey showed that:

- 44 of the 80 women (55%) surveyed reported seeing at least one of the three pamphlets — a very good response for a written product targeting a low-literacy group
- 67% of respondents aged 50+ had ever had a mammogram and 56% had had a mammogram in the past two years, compared to the general population of Elgin County (88% and 61% respectively)
- Participant feedback on education events and bus trips has been uniformly positive; women find the events informative and enjoy the “bus trip” concept as the means for getting screened

CRITICAL FACTORS FOR ADAPTATION

- Adapt low-literacy pamphlets with language and images specific to the targeted community
- Establish a relationship with the community by involving trusted individuals and agency members (e.g., the public health nurse who works closely with women and their families and Mennonite Central Services)
- Secure the support of influential women in the community, especially church leaders
- Involve women in the targeted community in the development and adaptation of low-literacy pamphlets
- Provide health information events at a time convenient and acceptable to the women; organize bus trips for screening
- Obtain financial support and devote adequate time to the program

CHALLENGES

- Despite plain-language efforts, it was unclear whether the target population understood all messaging in the low-literacy pamphlets

- Keeping materials up to date; due to changes in screening guidelines, only one of the three pamphlets is currently being used
- Communication with the women in the community

LESSONS LEARNED

- Programs offering transportation to screening require additional activities to make them more meaningful (e.g., provide education sessions on breast health and the importance of breast cancer screening; provide information about how the OBSP works and how to access the program)
- Many English words do not exist in Low German; the translator was aware of this challenge and the translation was well done
- Education sessions to build awareness were more effective when they included health representatives known and trusted by the community; were delivered in a setting where LG speaking Mennonite women congregated or lived; were translated into the target population’s own language and/or low-literacy English; and when shared with other family members
- Bus trips were more appealing if a shopping trip was included

ADAPTATION FROM OTHER PROGRAMS

Practices are congruent with the 1997 *Mandatory Health Programs and Service Guidelines*, General Standards, Equal Access, and with the current 2008 Ontario Public Health Standards

program links

www.elginhealth.on.ca

program contact

Rosemarie Vandenbrink, RN, BScN,
CCHN(C)
Public Health Nurse
Elgin St. Thomas Public Health
99 Edward St.
St. Thomas, ON N5P 1Y8
Phone: (519) 631-3159, ext. 267
E-mail:
rvandenbrink@elginhealth.on.ca;
cancerscreening@elginhealth.on.ca

Building Breast Healthy Neighbourhoods (BBHN)



TARGET AUDIENCE: Culturally diverse women; low income women; newcomers

Program focus: Breast cancer

Challenges/risks faced by target population: Breast cancer screening rates are low among newcomers and low-income populations due to cultural background, language concerns, knowledge gaps and low literacy.

Setting: South Riverdale Community Health Centre (SRCHC), Toronto

Province: Ontario

Theoretical background: Health belief model; social learning theory

Program status: Completed

Funder: Canadian Breast Cancer Foundation, Ontario Region

BRIEF OVERVIEW

- BBHN is a partnership between SRCHC, the Marvella Koffler Breast Centre at Mount Sinai Hospital and Toronto Public Health (TPH) to develop community-driven strategies to assist all women, including those often marginalized, living in the South Riverdale (SR) area to access appropriate breast health resources; the project emphasized community development and a holistic approach to breast health.
- More than 4000 women were reached during the two-year project; most of them were underserved women from low socioeconomic backgrounds.

PROGRAM GOALS AND OBJECTIVES

Short-term objective

- To get community buy-in from local agencies in SR neighbourhoods in order to reach SR women with messages about the importance of breast health

Long-term objective

- To improve breast health and early detection of breast cancer in all women in the SR area

PROGRAM IMPLEMENTATION STEPS

- Advisory project partners were the Canadian Cancer Society, Parent Resources, Ralph Thornton Centre and St. Michael's Hospital
- The program included four elements:
 1. Engaging and building the capacity of local community agencies to promote breast screening:
 - ♦ Local agencies were sought to help design, implement and evaluate activities (e.g., an "Attending to Breast Health" booth, facilitating or supporting workshops)
 2. Promoting breast health awareness by utilizing breast health champions (BHCs):

- ♦ BHCs from the target population were recruited, trained and supported to deliver education activities; training included an overview of breast health, nutrition and breast health, and how to carry out an evaluation
- 3. Implementing innovative community campaigns to reach underserved populations:
 - ♦ Tailored resources were developed to facilitate access to information and screening, including a Breast Health Care Package for homeless women; a nutrition guide available in English and Chinese to improve breast health for newcomers; and Shop Smart Breast Health Grocery Tours to reach out to newcomers and populations living in poverty
- 4. Providing information and navigation assistance for SR women:
 - ♦ The BBHN coordinator and culturally competent staff helped women access screening by accompanying them to screening sites and providing interpretation
 - ♦ Community-wide events were launched to sustain a high profile for breast health:
 - Go Screen Campaign: women who had mammograms were entered into a draw for a healthy food basket
 - Short Theatre Plan: developed in partnership with a local Chinese volunteer group, and delivered to Chinese communities in SR
 - Health Fairs and Forums: Multi-lingual breast health messages were disseminated through TV, radio and local newspapers

PROGRAM REACH

- More than 4000 women were reached

EVALUATION

Method

- Pre- and post-intervention surveys were given to BHCs to assess readiness, knowledge, confidence change and training satisfaction
- BHCs maintained activity logs over a 12-month period with number of women taught, type of activity and screening behaviours
- Informal individual or focus group interviews were conducted with participants regarding the planning and usefulness of certain community outreach strategies
- Logs were maintained to track media coverage of events, types of resources used and political presence at events (e.g., MP, MPP, MOHLTC or MHP)

Key findings

- 22 agencies were engaged and delivered 38 breast health educational events and activities, reaching 539 individuals
- 42 BHCs were trained
- About 60% of BHCs had basic breast health knowledge but most were new to health promotion activities
- At post training, 20 champions logged a total of 59 breast health education events: 30 workshops, 4 informal discussions, 10 screenings and 23 breast health displays; 2671 individuals were reached
- More than 4000 women received breast health information handouts and 163 women received assistance in breast screening
- 100 Breast Healthcare packages were given out at various drop in/hot meal programs
- Multimedia coverage included articles in local newspapers, special interviews on ethnic radio stations (estimated audience of 1000) and online live webcasts and archives

CRITICAL FACTORS FOR ADAPTATION

- Recruit a program coordinator for overall coordination of the project and to support BHCs, individuals going for screening and outreach activities
- Obtain funding to develop clear language products and to cover other expenses
- Obtain strong support, including time and technical expertise, from community agencies and partnering organizations

CHALLENGES

- Many workshop participants did not leave valid or correct/current contact information, making follow-up difficult
- BHCs had only short-term commitment

- Participating agencies had low interest in completing surveys

LESSONS LEARNED

- Patient navigation (e.g., booking and accompaniment to appointments) is important for the target women; a supportive, one-on-one relationship can help identify and address barriers that may not be easily visible (e.g., low literacy); it also helps ensure that women can experience the full spectrum of breast health services available
- Building meaningful, sustainable community capacity through the engagement of frontline workers requires management-level support from their organizations; without this, the level and scope of breast health education and support is limited
- Community workers need ongoing support and encouragement from within their organizations and from broader partnerships; support is particularly important in the delivery of breast health information to groups (vs. individuals) by trained frontline workers, allowing more women to be reached
- This project adhered to this core principle and mentored BHCs throughout the two-year funding period; teaching materials for group sessions and hands-on, one-to-one coaching and mentorship were provided continuously to ensure success of each and every workshop run by the champions

ADAPTATION FROM OTHER PROGRAMS

BBHN builds on the work of the "Joy Luck Women's Project (Phase 1)" (see page 96) and the "Joy Luck Women's Project: Building Capacity Project (Phase 2)" (see page 98).

program links

None currently available

program contact

Grace Ho, Outreach Worker
South Riverdale Community
Health Centre
955 Queen St. E.
Toronto, ON M4M 3P3
Phone: (416) 461-1925
E-mail: graceho@srhc.com

CDP Cancer Prevention and Screening Program



TARGET AUDIENCE: Underscreened women (and men) (Breast: older, low-income, immigrant or Aboriginal women; Cervical: older, low-income, immigrant or Aboriginal women; Colorectal: all adults)

Program focus: Breast, cervical and colorectal cancer

Challenges/risks faced by target population: Cancer screening rates in Toronto remain low: according to Cancer Care Ontario's Cancer System Quality Index, overall rates of breast, cervical and colorectal screening participation among eligible adults (in the Toronto Central LHIN) fall far below the provincial targets. Some groups of women — including older, low-income, disabled and Aboriginal women, as well as newcomers and women with low literacy or who speak English as a second language — are less likely to be screened and are much more likely to have negative outcomes.

Setting: City of Toronto

Province: Ontario

Theoretical background: Health belief model; social learning theory

Program status: Ongoing

Funder: Toronto Public Health

BRIEF OVERVIEW

- Toronto Public Health (TPH) raises awareness of cancer and the importance of early detection and screening through public engagement and education within communities; social marketing campaigns; and workshops and educational training sessions.
- Increasingly, TPH advocates for, supports and works in partnership with stakeholders to develop public policies to increase cancer prevention and early detection and screening.

PROGRAM GOALS AND OBJECTIVES

- To increase knowledge and awareness of breast, cervical and colorectal cancer screening in Toronto using a multi-strategy approach that consists of public education, community and regional partnerships, social marketing, community capacity building and supporting the development of healthy public policies

PROGRAM IMPLEMENTATION STEPS

- The CDP (chronic disease prevention) Cancer Prevention and Screening team participated in a consultation process to develop a cancer logic model and work plan
- An informal SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis was conducted to find existing, effective programs
- Key documents were reviewed for consistency (Ontario Public Health Standards; Ontario Cancer Plan 2008–2011; Cancer 2020)

- The team's lead manager and health promotion consultant liaised with the CDP Adult Audience Coordinating Group to ensure that the program would be implemented by all CDP public health nurses (PHNs) with an adult focus

Personal skill building, education, awareness raising

- PHNs provide presentations and displays/educational workshops on breast, cervical and colorectal health in various community settings, including ESL classes
- PHNs consult with community agency staff to train, support and explore opportunities to promote cancer screening and prevention in their setting, as well as ways to overcome barriers to screening

Networks/partnerships

- TPH links with internal and external stakeholders to coordinate services and develop consistent messaging, as well as advocate for inclusion of cancer prevention and screening messages in the development of programs, services and products

Social Marketing

- Multimedia outreach campaigns are timed to coincide with Cancer Month, Breast Cancer Awareness Month, Cervical Cancer Awareness Week and Colorectal Cancer Month
- TPH has implemented media outreach to ethnic communities in Toronto to raise awareness of cancer screening recommendations and promote access to screening to underscreened populations

- Print ads were translated in 10 priority languages and run annually in ethnic newspapers

Strengthening community action/community capacity building

- TPH partners with community agencies on multi-strategy outreach initiatives to underscreened populations to promote cancer screening and early detection

PROGRAM REACH

- Not available

EVALUATION

Method

- Various depending on program activity

Key findings

- Please contact program contact for more information

CRITICAL FACTORS FOR ADAPTATION

- Need a program lead manager dedicated to CDP/ cancer prevention and screening to advocate at high-level meetings
- Need a health promotion consultant to coordinate programs and ensure that key messages are incorporated within CDP programs, services and product development, and to help ensure that the program is consistent with those of other key stakeholders in cancer prevention and screening
- Need PHNs to consult with program development and implementation
- Dedicate a budget for CDP/cancer prevention and screening work

CHALLENGES

- Not enough support for research and evaluation in order to build on evidence and support for cancer prevention and screening to underscreened populations

LESSONS LEARNED

- Develop and provide training to new staff to orient them and transfer knowledge about cancer prevention and screening (e.g., to train a large influx of new staff, a knowledge base was created and stored onto a communal hard drive so that staff had easily accessible key information)
- Develop consultation tools that incorporate cancer screening messaging

- Develop service delivery procedures for each service provided in the community and workplace so that staff understand their role and what they can offer to their clients
- Use resource guidance documents to avoid duplication when ordering resources
- Have open lines of communication with staff via staff meetings, memos, e-mail, voice mail, a shared computer drive for resources and a knowledge base, etc.
- Program evaluators must work together from the beginning to incorporate evaluation into the program plan

ADAPTATION FROM OTHER PROGRAMS

None

program links

www.toronto.ca/health

program contact

Gina Ing
 Consultant Health Promotion (Acting)
 Chronic Disease Prevention
 Toronto Public Health
 Etobicoke Civic Centre
 399 The West Mall, 4th Floor
 Toronto, ON M9C 2Y2
 Phone: (416) 338-1762
 E-mail: gging@toronto.ca

Check It Out Guys: The Trans Men's Pap Campaign



TARGET AUDIENCE: Trans men and their healthcare providers

Program focus: Cervical cancer

Challenges/risks faced by target population: The lack of resources about trans men's need to get Pap tests has resulted in misconceptions (e.g., many trans men assume that once they have a hysterectomy they no longer need cervical screening; in fact some may still need screening). There is serious shortage of healthcare providers who are accepting new patients, and who are friendly to trans men and knowledgeable about their health issues. Many trans men feel that Pap tests undermine their gender identities.

Setting: Communities across Ontario

Province: Ontario

Theoretical background: None stated

Program status: 2009 to present

Funder: Sherbourne Health Centre with support from the Community One Foundation

BRIEF OVERVIEW

- The Check It Out Guys campaign was designed specifically to increase trans men's awareness and knowledge of the need for Pap testing and to provide trans men with strategies for making Pap tests easier and coping with the experience of getting tested.
- The campaign was guided by a reference group made up of trans men and trans healthcare providers.
- Evaluation of the campaign is currently underway.

PROGRAM GOALS AND OBJECTIVES

- To increase awareness among trans men of the need for them to get regular Pap tests and how to make getting the experiences of getting a Pap test easier

PROGRAM IMPLEMENTATION STEPS

- A reference group was formed with representatives from Sherbourne Health Centre, Planned Parenthood Toronto and healthcare workers who are trans men
- An online survey was conducted to gather information to help develop the campaign. Trans men were asked:
 - ♦ If they were getting Pap tests
 - ♦ About their experiences when they tried to access Pap testing
 - ♦ What information they needed about Pap tests, and
 - ♦ About barriers to Pap tests and how to eliminate them
- 75 trans men responded to the survey

- A creative firm was consulted to help determine what kind of approach or model would work effectively to reach out to trans men
- Based on the survey responses, it was decided that the campaign would move away from more traditional public health campaigns. Rather, a more somber approach was essential (in contrast to the more flirty, fun approach taken by the parallel Check It Out campaign for queer women; see page 72)
- Most survey respondents reported that they were willing to get a Pap test if they were given good enough reasons to do so; many, however, were not pleased with the idea of having the test
- A campaign website and materials were designed using well-known men in the trans community
- The website includes information about the campaign; Pap tests and who needs them; getting a Pap test; sex, HPV and cervical cancer; where trans men can get a Pap test; links to other health issues for trans men; and other information
- The website also allows users to send a Pap e-card reminder to a friend, share on social networking sites (e.g., Facebook) and download or order campaign materials, which are provided free to service providers and organizations across Ontario
- A campaign launch event was conducted in January 2010: materials were displayed, and performers from the trans community, music and food were used to get attendees excited about the campaign

- Future outreach activities being planned include presentations at community and healthcare provider conferences, and advertisements in magazines read by trans men and healthcare providers

PROGRAM REACH

- Not available

EVALUATION

Method

- Participants complete surveys based on three components:
 - ♦ Feedback about the campaign website and materials
 - ♦ Awareness and knowledge of Pap testing
 - ♦ Attitude towards Pap testing

Key findings

Evaluation to be completed in spring of 2010

CRITICAL FACTORS FOR ADAPTATION

- Have trans men create the campaign for trans men; although cervical health is a sensitive topic for trans men, they are receptive to messages that they feel are coming from other trans men
- Build extensive networks and contacts in the community to reach out to a broad range of trans men, including those who would not normally access trans men’s services or attend trans men’s events

CHALLENGES

- The ability to refer trans men to cervical health services is limited, as there are very few health clinics that are knowledgeable about trans men’s issues
- The cervical health services in Ontario that exist often have a waiting list or are unable to take clients who are not in their catchment area

LESSONS LEARNED

- When it comes to trans men’s health issues, there is often a tendency to lump them into programs for queer women; despite some commonalities related to cervical health, however, trans men’s needs are very different
- The trans men’s campaign was able to collaborate significantly with the “Check It Out: Queer Women Need Paps Too!” (see page 72) campaign (e.g., by sharing resources) while still managing to remain distinct

ADAPTATION FROM OTHER PROGRAMS

None (due to lack of available resources)

program links

www.checkitoutguys.ca

program contact

Ayden Scheim
 Project Coordinator
 Sherbourne Health Centre
 333 Sherbourne St.
 Toronto, ON M5A 2S5
 E-mail: tmen.Pap@gmail.com

Check It Out: Queer Women Need Paps Too!



TARGET AUDIENCE: Lesbian, bisexual, queer and gay women, or other women who have sex with women (WSW) and their healthcare providers

Program focus: Cervical cancer

Challenges/risks faced by target population: A recent Statistics Canada report found that fewer than two-thirds of lesbians reported having had a Pap test within the past three years, well below the figures for heterosexual (77.1%) and bisexual women (76.2%). These findings support those of the 2008 "(DIS)ENGAGED" report by Planned Parenthood Toronto in partnership with Sherbourne Health Centre, which found that both WSW and their healthcare providers are unclear about whether WSW need this screening.

Setting: Greater Toronto Area

Province: Ontario

Theoretical background: None stated

Program status: 2009 to present

Funder: TD Bank Financial Group

BRIEF OVERVIEW

- Check It Out: Queer Women Need Paps Too!, a project of the Queer Women's Health Initiative (a partnership between Toronto Planned Parenthood, Sherbourne Health Centre, Rainbow Health Ontario and Women's College Hospital), was specifically designed to promote Pap testing for lesbian, bisexual, queer and gay women, and other women who have sex with women (WSW).
- Evaluation of the campaign is still in progress; an estimated 250 women in the target audience have been reached to date.

PROGRAM GOALS AND OBJECTIVES

- To increase awareness and knowledge among diverse communities of lesbian, bisexual, queer and gay women, and other women who have sex with women (WSW), and their healthcare providers, about the need for Pap tests, why they are important and how to access them comfortably and sensitively

PROGRAM IMPLEMENTATION STEPS

- The Queer Women's Health Initiative and secondary partners formed a WSW Pap Campaign working group to develop and implement the campaign
- A focus group was conducted with WSW and queer women in Toronto to identify issues they faced related to Pap testing and to gather opinions about what would make a campaign effective; interviews were also conducted with service providers

- A design company was enlisted to help develop the campaign and resource materials; a community call for WSW and queer women to be models in the campaign was conducted
- Launches were held for the campaign website, the community and service providers
- A volunteer group was set up to help promote the campaign: posters, flyers and postcards were distributed at promotional events as well as places where WSW and queer women congregate
- The website includes information about the campaign; Pap tests and who needs them; getting a Pap test; sex, HPV and cervical cancer; where to get a Pap test; frequently asked questions; and other information
- The website also allows users to send a Pap e-card reminder to a friend, share on social networking sites (e.g., Facebook) and download or order campaign materials, which are provided free to service providers and organizations across Ontario
- Other outreach activities included:
 - A webpage on Facebook that promoted the campaign
 - A once-a-week Pap Drop-In Clinic at Women's College Hospital, administered by female physicians
 - Free workshops (more are being planned) on Pap testing for the target population, tailored according to participants' needs; they can be art or discussion-based

- The Hot Holistic Health Fest: A free day of sexual health workshops and a sexual health fair for lesbian, gay, bisexual, queer and transgender and transsexual women
- An evaluation survey was included on the campaign website to garner feedback about the campaign

PROGRAM REACH

- To date, approximately 250 women and trans men in the target population have been reached

EVALUATION

Method

- Participants complete surveys on the campaign website to:
 - Provide feedback about the campaign website and materials
 - Report their awareness and knowledge of Pap testing and their intention to get screened after using the website
- Follow-up interviews will be conducted with participants who attended the community launch event to ask if they have had or booked a Pap test since the launch

Key findings

Evaluation in progress

CRITICAL FACTORS FOR ADAPTATION

- Adapt the program according to the community's needs
- Consider the funding available in relation to the characteristics (e.g., population size) of the WSW and queer community in the targeted region
- Have WSW and queer women from the community be models for the campaign; they, in turn, became engaged and involved their friends in the campaign
- Have highly engaged campaign volunteers champion outreach efforts to involve other WSW and queer women
- Devote time to reach out to and connect with WSW and queer women

CHALLENGES

- Reaching out to WSW and queer women, as well as accessing WSW and queer women's places
- Reaching out to WSW who do not self identify as queer or with any label
- Reaching out to service providers who often have busy schedules

LESSONS LEARNED

- WSW and queer women are eager for health promotion materials and messages that speak to them directly
- WSW and queer women support each other and are invested in volunteering in and taking care of their community
- WSW and queer women are a very diverse group of people; therefore it is important to have campaign materials and events that reflect this diversity (e.g., posters for the Check It Out campaign included taglines that speak to different identities, sexual behaviours and relationships)
- The need for clarity about screening guidelines for Pap testing among WSW and queer women is an ongoing issue
- Spaces (e.g., free community events) are needed for WSW and queer women to meet

ADAPTATION FROM OTHER PROGRAMS

Ideas were taken from "Papalooza: The Smear Campaign" (Vancouver, <http://www.cwhn.ca/en/node/39588>) and campaigns conducted in Australia and the United States

program links

www.check-it-out.ca/

program contact

Program Coordinator
 Women's Programming
 Planned Parenthood Toronto
 36B Prince Arthur Ave.
 Toronto, ON M5R 1A9
 Phone: (416) 961-0113 ext. 123

A Community-Based Intervention to Increase Screening Mammography Among Disadvantaged Women at an Inner-City Drop-in Centre



TARGET AUDIENCE: Disadvantaged women, aged 50–70, at an inner-city drop-in centre

Program focus: Breast cancer

Challenges/risks faced by target population: Many women who use the drop-in centre have mental illness or addictions and are homeless or marginally housed. Women in these populations often have low mammography screening rates because of several barriers (e.g., competing priorities due to the need to attend to survival needs and difficulty negotiating the healthcare system).

Setting: An inner-city drop-in centre in Toronto

Province: Ontario

Theoretical background: Behavioural model for vulnerable populations

Program status: 2001–2002

Funder: Ontario Women's Health Council

BRIEF OVERVIEW

- In 2002, a drop-in centre in Toronto and a nearby hospital initiated a collaborative breast cancer screening project in which a staff member of the drop-in centre accompanied small groups of women for mammography visits at a weekly, pre-arranged time.
- Results indicated that the introduction of accompanied small-group visits was associated with significantly increased use of mammography in this group of disadvantaged women.

PROGRAM GOALS AND OBJECTIVES

- To determine the effectiveness of a community-based intervention to increase the use of screening mammography among disadvantaged women with a high prevalence of mental illness and homelessness at an inner-city drop-in centre

PROGRAM IMPLEMENTATION STEPS

- A demonstration project was undertaken in 2001 between drop-in centres in Toronto and St. Michael's Hospital to promote cancer screening among homeless and marginally housed women
- During the demonstration project to encourage screening mammography, a number of obstacles were encountered: women were reluctant to undergo screening mammography and it was difficult to obtain mammography appointments within the often short time frame during which women were both willing to go for

the test and in regular contact with the drop-in centre

- An alternative approach was implemented in 2002 to address these obstacles:
 - ♦ Three consecutive mammography appointments for women from the drop-in centre were held at St. Michael's Hospital once weekly in the early afternoon
 - ♦ On this day, women from the drop-in centre, aged 50–70, were invited for lunch followed by mammography
 - ♦ Women were selected at the discretion of drop-in centre staff; a family physician working at the centre served as the referring physician requesting a mammogram
 - ♦ Women were accompanied on mammography trips by a staff person from the drop-in centre whom they knew and trusted

PROGRAM REACH

- 26 of 89 eligible women using the drop-in centre in 2002 underwent mammography

EVALUATION

Method

- The age and housing status of women, aged 50–70 years, who used the drop-in centre in the years 1995–2002 were obtained from a computerized medical record system
- Interrupted time series analysis was used to test

the effect of the intervention program on rates of screening mammography

- Analyses were also conducted to compare the characteristics of women using the drop-in centre in the pre-intervention years versus the intervention year, and to compare women who did and did not undergo mammography in the intervention year

Key findings

- During the intervention year, 26 (29.2%) of 89 women underwent mammography, up from an annual average mammography rate of 4.7% among women using the centre between 1995 and 2001
- Age, psychiatric diagnosis, substance abuse and housing status were not significantly associated with the likelihood of undergoing screening mammography during the intervention year
- Of the 26 women who underwent mammography in 2002, only five did so independent of the intervention
- Only four of the 26 women had a previous mammogram within the past five years, indicating that the intervention reached individuals who had rarely undergone screening in the past

CRITICAL FACTORS FOR ADAPTATION

- The authors suggested that the success of the intervention was related to:
 - ♦ Established, trusting relationships between the clients and staff of the drop-in centre
 - ♦ The accompaniment of the women on the mammography visits by drop-in centre staff
 - ♦ The willingness of the mammography centre to accommodate flexible group scheduling
- The offer of a luncheon outing may also have been a significant motivating factor, although the specific effect of this particular component could not be determined in this study design

CHALLENGES

- Even after the intervention, a majority of women at the drop-in centre still do not undergo annual mammography, highlighting the continuing need to develop more effective methods to address gaps in the medical care of women affected by severe mental illness and/or homelessness
- The possibility that the increased mammography rates were due to other factors (e.g., changes in characteristics of women using the drop-in centre) could not be disregarded because this study did not

utilize an experimental design to compare changes in cohorts of women over time

LESSONS LEARNED

- The approach of seeking out women at popular gathering sites in the community, rather than waiting for them to present to a healthcare facility, is particularly appropriate for women affected by mental illness or homelessness
- Screening programs for this population need to address not only predisposing factors (e.g., lack of knowledge about screening) but also enabling factors (e.g., the need for assistance in negotiating the healthcare system)
- Similar screening programs can be initiated at a wide variety of sites, including agencies in the community that serve women who are at high risk for inadequate preventive healthcare (e.g., drop-in centres for people with mental illness and homeless persons)
- Partnership between a community-based service agency and a healthcare facility can improve the delivery of preventive healthcare services for disadvantaged women

ADAPTATION FROM OTHER PROGRAMS

None

reference

Heyding, R. K., Cheung, A. M., Mocarski, E. J. M., Moineddin, R., & Hwang, S. W. (2005). A community-based intervention to increase screening mammography among disadvantaged women at an inner-city drop-in-center. *Women & Health, 41*, 21-31.

program contact

Stephen W. Hwang, MD, MPH
Centre for Research on Inner City Health
St Michael's Hospital
30 Bond St.
Toronto, ON M5B 1W8
Phone: (416) 864-5991
E-mail: hwangs@smh.ca

Community Capacity Building Project



TARGET AUDIENCE: Seldom or never screened women in Ontario

Program focus: Cervical cancer

Challenges/risks faced by target population: The target population included women with low incomes, women living in rural locations, women with low literacy levels, new immigrants, Aboriginal and homeless women.

Setting: Four health units: Haliburton, Kawartha and Pine Ridge District Health Unit; Sudbury and District Health Unit; Leeds, Grenville and Lanark Health Unit; Porcupine Health Unit

Province: Ontario

Theoretical background: Community development

Program status: Completed in 2008

Funder: Cancer Care Ontario

BRIEF OVERVIEW

- Four proposals from public health units (PHUs) were chosen from a provincewide call to develop capacity-building strategies to increase cervical screening rates in seldom and never screened women in PHU communities.
- The Ontario Cervical Screening Program (OCSP) provided nominal seed funding for projects as well as expertise to help develop strategic and individualized logic models to guide community efforts and facilitate evaluation.
- Other tools, such as collaborative agreement and reporting templates, were also supplied, as was ongoing consultative support and communications.
- The use of collaborative agreements among project partners clarified roles and expectations, strengthened partnerships and resulted in smoother processes.

- Consistent with project criteria, proposals from four PHUs were chosen for funding
- OCSP provided seed funding of \$5000 per community, background documentation and expertise to help develop strategic and individualized logic models to guide PHU efforts
- A reporting template was provided for interim and final reports from each PHU
- The collective experiences of all six projects were reviewed

PROGRAM REACH

- Varied by community, as did clinical outcomes
- Almost half of screened women reported no recent Pap test

PROGRAM GOALS AND OBJECTIVES

- The pilot project's goal was to foster the development of solid collaboration and partnerships among multiple stakeholders in order to increase awareness of and participation in screening for cervical cancer

PROGRAM IMPLEMENTATION STEPS

- In 2005, the Pap test clinic strategy for promoting cervical screening was piloted in the Kingston area and in Sault Ste. Marie
- The following year, building on lessons learned from the pilot projects, OCSP released a provincewide call for proposals

EVALUATION

Method

- Interim and final reports provided information on clinical services as well as key findings/lessons learned and their applicability to other communities

Key findings

- This project provided an opportunity to strengthen existing partnerships within communities and develop new ones
- Activities have increased the visibility of the project partners

- “Piggy-backing” was consistently used to more effectively distribute resources and messages
- An important consequence of this project was the review of screening information/guidelines by local doctors, thereby reinforcing the content of and emphasizing the importance of adhering to guidelines
- Implementation of clinics resulted in decreased wait times and increased comfort levels for participants, especially where nurse practitioners and specially trained public health nurses performed Pap tests
- Offering clinical services at untraditional locations increased screening participation among underscreened women

CRITICAL FACTORS FOR ADAPTATION

- Respect the uniqueness of different communities; do not adopt a “cookie cutter” approach
- Have flexible timelines
- Open communication channels and opportunity for feedback

CHALLENGES

- The greatest strength of this project was the emphasis on the individuality of each region/community and the distinctive way in which they addressed the common goal of increasing cervical screening participation; nevertheless, the variety of approaches also presented a significant challenge for meaningful evaluation; this was especially true in assessing results and outcomes

LESSONS LEARNED

- A written collaborative agreement clarified expectations; solidified roles, responsibilities and respective expertise and resource contributions; and was helpful in establishing a working relationship with partner organizations
- Staffing changes, partnership issues, conflicting/emerging new priorities and unexpected events are some of the many reasons why well-planned projects can experience delays

ADAPTATION FROM OTHER PROGRAMS

This model was developed from a similar approach to building community capacity undertaken by the Manitoba Cervical Screening Program

program links

None currently available

program contact

Susan Larsh
 Health Promotion Specialist
 Cancer Care Ontario
 505 University Ave., 18th Floor
 Toronto, ON M5G 1X3
 Phone: (416) 971-9800 ext. 3447
 E-mail: susan.larsh@cancercare.on.ca

Consensus Guidelines for Primary Health Care of Adults with Developmental Disabilities



TARGET AUDIENCE: Primary healthcare providers caring for adult patients with developmental disabilities

Focus: All cancers, including breast, cervical and colorectal cancer

Challenges/risks faced by target population: People with developmental disabilities (DD) are less likely than the general population to be included in cancer prevention screening programs, such as cervical screening, breast examination, mammography and digital rectal exam. They are also less likely do self-examination or to report abnormalities.

Setting: Canada

Theoretical background: Best practice guidelines

Status: Revised consensus guidelines to be published in 2010

Funder: Ministry of Community and Social Services; Ontario Ministry of Health and Long-Term Care; Surrey Place Centre Foundation

BRIEF OVERVIEW

- In 2009, a review of the 2006 Consensus Guidelines for Primary Health Care of Adults with Developmental Disabilities was undertaken
- Experts agree that implementing the consensus guidelines for adults with DD would improve their health, minimize disparities in health and healthcare, and help increase awareness and screening rates for all cancers, including breast, cervical and colorectal.

GOALS AND OBJECTIVES

- To revise the 2006 consensus guidelines for primary healthcare providers, based on the best available evidence and expert clinical experience, for addressing health issues, including cancer screening, in adults with DD

PROGRAM IMPLEMENTATION STEPS

- In 2005, identified experts in healthcare of people with DD were invited to a five-day colloquium to examine proposed guidelines for primary health care of adults with DD
- Based on their feedback, the proposed guidelines were revised and submitted to *Canadian Family Physician* for peer-reviewed publication
- In March 2009, a one-day consensus conference was held; suggestions for revisions and new guidelines emerged
- The proposed guidelines were developed by expert Canadian clinicians based on their own clinical experience, a literature review with the help of a

research librarian, and consultations with other experts in the field

- The guidelines have three sections: general issues in primary care; physical health guidelines; and behavioural and mental health guidelines
- Consensus conference participants included family physicians, specialists, psychologists, psychiatrists, geneticists and ethicists with relevant expertise and clinical experience in DD
- Conference participants were sent a post-conference draft of the revised guidelines for additional feedback; an updated version with references and ranking of evidence is currently being reviewed
- Before publication, all participants will be required to signify general agreement with the revised guidelines and give permission for their names to appear on the document
- Four new proposed guidelines relate to increasing awareness and screening rates among women with DD:
 1. Disparities in primary care: To apply age- and gender-specific guidelines for preventative healthcare for adults in the general population as well as guidelines and tools adapted for individuals with DD
 2. Capacity for voluntary and informed consent: To always assess capacity for consent whenever proposing investigations or treatments for which consent is required
 3. Immunization: To discuss the HPV vaccine with female patients with DD and their caregivers, if appropriate; and

- 4. Cancer Screening: To perform breast, cervical and colorectal cancer screening for adult patients with DD in accordance with provincial guidelines

invasiveness of the procedure, however, the balance of benefits versus risks of such a recommendation must be carefully considered

PROGRAM REACH

- Family physicians who read the guidelines published in *Canadian Family Physician* (projected circulation 25,000)

EVALUATION

Method

- The intention is to update the consensus guidelines every three to five years based on the recommendations of the Guidelines Advisory Committee of Ontario
- As with all guidelines, it is difficult to measure impact

Key findings

- Experts agree that implementing the proposed guidelines would improve the health of people with DD, minimize disparities in health and healthcare, and help increase cancer awareness and screening rates
- The DD Primary Care Initiative (see page 80) was developed to facilitate and evaluate the implementation of the Consensus Guidelines

CRITICAL FACTORS FOR ADAPTATION

- Include experts involved in the training of family physicians and other healthcare professionals knowledgeable in best practices and effectively addressing challenges in care of persons with DD
- Interdisciplinary health care for adults with DD is critical, as is working with patients' families and support networks
- Pay attention to ethical issues, such as informed consent and avoidance of harm; some people with DD are habituated to always be compliant, others cannot communicate their wishes, and still others lack the capacity to give informed consent or can do so only with support
- DD are not grounds for care providers to withhold or to withdraw medically indicated interventions, such as cancer screening; decisions concerning such interventions should be based on patients' best interests
- People with DD are at increased risk of abuse (e.g., sexual abuse); some countries make it mandatory that women with DD have a Pap test as they are presumed to have been sexually abused; given the

CHALLENGES

- Given the many variables among adults with DD that are difficult to control in studies and the barriers that exist in respectfully recruiting such people as research participants, there is a paucity of Level I and Level II evidence. A "best available evidence" (Level III) standard for the guidelines was adopted

LESSONS LEARNED

- A thorough examination of relevant literature, and debate and discussion by people who will use the guidelines, ensure that they are accurate and realistic
- Guidelines must also be filtered by expert clinicians who can make judgments of benefits and burdens
- Those who draft guidelines need to be adequately prepared (e.g., have a thorough grounding in the literature) so the debate can occur at a more sophisticated level

ADAPTATION FROM OTHER PROGRAMS

None

reference

Revised guidelines to be published in 2010:
 Sullivan, W. F., Heng, J., Cameron, D., Lunskey, Y., Cheetham, T., Hennen, B., Bradley, E. A., Berg, J. M., Korossy, M., Forster-Gibson, C., Gitta, M., Stavrakaki, C., & McCreary, B. (2006). Consensus guidelines for primary health care of adults with developmental disabilities. *Canadian Family Physician*, 52, 1410-1418.

program contact

Dr. William F. Sullivan
 Family Physician
 Surrey Place Centre
 2 Surrey Place
 Toronto, ON M5S 2C2
 Phone: (416) 925-5141
 E-mail: bill.sullivan@SurreyPlace.on.ca

Developmental Disabilities Primary Care Initiative



TARGET AUDIENCE: Primary healthcare providers caring for adult patients with developmental disabilities

Program focus: Breast, cervical and colorectal cancer

Challenges/risks faced by target population: *Consensus Guidelines for Primary Health Care of Adults with Developmental Disabilities* were published in 2006 in *Canadian Family Physician*. Changes in practices, however, require a move beyond the published guidelines to develop more focused strategies to provide support to primary healthcare providers.

Setting: Canada

Theoretical background: Best practice guidelines

Program status: 2007–2012

Funder: Ministry of Community and Social Services (MCSS); Ministry of Health and Long-Term Care (MOHLTC); Surrey Place Centre Foundation

BRIEF OVERVIEW

- The Developmental Disabilities Primary Care Initiative was developed to facilitate the implementation of the 2006 *Consensus Guidelines for Primary Health Care of Adults with Developmental Disabilities* (revised guidelines to be published in 2010).
- To date, feedback from family physicians and other primary healthcare providers has been uniformly positive, indicating that the training program, information and tools to support the implementation of the guidelines is useful and relevant to their learning needs and clinical practice.

PROGRAM GOALS AND OBJECTIVES

- To improve primary healthcare provision for adults with DD, including cancer screening
- To provide primary healthcare providers with a training program, information and tools to support the implementation of the consensus guidelines (see page 78)

PROGRAM IMPLEMENTATION STEPS

- *Consensus Guidelines for the Primary Health Care of Adults with Developmental Disabilities* were developed in 2006
- A five-year plan to improve primary healthcare of adults with DD was drafted by a steering committee and submitted to MCSS, MOHLTC and Surrey Place Centre Foundation
- A training program was developed to teach family physicians and other primary healthcare providers about the guidelines and how to implement them
- The training consists of an initial workshop, four online case studies that participants work through

- and post responses to, followed by a monthly video-teleconference (webinar), and a final workshop
- Faculty include family physicians, nurses, psychiatrists and psychologists with expertise in the field of DD, from across Ontario and Halifax
- Faculty members teach at both workshops, facilitate the online learning, and give input for “best practice” care at monthly webinars
- The training program is accredited for Mainpro-C credits from the College of Family Physicians of Canada
- Recruitment is via e-mail with a brochure sent to primary healthcare providers by MCSS agencies serving people with DD, and a display (as well as a workshop) at the Canadian Annual Family Medicine Forum
- Participants in the training program identify learning issues and questions about how to implement the guidelines
- From their input, a number of tools (more than 20) have been developed or adapted (e.g., a tool for obtaining informed consent, genetic assessment, frequently asked questions, and tools to help with the care of patients with challenging behaviours)
- Regional clinical support networks are being developed to promote long-term sustainability

PROGRAM REACH

- 134 primary healthcare providers have been trained over the past three years; the number of women with DD to whom they provide healthcare is currently not known

EVALUATION

Method

- A program logic model was developed as a base for the evaluation
- Participants submit a needs assessment prior to training; evaluation forms are completed for the initial and final workshops, as well as each case study; participants are also asked to do a reflective exercise on changes in their practice (i.e., what they are doing now that they didn't do before?)
- Organizers are working with the Institute for Clinical Evaluative Sciences (ICES) to find a baseline measure for primary healthcare indicators in the population with DD, which can be compared with the general population
- Organizers are also developing a strategy to ascertain whether there is a difference in care, as measured by these indicators, in patients whose healthcare provider has participated in the training program; this is a complex and challenging undertaking related to respect for patients' and providers' rights, including privacy rights

Key findings

- Feedback from primary healthcare providers has been uniformly positive
- Most healthcare providers appreciate the significant work and time that went into the preparation of the training and find the case studies, small group discussions, tools and resources and networking relevant and useful
- Some healthcare providers expressed the need to learn more about local resources and expressed interest in information on regional clinical support networks

CRITICAL FACTORS FOR ADAPTATION

- Leadership and a clear focus
- Political timing is helpful: the announced closing of the last remaining regional centres caring for people with DD meant that a large number of complex patients would need primary care in the community, making this proposal timely
- A small group of committed leaders
- Sufficient funding to support a program of this scope
- With respect to cancer screening guidelines, practical and detailed discussions and tools related to obtaining informed consent are critical, especially when dealing with sensitive and invasive procedures like clinical

breast exams, mammography, Pap testing and digital rectal exams

- Having trained and knowledgeable professionals in each region; creating clinical support networks to provide support and ongoing learning

CHALLENGES

- Gaining the attention and participation of primary healthcare providers who are extremely busy, especially given that care of patients with DD is usually one small aspect of a large practice

LESSONS LEARNED

- Commitment and cooperation of a key group of committed faculty, and the vision and strategic leadership of the program director, have been key to success
- Varying skill levels for online learning required a practice session, ongoing tech support, use of webcams, and patience; many learners still prefer attending a workshop with focused learning and personal connections to e-learning; with training, however, comfort levels may increase
- E-learning can broaden program reach across the province and country, especially to care providers in more isolated centres
- Regional supports differ across Ontario, and primary healthcare providers need help learning about them and how to access them

ADAPTATION FROM OTHER PROGRAMS

This program was based on "Palliative Care Program for Family Physicians — A Problem-Based Learning Course"

program links

A dedicated webpage on the Surrey Place website will be available by the end of 2010

program contact

Dr. William F. Sullivan
Family Physician
Surrey Place Centre
2 Surrey Place
Toronto, ON M5S 2C2
Phone: (416) 925-5141
E-mail: bill.sullivan@SurreyPlace.on.ca

Female Sexuality Education Program



TARGET AUDIENCE: Women with mild to moderate developmental disabilities

Program focus: Breast and cervical cancer

Challenges/risks faced by target population: Research indicates that about 90% of adult women with developmental disabilities have been sexually assaulted at some point in their lives. In the past, there was no sex education in the school system for women with developmental disabilities and many did not have peers to consult or talk to.

Setting: Surrey Place Centre (interdisciplinary, community-based agency in Toronto)

Province: Ontario

Theoretical background: None stated

Program status: Early 1990s to present

Funder: Surrey Place Centre

BRIEF OVERVIEW

- The Female Sexuality Education Program was specifically designed to address the need for an abuse-prevention program for adult women with developmental disabilities.
- Although the focus of the education program was not specifically breast and cervical cancer screening, the curriculum included teaching women in the target population how to do breast self-examination, and provided knowledge on pelvic examinations.

PROGRAM GOALS AND OBJECTIVES

- To provide sexuality education information to women aged 18+ with developmental disabilities
- To decrease the incidence of abuse among women with developmental disabilities

PROGRAM IMPLEMENTATION STEPS

- The education program consists of 8–10 sessions, depending on the knowledge level of the group
- Each session lasts 1–1.5 hours, has about 7–10 participants and is facilitated by two staff members
- Before the education session, women are:
 - ♦ Pre-screened to assess if they can work well in a group setting
 - ♦ Asked to complete a pre-test questionnaire
 - ♦ Asked why they want to attend the education program, and
 - ♦ Asked what they want to learn from the program

- Education sessions are provided individually for women who are not comfortable or who do not function well in a group setting
- Outreach activities include consulting and training other agencies to conduct group education sessions and conducting education sessions at different workshops and day programs
- The education program is focused on developing basic sexuality knowledge by means of group discussion, and teaching factual information and concepts through the use of interactive games and activities, as well as visual diagrams and videos
- Topics include: feelings; self-esteem; relationships; private versus public places, behaviours, clothing and conversations; birth control; safer sex practices; sexually transmitted infections; body parts and functions; anything from birth to death (e.g., human reproduction); sexual abuse; menstruation; boundaries; and breast self-examinations
- Group participants are encouraged to share personal experiences, ask questions and participate in activities
- Participants also visit a hospital; a nurse practitioner and registered nurse talk to the group about women's health issues such as being comfortable with your doctor, pelvic exams and healthy eating, and allow the participants to look at some of the medical equipment used by physicians
- At the last session, participants complete a post-test questionnaire in a group setting

PROGRAM REACH

- Approximately 75 women have participated in the groups facilitated by Surrey Place Centre staff in the past 10 years

EVALUATION

Method

- Participants completed a shortened version of the Socio-Sexual Knowledge and Attitudes Assessment Tool-Revised (SSKAAT-R) questionnaire before and after the education program

Key findings

- In general, results indicated improvement in knowledge and awareness among participants from pre-test to post-test

CRITICAL FACTORS FOR ADAPTATION

- Participants should be screened to determine whether group education would be appropriate and beneficial to them
- Group facilitators must be interested in providing sex education and be comfortable talking about issues related to sexuality
- While staff members are there to facilitate the sessions, it is important that women in the group be empowered to decide what they want to talk about

CHALLENGES

- Explaining abstract concepts can be difficult for people with developmental disabilities who think in more concrete ways; the use of images can be helpful when explaining concepts that are difficult to understand (e.g., it is often difficult to understand whether someone is being loving or abusive and manipulative)
- It can be difficult to find the time to conduct the group sessions and to recruit women who are interested in participating

LESSONS LEARNED

- Due to the fact that women with developmental disabilities experience high rates of sexual abuse and often live in poverty, they will continue to come back to the programs at the centre
- Facilitators need to be as concrete as possible when communicating and to continuously adapt materials to meet participants' interests and learning styles
- Each group is different from the one before; facilitators need to adapt the program according to the needs and interests of participants, as well as the resources available

ADAPTATION FROM OTHER PROGRAMS

The education content for the program was taken from the following sources:

- Life Horizons program, LifeFacts Curriculum
- Books by Susan Ludwig, nurse practitioner
- Various workshops

program links

www.surreyplace.on.ca/clinical-programs/developmental-disabilities/pages/adult-programs-and-services.aspx

Health education booklets for women with developmental disabilities: *My Health, What I Need to Know ...* (developed by Surrey Place Centre)

program contact

Cheryl Bedard, Therapist
Surrey Place Centre
2 Surrey Place
Toronto, ON M5S 2C2
Phone: (416) 925-5141
E-mail: cheryl.bedard@surreyplace.on.ca

Gateways to Cancer Screening: A Participatory Needs Assessment of Women with Mobility Disabilities



TARGET AUDIENCE: Women with mobility disabilities living in the Greater Toronto Area

Program focus: Breast, cervical and colorectal cancer

Challenges/risks faced by target population: Women with disabilities face multiple barriers that challenge their access to screening and support. Barriers include lack of knowledge, neglect on the part of healthcare providers and barriers to physical access.

Setting: General Toronto Area (GTA), Toronto and Peel Region

Province: Ontario

Theoretical background: Participatory action research; community development

Program status: 2007–2008

Funder: Canadian Cancer Society, Diversity and Cancer Control teams

BRIEF OVERVIEW

- The Gateways community-based participatory project carried out a needs assessment.
- The project's aim was to explore the experiences and needs of women with mobility disabilities attempting to access breast, cervical and colorectal cancer screening.
- Using a participatory action research model, five peer-led focus groups were conducted with women with mobility disabilities. Accounts of their personal experiences helped to identify barriers to cancer screening and recommendations for improvement.

PROGRAM GOALS AND OBJECTIVES

- To assess the needs of diverse women with physical mobility disabilities in terms of accessing breast, cervical and colorectal cancer screening services
- To determine the gaps and barriers associated with accessing these services for women with physical mobility disabilities
- To develop a series of recommendations to be shared with key stakeholders involved in the delivery of screening services
- To focus on implementing these recommendations
- To produce new areas of knowledge that benefit people with disabilities, which in turn can be effectively transferred to key cancer-control professionals

PROGRAM IMPLEMENTATION STEPS

- An advisory committee was formed, with representatives from the disability community, healthcare settings and the educational sector
- A working group met regularly to facilitate and implement the focus groups
- A project coordinator was hired
- Focus group participants were recruited and screened by the coordinator
- Focus groups were co-facilitated by two peer support workers who were also wheelchair users
- Focus group participants were asked questions pertaining to their cancer screening experiences

PROGRAM REACH

- In total, five focus groups were conducted with approximately 23 women who self-identified as living with mobility disabilities
- A final report of the results was circulated widely among key stakeholders in the disability community and healthcare settings across Ontario
- A literature review conducted by the research team was published in the journal *Disability and Society*

EVALUATION

Method

- Focus group participants were prescreened by the project coordinator to ensure that they met the screening criteria
- Participants were to be at least 18 years old; have no previous history of breast, cervical or colorectal cancers; and live in the GTA

Key findings

Participant recommendations

- More screening sites are needed that have accessible exam tables and screening technology, as well as on-site attendant care
- These sites must be clearly publicized to the disability community
- Strategic health messaging with disability-positive images, and specific information for women with disabilities, are required to support self-advocacy in accessing screening
- More personnel are required to address disability-related needs and anxieties prior to screening procedures
- On-site health education sessions on screening guidelines and procedures, and body-specific strategies for optimal care, are needed for women with disabilities

CRITICAL FACTORS FOR ADAPTATION

- Recruit and screen participants to ensure eligibility criteria is met
- Maintain the peer-led component
- Ensure all focus groups are led by representatives of the community

CHALLENGES

- The research ethics board's approval process was systemically challenging in that the institutionalization of the healthcare setting does not typically acknowledge qualitative and participatory action research
- It is difficult to bridge the gap between healthcare provision and accommodations for people with disabilities

LESSONS LEARNED

- It is important to listen to the disability community regarding barriers to accessing appropriate healthcare
- Women with disabilities have had to be their own advocates in accessing services
- Women with disabilities were proactive in protecting their health needs, and were knowledgeable about their own health issues
- Barriers to screening were both internal and external to the healthcare system (e.g., transportation, attendant services)

ADAPTATION FROM OTHER PROGRAMS

None

program links

www.cilt.ca/Gateway_project.aspx

reference

Literature review available at
Disability and Society 24, 739–751

program contact

Nancy Barry
Peer Support Coordinator
Centre for Independent Living in
Toronto
365 Bloor St. E., Suite 902
Toronto, ON M4W 3L4
Phone: (416) 599-2458, ext. 227
E-mail: peers@cilt.ca

Greater Toronto Area (GTA) Cancer Prevention and Screening Physician Campaign Strategy



TARGET AUDIENCE: Family physicians in Ontario

Program focus: Breast, cervical and colorectal cancer

Challenges/risks faced by target population: Physicians are the key stakeholders in ensuring that the “Cancer 2020” screening targets are reached; some physicians, however, do not include referrals to screening as part of their everyday practice.

Setting: Not applicable

Province: Ontario

Theoretical background: None stated

Program status: 2006–2008

Funder: Greater Toronto Area Cancer Prevention and Screening Network

BRIEF OVERVIEW

- The Greater Toronto Area Cancer Prevention and Screening Network (GTA CPSN) published a series of cancer prevention and screening articles in the *Ontario Medical Review* (OMR) journal as a means of communicating with physicians about the current state of cancer prevention and screening in Ontario, as well as to encourage them to discuss and recommend appropriate screening to their patients.
- The strategy of targeting family physician through print articles is an excellent, inexpensive method to reach a large number of physicians at one time; in addition, many studies have documented that provider recommendation is the strongest predictor of whether patients will be screened.

PROGRAM GOALS AND OBJECTIVES

- To increase the number of family physicians who include breast, cervical and colorectal cancer screening in their everyday practice, thus improving cancer screening rates in Ontario and helping to achieve the province’s “Cancer 2020” long-term goals for cancer prevention and screening
- To provide family physicians with an overview of the state of cancer prevention and screening in Ontario
- To provide guidelines and education regarding evidence-based screening
- To provide strategies for physicians to help patients make appropriate health decisions about screening

PROGRAM IMPLEMENTATION STEPS

- The GTA CPSN formed a working group in 2006 to develop and implement this initiative, with staff from

- Toronto Public Health, York Region Public Health, Halton Region Health Department, Region of Peel Public Health, Simcoe Muskoka District Health Unit, Sunnybrook’s Odette Cancer Centre and the Ontario Breast Screening Program, GTA Region
- The working group chair first contacted the Ontario Medical Association to obtain their support and willingness to print the three articles in the OMR
- For each of the three articles:
 - ♦ The working group met to set timelines, compile the relevant information and draft an outline
 - ♦ A writer was then hired and provided with the outline
 - ♦ Based on the outline, the writer conducted additional research and literature reviews, produced a draft article and distributed it to the working group
 - ♦ The working group edited and revised the draft article collectively; the writer subsequently revised the article based on the suggestions provided
 - ♦ Once a final version of the article was achieved, the chair of the working group submitted the article to the OMR manager of publications
 - ♦ The OMR printed the article within a reasonable timeframe
- The first article, “Cancer screening: The key to early detection” was published in the April 2007 issue of OMR; it focused on the state of cancer screening in Ontario and the vital role physicians play in helping patients make appropriate health decisions about screening, and in the delivery of screening services

- The second article, “Breast screening in Ontario: Reaching for 2020 targets,” was featured in the March 2008 issue of OMR; it presented an overview of breast screening guidelines in Ontario, and highlighted the important role that organized screening programs play in the early detection of breast cancer
- The third article, “Improving cervical cancer prevention and screening rates: Reaching Ontario’s underscreened populations; physician strategies to help patients make appropriate health decisions,” was featured in the October 2008 issue of OMR; it provided an overview of the state of cervical cancer prevention and screening in Ontario, and provided strategies for physicians to help patients make appropriate health decisions about screening

PROGRAM REACH

- The OMR is circulated to an estimated 28,000 members of the Ontario Medical Association 11 times each year; therefore, approximately 28,000 physicians in Ontario received each of the three articles

EVALUATION

Method

- Not evaluated

Key findings

- Although this initiative was not evaluated, it was an inexpensive strategy to target a large number of physicians

CRITICAL FACTORS FOR ADAPTATION

- Interview potential writers and confirm that they have knowledge of the material and messaging
- Establish an agreement with the OMR (or other publication) to have potential articles printed, preferably on an ongoing or annual basis, rather than one time only

CHALLENGES

- Ensuring that the writer captured the ideas, information and revisions provided by the working group
- Ensuring that the writer stayed on schedule and met outlined objectives and deadlines
- Maintaining a consistent tone and flow in all three articles, as two different writers were engaged
- Budgeting time for several drafts to be developed and reviewed before reaching the final version

LESSONS LEARNED

- Ongoing communication with the writer and following outlined schedules and deadlines are essential to overcoming the challenges faced
- The working group has to be flexible with respect to publication dates: submission does not guarantee publication
- As this was a one-time strategy, it would have been beneficial to implement a long-range plan to update the articles and eventually reprint them in the OMR
- It would have been very difficult to complete this initiative by working as an individual health unit or agency, rather than as a cohesive GTA network

ADAPTATION FROM OTHER PROGRAMS

None

reference

Greater Toronto Area Cancer Prevention and Screening Network. (2008). Improving cervical cancer prevention and screening rates: Reaching Ontario’s underscreened populations; physician strategies to help patients make appropriate health decisions. *Ontario Medical Review*, 23–31.

program contact

Laura McDonald
 Health Promotion/Recruitment
 Ontario Breast Screening Program — GTA Region
 Regional Administrative Lead
 ColonCancerCheck — Toronto Central LHIN
 305 Milner Ave., Suite 904
 Scarborough, ON M1B 3V4
 Phone: (416) 298–2626 ext. 2231
 E-mail: Laura.McDonald@gtaobsp.ca



癌症普查 挽救生命

Cancer Screening Saves Lives

在什麼時候需要接受普查？

乳癌： 年滿五十歲的婦女應當進行乳房X光造影(Mammogram)檢查，一般來說每兩年檢查一次。

子宮頸癌： 所有有性生活的婦女需要每年做一次帕氏抹片檢查(Pap test)，連續三年，如果測試結果正常，可轉為每兩至三年檢查一次，直至七十歲為止。

結腸直腸癌： 年滿五十歲風險在一般水平的男女應當每兩年做一次大便隱血檢查(FOBT)。家族中有患結腸直腸癌的男女在醫生建議下，應當每五年做一次結腸鏡(Colonoscopy)檢查。

請和你的醫生或護士討論上述檢查和你的家族病史。你可能需要較早開始普查或更頻密的測試。

如需更多資料請聯絡：

- 你的醫生或護士
- 你本區的公共醫療單位
- 安大略省乳癌普查計劃 1-800-668-9304 或 www.cancercare.on.ca
- 加拿大癌症協會 1-888-939-3333 (你可以要求中文服務) 或 www.cancer.ca




CHECK IT OUT: QUEER WOMEN NEED PAPS TOO!, PAGE 72



PROMOTING CANCER SCREENING IN CHINESE COMMUNITIES IN ONTARIO, PAGE 116

Innovation in Service Delivery

Ontario Breast Screening Program | Mobile Coach in Northwestern Ontario



Mobile Coach Fast Facts

- 45.5 feet long, 8.5 feet wide, 12 feet in height (similar to a Greyhound Bus)
- Diesel engine: 500 horse power
- Self contained unit – insulated, air conditioned, no onboard water or toilet facilities.
- Wheelchair accessible entrance with automatic and manual control lift
- Power: onboard electrical generator or 80 amp electrical service for shore power at visiting sites
- Drivers require a D-2 license in Ontario. Total number of hours to train a driver upgrading from a standard driver's license is approx. 30 hours plus a two-day air brake program
- Communications: Bag cell phone, laptop for office communications and access to internet, hand-held cell phone
- Digital Lorad Selenia Mammography Unit installed November 2007
- Image transfer with on board lap top and stored memory sticks

Innovation for Program Operation

The program employs five part-time Mammography Technologists and Nurse Examiners who work as a team in four-day shifts to share screening, driving and coach set up/take down duties. The RN has additional clinical breast examination training and the Mammography Technologist is responsible for the operation of the digital mammography unit on the coach. Digital images are recorded, transferred to a memory stick for image transfer and read by program Radiologists at the hub office located in Thunder Bay.

The mobile program began in 1992 and screens 300 days/year, 173 days in the region and 127 days in the city and area during the winter months.

From April – October the coach visits up to 34 communities in the region, working 12-hour days and providing 31 screens/day.

From November – March the coach remains in the Thunder Bay area visiting 24 locations, working 8-hour days and providing 26 screens/day.



Program Performance

The mobile breast screening program has been shown to increase access and participation rates for women residing in remote and rural communities as well as in urban settings. The coach completes 6,560 screens annually and since 1992 has provided 92,775 mammograms.



Breast Screening Participation and Retention Rates

Cancer Care Ontario 2010 target: 70% of eligible women 50 – 74 years of age screened with mammography. The NW OBCSP mobile program achieved a rate of 49.7% in 2007.

Retention Rates: The NW OBCSP has one of the highest retention rates in the province for 36 month recall at 90%.



Improving access and reducing barriers to reach under-screened and never-screened populations

There are over 70 First Nations communities in Northwestern Ontario. Twenty-four (24) of these are isolated, far northern and remote communities that cannot be reached by road. The coach is unable to drive on dirt or gravel roads due to the sensitivity of the mammography equipment.

The OBCSP-NW program works with rural and remote communities to coordinate transportation to nearby communities. The program has partnered with Health Canada to fly women to nearby locations when the coach is visiting. Over 250 women from far-northern, fly-in communities are flown in annually to meet the coach in Red Lake, Sioux Lookout or Geraldton.

Regional Cancer Care's Aboriginal Health Promotion Planner is working with community leaders in those rural communities only accessible by gravel roads to coordinate local transportation to drive women from their community to the coach at a nearby location.



NORTHWESTERN ONTARIO BREAST SCREENING MOBILE PROGRAM, PAGE 110

Our experience using OMNI/Rogers Multicultural Media to provide information on women's cancers to the diverse communities in Toronto

The Toronto Cancer Prevention Coalition (TCPC) Early Detection and Screening Working Group, in collaboration with Toronto Public Health (TPH) and other partner organizations, planned, developed and implemented key messages with respect to the early detection and/or screening of breast, cervical and ovarian cancer through a partnership with OMNI and Rogers television. The goal of this initiative was to increase the awareness and knowledge base of women from priority populations on the importance and methods relating to the early detection and screening of women's cancers and the services and resources that are available to them in their language of origin. Once the script was developed, the information was presented by a designated member of the community and aired on the OMNI and Rogers Television Networks and videos were produced in three languages: Farsi, Ukrainian and Punjabi.

The script addressed key messages with respect to breast, cervical and ovarian cancers and covered the following topics:

- General information on all three cancers, i.e. incidence rate, signs and symptoms
- A description of the range of available screening methods
- Recommendations to have regular checkups in order to maintain good health
- Promotion of a collaborative patient/health care provider relationship, including tips for talking with physicians about screening and diagnostic tests
- Information on community resources, print resources, telephone numbers and website addresses that women can access in their communities
- Information on resources for women who do not have an Ontario health card.

As this project has created a lot of excitement and positive feedback from women and some men in both communities, measures are being taken to sustain the momentum and to maximize the interest through maintaining our linkages with the key contacts from all three communities to follow up on requests for information and resources triggered by the video.

As a result of the evaluations, the working group recommends to continue to address key messages to hard to reach communities through their own ethnic television programs, newspapers, radio, etc. Furthermore, according to the evaluation results, as there is more than 80% likelihood for viewers to consider screening after viewing these videos, further initiatives are strongly recommended to monitor this population to ensure actual behavior change. Collaborating with key partners and stakeholders to devise programs to facilitate screening participation among these populations is therefore highly recommended.



Toronto Cancer Prevention Coalition

Funding for this project was provided by Cancer Care Ontario and Toronto Public Health

Videos in Farsi, Ukrainian and Punjabi available upon request (Approximate time of each video is 10-12 minutes). Please contact Cathy Krizanovic - ckrizan@toronto.ca



OMNI/ROGERS WOMEN'S CANCER INITIATIVE FOR MULTI-ETHNIC COMMUNITIES, PAGE 112

Are you a Woman 50 or Over? Never Had a Mammogram?

ONE DAY ONLY
No appointment necessary!

Ontario Breast Screening Program invites you to join the



Come in for a mammogram!

When: Monday, October 26, 2009

Time: 8:00 a.m. to 8:00 p.m.

Where: 4 Walford Rd., Sudbury or 65 Larch St., Sudbury

Questions? 675-2283

Gifts & refreshments for all who attend!



programme ontarien de dépistage du cancer du sein
un programme de action cancer ontario



50 OVER 50 CHALLENGE, PAGE 54

Caafimaadkaaga awgii...

Joogtee sawirka naasahaaga iyo baadhitaanka ilmagaaleenka afkiisa (mammogram & Pap test) wuxuu badbaadin karaa naftaada

Weyddii dhaktarkaaga, kalkaalayaha caafimaad ama la hadal telefoonka codka afafka badan ee waaxda caafimaadka
613-580-6744 xidhiidhka 28020

من أجل صحتك...

قد تتخذ صور الثدي الشعاعية وفحوصات عنق الرحم المنتظمة حياتك!

تحدث مع طبيبك أو الممرضة الممارسة أو اتصل بخط المعلومات الصحية متعدد اللغات
613-580-6744 فرعي 28020

For your health...

Regular mammograms and Pap tests could save your life!

Ask your doctor, nurse practitioner or call the Multilingual Health Information Line:
613-580-6744, extension 28020



Pour votre santé...

Passer régulièrement une mammographie et un test Pap pourrait vous sauver la vie!

Parlez-en à votre médecin, votre infirmière praticienne ou appelez la Ligne info-santé plurilingue :
613-580-6744, poste 28020

South-East Ottawa Centre for a Healthy Community, Somali Centre for Family Services, Ontario Breast Screening Program and Ottawa Public Health in collaboration with Carlington Community & Health Services and Pinecrest-Queensway Health & Community Services.

INCREASING BREAST, CERVICAL AND COLORECTAL CANCER SCREENING AWARENESS AND PARTICIPATION IN THE ARABIC AND SOMALI COMMUNITIES, PAGE 94

Hand in Hand: Breast Cancer Prevention Project



TARGET AUDIENCE: Underserved Korean immigrant women

Program focus: Breast cancer

Challenges/risks faced by target population: Due to health screening by immigration officers, Korean women generally arrive in Canada in good health. Regardless of the number of years they live in Canada, however, the majority of Korean immigrant women continue to live in conditions of marginalization and lack of access to culturally and linguistically appropriate healthcare and services.

Setting: Greater Toronto Area and its vicinity

Province: Ontario

Theoretical background: Community development

Program status: 2006–2009

Funder: Canadian Breast Cancer Foundation, Ontario Region

BRIEF OVERVIEW

- Based on a peer-to-peer educator model, the project was designed by the Korean Canadian Women's Association (KCWA) Family and Social Services in partnership with various organizations, with the overall goal of educating women on the importance of early breast cancer detection.
- Results from the program evaluation indicate significant increases in knowledge of and positive attitudes towards early detection activities and breast cancer screening, as well as positive reactions to the program and a keen interest to see it sustained.
- Increased awareness and knowledge may change underserved and unserved Korean immigrant women's attitudes and behaviours toward early detection.

PROGRAM GOALS AND OBJECTIVES

- To increase awareness and knowledge of breast health and breast cancer
- To increase awareness of the importance of early detection
- To influence attitudes and behaviour towards breast health and breast cancer
- To increase the number of women accessing breast screening programs
- To increase the community's capacity to respond to breast cancer

PROGRAM IMPLEMENTATION STEPS

- An advisory committee was formed with members from South Riverdale Community Health Centre, Marvelle Koffler Breast Centre and Wellspring

- A coordinator was hired
- The coordinator prepared a training manual for peer leaders
- The coordinator went to places where Korean women congregated to promote the project and to recruit female peer leaders who would participate in the peer leader training
- 30 peer leaders were trained for 20 hours to deliver workshops in their circle of friends
- Training was broken down into four modules, which covered breast health, early detection-related activities, breast cancer, healthy lifestyle and supportive environment, and facilitation skills
- Peer leaders recruited workshop participants and conducted 15-hour workshops at homes, religious organizations, community agencies, etc.
- Regular monthly meetings were held between the coordinator and peer leaders for sharing feedback and follow-up educational sessions

PROGRAM REACH

- To August 2009, approximately 1000 women have been directly reached across the Greater Toronto Area and its vicinity
- Through the community media, 10,000 viewers were indirectly reached

EVALUATION

Method

- Participants completed questionnaires before and after the workshop
- The community's verbal and written feedback to the program was also gathered, including media coverage

Key findings

- There was a significant increase in knowledge of and positive attitudes towards early detection activities and healthy lifestyle
- Participant and community feedback to the program have been tremendously positive
- Breast cancer survivors formed a support group to mutually support one another
- There was a keen interest in the communities to see the program sustained

CRITICAL FACTORS FOR ADAPTATION

- Be flexible with the number of workshop hours and reformat presentation materials to meet the needs of diverse groups
- Recruit peer leaders with good facilitation skills and extensive networks in the community

CHALLENGES

- Korean immigrant women from other provinces also requested workshops; due to long distances, however, these could not be provided
- Reaching out to isolated and marginalized women was very challenging as they had to be identified through word of mouth

LESSONS LEARNED

- It is important to listen to the workshop participants and accommodate their needs with respect to time, venue, length, etc.

ADAPTATION FROM OTHER PROGRAMS

The program was adapted from the general peer-to-peer model program

program links

None currently available

program contact

Younglee Ha, Executive Director
KCWA Family and Social Services
27 Madison Ave.
Toronto, ON M5R 2S2
Phone: (416) 340-1234
E-mail: kcwaed@kcwa.net

Immigrant Women's Health Centre Mobile Health Clinic Program



TARGET AUDIENCE: Newcomers to Canada, older women, low-income women and women of low literacy or whose first language is not English

Program focus: Breast and cervical cancer

Challenges/risks faced by target population: The target populations are often hard to reach or marginalized. The Mobile Health Clinic first started providing services directly to immigrant women working in places such as garment factories and hotels in the Toronto downtown core; it was evident that these women were unable to access sexual health services due to their shift work and inability to take time off from their work to go to a doctor.

Setting: City of Toronto locations such as factories, women's centres, community centres, malls, refugee centres, religious organizations and English as a Second Language (ESL) delivery centres

Province: Ontario

Theoretical background: None stated

Program status: 1983 to present; started in 1981 as a three-year pilot project with Health Canada and has since continued

Funder: City of Toronto

BRIEF OVERVIEW

- The Mobile Health Clinic Program, operated by the Immigrant Women's Health Centre (soon to be renamed the Immigrant Women's Sexual Health Centre), is a travelling healthcare unit designed to provide sexual health services and education to hard-to-reach and marginalized women. The mobile clinic is a component of the centre's Healthcare in the Workplace Program.
- The mobile clinic is an alternative and accessible means to deliver sexual health services that aims to reduce or eliminate many concerns faced by marginalized women such as language barriers, transportation, religious concerns and employment constraints.
- The program has been evaluated by Toronto Public Health and found to be effective and successful.

PROGRAM GOALS AND OBJECTIVES

- To provide accessible clinical sexual healthcare and education, including breast and cervical cancer screening, to women who are marginalized from mainstream healthcare for any number of reasons (e.g., language barriers, isolation, poverty, lack of transportation and lack of knowledge around services, particularly for newcomers)

PROGRAM IMPLEMENTATION STEPS

- Women who were most unlikely to access mainstream sexual healthcare were identified
- Communities and language groups with the most need for such services were identified

- Staff from the target populations were hired to service these communities
- The Mobile Health Clinic Program and business case, including potential partners and initial geographical boundaries, were developed
- The Mobile Health Clinic was acquired and a 28-foot Winnabego camper was retrofitted to accommodate an examining room and an intake area
- Partnerships were created with employers and agencies that work with the program's target populations
- Trusting relationships were developed with the clients based on a non-judgmental and client-focused approach to sexual health
- Programming for the initial Mobile Health Clinic Pre-Visit Workshop was developed in multiple languages
- Relevant materials, including the Immigrant Women's Health Handbook, were translated into high-demand languages (e.g., Chinese, English, Hindi, Italian, Portuguese, Somali, Spanish, Tamil and Vietnamese)
- The Mobile Health Clinic provides the following services for free:
 - ♦ A complete sexual health examination
 - ♦ Pap tests
 - ♦ Breast examination
 - ♦ Pregnancy testing and abortion/pregnancy referral
 - ♦ Dispensing emergency contraception pills
 - ♦ Health tests (e.g., blood pressure, thyroid)
 - ♦ Infection tests

- Screening for sexually transmitted diseases and vaginal infections
- Counselling
- It is important to note that:
 - Women do not require provincial health insurance to access services
 - The tests and the examinations are conducted for free by female doctors
 - The Mobile Health Clinic does not perform specialized tests

PROGRAM REACH

- Since 1984, 16,000 Toronto women have received clinical services from the Mobile Health Clinic; many others have benefited from the workshops

EVALUATION

Method

- The effectiveness of the program was assessed by the number of women using the mobile service, the length of the waiting lists and the number of requests for the service
- Annual statistics were collected on clinic visits, locations served and services provided

Key findings

- Statistics indicated that the mobile service was successful, effective and a model system for healthcare delivery

CRITICAL FACTORS FOR ADAPTATION

- The program must be accessible in the context of the lives of the women it aims to reach
- Maintain a client-centred approach to delivering healthcare even though the program requires a greater investment of time, planning, organization, funding and staffing in order to start up and maintain; it is invaluable to clients
- Give due importance to women’s cultures and values, particularly when dealing with very sensitive sexual health issues such as sexual assault, abortion and female genital mutilation

CHALLENGES

- A lack of sustainable, long-term funding requires continued reliance on fundraising, donations and partnerships with other agencies

- Securing dedicated parking spaces for the mobile van is difficult; in some cases, this issue is resolved by partnering with a local hospital to provide a parking spot
- Buy-in and cooperation from primary healthcare providers is essential to ensuring critical follow-up care when health concerns are identified; some primary care physicians see referrals from the Mobile Health Clinic doctors as an intrusion on their practice
- Gender bias or discrimination, stigma and homophobia experienced by women in their families, communities, religions and cultures — as well as the public — can make it difficult and frightening for them to seek out essential health services
- The Mobile Clinic is still seen as an unconventional mode of healthcare delivery, requiring continuous education efforts with funders about its benefits in order to secure sustainable financial support

LESSONS LEARNED

- Important to diversify funding sources
- There was an initial resistance to talking upfront about sexually transmitted infections (STIs), HIV and AIDS, and birth control; cancer prevention and screening can be used as a springboard to opening up broader discussions around women’s sexual health

ADAPTATION FROM OTHER PROGRAMS

None

program links

Mobile Clinic Program:
www.immigranthealth.info/mobile.html

Healthcare in the Workplace Program:
www.immigranthealth.info/health_wplace.html

program contact

Anna Cioffi
 Counsellor & Mobile Health Clinic
 Coordinator
 Immigrant Women’s Health Centre
 489 College St., Suite 200
 Toronto, ON M6G 1A5
 Phone: (416) 323-9986
 E-mail: acioffi@immigranthealth.info

Increasing Breast, Cervical and Colorectal Cancer Screening Awareness and Participation in the Arabic and Somali Communities



TARGET AUDIENCE: Arabic and Somali women

Program focus: Breast, cervical and colorectal cancer

Challenges/risks faced by target population: Arabic and Somali women tend to be underserved.

Setting: Primarily community and health centres in Ottawa

Province: Ontario

Theoretical background: None stated

Program status: 1996 to present

Funder: In-kind donations from various organizations

BRIEF OVERVIEW

- The program intends to bring cancer screening to women and, more recently, men who underutilize available services.
- Evaluation of the program indicated an increase in the number of women who were aware of and participated in integrated cancer screening practices (i.e., breast, cervical and colorectal cancer screening).

PROGRAM GOALS AND OBJECTIVES

- To increase awareness of and participation in breast, cervical and colorectal cancer screening in the Arabic and Somali communities

PROGRAM IMPLEMENTATION STEPS

- A working partnership was formed with the South-East Ottawa Community Health Centre and the Ontario Breast Screening Program (OBSP); it was later expanded to include representatives from the Somali Centre for Family Services and Ottawa Public Health
- The program initially focused on breast cancer screening; cervical cancer screening was added in 2006 and colorectal cancer screening was added in 2008 in a move toward an integrated cancer screening model
- A bus poster was the initial outreach strategy; the photo used in the poster included known leaders from the target communities as well as other ethnic groups (e.g., Aboriginal, African, Arabic, Chinese, Somali and Vietnamese) so it could be used in future community programs

- Other outreach activities and resources included:
 - ♦ A cancer screening presentation, developed by Cancer Care Ontario, was translated and adapted into Arabic and Somali
 - ♦ Trained, highly qualified peer educators conducted presentations, hosted displays and implemented other health promotion activities related to all three cancers for their communities in their languages
 - ♦ Designated staff were made available to peer educators to address questions or concerns and to provide regular updates on current cancer screening information and practices
 - ♦ Culturally sensitive materials, including an office-sized poster, fact sheets and brochures, were developed and distributed through culturally appropriate locations such as grocery stores, ESL classes, mosques, health and community locations and the Multilingual Health Information Line at Ottawa Public Health
 - ♦ Health clinics with female physicians who speak Arabic or Somali provided Pap testing for women without a healthcare provider
 - ♦ Presentations of the project were made to key organizations (e.g., community health centres, Multicultural Health Coalition, etc.)
 - ♦ A project description and relevant materials were mailed to primary care providers to inform them about the initiative

PROGRAM REACH

- 16 peer educators were trained
- 38 presentations were conducted, with audiences of 6–70; displays attracted 100–300 people
- One group screen, with a cultural interpreter, was coordinated for the OBSP; others are being organized
- 850 posters ran on Ottawa city buses over a five-month period

EVALUATION

Method

- Pre- and post-questionnaires were used during the orientation and training of peer educators
- Feedback about the presentations was gathered from participants and peer educators, and OBSP database statistics

Key findings

- Positive evaluations, as well as the number of requests for presentations, displays and other health promotion activities by female and male audiences, indicated that presentations were the most effective engagement tool
- There was also an increase in the number of women who had Pap tests at community health centres and health clinics, as well as an increase in the number of women accessing the OBSP

CRITICAL FACTORS FOR ADAPTATION

- Ensure that all phases of development, implementation and evaluation are community driven
- Ensure that the program is adaptable enough to account for differences between communities (e.g., oral versus print societies)
- Ensure that resources are translated and adapted for the peer educators and their target audience
- Use visible community champions who are recognized by their community
- Use a leader from the target community(ies) to act in an organizational capacity to arrange health promotion activities and to keep in touch with the peer educators

CHALLENGES

- Finding the time to dedicate to the program on top of regular work duties
- Developing/adapting culturally sensitive resources
- Turnover of volunteer peer educators
- Attracting peer educators who are credible in their community, and have good networks and presentation skills

LESSONS LEARNED

- Although integrated cancer screening presentations are recommended, it is important to be flexible (e.g., some groups may be interested in learning only about breast cancer screening)
- Be prepared to respond to the needs that arise as a result of the program (e.g., helping women find clinics that have female, Arabic- or Somali-speaking physicians who provide Pap tests)
- Listen to the peer educators and community health centre workers associated with the program; they know the needs of their community and what will work best
- Be flexible: the program may need to be adjusted or adapted to the needs of a particular community
- Look for opportunities to incorporate and sustain the program and be prepared to use some funding from one's own agency or donated funds
- Peer educators may need stipends to help cover babysitting, transportation and other related costs while they participate in health promotion activities

ADAPTATION FROM OTHER PROGRAMS

Some of the resources were adapted from documents developed by Cancer Care Ontario and Ottawa Public Health

program links

None currently available

program contact

Suzie Joannis, Regional Administrator
Ontario Breast Screening Program
and ColonCancerCheck, Champlain
Region
1419 Carling Ave., Suite 214
Ottawa, ON K1Z 7L6
Phone: (613) 728-6508 or
1-800-465-6226
E-mail: sjoannis@ottawahospital.on.ca

Joy Luck Women's Project (Phase 1)



TARGET AUDIENCE: Underscreened women, including culturally diverse women, low-income women and newcomers

Program focus: Breast cancer and nutritional/physical activity risk reduction education

Challenges/risks faced by target population: Breast cancer screening rates have been low among certain immigrant populations; in South Riverdale (SR), where the most common language is Chinese, the mammogram rate was 33.7%, far below the Toronto average of 44.9% in 2002–2003.

Setting: Toronto, South Riverdale community

Province: Ontario

Theoretical background: Stages of change model; health belief model; social learning theory

Program status: 2002–2004

Funder: Canadian Breast Cancer Foundation, Ontario Region

BRIEF OVERVIEW

- A partnership was formed between South Riverdale Community Health Centre (SRCHC) and Mount Sinai Hospital to explore best practices to improve breast cancer screening rates.
- The program focused on providing breast health education to Chinese women, aged 50+ years. A trained Chinese health worker, working alongside a breast health nurse educator from Mount Sinai Hospital, used culturally tailored breast health educational material to deliver educational workshops to Chinese women.

PROGRAM GOALS AND OBJECTIVES

Short-term objectives

- To increase the number of Chinese women who know about breast screening services and resources and how to access them
- To increase the number of women using the program
- To increase awareness and knowledge of breast health practices
- To increase the number of women participating in screening programs
- To increase confidence and decrease anxiety following breast self-examination instruction

Long-term objective

- To increase utilization of breast cancer early detection programs in order to reduce cancer-related morbidity and mortality of Chinese women, predominately in the South Riverdale area

PROGRAM IMPLEMENTATION STEPS

- Educational resources on breast health in Chinese were developed

- 90-minute educational workshops in participants' mother languages (Cantonese and Mandarin) were delivered; childcare was also provided
- Support was provided, including booking appointments; escorting women to screening; companionship and interpretation during the Ontario Breast Screening Program (OBSP) mammogram visit; and liaising with the screening office and the women after screening if follow-up was needed
- Psychosocial support was provided after a diagnosis through individual and group activities
- The program wrote and filmed a 17-minute breast health video in Cantonese and Mandarin (later voiced over in Korean) that was used on local television
- The program carried out several health fairs attended by thousands of women

PROGRAM REACH

- 650 women attended workshops, of which 267 were aged 50+ years

EVALUATION

Method

- Time series, process evaluation and participant satisfaction

Time series

- Pre- and post-workshop questionnaires were administered to immigrant women, 50+ years, who participated in the workshop to assess breast screening history and knowledge. Assistance in Chinese was provided. Consent was obtained as well.
- Telephone follow-up calls were conducted at 9, 18 and 27 months to collect screening attendance information

Process evaluation

- Activities carried out and number of participants were monitored

Participant satisfaction

- Participants were asked if the workshop was useful, if speakers were knowledgeable, if the setting was suitable and whether they would recommend the program to friends

Key findings

- 46 workshops were delivered in the community, with approximately 10–15 women at each workshop, for a total of 650 women
- 267 of the 650 women were aged 50+ years and were followed
- Of these 267, 98 requested assistance with booking a mammogram, 80 booked appointments, and 53 had mammograms
- Reasons for not going to mammograms included: women booked their own appointments, wait was too long, no encouragement from family
- Breast self-examination increased from 57% to 76% at nine-month follow-up
- Clinical breast examination increased from 46% to 83% at nine-month follow-up
- The baseline mammogram rate of 44% increased significantly over time, to 80% at 27-month follow-up
- Knowledge about the OBSP significantly increased — from 50% to more than 90% by 18 months — and was maintained over 27 months
- Participant satisfaction was more than 80%; 97% would recommend the program to friends

CRITICAL FACTORS FOR ADAPTATION

- Integrate a culturally tailored approach to program delivery; this makes engaging immigrant women in health promotion possible
- Recruit community health workers with similar cultural backgrounds to the target audience; community health workers are the bridge or link to diverse communities and their participation results in better outreach

CHALLENGES

- Low literacy rates in English and Chinese led to several questionnaire changes
- Some women needed one-to-one help with forms
- Women needed support with booking mammograms and understanding which health and hospital cards were needed

- Attention span during workshops was limited at times; some older women had to leave due to childcare and family needs
- Clinical breast exams were not done if there was a male healthcare provider

LESSONS LEARNED

- Community-based educational workshops are well received and attended if adapted to cultural needs (e.g., language, childcare support, etc.)
- Well-trained community workers can help individuals navigate the healthcare system
- Community worker education and assistance positively influenced cancer screening attendance, knowledge and behaviour
- Lower levels of knowledge, cancer screening behaviours and attendance are associated with lower literacy levels
- Female nurse practitioners and examiners can provide physical exams to mitigate cultural and embarrassment concerns women may have with male physicians
- Video and resource packages are helpful; 70 communities requested these resources

ADAPTATION FROM OTHER PROGRAMS

A culturally tailored (simplified Chinese) breast health program developed by Mount Sinai Hospital for the general population in English

program links

None currently available

program contact

Maria Lee, Program Manager
South Riverdale Community Health
Centre
955 Queen St. E.
Toronto, ON M4M 3P3
Phone: (416) 461-1925 ext. 242
E-mail: mlee@srhc.com

Joy Luck Women's Project: Building Capacity (Phase 2)



TARGET AUDIENCE: Underscreened women (culturally diverse, low income, newcomer) and community health workers

Program focus: Breast cancer and nutritional/physical activity risk reduction education

Challenges/risks faced by target population: Breast cancer screening rates have been low among certain immigrant populations. In South Riverdale (SR), where the most common language is Chinese, the mammogram rate was 33.7%, far below the Toronto average of 44.9% in 2002/2003.

Setting: Toronto, South Riverdale community

Province: Ontario

Theoretical background: Stages of change model; health belief model; social learning theory

Program status: 2004–2006

Funder: Canadian Breast Cancer Foundation, Ontario Region

BRIEF OVERVIEW

- Building on the success of the Joy Luck Women's Project (Phase 1), additional partnerships were created with Toronto Public Health, the Canadian Cancer Society and local health and community agencies to reach a greater number of women from other diverse communities.
- A train-the-trainer program was developed to build community capacity.

PROGRAM GOALS AND OBJECTIVES

- To increase breast cancer screening attendance (mammography and clinical breast examination) for immigrant Chinese women, aged 50+ years, living in North York and Scarborough, as indicated by self-report and observed measures
- To improve volunteers' and community health workers' levels of knowledge and self-efficacy through a train-the-trainer series to deliver culturally tailored presentations on breast health strategies in their communities

PROGRAM IMPLEMENTATION STEPS

- The intervention for Chinese women followed the same steps as Phase 1 of the Joy Luck Women's Project, (see page 96), with dietitian support
- Focus groups were conducted to assess community health workers' (CHW) preferences in terms of time and the types of information and resources required to develop sessions

- CHW intervention flyers were sent out to centres, offering free breast health training to interested participants
- The train-the-trainer intervention included:
 - Obtaining written consent for the session and follow-up interviews
 - An eight-hour workshop that covered breast health information, dietary strategies, group work, case scenarios and key breast health points
 - Pre- and post-workshop questionnaires to assess change in knowledge and self-efficacy
 - Offers for future on-site support
 - A resource package with CDs, videos and written materials in language of choice

PROGRAM REACH

- 439 women attended workshops, of which 168 requested mammography screening

EVALUATION

Method

Time Series

- Pre- and post-workshop questionnaires were administered to immigrant women, 50+ years, who participated in the workshop to assess breast screening history and knowledge. Assistance in Chinese was provided. Consent was obtained as well.
- Telephone follow-up calls were conducted at 9, 18 and 27 months to collect screening attendance information

- For the train-the-trainer component, pre- and post-session tests were conducted to assess change in knowledge and self-efficacy
- Six- and 12-month follow-up assessed the number of sessions delivered by CHWs

Key findings

- 34 workshops were delivered to 439 Chinese women
- 168 women requested help to go to a mammogram centre; 106 women had a mammogram
- Two cancer support groups were organized for 17 women with breast cancer
- Six nutrition workshops, two grocery tours and one community kitchen/dining event were conducted
- Of the 26 trainees who completed six-month follow-up, 20 (77%) applied breast health knowledge at work, either in a group setting or on a one-to-one basis
- Of those, 12 reached women aged 50+ years for a total of 145 clients; eight reported using ethnic languages in Hindi/Urdu, Tamil, Korean, Cantonese/Mandarin and others

CRITICAL FACTORS FOR ADAPTATION

- Integrate a culturally tailored approach to program delivery; this makes engaging immigrant women in health promotion possible

- Recruit community health workers with similar cultural backgrounds to the target audience; community health workers are the bridge or link to diverse communities and their participation results in better outreach

CHALLENGES

- New immigrant women are a highly transient group, which makes follow-up difficult
- New immigrant women do not feel comfortable disclosing personal information over the phone
- The women do feel that breast health screening is a priority; however, they have to wait for OHIP coverage
- CHWs often have competing tasks that interfere with program delivery

LESSONS LEARNED

- CHWs are ideally suited to deliver breast health sessions in the community
- Success depends on support from CHW supervisors

ADAPTATION FROM OTHER PROGRAMS

Culturally tailored breast health program developed for Korean and Urdu populations by adapting Mount Sinai Hospital’s program for the general population in English

program links

None currently available

program contact

Maria Lee, Program Manager
 South Riverdale Community Health Centre
 955 Queen St. E.
 Toronto, ON M4M 3P3
 Phone: (416) 461-1925 ext. 242
 E-mail: mlee@srchc.com

The Lay Health Educator Breast Screening Program (LHEBSP)



TARGET AUDIENCE: South Asian immigrant women aged 50+ years

Program focus: Breast cancer

Challenges/risks faced by target population: Breast screening data indicated that women of South or East Asian ethnicity in Peel Region were less likely than other groups to report ever having a mammogram.

Setting: Large, urban communities in the Peel Region, including Mississauga and Brampton

Province: Ontario

Theoretical background: Health belief model; transtheoretical stages of change model

Program status: 2007–2009

Funder: Canadian Breast Cancer Foundation

BRIEF OVERVIEW

- A two-year pilot project, implemented by Peel Public Health, was specifically designed for South Asian (SA) women, 50+ years, to increase breast cancer awareness and screening rates in Peel region.
- Results from the program evaluation indicate an increase in participants' knowledge and awareness of breast health and screening.

PROGRAM GOALS AND OBJECTIVES

- To increase knowledge and awareness among SA women about breast health and screening, and to facilitate access to the Ontario Breast Screening Program (OBSP)

PROGRAM IMPLEMENTATION STEPS

- Community stakeholders were consulted on the development of the program and a needs assessment was conducted with clients from the community
- A community advisory committee with representatives from diverse community agencies and cultural backgrounds was formed
- A part-time project coordinator and eight lay health educators (LHEs) from SA communities were hired and trained (45 hours over a four-week period) to deliver breast health and screening workshops
- The LHEs were involved in developing the presentation delivered at the workshops
- Key messages promoted breast health awareness, clinical breast examination, mammography and healthy lifestyles

- Workshop participants were primarily recruited through community agencies, educational institutions, apartment buildings, places of worship and hospitals serving SA communities in Peel
- Two-hour workshops were held at diverse places in the community and were delivered in various SA languages (i.e., Punjabi, Hindi, Urdu and Tamil) and English
- All workshop materials were made available in SA languages and offered to participants in their preferred language
- Participants could request assistance in booking a mammogram at the end of the workshops or during the three- or six-week follow-up calls

PROGRAM REACH

- Between June 2007 and February 2008, 50 community workshops were held across 35 different locations in Peel, reaching approximately 712 women

EVALUATION

Method

- 532 participants completed questionnaires before and after the workshop
- 207 participants were reached via phone for an eight-week follow-up survey

Key findings

- Questionnaire findings indicated that participants had increased knowledge and awareness about breast health and the life-saving potential of mammograms

- A total of 58 out of 304 participants, aged 50+ years, requested assistance in booking a mammogram at an OBSP site
- Of the 207 participants reached during the eight-week follow-up, 37 had had a mammogram and 13 had made an appointment
- In all, one in four women aged 50+ years reported having had a mammogram eight weeks after participating in the workshops
- LHEs reported that due to their participation in the LHEBSP, their knowledge increased and they gained confidence and public speaking skills
- Offer program in a range of South Asian languages (e.g., Gujarati)
- Hold regular meetings with LHEs to facilitate sharing and learning
- Budget for a full-time project coordinator
- Accompany women to their mammogram appointments
- Recruit workshop participants through SA community leaders instead of flyers; community leaders commented that face-to-face meetings over tea should occur first

CRITICAL FACTORS FOR ADAPTATION

- It is essential to have a project coordinator
- Recruit the project coordinator and LHEs from the target population, and involve them in the development and implementation of the program
- Consider costs such as staffing, training (i.e., initial and ongoing transportation, food, room rental fees, handouts and advertising)
- Have a multidisciplinary team (e.g., public health nurses, LHEs, coordinator, health promotion officer and advisory committee members)

CHALLENGES

- A significant amount of time was needed to identify and communicate with community partners
- Participants’ spoken and written skills varied greatly
- The evaluation component required a fair amount of paperwork to be completed at the workshops
- SA women may be reluctant to disclose personal information on the consent form and questionnaire
- Words such as “breast” and “cancer” are not easily spoken in SA communities; “Women’s Health Workshops” might be a better alternative
- Some men were interested in participating in the workshops, which made some women uncomfortable; whenever possible, alternative presentations were offered for men

LESSONS LEARNED

- Allot time to meet and promote the program to target communities before the program launch
- It may have been beneficial to connect with workplaces that employ SA women
- Pictures are helpful for women with low literacy levels
- Involve local community agencies to recruit LHEs from the target age group (i.e., 50+ years)

ADAPTATION FROM OTHER PROGRAMS

The program was largely based on the York Region Health Educator Program and the City of Hamilton Women’s Health Educator Program (see page 128). The following groups were also consulted:

- Mujer Sana — Comunidad Sana / Healthy Women — Healthy Communities research project (Ottawa)
- South Riverdale Community Health Centre Joy Luck Women’s Project (Toronto) (see pages 96 and 98)
- Working Women Community Centre Breast Cancer Education Project for Immigrant & Refugee Women (Toronto)

program links

None currently available

program contact

Julie Atkinson, Supervisor
Chronic Disease and Injury
Prevention
Peel Public Health
10 Peel Centre Dr., Suite B
P.O. Box 2009, Station B
Brampton, ON L6T 0E5
Phone: (905) 791-7800 ext. 2117
E-mail: julie.atkinson@peelregion.ca

Lay Health Educator Program aka Screening Saves Lives Program



TARGET AUDIENCE: Hard-to-reach or underserved populations, including older women, low-income women, disabled women and Aboriginal women

Program focus: Breast, cervical and colorectal cancer

Challenges/risks faced by target population: Despite having access to screening facilities, the screening rates were low in Northeastern Ontario, as compared to other parts of Ontario.

Setting: Sudbury (downtown core), Timmins (45% francophone), Cochrane (small community of about 6000 people) and Manitoulin Island (seven First Nations communities)

Province: Ontario

Theoretical background: Community development; transtheoretical stages of change model

Program status: 2006 to present

Funder: Canadian Cancer Society

BRIEF OVERVIEW

- Based on a lay health educator model, the Screening Saves Lives program was designed with the overall goal of increasing screening rates for breast, cervical and colorectal cancer in four geographic areas in Northeastern Ontario.
- The program evaluation indicated significant increases in knowledge about and positive attitudes towards cancer screening, as well as a keen interest to see the program sustained.

PROGRAM GOALS AND OBJECTIVES

- To increase awareness and knowledge of, and change attitudes towards, breast, cervical and colorectal cancer screening
- To influence individual breast, cervical and colorectal screening behaviour
- To increase the number of women participating in regular breast, cervical and colorectal screening programs
- To empower communities with knowledge about the importance of screening, and to reduce gaps and barriers

PROGRAM IMPLEMENTATION STEPS

- An advisory committee was formed with members from public health units throughout Northeastern Ontario, Cancer Care Ontario, the Canadian Cancer Society (Ontario Division), the Regional Cancer Program of

Hôpital régional de Sudbury Regional Hospital, Victorian Order of Nurses and the Federation of Women's Institutes.

- Community leaders were consulted about hiring qualified coordinators from each community and identifying sites where women congregate
- The coordinators formed a community advisory group; the group's main role was to help the program connect to women in the target communities
- The coordinators went to places where women congregated, gave educational presentations and also recruited women volunteers in their communities to be "natural helpers"
- Natural helpers were trained to talk with men and women in their social and work networks; clarify misconceptions about breast, cervical and colorectal cancers and their screening tests; identify barriers to screening; provide information about breast, cervical and colorectal cancer screening; and to facilitate access to screening services
- Training was broken down into six modules (totalling 20–23 hours), which covered cervical, breast and colorectal anatomy and screening, the importance of screening and "stages of change" theory

- Regular meetings, as well as follow-up educational sessions, were held between the coordinator and volunteers

PROGRAM REACH

- As of August 2009, approximately 15,000 women and men had been reached across the four locations

EVALUATION

Method

- Volunteers completed questionnaires before and after the training; community feedback was also gathered through focus group interviews held in each of the four locations

Key findings

- There was a significant increase in knowledge of and positive attitudes towards cancer screening
- Community reactions to the program were positive and there was a noted increase in community empowerment regarding screening behaviour as well as for supporting people living with cancer
- Communities expressed a keen interest to see the program sustained

CRITICAL FACTORS FOR ADAPTATION

- Be flexible throughout the application of the model; the unique needs of the community are paramount and must drive program implementation and ongoing operation
- Hire people in the communities with well-established networks and who have an understanding of the fabric of the community

CHALLENGES

- The remoteness of some of the First Nations communities complicated some of the meeting and training sessions (e.g., the coordinator in Manitoulin Island had to train some of the volunteers individually because of the distance between the communities on the Island)
- Although one of the program's targeted populations was women living in poverty, it was very difficult to connect with these women because they were isolated and marginalized; hence, it took longer to build a relationship with them

LESSONS LEARNED

- It is crucial to listen to the communities, to understand what they want and need, and for members to have input on how the program is run

ADAPTATION FROM OTHER PROGRAMS

The program was adapted from the model used by the North Carolina Breast Cancer Screening Program lay health advisor model

program links

None currently available

program contact

Claire Cressey-Forsyth
 Program Manager
 Canadian Cancer Society (Ontario)
 55 St. Clair Ave. W., Suite 500
 Toronto, ON M4V 2Y7
 Phone: (705) 865-3309
 E-mail: ccesseyforsyth@ontario.cancer.ca

Let's Take a Stand Against ... Colorectal Cancer!



TARGET AUDIENCE: Aboriginal women and their healthcare providers

Program focus: Colorectal cancer

Challenges/risks faced by target population: A large, provincial-scale needs assessment revealed a lack of cancer-related resources and educational materials for the target population. A follow-up needs assessment conducted by Cancer Care Ontario (CCO) confirmed this finding. In addition, surveillance data generated by CCO indicated that colorectal cancer is on the rise for the Aboriginal population, suggesting a strong need for programs on colorectal cancer screening.

Setting: First Nations (on- and off-reserve), Inuit and Métis communities

Province: Ontario

Theoretical background: None stated

Program status: 2006 to present

Funder: Cancer Care Ontario; Health Canada, First Nations and Inuit Health; Ontario Ministry of Health and Long-Term Care (primary funder)

BRIEF OVERVIEW

- Launched in 2008, *Let's Take a Stand Against ... Colorectal Cancer!* is a train-the-trainer education program developed to equip health service providers working with First Nations, Inuit and Métis populations with culturally relevant health education tools and training to promote awareness about colorectal cancer and screening.
- Although evaluation is still underway, initial feedback from service providers indicates that the education materials are culturally appropriate and user friendly, and the training sessions are informative and support workers in educating their communities about colorectal cancer and screening.

PROGRAM GOALS AND OBJECTIVES

- To increase colorectal cancer prevention and screening knowledge in First Nations, Inuit and Métis communities in Ontario through culturally appropriate education that aligns with the provincewide screening program, ColonCancerCheck, and promotes use of the Fecal Occult Blood Test (FOBT)

PROGRAM IMPLEMENTATION STEPS

- Staff from CCO's Aboriginal Cancer and Prevention Team developed and implemented the program
- Aboriginal communities were first consulted during the development phase to ensure that the program would be beneficial to them
- Focus group sessions with service providers and members of the Aboriginal communities were held to gain feedback on draft materials; materials were revised accordingly

- The education delivery method was pilot-tested in 10 First Nations communities, which showed high acceptance of the train-the-trainer approach
- The program was launched in 2008 and implemented provincewide
- Program components include a toolkit, public-facing resources and regional training, which are provided at no cost; CCO provides travel support to all training participants
- A media campaign using radio and print public-service announcements was launched to advise service providers about the toolkit and upcoming training sessions, and to generate public awareness about colorectal cancer and screening access
- Regional training for service providers on effectively using the toolkit to educate Aboriginal community members is currently being conducted by a provincial health educator; training is tailored according to the needs and schedules of service providers
- The toolkit includes a reference manual and a facilitator's manual
 - The reference manual includes an introduction to cancer; cancer myths; cancer prevention; introduction to colorectal cancer; risk factors; and cancer screening
 - The facilitator's manual contains handouts and activities to reinforce knowledge transfer, and instructions on how to conduct the community education sessions
- Public-facing resource tools include posters based on the Cycle of Life and Seven Grandfathers Ojibway

Teachings; a signs and symptoms wheel; and a deck of cards with colorectal cancer prevention and screening messages

- A CD with ready-to-go presentations on subject topics is included for use
- An evaluation form for participants who attend the education sessions led by the service providers is also provided

PROGRAM REACH

- To date, resource toolkits have been distributed to 1500+ Aboriginal and mainstream organizations; approximately 15 training sessions have been conducted with 7–50+ attendees

EVALUATION

Method (evaluation in progress; final report is expected by July 2010)

- Preliminary feedback has been gathered from service providers who participated in the pilot training sessions

Key findings (pilot evaluation)

- Initial feedback indicates that the resource toolkit materials are culturally appropriate and user-friendly, and that the training sessions are informative and support workers in educating their communities about colorectal cancer

CRITICAL FACTORS FOR ADAPTATION

- Create program tools and materials that are user-friendly and ready-to-use
- Invest time in communicating with key stakeholders and organizations about the program and training sessions; identify appropriate (and current) key contacts to foster greatest uptake and mobilization
- Use a prominent, credible role model from the target population to promote the program (e.g., a well-known Aboriginal personality lent his voice and image in the radio and poster advertisements promoting this program, which has contributed to the program's increased recognition)
- Create a supportive and collaborative network of training participants; CCO will create and make available a Master Trainer list on the project's web page

CHALLENGES

- Insecure funding affected the planning and implementation process
- There is a constant need to let people know about the availability of the resources and to secure regional/local leads to provide coordination assistance for

training sessions

- At the initial stage, program staff were not able to capitalize on the huge interest generated by the program promotion (e.g., several agencies that received the toolkit requested training sessions but an educator had not yet been hired; the resulting gap contributed to the decreased interest among agencies)
- Finding an Aboriginal staff person with experience and expertise working in Aboriginal communities across Ontario to conduct the regional training; contending with staffing challenges (e.g., re-staffing the educator position after a resignation; the need to bring new staff up to speed)
- Turnover of trained regional staff affected sustainability and continued knowledge transfer

LESSONS LEARNED

- It takes time to develop comprehensive contact lists so that no one is overlooked and information gets disseminated as effectively as possible
- Program staff need to be trained and prepared, as funding can sometimes be granted at the very last minute and under the condition that it be spent within a very limited timeframe
- The program has been worthwhile and has generated a significant amount of interest and positive feedback; CCO is sharing this experience and program delivery model by presenting in national conferences

ADAPTATION FROM OTHER PROGRAMS

None

program links

www.cancercare.on.ca/about/programs/aborstrategy/ltsacc/ltsacctk

program contact

Rina Chua-Alamag, Manager
Aboriginal Cancer and Prevention Team
Cancer Care Ontario
505 University Ave., 18th Floor
Toronto, ON M5G 1X3
Phone: (416) 971-9800 ext. 3271
E-mail: Rina.Chua-Alamag@cancercare.on.ca

The Making of the *Fotonovelas*



TARGET AUDIENCE: Portuguese-speaking women

Program focus: Breast cancer

Challenges/risks faced by target population: Workshops and discussions with Portuguese-speaking women in Toronto revealed that they distrusted the medical establishment and did not usually access information from print sources (either in Portuguese or in English). When the project first started, existing breast health education materials were often written and illustrated in manners that were not culturally sensitive.

Setting: St. Stephen's Community House, a multi-service social agency in Toronto

Province: Ontario

Theoretical background: Health promotion; community development

Program status: 2001–2004

Funder: Canadian Breast Cancer Foundation, Ontario Region

BRIEF OVERVIEW

- The project used an information booklet in the form of a *fotonovela* — a booklet that tells a story using photos and word balloons — to present the story of a woman worried she might have breast cancer. The *fotonovela* was used to encourage Portuguese-speaking women to get regular screening for breast cancer, to dispel counterproductive beliefs and to provide accurate and useful information.
- Evaluation indicated that the *fotonovela* was an efficient way to educate women about the need for breast cancer screening.

PROGRAM GOALS AND OBJECTIVES

- To use a *fotonovela* (i.e., a booklet that tells a story in pictures and text, usually based on themes common in soap operas) to explore the issue of breast cancer in the Portuguese-speaking community, and to encourage women at risk to get regular screening for breast cancer through mammograms

PROGRAM IMPLEMENTATION STEPS

- The Women's Health Screening Community Workgroup, a partnership between St. Stephen's Community House, Access Alliance Multicultural Community Health Centre and Working Women Community Centre, was formed
- The workgroup decided to engage their target population in cancer screening through the use of *fotonovelas*
- A discussion was held with 17 Portuguese-speaking women about the barriers they faced in cancer screening
- A brief outline of the *fotonovela* was developed in English; the storyline incorporated many of the barriers

identified by the women

- The outline was translated into Portuguese
- A group of Portuguese breast cancer survivors, aged 50+ years, were recruited to further develop the storyline, write the dialogue and pose for photographs
- Meetings were held with the group to modify and script the *fotonovela* into Portuguese
- A volunteer artistic director was recruited to work with the women to shoot the scenes
- Venues and props such as mammography machines were coordinated with the help of workgroup members
- The artistic director assembled the photographs and text into the finished 12-page booklet and arranged for publication
- The first *fotonovela* has also been re-scripted into Spanish

Story outline

- The story follows a Portuguese woman named Esperanca whose husband discovers a lump in her breast
- Esperanca then calls on the resources of her family and community for comfort and learns from them about the screening processes and the value of self-care
- The story ends without a diagnosis, as the women who scripted the *fotonovela* felt that a sequel should follow with a positive diagnosis and treatment for breast cancer
- The second *fotonovela* was developed: it follows Esperanca's biopsy and treatment process and focuses more on how family and friends could provide support rather than the technical details of the treatment

PROGRAM REACH

- About 4000 copies of the first *fotonovela* were distributed through the project launch, workshops, doctor's offices, health fairs and peer workers; they were also distributed internationally through a workshop for social workers from the Azores, Portugal
- The *fotonovela* was presented at conferences in Vancouver and Australia
- Requests for copies have also been received from Tennessee and Brazil

EVALUATION

Method

- A focus group was conducted with six senior Portuguese-speaking women; they were asked about their knowledge of and feelings towards breast cancer screening before and after reading the *fotonovela*, and whether their opinion on breast screening had changed

Key findings

- After reading the *fotonovela*, the women identified two key messages: the importance of screening; and the role of family and friends in providing support
- They found the *fotonovela* easy to read, helpful, relevant, important and useful as a tool to educate women about breast cancer screening
- One of the women who had never had a mammogram got screened with assistance from the community centre; two women who had had mammograms, but did not continue due to bad experiences, also got screened
- The second *fotonovela* could not be evaluated because of limited funding

CRITICAL FACTORS FOR ADAPTATION

- Be prepared to commit time, energy and money
- Be able to handle questions that come up as a result of the program or to make referrals (e.g., after reading the *fotonovela*, some women telephoned the community centre to ask for assistance and support with breast cancer screening)
- Examine whether the *fotonovela* format is suitable for the target population or community; Spanish- and Portuguese-speaking communities prefer to get health information from family and friends; other groups may prefer to get information from doctors and nurses
- To adapt the *fotonovela* to other groups, the story would have to be re-scripted and re-shot to make it culturally appropriate

CHALLENGES

- The *fotonovela* took a long time to develop, as it required a significant amount of scripting and modifying
- The women involved with the project were older and had some physical difficulties, which posed some challenges (e.g., sometimes the women could not show up for the photographing of the scenes or had to leave early, requiring a fill-in to be found at short notice)
- Funding was provided on a year-to-year basis and the process of applying and waiting for approval was long
- At the time (2001–2002), there were very few resources to refer to for help with developing a *fotonovela*

LESSONS LEARNED

- Using *fotonovela* is an innovative and effective way to engage Portuguese-speaking women in breast cancer screening
- It is equally crucial to examine and attend to the barriers to screening faced by these women
- It would have been very helpful to have a larger budget, two-colour printing, a Portuguese-speaking professional artist/photographer and an agency that distributes nationally

ADAPTATION FROM OTHER PROGRAMS

None

program links

None currently available

program contact

Randi Reynolds, Manager
Wellness Promotion Program
St. Stephen's Community House
91 Bellevue Ave.
Toronto, ON M5T 2N8
Phone: (416) 925-2103 ext. 224
E-mail: rrandi@ststephenshouse.com

The Making Us Visible Peer Education Program



TARGET AUDIENCE: Lesbian and bisexual women

Program focus: Breast cancer

Challenges/risks faced by target population: Very few materials on breast health focus on (or are inclusive of) lesbian and bisexual women, for whom some risk factors are particularly relevant. Lesbian and bisexual women may not practise screening and preventive behaviours as often as straight women, and may have unique concerns about breast and general health not addressed in other materials and educational efforts. Homophobia and biphobia may prevent or delay lesbian and bisexual women from accessing medical care.

Setting: Toronto

Province: Ontario

Theoretical background: Health promotion model of peer-led outreach and education events and materials

Program status: 2004–2006

Funder: Canadian Breast Cancer Foundation, Ontario Region

BRIEF OVERVIEW

- The peer education program was a health promotion project designed to increase lesbian and bisexual women's involvement in the community and their understanding around breast health in a positive and fun way; volunteers from the lesbian and bisexual community were recruited and trained to create and conduct individual events to promote breast health in specific segments of the community with whom they were connected.
- Evaluation of the project indicated increased volunteer and community involvement, as well as ownership and understanding of breast cancer issues. Volunteers used existing skills and developed new skills in conducting events to reach lesbian and bisexual women in the community, while event participants particularly appreciated the celebratory approach to breast health.

PROGRAM GOALS AND OBJECTIVES

- To have diverse volunteers from the lesbian and bisexual community participate in a training program to deepen their knowledge of breast health and breast cancer issues, and then plan individual events designed to meet the needs of their own circles of community members

PROGRAM IMPLEMENTATION STEPS

- A partnership was formed between Sherbourne Health Centre, the Ontario Breast Cancer Community Research Initiative, Gilda's Club Greater Toronto, Willow Breast Cancer Support Canada and the Metropolitan Community Church of Toronto to develop the breast health project

- The motivation for the project came out of recommendations from the Ontario-based Lesbians and Breast Cancer Research Project (<http://dawn.thot.net/lbcp/>)
- A project coordinator was put in charge of managing all aspects of the program
- Five volunteers were recruited from the target population to plan and carry out individual events on breast health and breast cancer issues in their own communities
- Volunteers were first trained on breast health and breast cancer, lesbian and bisexual women's health issues, and peer and popular education approaches
- Each volunteer then completed an event proposal
- Regular meetings were held to support the volunteers through the planning and delivery of their individual events
- Materials were created and distributed to promote the events
- Five events were held:
 - ♦ "Breast Fest 2005," a celebration of lesbian, bisexual and trans women's breasts on Dyke Day during Toronto's Pride Week
 - ♦ "Breasts Are Beautiful: Naturopathic Tips for Lesbian, Bisexual & Queer Women to Support Breast Health"
 - ♦ "My Breasts, My Health, My Language," a workshop for lesbian and bisexual immigrant women on breast health
 - ♦ "Bust the Page: A Three-Week Zine-Making Series"
 - ♦ "Love Your Breasts: Breast Health Awareness through Yoga!"

- Participants provided feedback about the events
- Each volunteer wrote a story about the experiences of her unique event; volunteers also completed program evaluation forms
- The program’s conclusion was celebrated

PROGRAM REACH

- Approximately 145 women attended all events

EVALUATION

Method

- Volunteers completed feedback forms and wrote detailed reports about their experiences in the program
- Participants in each volunteer-run event filled out anonymous evaluation forms

Key findings

- Volunteers reported feeling invested and proud and having a sense of individual and community ownership in their projects
- They were able to use existing skills and develop new skills and experience in event planning, promotion and coordination
- Volunteers also reported increased confidence and self esteem, as well as positive feelings about their breasts
- Feedback from event participants was generally positive; participants particularly appreciated a positive (rather than fear- or disease-based) approach to breast health and safe spaces in which to discuss breast health issues with other lesbian and bisexual women
- Lesbian and bisexual women of colour and new immigrants appreciated meeting with others in their specific communities

CRITICAL FACTORS FOR ADAPTATION

- Have a coordinator oversee all parts of the program
- Outline clear volunteer responsibilities
- Have a time-limited commitment
- Develop group guidelines to create safe space for volunteers and for events
- Create a detailed proposal form for events
- Provide necessary education, using external sources and a variety of perspectives; don’t be afraid to explore controversies
- Guide the process, but have it be volunteer driven
- Respect and value each volunteer’s perspective, desires, needs and limitations

- Attach program events to existing, large-scale events (e.g., Pride)
- Consider wider, targeted promotional efforts for “minorities within a minority” (e.g., immigrant lesbian and bisexual women)
- Include food for volunteers and for each event

CHALLENGES

- Scheduling meetings and meeting deadlines
- Knowledge gaps and differences: understanding and working through breast screening controversies (e.g., breast self exam, mammograms, and allopathic versus naturopathic approaches)
- Differing understandings and expectations of volunteer commitments
- Trans people were included in this project; however this specific population requires programs specifically designed for them
- Volunteers’ desire for more time and financial resources than were available
- High levels of volunteer anxiety and emotion around breast health and breast cancer

LESSONS LEARNED

- Build in more time; the project took longer and volunteers needed more support than anticipated
- Be aware in advance of possible points of conflict and controversy in volunteer groups

ADAPTATION FROM OTHER PROGRAMS

None

program links

www.sherbourne.on.ca/PDFs/doc-makingusvisible-05.pdf

program contact

Anna Travers, Director
 Rainbow Health Ontario
 Sherbourne Health Centre
 333 Sherbourne St.
 Toronto, ON M5A 2S5
 Phone: (416) 324-4168
 E-mail: atravers@rainbowhealthontario.ca

Northwestern Ontario Breast Screening Mobile Program



TARGET AUDIENCE: Underscreened and never screened women, including rural and/or geographically isolated women and Aboriginal women

Program focus: Breast cancer

Challenges/risks faced by target population: Women living in communities in Northwestern Ontario have difficulties accessing preventive screening services. Some of these communities can be reached only by air, resulting in inequitable participation in breast screening services.

Setting: Communities in Northwestern Ontario, including 70+ First Nations and Aboriginal communities

Province: Ontario

Theoretical background: None stated

Program status: 1992 to present

Funder: Cancer Care Ontario

BRIEF OVERVIEW

- The Ontario Breast Screening Program's (OBSP) Mobile Program travels 10,000 km. across Northwestern Ontario each year to provide digital mammography to women aged 50–74.
- To date, participation and retention rates are higher than provincial rates and indicate that the mobile program is effective in increasing screening rates for underserved populations.

PROGRAM GOALS AND OBJECTIVES

- To provide mobile breast screening with digital mammography to 70% of eligible women aged 50–74 in Northwestern Ontario

PROGRAM IMPLEMENTATION STEPS

- Each year, the OBSP's mobile coach travels to more than 30 northwestern communities from April to October, and to 26 locations in the Thunder Bay area from November to March
- Eligible women can call a toll-free number to find out when the coach will be in or near their communities; they can also talk to their healthcare providers for more information
- Partnerships were developed with Health Canada and the local communities to bring women to the coach (e.g., eligible First Nations women in far-northern

remote communities that are inaccessible by roads are flown to three regional sites biennially for screening)

- To increase awareness about and participation in the Mobile Program, the following outreach activities were conducted:
 - ♦ Video and teleconferencing with staff at nursing stations in the communities to provide information about cancer prevention and screening services
 - ♦ Culturally appropriate posters were sent to the nursing stations to remind them and their patients about breast screening
 - ♦ Print advertisements and articles (e.g., in local newspapers)
 - ♦ Mail-outs to eligible women
 - ♦ A First Nations health promoter was hired to identify champions — such as breast cancer survivors or local leaders — in the communities to raise awareness about cancer prevention and screening

PROGRAM REACH

- 6500 women are screened annually

EVALUATION

Method

- Based on the OBSP's annual statistics

Key findings

- The mobile coach is booked to full capacity
- In 2007–2008, 52.81% of eligible women in Northwestern Ontario were screened through the OBSP (as compared to the provincial OBSP participation rate of 41.74%)
- The retention rate is 90% (i.e., 90% of the women screened return to the coach services within 30 months for their biennial screening)

CRITICAL FACTORS FOR ADAPTATION

- Be flexible and try different ways to reach women (e.g., have a drop-in clinic for women who may not want to book an appointment, and utilize radio and television advertisements, or social media networks like Facebook)
- The Mobile Program provides weekend and evening appointments to increase accessibility and accommodate different schedules
- Consider factors related to providing a program across large geographic areas, such as staff wages and costs related to driving long distances, fuel, repairs and maintenance

CHALLENGES

- Weather and road conditions (e.g., the coach cannot be driven on gravel roads and has to be parked in a heated garage during winter months because of specific temperature specifications for the digital mammography unit)
- Part-time clinical staff drive the coach in the region and are scheduled for four-day, 12-hour shifts
- A minimum of 13 women need to be screened in a half day in order for the mobile unit to be efficient, therefore eligible women from smaller communities need to be driven to larger nearby communities for screening

LESSONS LEARNED

- In order to effectively reach out to First Nations and Aboriginal communities, it is necessary to hire staff who understand the communities and to provide cultural competency training
- Work with communities to identify opportunities to increase participation (e.g., to find ways to drive women to the coach location if the coach is unable to drive to that community)
- Utilize innovative technology such as videoconferencing to link with remote community health staff and community members
- Look for opportunities to use integrated screening and prevention messaging to reduce duplication with other chronic diseases

ADAPTATION FROM OTHER PROGRAMS

None

program links

www.cancercare.on.ca

program contact

Alison McMullen, Director
Preventive Oncology Regional Cancer
Care
Thunder Bay Regional Health
Sciences Centre
980 Oliver Rd.
Thunder Bay, ON P7A 6V4
Phone: (807) 684-7214
E-mail: mcmullea@tbh.net

OMNI/Rogers Women's Cancer Initiative for Multi-Ethnic Communities



TARGET AUDIENCE: Farsi, Ukrainian and Punjabi women

Program focus: Breast, cervical and ovarian cancer

Challenges/risks faced by target population: Toronto is recognized as the most ethnoculturally diverse city in the world, with more than 170 different ethnic groups speaking more than 100 languages. Barriers to accessing screening for the target population may thus include lack of culturally specific information about cancer risks and the benefits of early diagnosis. Cultural and personal beliefs and values may prevent many women in the target population from accessing screening services.

Setting: Greater Toronto Area

Province: Ontario

Theoretical background: None stated

Program status: 2004–2005

Funder: Cancer Care Ontario; Toronto Public Health

BRIEF OVERVIEW

- The OMNI/Rogers Women's Cancer Initiative project was developed to increase knowledge of and awareness about breast, cervical and ovarian cancer and screening methods among specific priority populations through the use of ethnic television broadcasts.
- Results indicate that more than 80% of women from the target communities are more likely to go for screening after viewing the video broadcasts; in future, evaluation methods should assess changes in screening behaviour.

PROGRAM GOALS AND OBJECTIVES

- To increase the awareness and knowledge base of women from specific priority populations on the importance of and methods relating to the early detection and screening of women's cancers, and the services and resources that are available to them in their language of origin

PROGRAM IMPLEMENTATION STEPS

- The Toronto Cancer Prevention Coalition Early Detection and Screening working group collaborated with Toronto Public Health (TPH), the Ontario Breast Screening Program, the Ontario Cervical Screening Program, the Canadian Cancer Society and the National Ovarian Cancer Association to plan, develop and implement key messages about the early detection and screening of cancer
- Building on previous successes, the use of ethnic television was determined to be an effective means of relaying cancer information to immigrant communities

- Farsi and Ukrainian communities were selected based on statistics for population by knowledge of language
- A partnership was formed with OMNI and Rogers multicultural television networks
- A video production company was hired
- Partners and stakeholders (e.g., provincial and national screening programs and associations) were consulted
- A video script was written, reviewed, modified and translated into the target languages
- The script was vetted to ensure the information provided was relevant and respectful of the beliefs and values of the target groups and their communities at large
- A credible speaker from each of the target populations was filmed reciting the script (e.g., a well-known and respected pharmacist was selected from the Ukrainian community)
- Links were made with community agencies to promote the project and to act as key contacts to address requests for information and resources triggered by the video
- The script covered the following topics:
 - ♦ General information on incidence rate, signs and symptoms of all three cancers
 - ♦ A description of the range of available screening methods
 - ♦ Recommendations to have regular checkups to maintain good health
 - ♦ Promotion of a collaborative patient/healthcare provider relationship, including tips for talking with physicians about screening and diagnostic tests

- Information on community and print resources, telephone numbers and websites that women can access
- Information on resources for women without an Ontario health card
- Each of the two 10-minute videos was then aired in the target community network on OMNI and Rogers television for a few times throughout a 4–6 month period
- The videos were made available online and in hard copy to TPH and relevant community agencies, and shown at public health forums and workshops
- After the success of the first two efforts, funding was secured to produce videos for other target populations, such as Punjabi women

PROGRAM REACH

- Target immigrant populations range in the hundreds of thousands; the television broadcasts reached about 90% of them

EVALUATION

Method

- Written (translated) evaluation forms were completed by Farsi- and Ukrainian-speaking women in focus groups; informal feedback was also obtained from community members

Key findings

- Of the 19 Farsi-speaking participants, 100% stated that the video would be very helpful to members in their community; although more than 50% of women already had some knowledge about cancer screening, close to 90% stated that they knew more than before about the three cancers after watching the video; 89.5% of participants stated that, as a result of viewing the video, they were more likely to seek screening for breast cancer and 84.2% for cervical cancer
- Of the 14 Ukrainian participants, 86% stated that the video would be very helpful to members in their community; although more than 64% of women already had some knowledge about cancer screening, 88% stated that after watching the video, they knew more than before about the three cancers; 100% of the participants stated that, as a result of viewing the video, they were more likely to go for breast screening in the next six months; 92% planned to go for cervical screening
- Informal feedback from both communities was very positive and recommendations were made to continue with the project

CRITICAL FACTORS FOR ADAPTATION

- Keep the script short and catchy, providing only key messages; most viewers have some cancer screening knowledge
- Collaborate with key ethnic programming contacts within the television networks
- Collaboration with key partners and stakeholders to devise programs to facilitate screening participation among these populations is highly recommended
- Ensure appropriate translation of materials into the languages of the target populations, and broadcast information through their own ethnic media

CHALLENGES

- It is time-intensive to conduct a project of this scope; coordinating all the administrative work and reaching the different partners consumed a significant amount of time

LESSONS LEARNED

- Continue to address key messages to underserved communities through their own ethnic television programs, radio and newspapers
- Include an evaluation component that examines the effectiveness of using ethnic television as a vehicle to increase cancer knowledge and screening among underserved populations

ADAPTATION FROM OTHER PROGRAMS

This program builds on the success of cancer information videos produced in 2003 by TPH and aired on OMNI and Rogers in Somali and Arabic

program links

www.toronto.ca/health/resources/tcpc/index.htm

program contact

Cathy Krizanovic
Public Health Nurse
Toronto Public Health
524 Oakwood Ave.
Toronto, ON M6E 2X1
Phone: (416) 338-7592
E-mail: ckrizan@toronto.ca

Promoting Cancer Screening and Prevention in the Workplace (Toolkit)



TARGET AUDIENCE: Occupational health nurses and health promoters practising in workplace settings

Program focus: Breast, cervical and colorectal cancer

Challenges/risks faced by target population: Approximately 30% of new cancer cases will occur in young and middle-aged adults aged 20–59. This project encourages working women/men to take the time for cancer screening and “Check it off your to-do list.”

Setting: The materials were created for workplaces, but can be used in a variety of settings

Province: Ontario

Theoretical background: Health belief model

Program status: Ongoing

Funder: Cancer Care Ontario

BRIEF OVERVIEW

- The Promoting Cancer Screening and Prevention in the Workplace toolkit was developed for health promoters practising in workplace settings.
- Contents include a poster, fact sheet, an interactive game and background/supporting materials.
- The toolkit has been carefully designed to raise awareness and advance knowledge of the benefits of regular breast, cervical and colorectal cancer screening as well as to promote cancer prevention behaviours.

PROGRAM GOALS AND OBJECTIVES

Short-term objective

- To increase the capacity of occupational health nurses and health promoters practising in workplace settings to deliver programming to raise awareness about the primary prevention of cancer, as well as about the benefits of breast, cervical and colorectal screening

Long-term objectives

- To raise awareness and advance knowledge in Ontario workers of the benefits of regular breast, cervical and colorectal cancer screening as well as to promote cancer prevention behaviours
- To increase breast, cervical and colorectal cancer screening rates

PROGRAM IMPLEMENTATION STEPS

- 2006: A booth was held at the Ontario Occupational Health Nurses Association (OOHNA) conference
- 2007: Visitors to the OOHNA booth were surveyed for feedback on what resources would be useful to them and preferred workshop content for the 2008 conference
- 2008: A workshop at the OOHNA conference highlighted Cancer Care Ontario (CCO) screening program updates, existing resources and two examples of successful workplace programs; participants were also asked to rate the usefulness of a variety of possible toolkit resources
- Fall 2008: Public health nurses and health promoters at Ontario Breast Screening Program (OBSP) sites were surveyed on their choices for toolkit contents
- Fall 2008–spring 2009: Poster and fact sheet were developed; online feedback was received from OOHNA members, public health nurses and other health promoters
- Summer 2009: Revisions were made; supporting materials were developed
- Fall 2009: The toolkit was launched and materials were made available from a designated webpage
- Winter 2010: Evaluation in process

PROGRAM REACH

- Orders have been placed from across the province, from a variety of public health units and private corporations
- As of February 2010, the following orders have been filled:
 - ♦ Poster (English) 8 x 11: 2561
 - ♦ Poster (English) 11 x 17: 1223
 - ♦ Poster (French) 8 x 11: 432
 - ♦ Poster (French) 11 x 17: 97
 - ♦ Fact sheet (English): 6999
 - ♦ Fact sheet (French): 1072
- Total numbers of downloaded supporting documents are available

EVALUATION

Method

- A two-stage approach was adopted for evaluating this program:
 - ♦ Stage 1 used a formative evaluation to assess the content and design of the toolkit components through a web-based survey of potential users; results were used in finalizing components
 - ♦ Stage 2 uses a second web-based survey to learn about how toolkit components have been used and with what effects, as perceived by users; this survey will identify challenges and solicit suggestions for further improvements

Key findings

- Evaluation is ongoing

CRITICAL FACTORS FOR ADAPTATION

- Collaborate with experts from the field of workplace health promotion to develop the toolkit; while CCO supplied the cancer screening and prevention content, experts in the field of workplace health promotion provided insight into effective tools and their design; they also helped promote the project among their peers

CHALLENGES

- This was a collaborative project with many levels of consultation, both internally and externally; thus timelines were longer than expected
- Selection of appropriate toolkit components needed to reflect the diverse methods used by the target audience to utilize and disseminate materials

LESSONS LEARNED

- The order of the screening programs was changed to put colon cancer first in order to make it more relevant for male workers
- The content of the fact sheet was drastically shortened from the original version
- The option of two sizes of poster is preferred

ADAPTATION FROM OTHER PROGRAMS

The toolkit was adapted from York Region Public Health's Cancer Screening in the Workplace Toolkit

program links

Materials are available to order or download from
www.cancercare.on.ca/workplacetoolkit

program contact

Susan Larsh, Health Promotion Specialist
Cancer Care Ontario
505 University Ave., 18th Floor
Toronto, ON M5G 1X3
Phone: (416) 971-9800 ext. 3447
E-mail: susan.larsh@cancercare.on.ca

Promoting Cancer Screening in Chinese Communities in Ontario



TARGET AUDIENCE: Chinese women of all ages, via healthcare providers, health promoters and community workers who promote breast, cervical and colorectal screening within the Chinese community

Program focus: Breast, cervical and colorectal cancer

Challenges/risks faced by target population: Cancer screening rates among newcomers to Canada are lower than those for the general public. Chinese women in particular are less likely to participate in screening and may require customized interventions. At the time of development (2001), Chinese was the third most frequently spoken language in Ontario, which indicated a significant "priority population."

Setting: The materials have been created to be used in community-based interventions by same-language educators

Province: Ontario

Theoretical background: Health belief model; community development model

Program status: This project was conducted in two phases: 2002–2003 and 2006–2008

Funder: Cancer Care Ontario; Canadian Cancer Society, Ontario Division

BRIEF OVERVIEW

- The goal of this project was to increase the capacity of Ontario health promoters to educate Chinese women (and men) regarding the importance of regular cancer screening.
- Translated, culturally sensitive promotional and educational resources on cancer screening for the Chinese population were developed.
- In Phase I, a resource toolkit was distributed at no cost to all public health units (PHUs) and other community organizations throughout Ontario. In Phase II, although notification went out broadly, placing an order was necessary to receive the materials.
- Findings indicated that several organizations and PHUs with programs in Chinese communities made extensive use of the materials and to date, feedback about the resource kit has been very positive.

- to help plan and to develop materials for a resource toolkit
- Working group members and community groups were surveyed to determine toolkit materials
- Principal barriers to screening were identified and key messages addressing these barriers were included in the resource toolkit
- The kits and new promotional materials were distributed to PHUs and community groups to plan outreach initiatives in their areas
- Feedback about the resources was gathered from kit recipients and the general public
- (Phase II) The resource toolkit was updated between 2006 and 2008 with a working group made up of members from PHUs, community health centres, the Canadian Cancer Society, a hospital and university students; in this phase, information on colorectal cancer was added
- Members were surveyed to inform key messages about perceived barriers to health promotion efforts in the Chinese population regarding cancer screening
- A multi-strategy resource kit was developed, which included a PowerPoint presentation on "Cancer Screening: What You Need to Know," a poster, a bookmark and supporting resources
- Four focus groups (in Cantonese and Mandarin) were held to pilot-test the materials
- A wide range of potential users were notified via e-mail about the availability of the resources
- An evaluation plan was implemented

PROGRAM GOALS AND OBJECTIVES

- To increase the capacity of Ontario health promoters to educate Chinese women (and men) regarding the importance of regular cancer screening

PROGRAM IMPLEMENTATION STEPS

- (Phase I) Program advisory committees and key stakeholders in the community collaborated to plan and implement health promotion strategies; the need for culturally appropriate materials to promote breast and cervical cancer screening among Chinese women was confirmed
- A working group of health promoters was established

PROGRAM REACH

- In Phase I of the project, 74 resource toolkits were distributed
- In Phase II of the project, by mid-June 2008, 69 kits had been ordered and distributed
- Orders have been received from people and organizations outside the original distribution list of 135 names and organizations

EVALUATION

Method

- Recipients of the resource toolkit completed surveys to provide feedback

Key findings

- In Phase I, 11 of 74 (14.8%) recipients reported using the resources and only six used resources directly with the intended population
- This very limited uptake of resource kits was attributed to the fact that material distribution coincided with the first SARS episode in the spring of 2003 in Ontario
- In Phase II, 89% of respondents to date reported that the materials were very relevant; 78% of respondents rated the quality of the resource kits as excellent
- Feedback is ongoing; to date, however, it has been very positive, with all respondents indicating that the resource toolkit will be “very useful” in their work

CRITICAL FACTORS FOR ADAPTATION

- Resources developed for the target population need to be evidence-informed, culturally sensitive and translated, as well as developed in partnership with stakeholders and the target population
- Strong collaboration and partnerships between stakeholders and community partners are essential to develop customized interventions that are meaningful for specific target populations, as well as to ensure that the best materials are available to meet the unique needs of specific communities and ethnocultural groups
- Address the needs of both the service providers and target population

CHALLENGES

- The SARS outbreak in Ontario coincided with the distribution of materials in Phase I of the project, which drew attention away from the efforts to promote screening; PHU resources were dedicated to responding to this high-priority public health emergency
- A collaborative/consultative process, while necessary, is labour- and time-intensive, as is working in two languages
- The impact of this initiative on awareness and screening participation could not be measured

LESSONS LEARNED

- Timing is everything
- Collaboration is powerful (e.g., project success was the result of community partners and stakeholders working together to meet the needs of vulnerable populations); in addition, interactions among CCO’s screening and prevention programs was enhanced as a result
- This project provides a model that could be adapted for use with other underscreened communities

ADAPTATION FROM OTHER PROGRAMS

None

program links

www.cancercare.on.ca/common/pages/UserFile.aspx?fileId=13402

reference

Howlett, R. I., Larsh, S., Dobi, L., & Mai, V. (2009). Promoting cancer screening among Ontario Chinese women. *Canadian Journal of Public Health, 100*, 315–319.

program contact

Lorna Dobi, Health Promotion Specialist
Education Unit Prevention & Screening
Cancer Care Ontario
505 University Ave., 18th Floor
Toronto, ON M5G 1X3
Phone: (416) 971-9800, ext. 1126
E-mail: lorna.dobi@cancercare.on.ca

Scarborough Breast Health Community Action Project



TARGET AUDIENCE: Newcomers to Canada, immigrant women, older women, low-income women, and women of low literacy or whose first language is not English

Program focus: Breast cancer

Challenges/risks faced by target population: The targeted populations are underscreened for breast cancer, putting them at increased risk for poor health outcomes.

Setting: Mainly Armenian, Greek (only in Phase 1), Urdu, Tamil, Chinese, Somali, English and other low-income, immigrant communities in Scarborough

Province: Ontario

Theoretical background: Health promotion

Program status: Phase 1: 2005–2007; Phase 2: 2007 to present

Funder: Canadian Breast Cancer Foundation

BRIEF OVERVIEW

- The Scarborough Breast Health Community Action project was a collaborative, community-based project led by St. Paul's L'Amoreaux Centre.
- Through trained peer leader outreach, more than 7000 women have been reached through workshops and display booths; 600 women have since gone for a mammogram.

PROGRAM GOALS AND OBJECTIVES

- To increase participation in breast cancer screening among low-income and immigrant women in Scarborough

PROGRAM IMPLEMENTATION STEPS

- The program was based on a needs assessment conducted before 2005
- An advisory committee group was formed to address the identified needs with representatives from St. Paul's L'Amoreaux Centre, Agincourt Community Service Association, Immigrant Women's Health Centre, Toronto Public Health and individuals (e.g., breast cancer survivors and family physicians)
- Part-time, contract, multi-lingual peer leaders were employed to provide outreach, education and support to the women

- Peer leaders were trained about basic breast health and screening information, as well as breast screening services available in Scarborough
- Project flyers with key breast cancer screening message were developed and distributed in the languages the project served
- The main outreach activities included interactive displays and workshops
- Display booths are set up at places of worship, apartments, malls and grocery stores where women can sign up for a mammography appointment through the peer leaders
- Workshops were conducted at more than 90 convenient locations in Scarborough
- Workshops were conducted in Urdu, Tamil, Somali, Mandarin, Cantonese and English, and focused on breast cancer prevention and screening
- Other outreach activities involve local and ethnic media, and press releases
- Peer leaders book appointments at the OBSP location of the women's choice and meet them on-site to provide support; women are given transit tokens and instructions on how to get to the screening location

PROGRAM REACH

- From 2005 to 2009, approximately 3700 women had been reached through workshops and about 4000 women through display booths; 600 women had gone for a mammogram

EVALUATION

Method

- Women completed surveys at the end of the workshops and participated in telephone surveys three to four months after the workshop

Key findings

- Removing language, information and transportation barriers as well as providing support for appointment booking motivated women to attend breast screening

CRITICAL FACTORS FOR ADAPTATION

- Train the peer leaders and provide them with continuous supervision, support and education
- Use multiple strategies to reach women, such as displays, media and workshops

CHALLENGES

- Hiring competent and dedicated peer leaders from smaller ethnocultural community groups proved challenging
- Different screening locations have different screening practices; although the Ontario Breast Screening Program (OBSP) has provided guidelines for breast screening, there are still inconsistencies in practices
- Because of the wealth of breast cancer information available at the community level, women assume that they know all about breast cancer, making it difficult to get them to attend the workshops

- Older women also assume that they no longer need to go for breast screening because the OBSP had stopped sending them reminder letters; hence, it is difficult to get them to go for screening

LESSONS LEARNED

- Grocery stores might not be a strategic location for display booths because people in the stores are often in a rush and focused on buying groceries; considering the cost of renting a space in grocery stores, this strategy might not be cost effective
- Using free media might work against the program because the program loses control over messaging and communications about breast screening guidelines

ADAPTATION FROM OTHER PROGRAMS

The program was based on a literature review, which suggested that using peer leaders was an effective strategy to reach out to multicultural groups

program links

www.splc.ca

program contact

Sarafina Hui
Community Health Promotion
Programs Manager
St. Paul's L'Amoreaux Centre
3333 Finch Ave. E.
Scarborough, ON M1W 2R9
Phone: (416) 493-3333 ext. 223 /
(416) 490-2972
E-mail: sarafina@splc.ca

Are you **50** or older?



Breast Screening could save your life.

Call today to book a mammogram or talk to your doctor.
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www.cancercare.on.ca

ontario breast screening program
cancer care ontario program
programme ontarien de dépistage du cancer du sein
un programme de action cancer ontario

*This resource is funded by the Canadian Breast Cancer Foundation - Ontario Chapter.

ABORIGINAL BREAST HEALTH TRAIN-THE-TRAINER PROGRAM, PAGE 58

Breast Health for Women

The Breast


The Breast
This paper will tell me about my breasts.
It shows some problems many women can get with their breasts. It tells me what to look for. The paper also shows what I can do to try and keep my breasts healthy. Because the more I know, the better I can take care of my breasts.

Simply Health helps me learn more about health care. Simply Health gives me the information I need to talk to my doctors.

Simply Health

What are normal, healthy breasts?


Normal, healthy breasts are many shapes. They can be many sizes. Each woman is a different shape. The picture (pik-chur) shows how women are different.



What are breasts made of?

Breasts have parts to help feed a baby. I have these parts even if I do not have a baby. They are there even if I do not **breast-feed**. Healthy breasts have these parts:

- **Lobes** are the parts that make milk.
- **Milk ducts** are tubes. They carry milk to the nipple (nih-pull).
- **Nipples** are what a baby sucks from.
- **Areolas** (air-ee-oh-lahs) are the pinky-brown part. They are around the nipple.
- Fat gives shape to the breast.
- Tissue (tih-shoo) keeps breast shape.
- Blood vessels run blood and **fluid** (floo-idd) to the breasts.
- **Lymph** (limf) tubes help move **fluid** (floo-idd).



What can I do to help keep my breasts healthy (hell-thee)?


Be active (ack-tiv) and keep fit

- I am active when I move a lot, such as run, swim, play a sport, walk my dog.
- Active women get less breast cancer.
- Women who stay still get more breast cancer. So go have fun!
- I can ask my doctor how I can be active.



Good foods I can eat

These foods help keep my breasts healthy:



Eat good foods

- Cook good foods.
- The Canada Food Guide to Healthy Eating (guide sounds like wide) will tell me about good foods.
- I can ask my doctor what foods help stop breast cancer before it starts.

Eat fruits and vegetables

- Do not eat a lot of food from cans.
- Fruit and vegetables have lots of good things for my body, such as vitamins (vie-ta-minz).

Brown breads and cereals

Brown bread is the best bread. It has more good things for my body than white bread. Cereal, such as bran flakes, is also good for my body.

Eat fish

- Salmon
- Tuna

THE VOCATIONAL AND REHABILITATION RESEARCH INSTITUTE (VRRRI) SIMPLY HEALTH: THE BREAST — HEALTH FOR WOMEN, PAGE 36

BC Cancer Agency | Screening Mammography Program
CARE + RESEARCH
Agency of the Provincial Health Services Authority

BALANCING YOUR HEALTH NEEDS



Life is a balance of physical, social and spiritual well-being. First Nations women are often the caretaker, so balancing your health needs is important. Screening Mammography Program of BC provides BC First Nations women ages 40-79 with free screening mammograms. Screening mammograms can save lives by finding most types of breast cancer early - usually before it has spread

Keep things in balance - make an appointment by calling: **1-800-663-9203**
Go to www.smpbc.ca for more information



MAMMOGRAMS

Your Step-by-Step Guide

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乳房 X 光攝影檢測:
步驟指南

유방조영상(Mammograms):
촬영 절차 안내



BC Cancer Agency
CARE + RESEARCH
Agency of the Provincial Health Services Authority
Screening Mammography Program

THE SCREENING MAMMOGRAPHY PROGRAM OF BC, PAGE 30




**Take the time.
Get checked for colorectal cancer.**



- Men and women 50 years and over – do a Fecal Occult Blood Test (FOBT) every 2 years
- If a parent, brother, sister or child has had colorectal cancer - have a colonoscopy. Begin at age 50 or ten years earlier than your family member's age at diagnosis
- Talk to your doctor or nurse about what screening test is right for you
- If you do not have a doctor, go to ColonCancerCheck.ca or call 1-866-410-5853

416.338.7600
toronto.ca/health | Toronto Public Health

save your life!

CDP CANCER PREVENTION AND SCREENING PROGRAM, PAGE 68

**Take the time.
Get checked for breast cancer.**



Screening can save your life!

- Women 50 years and over – go for a mammogram at least every 2 years
- Women 50 years and over can book their own free mammograms – call the Ontario Breast Screening Program at 1-800-688-9304
- Women aged 40-49 – talk to your doctor or nurse about mammograms
- All women – have a breast exam done by your doctor or nurse at your health check up every 1 to 2 years
- Get to know how your breasts usually look and feel – talk to your doctor or nurse about any changes

**Take the time.
Get checked for cervical cancer.**



Screening can save your life!

- All women – go for a Pap test within three years of your first sexual activity
- Have a Pap test once a year
- If test results are normal for three years in a row, Pap tests can be done every 2 to 3 years
- Have regular Pap tests until at least age 70
- Women who have had the HPV vaccine still need to have Pap tests
- Talk with your doctor or nurse about screening for cervical cancer

416.338.7600
toronto.ca/health | Toronto Public Health

BUILDING BREAST HEALTHY NEIGHBOURHOODS (BBHN), PAGE 66

PAPS MATTER FOR TRANS MEN



checkitoutguys.ca

CHECK IT OUT GUYS: THE TRANS MEN'S PAP CAMPAIGN, PAGE 70



*"Let's take a stand against...
Colorectal Cancer!"*

**Community Learning Series
Reference Manual**



LET'S TAKE A STAND AGAINST ... COLORECTAL CANCER!, PAGE 104

Somali Community Breast Health Project



TARGET AUDIENCE: Somali women in Toronto

Program focus: Breast cancer

Challenges/risks faced by target population: In the 10–15 years preceding the project, an influx of Somali immigrants moved to Toronto. Somali women, as with women from other immigrant groups, are less likely than the general population to participate in breast cancer screening. To date, few, if any, breast health programs focus specifically on Somali women in Toronto.

Setting: City of Toronto

Province: Ontario

Theoretical background: None stated

Program status: 2009 to present

Funder: Toronto Public Health

BRIEF OVERVIEW

- The Somali Community Breast Health Project was developed to increase knowledge of breast health and screening among Somali women by engaging Somali vendors at shopping malls to talk with their clients about breast health and the importance of regular breast cancer screening.
- Additional activities include: culturally appropriate breast health presentations by peer leaders from the community; a media campaign; and outreach to family physicians, healthcare providers and the Ontario Breast Screening Program (OBSP).
- Program implementation is in progress.

PROGRAM GOALS AND OBJECTIVES

- To increase the number of Somali women who are knowledgeable about breast health and screening
- To increase the number of Somali women, aged 50+ years, who participate in regular breast screening

PROGRAM IMPLEMENTATION STEPS

- Initiated by Toronto Public Health, an advisory committee, which included two members from the Somali community, was formed to develop the program
- Key Somali agencies in the community were consulted and presented with program ideas; support was gained and working partnerships were established with the agencies
- Outreach to various agencies and businesses in Toronto that worked with the Somali community was also conducted

- Out of these meetings, a decision was made to undertake a “mall initiative,” in which vendors in shopping malls would be trained to promote breast health awareness and screening to their clients
- Interest and support were solicited from vendors at two Somali shopping malls in the west end of Toronto frequented most by Somalis from across the Greater Toronto Area
- Focus group sessions were conducted with vendors to identify the materials they would need to promote breast health to their clients, to test the tagline and to obtain feedback on the poster and pamphlet
- Implementation of the mall initiative is planned for October 2010
- Vendors will be trained about breast health and screening, and provided with a list of key messages as well as a poster to display in their shops
- A Somali tagline, “Daryeel Caafimaadka Naasahaaga,” which means “Take care of your breast health,” will be used in all promotion materials
- After educating their clients, vendors will give them pamphlets, written in Somali and English, containing more detailed information about breast health and screening, and two promotional items: a keychain with the tagline, and a pink reusable shopping bag with the tagline and TPH logo, at the point of purchase

- Other strategies to reach out to the Somali women are being planned:
 - ♦ A culturally appropriate breast health presentation is being piloted with organizations working with the Somali population; the presentation will be revised based on feedback and translated into Somali; eventually, peer leaders from the Somali community will be trained to deliver the presentation
 - ♦ A media campaign to promote and increase awareness about breast health and screening through Somali newspapers, radio and television stations
 - ♦ Outreach to family physicians, healthcare providers and OBSP staff

PROGRAM REACH

- Not available

EVALUATION

Method

- A pre- and post-intervention survey will be conducted to evaluate changes in knowledge and awareness about breast health and screening (e.g., “Have you ever heard of a breast screening test called the mammogram?,” “How often is a mammogram recommended?,” and “What does taking care of your breasts mean to you?”)

Key findings

- Not available

CRITICAL FACTORS FOR ADAPTATION

- It is essential to have an advisory committee group with one or more members from the target population
- Involve members from the community in the program from the beginning; work in partnership with various agencies serving the target population
- Use a well-known and well-respected person from the target population to be the spokesperson for the program (e.g., a famous Somali singer was recruited to be the model in the program posters and pamphlets)
- Be aware of the barriers faced by the target population and take those barriers into consideration when developing programs (e.g., lack of knowledge about breast screening, embarrassment associated with talking about breasts, fear and stigma related to breast cancer)

CHALLENGES

- Initially, it was difficult to connect with the Somali communities; members from the advisory committee who are Somali were key to establishing positive relations
- Implementation of the program was delayed for a long while because of unexpected and uncontrollable circumstances (e.g., labour disruption and H1N1 pandemic)

LESSONS LEARNED

- Having someone from the target population involved in every step of the program can significantly move the program forward
- Cultural differences can be very complex; program staff must be open-minded and flexible, and take the time to clarify or work through issues with the community
- A significant amount of time is needed to develop relationships with the target population and to develop and implement the program within the community

ADAPTATION FROM OTHER PROGRAMS

This idea was based on the “Be a Breast Friend” Salon Project (see page 60)

program links

None currently available

program contact

Gail Richey, RN, BScN
 Public Health Nurse
 Toronto Public Health
 399 The West Mall, 4th Floor
 Toronto, ON M9C 2Y2
 Phone: (416) 338-1844
 E-mail: grichey@toronto.ca

South Riverdale Community Health Centre Women's Screening Clinic



TARGET AUDIENCE: New immigrants or women with language barriers and culturally sensitive issues related to cancer screening

Program focus: Breast and cervical cancer

Challenges/risks faced by target population: Despite learning — through a range of community outreach strategies conducted by the South Riverdale Community Health Centre — the importance of early detection of breast and cervical cancer, women from the target populations expressed difficulties in getting screening services; many reported barriers to scheduling their first screening.

Setting: Toronto East (27% are low-income families; 40% are visible minorities; top recent immigrants are from East Asia and South Asia)

Province: Ontario

Theoretical background: Community development

Program status: 2005 to present

Funder: Part of core funding from Ministry of Health and Long-Term Care

BRIEF OVERVIEW

- The South Riverdale Community Health Centre (SRCHC) Women's Screening Clinic was set up to provide culturally and language-appropriate breast and cervical screening services to women in the target communities.
- To December 2009, about 200 women have been screened by the clinic; evaluation results indicate that most (87.6% of 137 respondents) had their first screening at the clinic. The majority of the women (83.2%) reported they would consider going back to the clinic for screening in the coming year and almost all the women (98.6%) requested the clinic to be part of regular service.

PROGRAM GOALS AND OBJECTIVES

- To empower communities with knowledge about the importance of breast and cervical screening and to reduce gaps and barriers
- To provide screening access for women living in the SRCHC catchment area or people who have access barriers (e.g., language, culture, religion, etc.) for breast screening, gynaecological examinations and Pap tests
- To encourage women to get clinical breast examinations (CBE) and Pap tests

PROGRAM IMPLEMENTATION STEPS

- SRCHC received project funding from the Canadian Breast Cancer Foundation to promote breast cancer awareness in the catchment area for six years

- Three projects (Joy Luck Women's Project — see page 96; Joy Luck Women's Project: Building Capacity — see page 98; and Building Breast Healthy Neighbourhoods — see page 66) were implemented and evaluated; although results from these project evaluations indicated significant increases in knowledge of and positive attitudes towards cancer screening, a significant portion of participants stated that they would be more likely to get screening if prominent barriers in language and cultural sensitivity were addressed appropriately
- Hence, a work group that included an outreach worker, nurse practitioners, a clinical manager and a health promotion manager was formed to identify the best ways to respond to the community's needs without additional funding from the ministry
- A free, by-appointment Women's Screening Clinic was set up at SRCHC to address the aforementioned barriers; culturally and language-appropriate screening services (CBEs and Pap tests) were provided to the target women:
 - ♦ Screening examinations were conducted by female practitioners
 - ♦ Interpretation services were offered
 - ♦ If needed, referral to mammogram screening was made for clients
- Outreach to local family doctors' offices and community agencies was conducted to let them know about the Women's Clinic services and to provide them

with information about the clinic's vision and service boundaries

- To continue the SRCHC's work on promoting cancer awareness, the outreach worker gave workshops to the community and provided information sheets to individual women to encourage them to go for screening and to inform them about the Women's Clinic

PROGRAM REACH

- To December 2009, approximately 200 women have been screened

EVALUATION

Method

- Women completed questionnaires on service quality and behavioural change after screening

Key findings (N = 137)

- The majority of clinic clients (72%) were referred from community agency staff; other referrals came mostly from friends and family doctors; a steady increase in the number of referrals from local family doctors was noted
- Women of all ages came for screening; about half (53.3%), however, ranged in age from 35 to 55
- Most women (87.6%) had their first screening at the clinic
- English was a barrier to the women who came to the clinic; they did not speak English at all and the majority (94.2%) preferred to communicate in their native languages, such as Cantonese and Mandarin
- All the women (100%) rated the clinic a helpful service after screening
- A high percentage of women (83.2%) stated they would consider coming back the next year
- Almost all the women (98.6%) requested that the clinic be a part of the SRCHC's regular services

CRITICAL FACTORS FOR ADAPTATION

- Accommodate specific needs for immigrant communities
- Work alongside primary healthcare sectors
- Staff involved in registration, education and screening should speak languages of women in the target

population; staff must be sensitive to cultural differences and preferences

- Female practitioners must provide screening services

CHALLENGES

- Following up with women who have abnormal screening results can be challenging
- The screening clinic is provided only once a month for three hours; it should be able to serve more women if more time is made available
- The female practitioners can offer only limited time to the clinic; hence the clinic is not able to cater to the significant demand for screening by the target population

LESSONS LEARNED

- It is important to listen to the communities and to be responsive to what they need
- It is crucial to get full support from management in allocating necessary resources
- Female practitioners play a vital role in breaking down gender barriers

ADAPTATION FROM OTHER PROGRAMS

None

program links

www.srchc.ca

program contact

Grace Ho, Outreach Worker
South Riverdale Community Health
Centre
955 Queen St. E.
Toronto, ON M4M 3P3
Phone: (416) 461-1925 ext. 248
E-mail: graceho@srchc.com

A Tailored Intervention to Promote Breast Cancer Screening Among South Asian Immigrant Women



TARGET AUDIENCE: South Asian immigrant women

Program focus: Breast cancer

Challenges/risks faced by target population: Several studies reported that South Asian (SA) immigrant women have low breast cancer screening rates due to information, economic, systemic, cultural and linguistic barriers. Childcare and household responsibilities may contribute to SA immigrant women neglecting their health, especially in terms of preventive practices when benefits appear distant. Cultural-based norms and beliefs (e.g., perception of high seriousness of and low susceptibility to breast cancer and cultural taboos and modesty, as well as limited knowledge about screening procedures and available services) may also contribute to the low screening rates.

Setting: Toronto

Province: Ontario

Theoretical background: Health belief model; trans-theoretical stages of change; decisional balance model; socio-cultural constructs

Program status: Completed

Funder: Canadian Breast Cancer Foundation

BRIEF OVERVIEW

- A series of 10 socioculturally tailored breast-health articles were published in Urdu and Hindi community newspapers and mailed to study participants.
- “Tailoring,” or sociocultural sensitivity, refers to the development of health messages, materials and interventions according to the cultural beliefs and characteristics of the targeted population.
- Results supported the effectiveness of written, socioculturally tailored, language-specific health education materials in promoting breast cancer screening among SA women.

PROGRAM GOALS AND OBJECTIVES

- To develop and evaluate a socioculturally tailored intervention to promote breast cancer screening among SA immigrant women from India, Pakistan, Sri Lanka and Bangladesh
- To increase overall knowledge about breast cancer and screening
- To increase the uptake of clinical breast examination (CBE)
- To investigate study participants’ change in knowledge level and health beliefs

PROGRAM IMPLEMENTATION STEPS

- A literature review was conducted to identify factors associated with cancer screening practices of SA immigrant women

- The research team then developed 10 socioculturally tailored, plain-language breast-health articles that incorporated the literature review findings. The articles:
 - ♦ Addressed SA women’s misperceptions about breast cancer
 - ♦ Described benefits of screening
 - ♦ Provided information about screening procedures, referral system and availability of female health personnel
 - ♦ Acknowledged women’s dual workload as a potential barrier to screening and encouraged women to overcome this barrier
 - ♦ Repeatedly encouraged women to discuss breast health concerns with family, friends and healthcare providers
 - ♦ Included a South Asian cancer survivor’s story
- The articles were translated into Urdu and Hindi and tested for clarity and acceptability with 10 focus groups of Hindi- and Urdu-speaking SA women
- The articles were published every two weeks in Hindi and Urdu newspapers, 10,000 copies of which were available free of charge at SA grocery stores; study participants received the articles in the mail
- Participants were recruited at immigration and resettlement community agencies and three group practice clinics in the Greater Toronto Area
- Pre- and post-intervention data were collected from participants to evaluate the impact of the mailed articles

PROGRAM REACH

- 82 women completed the pre-intervention questionnaire and received the articles; 74 women completed the post-intervention questionnaire

EVALUATION

Method

- Participants completed a pre-intervention questionnaire at the site of recruitment, received the intervention for a period of five months and completed a post-intervention questionnaire through telephone interviews two weeks after the mailing of the last health article

Key findings

- There was a significant increase in participants' breast cancer knowledge and self-efficacy to discuss and undergo breast examination, as well as uptake in CBE
- There was a significant decrease in participants' perceived barriers to CBE and misperceptions of low susceptibility to and high seriousness of breast cancer
- Change in participants' perceived barriers significantly and independently predicted the uptake of CBE, over and above other predictor variables
- There was no significant increase in breast self-examination and in perceived benefits of CBE
- Overall, findings indicated that participants were in the pre-contemplation stage before the intervention (i.e., they had no intention of taking action in the foreseeable future because they were either unaware or under-informed of available options, and needed an intervention to promote breast screening)

CRITICAL FACTORS FOR ADAPTATION

- Tailor strategies according to the stage of change for a targeted population
- Address perceived barriers through sociocultural tailoring of health messages to improve breast cancer screening; the decrease in perceived barriers as the most significant predictor of CBE uptake highlights this important factor
- Use strategies consistent with the desire of the targeted immigrant community to emphasize their uniqueness and value their differences
- Convey the health message not only to women in the target population but also to the entire family unit, to address the SA community's strong family orientation and the likelihood that SA women will seek medical

advice only with the sanction and encouragement of important family members or close friends

CHALLENGES

- The SA community's cultural norms, where touching one's own body is taboo, may have accounted for the statistically insignificant increase in BSE
- The impact of the newspaper articles among women residing in the community who did not participate in the study could not be examined
- Valid conclusions about the intervention effect could not be reached because of a lack of comparison group

LESSONS LEARNED

- The use of ethnic newspapers to promote health has the potential to provide wide coverage at low cost within the targeted populations
- Future research should test the intervention in other vulnerable populations, and include comparison groups and non-participants

ADAPTATION FROM OTHER PROGRAMS

None

reference

Ahmad, F., Cameron, J. I., & Stewart, D. E. (2005). A tailored intervention to promote breast cancer screening among South Asian immigrant women. *Social Science & Medicine*, 60, 575–586.

program contacts

Women's Health Program
University Health Network
657 University Ave.
Toronto, ON M5G 2N2

Primary author:
Farah Ahmad, MBBS, MPH, PhD
Assistant Professor
Dalla Lana School of Public Health
University of Toronto
155 College St., Room 582
Toronto, ON M5T 3M7
Phone: (416) 978-7514
E-mail: farah.ahmad@utoronto.ca

Women's Health Educator Program



TARGET AUDIENCE: Newcomers to Canada, and women of low literacy or whose first language is not English

Program focus: Breast and cervical cancer

Challenges/risks faced by target population: On average, immigrant women are less likely to have screening tests due to multiple barriers (e.g., fear, lack of knowledge, lack of culturally sensitive healthcare services).

Setting: Communities throughout the City of Hamilton

Province: Ontario

Theoretical background: PRECEDE-PROCEED model; transtheoretical stages of change model; Campinha-Bacote's model of cultural competence

Program status: 2003 to present

Funder: City of Hamilton Public Health Services; Public Health Research, Education and Development

BRIEF OVERVIEW

- The program was developed to promote breast and cervical cancer screening among immigrant women in Hamilton, Ontario; women health educators (WHEs), with support from public health nurses (PHNs), were trained to deliver culturally sensitive education sessions to targeted women.
- Results indicated that the inclusion of WHEs is an effective strategy, as evidenced in an increased awareness of early detection and health promotion, as well as improved access to cancer screening among the immigrant women following the intervention.

PROGRAM GOALS AND OBJECTIVES

- To evaluate how WHEs, with the support of PHNs, can work with women of the same culture to improve women's health and to increase knowledge of and screening for breast and cervical cancer
- To provide immigrant women and their families with culturally tailored chronic disease prevention education and peer support to encourage the adoption of healthy living and cancer screening behaviours

PROGRAM IMPLEMENTATION STEPS

- A collaborative working group, which included a university faculty member and PHNs, was convened, and an extensive literature review was conducted
- Key community members provided advice and cultural insights
- Focus groups were conducted with the target audience to obtain information on knowledge and beliefs about

- cancer screening, preferred teaching and learning methods, barriers and unmet needs regarding cancer and health issues in general, and strategies for promoting cancer screening
- Culturally tailored curricula were developed and indigenous WHEs were recruited and trained to teach, support and reduce barriers to screening
- Four days of training by PHNs included instructive and practice sessions, information about breast and cervical cancer, site visits to local health services and documentation requirements
- WHEs then conducted educational sessions with members of the target audience
- If needed, WHEs arranged breast and cervical screening appointments for women and accompanied them to screening for language and cultural support
- Ongoing meetings were held between PHNs and WHEs to problem-solve issues and discuss strategies for outreach

PROGRAM REACH

- From 2003 to 2005, 50 cancer screening presentations were delivered to about 517 women; in 2007, 38 presentations were delivered to 520 women; in 2008; 26 presentations were delivered to 380 women; and in 2009, 25 presentations were delivered to 347 women
- In 2008, the WHE program expanded to other chronic-disease prevention initiatives (physical activity and healthy eating), resulting in lower numbers for the program's cancer screening focus

EVALUATION

Method

- From 2003 to 2005, pre- and post-information session questionnaires were conducted, with four-week and four-month follow-up telephone interviews
- From late 2005 to 2007, pre- and post-information session questionnaires were employed, with a four-month follow-up telephone interview
- Since 2008, formal research data collection has ended; program outcome measures are group and appointment participation rates

Key findings

- WHE pilot project (October 2003–February 2005) reached approximately 517 Chinese and Vietnamese women; of the 153 women who participated in the four-month evaluation, uptake of Pap tests, clinical breast exams and mammograms were:
 - 77%, 83% and 67% (respectively) for Chinese participants and
 - 74%, 75% and 64% (respectively) for Vietnamese participants
- WHE Program (September 2005–December 2007): Of the 512 women from South Asian, Arabic and Chinese communities who attended the education session, 161 were reached for the four-month follow-up interview:
 - Almost 50% of the women contacted (who met the cancer screening guidelines) had actually made appointments and/or had a Pap test or a mammogram
 - After the education session, women surveyed were much more aware of the services provided by public health and community agencies
- Participants, WHEs, PHNs and the involved agencies gained capacity and skill building and increased cultural competence

CRITICAL FACTORS FOR ADAPTATION

- Network and build relationships with community leaders and key informants
- Avoid advertising sessions as “cancer screening presentations,” as this topic is scary for many women
- Recruit the WHEs as paid staff rather than volunteers in recognition of the commitment and qualities needed for this work
- Provide education and accompaniment to screening appointments

CHALLENGES

- Finding Pap test access points (e.g., walk-in clinics) was a challenge
- Many participants were reluctant to complete the consent and evaluation forms; low literacy contributed to this issue, which was somewhat mitigated as trust was built between the women and WHEs
- The participant dropout rate over time was high
- There was limited funding for WHEs

LESSONS LEARNED

- WHEs bridge the gap between communities and the healthcare system, leading to increased cultural competency for health professionals, more effective service delivery and greater uptake of disease-prevention messages by communities
- It takes time and sustainable funding for the WHEs to connect with and address community needs
- Sustainability is not only about funding but also relies on building trust with the community, building effective partnerships and ongoing support from policymakers

ADAPTATION FROM OTHER PROGRAMS

- Curriculum was adapted with permission from the Sudbury and District Health Unit Healthy Babies, Healthy Children Training Manual (1998) and the Ontario Ministry of Food, Agriculture and Rural Affairs’ Community Food Advisor Training Manual
- Consultation for the WHE Pilot Project 2003–2005 evaluation tools from York Region Breast and Cervical Health Coalition

program links

www.hamilton.ca/cancer
www.padec.ca

program contact

Tricia Hack, Public Health Nurse
Women’s Health Educator Program
Healthy Living Division, Public Health
Services
City of Hamilton
1447 Upper Ottawa St.
Hamilton, ON L8W 3J6
Phone: (905) 546-2424 ext. 3760
E-mail : Tricia.Hack@hamilton.ca

Your Health Matters: Ethno Cultural Project



TARGET AUDIENCE: Newcomers to Canada with low literacy or whose first language is not English

Program focus: Breast, cervical and colorectal cancer

Challenges/risks faced by target population: While cancer screening programs have become increasingly accessible, screening participation is still affected by factors including socioeconomic and immigrant status, proximity to urban areas, and length of stay.

Setting: Six urban, ethnocultural communities in Windsor-Essex

Province: Ontario

Theoretical background: Principles of adult learning; peer educator outreach to ethnocultural populations; community capacity building; health promotion and behaviour change theory

Program status: 2009 to present

Funder: Green Shield Foundation; Healthy Communities Fund; in-kind contributions from University of Windsor and Erie St. Clair Regional Cancer Program; support from Canadian Cancer Society, Ontario Division

BRIEF OVERVIEW

- Building on the success of a previous project that used a peer educator model to improve breast health among women from ethnocultural communities, and the “Your Health Matters in the Workplace” initiative, this project was developed to increase overall awareness of personal cancer risk factors and preventability, and improve screening rates, among six ethnocultural populations in Windsor-Essex.
- Peer educators from the target communities were recruited and trained to deliver education sessions to the target populations.
- Program implementation of Phase I has just finished and evaluation is currently underway.

PROGRAM GOALS AND OBJECTIVES

- To identify, educate and refer eligible participants to applicable cancer screening programs in Ontario, including the Ontario Breast Screening Program (OBSP), the Ontario Cervical Screening Program (OCSP) and ColonCancerCheck
- To educate participants on personal, modifiable risk factor status and to refer them to appropriate community support programs
- To examine the impact of the Your Health Matters program on awareness of modifiable risk factors with respect to cancer; short-term action and behaviour change with respect to modifiable risk; and cancer screening awareness and participation
- To determine the prevalence and impact of modifiable risk factors, and screening knowledge and behaviours, within hard-to-reach ethnocultural communities

- To develop a best practice, culturally sensitive, prevention and educational tool for use in other hard-to-reach populations and for use in program planning at the Multi Cultural Council Windsor-Essex

PROGRAM IMPLEMENTATION STEPS

- Representatives from Erie St. Clair Regional Cancer Program, Multi Cultural Council Windsor Essex, the University of Windsor and the Canadian Cancer Society (Ontario) partnered to plan and implement the program
- Health professionals from the target populations were recruited as peer educators (PEs) to deliver education sessions in their communities through posters and word of mouth, religious and social organizations and shopping malls
- PEs were trained and involved in focus group discussions regarding the applicability of survey research data collection, cultural sensitivity and relevance, translation needs and clarity of program materials
- Participants completed a baseline survey and consent form (translated into their native language)
- PEs facilitated the education sessions using an English PowerPoint presentation, which they interpreted
- Eligible participants were referred to screening programs and primary healthcare providers; those without primary healthcare providers were referred to the Community Care Access Centre program (Health Connect) that links unattached patients to providers

- Participants who identified a modifiable risk factor they would like to change were referred to follow-up community programs
- An individual risk tracking card and preventative maintenance card was translated and distributed to all participants
- All program materials, except the baseline survey, were translated and a program manual was developed

PROGRAM REACH

- Estimated reach for the pilot phase was 350 women and men across seven urban ethnocultural communities

EVALUATION

- The Ethno Cultural project’s data analysis and reporting are not completed yet; measured biometrics, rather than self-reported data, will be used

CRITICAL FACTORS FOR ADAPTATION

- Have a comprehensive program that focuses on integrated screening (breast, cervical and colorectal) and chronic disease prevention and that includes men
- Partner with relevant, local community networks (e.g., multicultural agencies) to gain support and resources; the University of Windsor provided fourth-year nursing students to support community presentations and implement research projects and in-kind evaluation support
- Provide honorarium fees to PEs in appreciation of their time and expertise
- Provide education sessions in places that are comfortable to the ethnic group (i.e., community gathering places such as social centres, mosques)

CHALLENGES

- Coordinating and providing research support, scheduling and translation services for multiple communities
- Changes in partner schedules have interfered with support for program implementation from cancer program health representatives
- Translation and graphic design of tracking cards; different languages changed the design of the original card
- Ensuring that content was culturally sensitive and appropriate (e.g., some ethnocultural groups do

not eat meat, and content needed to be revised accordingly)

LESSONS LEARNED

- These types of projects are time consuming and logistically demanding; each phase of the project took longer than expected; recognize this when establishing the project timeline and have one, designated coordination resource
- In their interest to promote the project, PEs over-recruited participants, and some sessions were unmanageable with 85+ people; session limits of 20 people have now been established
- Sessions with many people with limited language ability and many seniors were difficult to manage from a research perspective as the survey was guided but not translated; sessions need to be limited with additional interpretation support
- Be clear about the anticipated length of the session and survey; the survey (guided by the peer educator) and information session took 2+ hours to complete

ADAPTATION FROM OTHER PROGRAMS

“Promoting Access to Breast Health for Ethnocultural Communities in an Underserved Health Area: Barriers, Facilitators and Best Practices” project by Anucha, Yiu, Smylie, Dlamini, Lewis & Mitchell, 2007

Adapted from the “Your Health Matters’ Understand Your Cancer Risk — Workplace Cancer Prevention and Screening” program for the workplace target population

program links

None currently available

program contact

Nicole Robinson, Coordinator
 Cancer Prevention & Patient
 Education
 Windsor Regional Hospital, Erie St.
 Clair Regional Cancer Program
 1275 Walker Rd., Unit 10
 Windsor, ON N8Y 4X9
 Phone: (519) 253-3191 ext. 52830
 E-mail: Nicole_robinson@wrh.on.ca

The Use of Mobile Screening Units to Reach Women Living in Remote Areas



Target audience: Rural and/or geographically isolated women

Program focus: Breast cancer

Challenges/risks faced by target population: Lack of healthcare providers, geographic distance or terrain or a lack of transportation often precludes rural or geographically isolated women from accessing breast cancer screening. Taking screening to these women via mobile screening units can ensure equity of access to screening mammography.

Setting: Remote communities, including those in Nunavik

Province: Québec

Theoretical background: None stated

Program status: 2002 to present

Funder: *Programme québécois de dépistage du cancer du sein*

BRIEF OVERVIEW

- The Québec Breast Screening Program (*Programme québécois de dépistage du cancer du sein*; PQDCS) utilizes two mobile units, “Clara” and “Sophie,” to bring mammography screening to women living in remote regions with no fixed screening centres or with limited road access.
- Findings from PQDCS data revealed that approximately 17,800 mammography examinations had been conducted from 2002 to 2006 using the mobile screening units. Although their contribution to the overall provincial participation rate was minimal, mobile screening units played a major role in improving screening rates among women living in areas without fixed screening centres, especially Aboriginal women.

- The PQDCS coordinates with communities in the remote regions to schedule mobile screenings for groups of qualified women
- The mobile units are run by the *Institut national de santé publique du Québec* (INSPQ)
- Two mobile units are used:
 - ♦ The mobile unit “Clara” has the facilities of a complete clinic with a mammography machine; the coach visits the isolated region of Abitibi-Témiscamingue, Côte-Nord and Terres-Cries-de-la-Baie-James, as well as other communities that have difficulty accessing mammography services (Fermont, Radisson, Temiscamingue, etc.)
 - ♦ The portable unit “Sophie” is a compact mammography machine on wheels that can be put onto an airplane, ship, coach or a train; “Sophie” is flown to serve the screening needs of women living in Côte-Nord, Nunavik and Terres-Cries-de-la-Baie-James, as well as communities that have limited road access (Shefferville, Blanc- Sablon, etc.)

PROGRAM GOALS AND OBJECTIVES

- To reduce mortality due to breast cancer by at least 25% among women aged 50–69, over a 10-year period
- To provide mammography screening to women living in remote areas without fixed screening centres or with limited road access
- To compensate for delays in mammography screening in other regions

PROGRAM IMPLEMENTATION STEPS

- The PQDCS utilizes mobile screening units to reach underserved women living in remote communities who would otherwise not have access to mammography services

PROGRAM REACH

From 2002 to 2006:

- 15,655 mammography screenings were performed using “Clara”
- 2,156 mammography screenings were performed using “Sophie”

EVALUATION

Method

- Data from the PQDCS information system for the period 2002 to 2006 were analyzed
- The screening participation rates of fixed and mobile screening centres in groups of regions were compared

Key findings

- 17,811 (1.6% of 1,114,315) mammography examinations were conducted using the mobile screening units, compared to 1,096,404 mammography examinations conducted at fixed screening centres
- Although this figure did not contribute significantly to the overall participation rate, mobile screening units have a major impact on the screening rates among women living in areas without fixed screening centres, especially among Aboriginal women
- In 2006, the participation rate reached 52% and 69.9% (compared to 51.5% for the general population) in the northern regions of Nunavik and Terres-Cries-de-la-Baie-James, respectively; before the introduction of mobile units, few mammography screening services were provided in these regions
- Despite limited statistical power, performance indicators (e.g., detection and recall rates) support the notion that utilizing mobile screening units to reach women living in remote communities is an effective way to ensure equity of access to quality screening with mammography

CRITICAL FACTORS FOR ADAPTATION

- Have sufficient funding to cover costs (e.g., long-distance driving, transportation of equipment and staff by airplane, fuel, repairs and maintenance, and staff wages)
- Have sufficient funding for digital mammography to replace actual equipment

CHALLENGES

- The coach could be on the road for seven days straight
- Weather and road conditions:
 - Winter road conditions make it difficult to drive the coach, but most women in the communities are available in the wintertime
 - The coach cannot be driven on gravel roads
 - During spring and summer, precautions have to be taken to ensure that dust does not get into the coach

- Weather conditions have a major impact on whether “Sophie” can be flown to the communities
- Time constraints: screening staff is able to stay in each region for only six weeks or so, administering an average of 33 mammography screenings per day; this is to prevent having to follow up with too many screenings and to ensure that services are provided to other regions
- Diagnostic mammogram is not done on the coach. Therefore, if any breast abnormality is detected in a woman, she has to go to a health centre in other places for follow-up; if she lives in a community with limited road access, she has to be flown to the nearest health centre

LESSONS LEARNED

- The visit of the mobile unit provides mammography screening service to communities that previously did not have access to this service
- The northern regions have one of the best participation rate in Québec; maintaining access to this service is certainly a challenge

ADAPTATION FROM OTHER PROGRAMS

None

program links

www.msss.gouv.qc.ca/sujets/santepub/pqdcs/index.php?home

program contact

Anne-Marie Langlois
Ministère de la santé et des services sociaux
1075 chemin Ste-Foy
Québec City, QC G1S 2M1
Phone: (418) 266-7512
E-mail: anne.marie.langlois@msss.gouv.qc.ca

Over 40 Screening Program



TARGET AUDIENCE: Rural women (and men) aged 40+

Program focus: Breast, cervical, colorectal and prostate cancer screening, as part of a comprehensive healthcare program

Challenges/risks faced by target population: Colorectal cancer rates are on the rise in New Brunswick. The local 15-bed hospital transitioned to a community health centre (CHC) on July 1, 2008, moving from a model of acute care to health promotion and prevention.

Setting: Community Health Centre

Province: New Brunswick

Theoretical background: None stated

Program status: 2009 to present

Funder: Horizon Health Network

BRIEF OVERVIEW

- The Community Health Centre's mandate is health promotion and preventive care. The centre's priority is to help residents meet individual health needs by booking health-maintenance and disease prevention checkups.
- The Over 40 Screening Program was developed to promote screening access for a range of health conditions including breast, cervical, colorectal and prostate cancer screening; diabetes and cholesterol screening; and immunizations. Screening reminder letters are sent to participating patients the month prior to their birthday.
- While the program is in the early stages of implementation, response to date indicates that this is a promising practice to engage rural women and men due for screening.

PROGRAM GOALS AND OBJECTIVES

- To provide women (and men) aged 40–80 with access to screening according to provincial cancer screening guidelines

PROGRAM IMPLEMENTATION STEPS

- In the fall of 2009, nurses called all eligible CHC patients to get their permission to be part of the Over 40 Screening Program
- Each month, a list of female and male CHC patients aged 40+ years with a birthday in the coming month is generated from electronic medical records
- The registered nurse in charge of this program determines what screening is required for each patient

based on the clinical practice guidelines and provincial screening guidelines

- Patients who are up to date with screening are not sent a letter
- Screening includes mammography; Pap test; FOBT; annual checkup; blood sugar; cholesterol; PSA testing; and pneumonia, tetanus and flu shots
- A letter explaining the importance of prevention, early detection and screening, with instructions on how to book an appointment, is sent to invite eligible patients to book an appointment, come in for a referral and/or pick up an FOBT kit
- Interested patients contact the nurse to schedule a screening appointment or to book a mammogram
- The CHC is open 24/7
- The program is publicized through promotional ads in bulletins and the CHC's newsletter, and through word of mouth
- The nurse in charge of the program follows up monthly over a period of three months to see if patients have come in for testing
- Ultimately, it is the patient's responsibility to come in for testing

PROGRAM REACH

- Approximately 10–12 patients are contacted each month

EVALUATION

Method

- The program is still in the beginning stages; quantitative statistics are being tabulated to track response rates (i.e., changes in screening behaviour)

Key findings

- Patients in the program have had positive test results, and follow-up has been done
- Response rates have been variable; most patients take the required action in response to the letter (e.g., come to pick up the FOBT kit or mammogram referral), but some go directly to their doctor
- Most patients would not get screened if they did not get a letter

CRITICAL FACTORS FOR ADAPTATION

- Access to an electronic database with accurate and up-to-date patient information
- A way of identifying “active” patients for Horizon Health Network clinic physicians
- Consistent program staff

CHALLENGES

- Updating the list (i.e., tracking new patients, the deceased, patients who have moved to another doctor or have transferred to a CHC physician, walk-ins, patients coming in only for dressing changes or IV therapy, out-of-town travellers, etc.)
- Some doctors feel the program is an intrusion on their practice
- Getting reports to family physicians who are outside of the CHC
- Some people hear about the program from a friend, but are not a patient of one of the three clinic physicians; these patients can join, but the results go to their primary care provider and ordering doctor
- Communications within the CHC as different nurses are in on different days

LESSONS LEARNED

- Screening has given the patients an opportunity for early detection of various diseases
- We could not provide this service in our previous model of acute care
- A new procedure, a consent, has been developed with new patients to ask them if they want to participate in the program
- Response to the letter has been unpredictable (e.g., patients who appear to not look after their health and who rarely see the doctor are at the doorstep the next day or within a week of receiving the letter)
- Female Pap test providers have been coordinated for male doctors

ADAPTATION FROM OTHER PROGRAMS

None

program links

None currently available

program contact

Renelle Thibodeau, Nurse Manager
Tobique Valley Community Health
Centre
120 Main St.
Plaster Rock, NB E7G 2E5
Phone: (506) 356-6627
E-mail: Renelle.Thibodeau@
horizonnb.ca



TARGET AUDIENCE: All women, including underscreened women

Program focus: Breast and cervical cancer

Challenges/risks faced by target population: Breast cancer is the most common cancer among women in New Brunswick. Although the 2008 Canadian Community Health Survey (CCHS) reported that 74% of women aged 50–69 in the province had mammograms in the previous two years and that more than 70% of women reported having a Pap test in the last three years, it has been challenging to identify the women who are not being screened in the province. To that end, this program targets all women in order to capture the underscreened in the process. Low education and low income are associated with fewer mammograms; according to New Brunswick CCHS 2008 data, 21% of residents do not have a high-school diploma, 16% live in lone-parent families and 13% live on a low income.

Setting: Throughout New Brunswick

Province: New Brunswick

Theoretical background: None stated

Program status: 2007 to present

Funder: Canadian Cancer Society New Brunswick

BRIEF OVERVIEW

- Pink Parties are designed to be a fun and informal way to share life-saving information about breast and cervical health and cancer screening with friends and colleagues — and to get women talking about their breasts!
- Women can hold Pink Parties in a variety of ways (e.g., over lunch with the women at the office, as part of a “Pink Potluck” or with a group of girlfriends on a Saturday night).
- Although no formal evaluation has been conducted, participant feedback has been positive and to date, more than 2700 women have been reached.

PROGRAM GOALS AND OBJECTIVES

- To increase awareness of breast and cervical health and cancer prevention in a celebratory way

PROGRAM IMPLEMENTATION STEPS

- The Canadian Cancer Society (CCS) New Brunswick developed the Pink Parties program based on the lay health educator and home-sale party concepts (where women sell jewelry, candles, etc.)
- The program is designed to raise awareness and share information about breast and cervical cancer among lay women in an informal, festive atmosphere, rather than in a formal educational context
- As the advertising budget was very limited, the local newspaper was approached during the program launch

to print a story about breast cancer along with information about Pink Parties; this generated a significant amount of interest from the public

- The program was also advertised through the CCS website; flyers at health fairs, workplaces and public presentations; and word of mouth
- Women in New Brunswick interested in hosting a party can call or e-mail the CCS to obtain a free party kit in English or French
- The kit includes:
 - ♦ Some suggestions and guidelines on hosting a party (e.g., where to host the party and the ideal number of guests)
 - ♦ A breast trivia game to start the party conversation
 - ♦ A cervical cancer quiz and brochure
 - ♦ “Thingamaboob” keychains, which show the different lump sizes that can be detected through a variety of breast screening methods
 - ♦ Early detection and screening pamphlets
 - ♦ Shower and health pledge cards to act immediately on the information learned (e.g., pledging “I will have a Pap test regularly”) and
 - ♦ Pink-themed decorating, food and drink ideas
- An evaluation form with a prepaid envelope is also included to obtain feedback about the Pink Parties; the evaluation at this stage does not assess changes in

health and screening behaviours of women who attend the parties

- In fall 2010, an optional “purple” (colour to be determined) component will be added to the kit to address men’s health issues (through women), including colorectal cancer screening

PROGRAM REACH

- From 2008 to 2010, 2700 women were reached

EVALUATION

Method

- Party participants are asked to complete a short survey and return it to CCS
- The survey asks participants to rate the value of the breast and cervical cancer educational tool, comment about whether the party was valuable and informative, include questions to follow up and provide suggestions for improvement

Key findings

- Although the survey return rate has been very low, those received indicate very positive responses (e.g., “Our Pink Party was a huge success...There was a lot of conversation and sharing of experiences with the group”)
- Some respondents included photographs of the party and suggested creative ideas to host the party
- The fact that 2700 women have participated to date, a significant number for a small province, also indicates that the program is successful at attracting rural and/or geographically isolated women

CRITICAL FACTORS FOR ADAPTATION

- Base similar programs on a festive gathering among friends rather than a stagnant, stiff education session; this is the crucial quality that makes the Pink Party program attractive to women
- Promote the program periodically through a variety of means (e.g., radio, workplace, print)
- Limit the number of party guests per kit to 25 to prevent large groups and commercial businesses (e.g., gyms) from ordering the kit just to obtain the Thingamaboob keychains
- Refresh and change the kit regularly

CHALLENGES

- It was challenging to promote and raise awareness about the program as it was one of numerous CCS events and activities, and with limited funds
- It is difficult to evaluate whether the program has any impact on participants’ health and screening behaviours (e.g., talking to family physicians about breast and cervical cancer and obtaining the necessary screening)

LESSONS LEARNED

- Never underestimate the power of a little gadget like the Thingamaboob keychain to generate interest in a program
- Ultimately, women are their own experts in terms of their own health; often, they simply require appropriate and reliable health information; this may require the role of the health expert to be deconstructed

ADAPTATION FROM OTHER PROGRAMS

Based on the lay health educator and home party concepts

program links

[www.cancer.ca/New Brunswick/Prevention/Have a Pink Party.aspx?sc_lang=en](http://www.cancer.ca/New_Brunswick/Prevention/Have_a_Pink_Party.aspx?sc_lang=en)

program contact

Rosemary Boyle
Manager, Prevention
Canadian Cancer Society, New Brunswick
133 Prince William St.
P.O. Box 2089, Suite 201
Saint John, NB E2L 3T5
Phone: (506) 634-6267
E-mail: rboyle@nb.cancer.ca



TARGET AUDIENCE: Unscreened or underscreened patients at Stanley Health Centre

Program focus: Breast, cervical and colorectal cancer

Challenges/risks faced by target population: The target audience is at increased risk for cancer because, although they are eligible for screening, they do not follow recommended guidelines for screening.

Setting: Health clinic

Province: New Brunswick

Theoretical background: None stated

Program status: 1990s to present

Funder: Stanley Health Centre

BRIEF OVERVIEW

- The Stanley Health Centre Primary Care Practice makes telephone calls to all unscreened and underscreened patients, aged 50+ years, to notify them that they are due for colorectal cancer screening and to schedule an appointment.
- The clinic also sends mammogram requests to all unscreened and underscreened female patients, aged 50+ years.
- Based on the health centre's experiences, personal contact with patients seems to produce the best screening participation rates.

- Health centre nurses telephone patients to notify them that they are due for colorectal cancer screening and to invite them to book an appointment
- Mammogram requests are sent to female patients, although they can also self-refer
- Currently, the health centre does not call patients for cervical cancer screening; screening is done as the patients present at the centre

PROGRAM REACH

- Not available

PROGRAM GOALS AND OBJECTIVES

- To provide the full circle of care for the lifelong physical and emotional care of patients

PROGRAM IMPLEMENTATION STEPS

- A list of patients due for screening is produced each month:
 - Female patients aged 50+ years for breast cancer screening
 - Female patients aged 18+ years for cervical cancer screening and
 - Women and men aged 50+ years for colorectal cancer screening

EVALUATION

Method

- Monthly data of screening participation rates and results are collected for colorectal cancer

Key findings

- Calling eligible patients directly to participate in annual screening has been found to produce the best rate of participation among the centre's patients

CRITICAL FACTORS FOR ADAPTATION

- Personal phone contact with patients about their screening needs
- Allocate time to make the telephone calls
- A database is required to produce a list of patients due for screening each month

CHALLENGES

- Having sufficient time to make all the telephone calls; the calls are made during evening hours when the office is quieter or on a day when the physician is not in the office and has no patients

LESSONS LEARNED

- Personal contact leads to the best response for screening participation

ADAPTATION FROM OTHER PROGRAMS

None

program links

None currently available

program contact

Charlene Merrill, Nurse Manager
Stanley Health Centre
32 Limekiln Rd.
Stanley, NB E6B 1J8
Phone: (506) 367-7730
E-mail: Charlene.Merrill@horizonnb.ca

Well Woman Program



TARGET AUDIENCE: Women living in three rural communities in New Brunswick

Program focus: Cervical and colorectal cancer

Challenges/risks faced by target population: Cancer screening rates among the target audience were low. One barrier to screening identified was that the women live in small communities in which only male physicians are available; the physicians have worked in the community for a long time and are often friends of many of these women. These social relationships, in turn, can prevent the women from accessing their family physicians for more sensitive, well-woman health issues, such as Pap tests.

Setting: Health centres in three rural communities: Harvey, Nackawic and McAdam

Province: New Brunswick

Theoretical background: None stated

Program status: 1994 to present

Funder: Horizon Health Network

BRIEF OVERVIEW

- The Well Woman Program was developed to improve cervical and colorectal cancer screening rates among women living in three rural communities by providing them with access to a female practitioner and easier access to screening services.
- Although indicators to measure the effectiveness and utilization of the service are still in the planning process, to date, approximately 500 women have been reached in each community.

PROGRAM GOALS AND OBJECTIVES

- To provide access to cervical and colorectal cancer screening for rural women as well as age- and sex-specific screening for all patients

PROGRAM IMPLEMENTATION STEPS

- The Health Centre was first established in 1994
- Shortly thereafter, a needs assessment was conducted with women in the three target communities
- Health centre staff were able to get a visiting female physician to periodically offer a clinic in Harvey and McAdam, and women were able to book appointments regardless of whether they already had a family physician

- Local family physicians supported these efforts, especially after the first couple of clinics indicated that the majority of women accessing the service had not had a Pap test in more than five years
- In 2009, a nurse practitioner was hired to offer the Well Woman Program in Harvey, McAdam and Nackawic; McAdam, however, has both a female visiting physician and nurse practitioner; the nurse practitioner was hired to increase access to primary care services in these communities
- The nurse practitioner is available during regular clinic days and hours; evening hours were added to allow access to the working population
- Patient chart face sheets record if screening has been completed; a regular chart review during each woman's birthday month indicates whether any component of screening (e.g., cervical, breast, colorectal, diabetes, blood pressure, bone density, immunization status, lipid profile, thyroid, B12 and folate, mobility (age specific), memory (age specific), depression (as indicated)) is outstanding
- The Well Woman Program is promoted through paid advertisements in local service-organization newsletters delivered to every household, and displays at health fairs; women are contacted as needed via telephone to offer them screening appointments; they can also self-refer

- Youth under age 24 are served in close collaboration through a sexual health clinic, which is located within the health centre

PROGRAM REACH

- Approximately 500 women were reached in each community

EVALUATION

Method

- Indicators to measure the effectiveness and utilization of the Well Woman Program are being determined

Key findings

- Not available

CRITICAL FACTORS FOR ADAPTATION

- Collaboration among relevant partners (e.g., physicians, public health, sexual health, regional laboratory, community advisory groups) is crucial
- The program needs a database system in place to identify patients who are unscreened or underscreened, and the capability of offering them an appointment
- Targeted strategies (e.g., female healthcare providers) are required to address relevant barriers to screening
- Offer hours of operation that are accessible to underserved women (e.g., evening hours)
- Start with a smaller control group to work out the process, and then widen the scope

CHALLENGES

- None; everyone worked well together to provide the service

LESSONS LEARNED

- It is important to advertise the program periodically in order to keep it top of mind for clients
- Screening programs, in conjunction with a Well Woman Program, offer women a more comprehensive service

ADAPTATION FROM OTHER PROGRAMS

None

program links

None currently available

program contact

Shirley Baisley-Moffatt
 Nurse Manager
 McAdam/Harvey/Nackawic Health
 Centres
 15 Saunders Rd.
 McAdam, NB E6J 1K9
 Phone: (506) 784-6300
 E-mail: Shirley.Moffatt@horizonnb.ca

Nova Scotia Breast Screening Program (NSBSP) Mobile Breast Screening Service



TARGET AUDIENCE: Women living in communities where breast screening is not easily accessible

Program focus: Breast cancer

Challenges/risks faced by target population: Equal access to breast screening is an issue for women in the target population. Some women live in remote areas and have to travel very long distances to a fixed site in order to get screened. Taking screening to these women via a mobile screening unit can ensure more equitable access. It is important to note, however, that this does not mean that all eligible women will access mobile screening. Therefore, it is equally important to find out why the identified unscreened women do not access screening (e.g., cultural barriers).

Setting: Eastern, western and northern regions of Nova Scotia

Province: Nova Scotia

Theoretical background: None stated

Program status: 1994 to present

Funder: Nova Scotia Department of Health

BRIEF OVERVIEW

- The Nova Scotia Breast Screening Program (NSBSP) administers three mobile screening vans to bring mammography screening to women living in areas in which screening services are not easily accessible.

PROGRAM GOALS AND OBJECTIVES

- To provide equitable service to all women of Nova Scotia, regardless of where they live in the province

PROGRAM IMPLEMENTATION STEPS

- The NSBSP operates three mobile screening vans:
 - ♦ The Eastern Mobile, with a digital mammography unit, travels throughout Cape Breton Island and provides screening services to the women in the Eastern Health Region
 - ♦ The Western Mobile provides screening services primarily to the women in the western region of Nova Scotia
 - ♦ The Northern Mobile provides screening service to the province's northern region
- The mobile screening service focuses on reaching the underserved or hard-to-reach populations (e.g., African Canadian and First Nations women)
- To increase awareness about and participation in mobile screening, the following outreach activities are conducted:
 - ♦ Local radio stations and newspapers announce when the mobile service will be in the area; women can then call in to make appointment

- ♦ In some private clinics (First Nations in particular), a liaison person is assigned by the community to conduct outreach to the women in the community:
 - To ensure that the women are eligible for screening, they have to complete a "walk in form"
 - These forms are then faxed to the Central Booking at NSBSP to ensure that these women are in fact due for breast screening
 - If the women are due, they will be scheduled an appointment
 - If they are not due, the forms will be sent back to the liaison person
- ♦ The mobile service schedule is also available on the NSBSP website
- Generally, each mobile van travels to one community in one year and to a neighbouring community in the next year; in an effort to reach hard-to-reach women, however, it travels to their communities every year
- The mobile schedule is made known one month prior to visiting a community; plans are underway to open the mobile schedule one year in advance

PROGRAM REACH

- Not available

EVALUATION

Key findings

- Approximately 20% of the women in the target population (ages 50–69) have been screened on the mobile vans; however, because the mobile van is also used to decrease the wait times at fixed sites, this number does not truly represent screening rates for the hard-to-reach population

CRITICAL FACTORS FOR ADAPTATION

- Open the mobile schedule in advance to accommodate changes in dates that are sometimes necessary
- Provide access to screening for women regardless of where they live

CHALLENGES

- Covering the costs of running the mobile screening vans (e.g., fuel, repairs and maintenance, staff wages)
- Scheduling of services to complement the fixed screening; currently the mobile vans are used to complement fixed screening sites as a way to decrease wait time as well as target hard-to-reach populations:
 - ♦ This challenge will be significantly reduced with the introduction of digital mammography across the province; the increased capacity at the fixed sites will lessen the need for the mobile vans to stop in these areas; the mobile vans can then be used to focus on targeting hard-to-reach populations
- Generally it is not hard to get screenings booked for the mobile vans; in fact, in some areas, available appointments exceed demand; without knowing what the target population is for an area/community, it is very difficult to know the percentage of eligible women being screened
- If a woman calls to book an appointment but the mobile schedule is not available, she is told to call back closer to a certain date; this practice may deter women from calling back

LESSONS LEARNED

- Bringing screening services to an area does not necessarily mean that the women in the area will make use of the service
- Invest heavily in breast health education in the community beforehand in order to educate women about the need for screening and bring them into the system
- Having a liaison person in the community helps get hard-to-reach women to screening

ADAPTATION FROM OTHER PROGRAMS

None

program links

www.breastscreening.ns.ca

program contact

Theresa Foley, Program Manager
Nova Scotia Breast Screening Program
7001 Mumford Rd., Unit 603L
Halifax, NS B3L 2H8
Phone: (902) 473-3956
E-mail: foleyt@cdha.nshealth.ca

Using Data and GIS Technology to Understand Uptake and Target Interventions



TARGET AUDIENCE: District health authority administrators and Pap test providers

Program focus: Cervical cancer

Challenges/risks faced by target population: Access to healthcare providers is a challenge for many Nova Scotia women, putting them at risk for cervical cancer and its precursors if not adequately screened. Nova Scotia has one of the highest rates of cervical cancer in North America (10.0 cases/100,000), which may be associated with poor Pap screening uptake by women in the province.

Setting: Urban and rural communities

Province: Nova Scotia

Theoretical background: Population health approach

Program status: 2009 to present

Funder: Province of Nova Scotia

BRIEF OVERVIEW

- This pilot study was conducted to better understand barriers and incentives to Pap screening at the community level, and to share those learnings with decision makers and healthcare providers.
- Assuming access to complete and reliable data sources, Geographic Information System (GIS) technology can be an effective means to identify and understand predictors of Pap screening uptake and to target interventions to underscreened populations.

PROGRAM GOALS AND OBJECTIVES

- To provide a first examination of the spatial variability in Pap screening participation rate (uptake) at three levels of spatial aggregation
- To examine potential predictors of Pap screening uptake
- To identify vulnerable segments of the population

PROGRAM IMPLEMENTATION STEPS

- 85,983 Nova Scotia women aged 35–49 years with at least one Pap test between 2005 and 2007 were identified from the provincial cytology registry maintained by the Nova Scotia Cervical Cancer Prevention Program (CCPP)
- NS women eligible for Pap screening were determined for three levels of spatial aggregation: District Health Authority (DHA, $N = 9$), county ($N = 18$) and dissemination area (DA, $N = 1609$)
- A woman's primary residence and Pap test provider location were geo-coded based on postal code at the time of the Pap test, allowing spatial referencing and calculation of linear distance

- Regardless of the number of Pap tests received during the index period, only the most recent was used to report three-year, age-standardized Pap screening participation rates (PSPR)
- DA-level PSPR were derived from spatially smoothed Pap test counts using an empirical-Bayes approach that redistributed Pap tests that exceeded a local population to neighboring DAs; this algorithm respected the age-specific conditional distributions of PSPR and was simulated over 10,000 randomly initialized configurations
- Screening uptake was modeled with a Generalized Additive Model separately for urban and rural strata, and weighted by population size; potential predictors of PSPR were modeled along with other population characteristics
- Potential predictors were selected on known barriers to screening relevant to NS women: distance from Pap test provider; gender and number of test providers; urban/rural; unemployment rate and lone parent status
- Deviance from expected PSPR (residuals) was mapped in a geographic information science (GIS) context to identify potential target areas for intervention

PROGRAM REACH

- 85,983 women from across NS

EVALUATION

Key findings (based on the best available data at the time of the study)

- 67% of rural women and 81% of urban women (35–

49 years) had a Pap test in the last three years; this is below the Canadian screening target of 85%

- Identification of areas with lower PSPR depended upon the level of spatial aggregation reported; at the resolution of DHAs, PSPR were centred around the mean with a range of 59–87%; at the county level, the range increased to 55–100%; at the finest spatial resolution (i.e., DA), the range expanded to 0–100%
- In urban DAs, PSPR decreased up to 20% below average for women living more than 25 km from their provider, and up to 7% for those living in areas with an increased proportion of lone parents; conversely, the uptake increased up to 7% above average in areas where the number of female providers increased, and up to 4% above average with increased unemployment rate
- In rural DAs, uptake was modal with a maximum of 25% above average for women living at 60 km of their provider; and increased with the number of providers
- Vulnerable segments of the population were identified from lower than expected PSPR (residual) (i.e., areas where factors other than those examined caused the low uptake)

CRITICAL FACTORS FOR ADAPTATION

- GIS technology is central because:
 - ♦ Identification of geographic areas and groups at risk are key to effective public health practice
 - ♦ Decision makers need information
 - ♦ It offers tools to manage, integrate, process, analyze and display spatially referenced data
- Access to a complete, reliable, population-based database of Pap tests
- Data sources that have complete, reliable data on factors such as hysterectomies, as well as the location, status, gender and specialty codes of Pap test providers, including nurses and nurse practitioners

CHALLENGES

- Geo-referencing PS data using only postal code: Statistics Canada randomly assigns the postal code to any one of the DAs included in that area; this results in having all the Pap tests associated with that postal code allocated to one DA where the number of Pap tests recorded may greatly exceed the total female population for that DA
- In the CCPP database, Pap test providers are not deleted or identified as being active for a certain time

period; there is a need to better quantify the numbers and genders of providers serving an area at a given time

- Women in the database are not currently flagged for hysterectomy/risk status, nor is there a usable rate of hysterectomy for the NS population; this work, to be done over the next 12 months, is complex and, may initially provide incomplete prevalence

LESSONS LEARNED

- Obtaining civic address or longitude and latitude is imperative; it is not effective to geo-reference on postal code, particularly in rural areas
- Adjust data for hysterectomy status prior to calculating and plotting Pap screening participation
- Ensure status (active or inactive) of healthcare providers for period of interest if using provider as a predictor of uptake
- Report at the appropriate level of spatial aggregation (e.g., in NS, "county" is too high and "dissemination areas" is too fine a level; "community" should be appropriate)

ADAPTATION FROM OTHER PROGRAMS

Harnessing the potential of GIS technology to better understand unmet health needs

program links

The aim is to upload Pap screening data into Google Earth for interactive and useful information at the district health authority level

program contacts

Amy Folkes, Manager
Cervical Cancer Prevention Program
Cancer Care Nova Scotia
Phone: (902) 473-7438
E-mail: amy.folkes@ccns.nshealth.ca

Nathalie Saint-Jacques, Epidemiologist
Cancer Care Nova Scotia
Phone: (902) 473-3749
E-mail: Nathalie.st-jacques@ccns.nshealth.ca

What Women Want: One Stop Team Based Cancer Screening



TARGET AUDIENCES: Unscreened and underscreened women aged 40+ years; First Nations and African Nova Scotian women; hard-to-reach women

Program focus: Breast, cervical and colorectal cancer

Challenges/risks faced by target population: Cancer screening for women in Nova Scotia is fragmented, with inconsistent information on colorectal cancer risk and screening. Nutrition education and counselling has not yet become a formal component of cancer prevention. Nova Scotia also has persistently higher rates of most cancers as compared to provincial and national averages. Hard-to-reach women are often those living in poverty; those with low socioeconomic status and literacy and education levels; those living in deep rural areas; those without transportation; and those living in abusive situations.

Setting: Nine geographically isolated communities across rural Cape Breton

Province: Nova Scotia

Theoretical background: None stated

Program status: 2008–2010

Funder: Nova Scotia Department of Health, Primary Care

BRIEF OVERVIEW

- A pilot project was designed to study the effectiveness of a one-stop, team-based approach to cancer prevention and screening to reach underserved women in the Cape Breton District Health Authority (CBDHA).
- Preliminary results indicate that the One Stop program was effective at increasing screening rates among un- and underscreened women; support at the district and provincial levels will ensure that the program becomes a permanent primary health service.

PROGRAM GOALS AND OBJECTIVES

- To plan, implement and evaluate a team-based approach to cancer prevention and screening for women within the CBDHA
- To identify the strategies and resources required to provide quality primary health services and education to promote early detection and ultimately reduce the incidence of cancer in the target population
- To build credible and informed partnerships between provincial, district and First Nations health programs and providers in a move toward integrated, shared service-delivery models
- need to streamline primary health and screening services
- A pilot coordinator, nurse, dietician and part-time administrative assistant were hired
- An advisory committee made up of health providers, agency partners and community representatives was established
- One Stop clinics were set up to coincide with the Nova Scotia Breast Screening Program's (NSBSP) mobile screening service
- Partnerships were established with health facilities and community partners to secure space close to the mobile unit, and to recruit and market the One Stop screening service
- The pilot coordinator worked with the district mammography team and the NSBSP to block and coordinate mammography appointments
- A central booking process was later developed (i.e., one toll-free number to book one appointment for all three services)
- One Stop screening includes three key components: mammography through the mobile breast screening unit; a well woman's visit with a specially trained registered nurse; and nutrition education for cancer prevention with a registered dietician
- Well woman visits included a Pap test (if indicated), a clinical breast exam, information on colorectal cancer risk and screening, and nutrition and healthy lifestyle counselling; additional screening, health information and referrals were based on client need and assessment findings
- A nutrition working group was formed to develop an

PROGRAM IMPLEMENTATION STEPS

- A literature review of team-based approaches to screening, education and health services in rural areas was conducted
- A one-stop, team-based approach was selected in response to repeated suggestions by women and the

approach, and an assessment and education tool, that targeted healthy eating for cancer prevention

- Staff were trained in cultural competency
- Recruitment strategies included newspaper and radio ads, interviews with One Stop health providers, clinic posters and mail-outs to every home in selected rural areas

PROGRAM REACH

- From October 2008 to November 2009, 1117 women attended one of 135 One Stop clinics

EVALUATION

Method

- Feedback forms and interviews

Key findings (preliminary)

- 817 women (73%) accessed the three components of the One Stop pilot; 268 women (24%) accessed two services
- 87% of women were aged 40–74 years
- 79% of women had a mammogram; 25% of these were first-time screens (a 10% increase from rates of the mobile unit)
- 77% of women had a Pap test; 4% of these were first-time tests; 34% were underscreened (i.e., three or more years since last Pap test)
- 57% of women reported that this was their first one-to-one session with a dietitian on health promotion and cancer prevention
- Women appreciated being able to call one number to access all services in or close to their communities, at convenient times and locations, by the most appropriate provider
- Suggestions to further streamline services included providing FOBT screening kits and mailing out Pap test results to women

CRITICAL FACTORS FOR ADAPTATION

- Partnerships with provincial programs toward an integrated model of primary health and screening services
- Cooperation and collaboration of a range of stakeholders at the district and provincial levels, within and outside the health system
- Annual cancer screening schedules to enable communities to prepare and recruit women, particularly those who are high-risk and/or underscreened
- A central booking service
- Services in or close to women's communities
- All-female health providers
- Varied clinic hours

- Nutrition education for cancer prevention
- A provincial repository that integrates data from all cancer screening programs
- Use of electronic records to identify and recruit underscreened populations
- Processes in place for the reporting of abnormal results and clinical findings

CHALLENGES

- Location and timing; the One Stop clinics could not be planned until the mobile screening service determined its exact schedule
- Booking and scheduling; One Stop was unable to recruit women through the NSBSP, resulting in significant spending on marketing and recruitment, a duplication of recruitment strategies, and confusion for women being targeted by both programs
- Space (i.e., finding rooms plus a waiting area in a primary healthcare setting close to the mobile unit during peak daytime hours)
- Data collection and reporting
- Reaching the underscreened

LESSONS LEARNED

- Stakeholders recognized the need to promote the pilot and want to ensure the One Stop program becomes a permanent primary health service in the CBDHA
- Cultural competency training improved awareness and motivated staff to modify the provider-patient encounter
- Recruiting hard-to-reach women requires a long-term commitment to relationship building, coupled with the provision of accessible and consistent screening services
- For many women, this was the first time they had heard of the importance of colorectal cancer screening and most planned to follow up with their doctor

ADAPTATION FROM OTHER PROGRAMS

None

program links

www.cbdha.nshealth.ca

program contact

Valerie Nugent, RN, BScN, CCNP
Manager
Cancer Prevention & Screening
Cape Breton District Health Authority
520 Purves St., PO Box 399
North Sydney, NS B2A 1E5
Phone: (902) 794-8958
E-mail: nugentv@cbdha.nshealth.ca

Screening Awareness Project Initiative: getscreenedpei.ca



TARGET AUDIENCE: Rural Islanders aged 40–60 years, and health professionals

Program focus: Breast, cervical and colorectal cancer

Challenges/risks faced by target population: Statistics show that Prince Edward Island has higher rates of most cancers as compared to provincial and national averages; a survey conducted before this campaign revealed that many Islanders are not getting screened and do not know enough about screening. For example, 30–40% of women are unscreened or underscreened for cervical cancer. Most Islanders rely only on their family doctor to tell them to get screened.

Setting: Rural communities across Prince Edward Island; online

Province: Prince Edward Island

Theoretical background: None stated

Program status: 2009 to present

Funder: Canadian Cancer Society; Public Health Agency of Canada

BRIEF OVERVIEW

- The Screening Awareness Project Initiative was created to increase awareness about screening, and screening rates, among underscreened, rural and geographically isolated Islanders.
- The initiative engaged community and health professionals and used a public awareness campaign.
- Although the effectiveness of this provincial campaign in increasing screening rates could not be determined, preliminary results indicate that the campaign has been well received.

PROGRAM GOALS AND OBJECTIVES

- To increase knowledge of screening recommendations among Islanders aged 40–60 years
- To increase participation in recommended screening activities among Islanders aged 40–60 years

PROGRAM IMPLEMENTATION STEPS

- A screening advisory committee was established with representatives from the Department of Health & Wellness, diagnostic imaging, the Medical Society of PEI, a community health centre and the CCS
- A survey was drafted and pilot-tested to assess screening behaviours and inform the direction of the initiative; an external agency was then hired to conduct a pre-campaign phone survey
- A creative team was hired to design a public health campaign to create a “culture of screening” on PEI: the message focused on finding cancer when it is most treatable (e.g., “You can’t find itsy bitsy, teeny weeny but cancer screening can.”)

- The initiative included three key elements: a public awareness campaign; community engagement; and health professional engagement
- Public awareness materials (e.g., brochures; banners; displays; posters; and TV, newspaper, radio and online advertising) were created
- A dedicated website featuring information and interactive registration for individual screening reminders at appropriate intervals was created; those who sign up received an age-tailored screening reminder each year on their birthday
- A letter promoting the campaign was sent to all PEI family physicians
- The campaign was launched in January 2010
- Community engagement was promoted through:
 - Information booths/displays and presentations at existing CCS events
 - Potluck With A Purpose (PWAP), a fun and informal way to share life-saving information about cancer screening and healthy lifestyles with friends and family. The PWAP kit includes a re-useable CCS grocery bag; a “how-to” guide for the host; trivia questions on screening; a PEI cancer fact sheet; brochures and postcards; pens; coupons; keychains; a host evaluation sheet; and future host sign-up sheet
 - Incentive prizes: Sponsorships were solicited for incentive prizes (e.g., the first 100 hosts to submit their evaluation got a Paderno cooking pot)
- Health professional engagement activities are meant to encourage doctors to talk to their patients about

screening and be prepared for patients to ask about screening; activities to date include presentations to physician committees, a physician survey, articles in the medical society newsletter and displays at their events and continuing medical education sessions on cancer screening

- A webinar was conducted to share the campaign with CCS divisions across the country

PROGRAM REACH

- Tens of thousands of Islanders, including healthcare providers, have been reached through the campaign ads, website and outreach activities

EVALUATION

Method

- Pre- ($N = 397$) and post- ($N = 153$) campaign telephone surveys were conducted with two independent random samples of Islanders, aged 40–60, to assess the effectiveness of the campaign in increasing cancer awareness and intention to screen; post surveys were conducted about two months after the campaign

Key findings

Pre-campaign

- Self-reported screening completion in the previous two years was 60% for mammogram, 76% for Pap test and 22% for FOBT
- 83% of respondents reported that their doctor is their most preferred person to talk with about cancer screening; 41% reported that they most prefer to receive information on cancer screening from their doctor

Post-campaign

- The proportion of respondents who agreed that cancer screening tests can detect cancer increased significantly, from 77% at baseline to 84% at follow-up
- The proportion of respondents who indicated that they were “very likely” to look or ask for information on cancer screening in the next year increased significantly, from 31% at baseline to 45% at follow-up
- It could not be ascertained whether these increases were due to the campaign
- For each type of cancer, the percentage of people who said that they were very likely to get screened in the next year was generally similar to rates of actual screening test completion over the previous two years

CRITICAL FACTORS FOR ADAPTATION

- Establish a clear, multi-year budget; it is costly and time consuming to launch a provincewide public awareness campaign
- Secure long-term, sustainable funding (e.g., for ongoing upkeep of website)
- Set clear campaign objectives
- Focus on one main topic and maximize efforts to promote community engagement

CHALLENGES

- Communication: it was difficult to work with a large creative team based in another province
- Time management: it was hard to coordinate schedules and responses of multiple partners
- The project timeline did not allow enough time to adequately vet and pilot-test campaign messaging and materials, especially when dealing with sensitive subject matters
- Funding, especially with a project requiring significant design and marketing costs

LESSONS LEARNED

- More time and money, and better communication, would have enhanced the campaign process and outcome

ADAPTATION FROM OTHER PROGRAMS

None

program links

www.getscreenedpei.ca

program contact

Amber Coffin
Screening Awareness Project
Coordinator
Canadian Cancer Society
1 Rochford St., Suite 1
Charlottetown, PEI C1A 9L2
Phone: (902) 566-9926
E-mail: acoffin@pei.cancer.ca

Site Specific Planning



TARGET AUDIENCE: Communities identified as less than 30% screened, including rural and remote women, Aboriginal women and/or low-income women

Program focus: Cervical cancer

Challenges/risks faced by target population: Rural geography, accessibility to health services, literacy and low income levels; with 10,000 mostly rural communities and miles upon miles of coastline, the most significant barrier to screening in Newfoundland is access to screening services. Women in small, isolated communities have some of the highest screening rates due to well-established relationships with regional nurses; many Aboriginal communities also have strong health promotion outreach. Screening rates for rural remote women, however, are very low because they are the most marginalized by accessible health services.

Setting: Rural and rural remote communities across Newfoundland

Province: Newfoundland

Theoretical background: Social determinants of health; population health framework; public health framework; adult learning principles

Program status: 2005 to present

Funder: Cervical Screening Initiatives Program

BRIEF OVERVIEW

- Site-specific planning uses a community profile tool and screening by place of residence to develop targeted strategies aimed at increasing screening rates among at-risk populations.
- Feedback from healthcare providers and three-year screening rates indicate significant knowledge translation and changes in preventive screening behaviour among underscreened populations.

PROGRAM GOALS AND OBJECTIVES

- To create a framework for site-specific planning that targets the at-risk population and enhances the local area's capacity to develop a multi-pronged health promotion and education plan to promote and provide screening

PROGRAM IMPLEMENTATION STEPS

- A framework was developed to support program objectives and strategies
- At-risk populations (i.e., <30% screened) were identified by five-year age groups for every community in the eligible area
- Opportunities for education, promotion and screening services were identified (e.g., screening rates may suddenly drop after age 45, suggesting that strategies target women over 50)
- A consultation process was developed with healthcare providers, health promoters and educators, and

- community groups (e.g., local branches of the Canadian Cancer Society and women's groups)
- A community profile tool was used to identify community characteristics, healthcare provider characteristics and prospective partner agencies, and to help create a plan uniquely targeted to the at-risk population
- Ad hoc local groups were formed in given geographic areas or disciplines to create site-specific plans and to determine the target population by age group, geography or healthcare-provider networks
- Plans address three questions: 1) What needs to be done to increase screening awareness and uptake among underscreened women? 2) What are the related education needs? and 3) How can the identified screening opportunities be made available to women in the communities in which they live?
- Local promotional events using non-traditional disseminators (e.g., a beauty salon or bingo campaign), can be used to promote screening opportunities and introduce women to the visiting nurse practitioner
- Access to Service grants were created to help Pap test clinics with broader planning approaches increase screening (e.g., to create an open-door clinic)

PROGRAM REACH

- An estimated 137,000 un- or underscreened Newfoundland women

EVALUATION

Method

- Quantitative and qualitative host/facilitator and participant evaluation tools are available in an education binder for every intervention
- Using a standardized template, regional coordinators track and analyze changes in annual screening rates by community, noting any interventions (including healthcare provider interactions), successes, failures and extraneous factors (e.g., the primary healthcare provider position was vacant for six months)
- Retention rates are tracked using participation rates over three-year periods to examine changes in screening behaviour
- The provincial database is continuously being restructured to support stronger performance monitoring

Key findings

- Over the past 12 years, thousands of qualitative consultations and feedback forms have been completed with underserved women to identify enablers and barriers to screening, and to tailor messaging and services
- Healthcare providers are pleased to see more women from at-risk populations coming in for services; Cervical Screening Initiatives Program (CSIP) helps streamline Pap test service delivery by taking an evidence-based approach to women's wellness (e.g., suggesting screening clinics versus head-to-toe diagnostic assessments) and measures uptake (i.e., number of Pap tests per healthcare provider) and recognizes those who conduct 250 or more Pap tests per year
- CSIP's rigorous attention to evaluation has informed policies and practices that promote sustainability within the health system and positive changes in service delivery models
- While annual provincial screening rates have risen modestly in the last seven years (from 35% to 42%), three-year screening rates indicate significant knowledge translation and changes in preventive screening behaviour:
 - In the period 2001 to 2003 (pre-program), 58% of women had had a Pap in the last three years
 - In the period 2003 to 2005, the three-year screening rate was 63%; in 2005 to 2007, the rate was 72%

CRITICAL FACTORS FOR ADAPTATION

- Templates or tools: GIS, community profile tool, and

screening by place of residence

- Educational resources that can be used and adapted for different groups and learning needs (e.g., an interactive learning display in a grocery store, static display in a library or informational ad in a church bulletin)
- Adequate personnel (e.g., for an eligible population of 250,000 women, CSIP has five full-time nurses and administrative staff)
- Funding to support site-specific planning

CHALLENGES

- Developing the content section in preparation for site-specific planning (i.e., multiple data sources, environmental scans and consultation to determine partners)

LESSONS LEARNED

- Build on successes; do what works and adapt practices to environmental factors specific to the identified at-risk populations
- Don't expect what works in one scenario to work in another and don't think that any one approach alone will work
- Pre- and post-intervention screening rates are good short-term outcome measures; if the whole eligible population is considered, however, rates level out; one-in-three-year rates are a better indicator of an intervention's success

ADAPTATION FROM OTHER PROGRAMS

None

program links

westernhealth.nl.ca/index.php/programs-and-services/services-a-z/provincial-cervical-screening-initiatives-program

program contact

Lori Harnett
Provincial Women's Health Educator
Cervical Screening Initiatives Program
58 Oregon Dr., Second Floor
Stephenville, NL A2N 2Y1
Phone: (709) 643-8719
E-mail: loriharnett@westernhealth.nl.ca



TARGET AUDIENCE: Geographically isolated women, older women, low-income women, Aboriginal women and women who self-identify as lesbian

Program focus: Breast, cervical and colorectal cancer

Challenges/risks faced by target population: Women in Newfoundland and Labrador have the highest rate of cervical cancer in Canada; only approximately 40% of eligible women, however, are screened in Labrador West. Family physician recruitment is a challenge in this geographically isolated community, and more female primary providers are needed to meet the needs of women.

Setting: Hospital clinic in Labrador City, an isolated urban mining community (population 12,000)

Province: Newfoundland and Labrador

Theoretical background: Health promotion

Program status: Early 1990s to present

Funder: Labrador-Grenfell Health Authority

BRIEF OVERVIEW

- In the early 1990s, a Well Women's Clinic (WWC) was established at the local hospital to provide women with access to female Pap test providers, and later, breast screening. Eventually, the WWC's scope broadened to holistic health services and comprehensive health promotion strategies, including colorectal screening, chronic disease management, and lifestyle and nutritional counselling.
- Results to date indicate that women like the "one-stop shopping" approach to meet their health needs, being able to talk to a female healthcare provider, and not being rushed.

PROGRAM GOALS AND OBJECTIVES

- To provide access to preventative health services in the community
- To increase knowledge and awareness about screening and preventative health and to increase cancer screening rates

PROGRAM IMPLEMENTATION STEPS

- In the early 1990s, the WWC was established at the local hospital to provide cervical screening by a female provider; breast cancer screening was added a few years later based on population needs
- In 2005, a half-time primary healthcare nurse practitioner (PHCNP) and a licensed practical nurse were hired
- Services were expanded to comprehensive, holistic healthcare — including cancer screening services and referrals — as a support and augmentation to family physicians

- The PHCNP provides cancer screening, chronic disease management, physical examinations, lifestyle and nutritional counselling, and referrals for colorectal screening, mammography and other diagnostic services
- The clinic also conducts three to four educational presentations annually to local women in church groups, sports groups, etc.
- Educational presentations are advertised through bulletin boards, relationships with pharmacists and other local professionals and businesses (e.g., Curves), and via e-mail messages through more than 30 groups including the local women's centre, chamber of commerce, a community advisory panel made up of intersectoral representatives from the mining industry, a family resource centre, primary and secondary schools, hospital, local wellness committee, etc.
- Educational presentations are guided by cervical screening guidelines and supported by the provincial Cervical Screening Initiatives Program (CSIP), responsible for raising awareness. The CSIP provides promotional materials such as pamphlets, games, lip balms and pens
- CSIP also funds healthcare providers to offer extended hours to do more Pap tests and supports practices to raise cervical screening numbers (e.g., by offering transportation, free childcare and food vouchers to women in low-income areas who attend screening)
- The PHCNP also conducts general wellness sessions targeted to relevant age groups across the lifespan
- The PHCNP works in close partnership with Labrador Status of Women (Women's Centre), which works with

survivors of violence, thereby building rapport and trust with clients and engaging them in discussion of screening; this work often leads to referrals

PROGRAM REACH

- Approximately 1000 women visit the WWC annually and 200 people are on the wait list; hundreds of women attend WWC educational sessions and events each year

EVALUATION

Method

- Client satisfaction surveys
- Analysis of annual provincial screening rates
- Provincial CSIP gives out awards and hosts a recognition dinner for Pap test providers who perform more than 250 tests per year

Key findings

- Client surveys are uniformly positive
- In particular, women like the one-stop shopping approach, being able to talk to a healthcare provider and not feeling rushed
- The WWC PHCNP has been recognized annually by the provincial CSIP for performing more than 200 Pap tests a year (in the last 3 years, >500 tests performed annually)

CRITICAL FACTORS FOR ADAPTATION

- Partner with other women-oriented programs and services to reach a larger audience; for example, the WWC partners with a local Curves franchise (next door to the clinic) to offer education programs; the franchise advertises programs, refers women to the clinic and offers gift certificates and T-shirts to women who attend the Women's Clinic and its programs
- Remember to include professionals, such as pharmacists, who see high numbers of patients daily; pharmacists also refer women in need of screening to the WWC
- Be holistic; women like "one-stop shopping" to meet their health needs
- Conduct screening assessments with every visit regardless of the presenting health concern (e.g., a woman may come in with a sore throat and, if warranted, also be provided with an FOBT kit)
- Use e-mail lists, listservs and cooperating organizations' e-mail lists for outreach
- Ensure that the clinic is comfortable and inviting for women

CHALLENGES

- Collaborating with some fee-for-service family physicians who sometimes feel the WWC is competing with them for patients
- Monitoring local recall lists and screening rates is often challenging with existing financial and human resources
- Shortage of available personnel (e.g., LPNs) and competing organizational demands
- Securing funding for clerical support

LESSONS LEARNED

- Women need to be invited and encouraged by another woman to attend the clinic; word of mouth and education sessions are also effective
- Women need to develop a relationship with their healthcare provider to feel comfortable discussing sensitive health issues, such as incontinence, loss of libido and menopause
- Clarify to clients and medical community that WWC services augment and support, but do not replace, family physicians
- Women like to address a comprehensive range of healthcare issues in one visit
- Women prefer to talk to a healthcare provider without feeling rushed
- Educational presentations and wellness events are a great use of limited resources: if 30 women attend and two learn about and subsequently attend screening, the return on investment is astronomical

ADAPTATION FROM OTHER PROGRAMS

None

program links

None currently available

program contact

Karen Oldford, RN PHC NP
Labrador-Grenfell Health
Captain Wm. Jackman Memorial
Hospital
410 Booth Ave.
Labrador City, NL A2V 2K1
Phone: (709) 944-9227
E-mail: karen.oldford@lghealth.ca



Working Toward Best Practices



This compendium demonstrates that, when barriers are addressed, seldom or never screened women are responsive to programs aimed at increasing cancer awareness and screening participation. It also demonstrates that, to be successful, programs must be tailored to the needs and perspectives of the women they aim to reach and offered in the context of the local setting.

This compendium also showcases the learning that takes place — for program providers, their target audiences, and, more widely, for agencies with a mandate to serve underscreened populations — as programs are organized and offered in local environments, and adapted and tailored to specific communities. Turning promising practices into best practices requires ongoing funding, research, support, collaboration and rigorous evaluation. This represents a major concern for the field.

A great deal of the commentary captured in the practice descriptions aligns with theoretical concepts and established knowledge translation literature and practice. Further, many of the practices build on the success of previous research and/or were adapted from existing programs. The project team believes this demonstrates the potential for this pan-Canadian resource to be the basis for future endeavours in research, program evaluation, and program development and implementation.

The following points — based on the collective learnings inherent in the literature review and environmental scan — represent some overarching ideas and messages from the practice descriptions. They may serve as a useful starting point or checklist for planning and implementing programs and initiatives to engage targeted populations.

RELATIONSHIP BUILDING AND COMMUNITY ENGAGEMENT

- Understand that it takes time to build trust with and engage a community. Program coordinators consistently cite lack of sufficient time to build relationships as a top challenge.
 - ♦ When writing funding proposals and program plans, factor in the time and human and financial resources necessary to build trust and meaningfully engage your target population.
 - ♦ Work to build knowledge of and establish trusting and meaningful relationships with your target population early in the process:
 - Gain support from credible members from the community to act as “champions” or “links” (e.g., community health representatives, community and religious leaders)
 - Ensure representation from the target populations on advisory and steering committees, focus groups and other participatory approaches.
 - Incorporate participatory approaches throughout program planning, implementation and evaluation.
 - Understand your community’s values, attitudes and perceptions, as well as any perceived barriers to screening.
 - Conduct pilot tests, focus groups and needs assessments *before* program development.
- Consult and engage key partners and stakeholders, including primary healthcare providers, policymakers, members of the target population and relevant community agencies.

COMMUNICATIONS

- At the outset, develop plans and channels for ongoing, open and effective lines of communication among program staff, key partners and stakeholders.
- Share success stories as often as possible and establish/consult an ongoing forum for the exchange of best and promising practices in cancer prevention and screening.
- Tailor messages, tools and materials (for recruitment, education, etc.) to your target audience:
 - ♦ Use photographs and images that represent your target population.
 - ♦ Use media that best reach your target population (e.g., local or ethnic radio stations and newspapers).
 - ♦ Use plain language.
 - ♦ Where necessary and possible, translate messages and materials, and deliver workshops and presentations in the language(s) of the target population.
 - ♦ Ensure that basic health knowledge and literacy levels are appropriate.
 - ♦ Design tools and materials that are adaptable and ready to use.
 - ♦ Use images and formats such as DVDs, videos, photovoice and *fotonovela* to reach women of low literacy, women whose first language is not English, women with developmental disabilities, women from oral-based cultures, etc.
- Advertise your program periodically as a reminder to your target audiences.
- Consider framing messages and programs positively, (i.e., “well woman” programs and visits, “breast health” or “healthy lifestyle” programs instead of “cancer prevention” programs).

ACCESSIBILITY, SELF-EFFICACY, SELF-ADVOCACY AND EMPOWERMENT

- Tailor the program to the population; be flexible and willing to adapt your program in response to participants’ needs.
 - ♦ Consider your target community when scheduling program dates and mobile unit visits (e.g., weather/road conditions, religious holidays and seasonal hunting and food gathering activities).
 - ♦ Keep in mind that some groups may not see cancer screening as a priority, (e.g., diabetes is a priority for Aboriginal women; employment and/or financial security may be a more pressing determinant of health for newcomers to Canada).
- Consider adopting an integrated cancer prevention and screening program design, or an integrated model of primary health and screening services:
 - ♦ Target two or more cancer sites (breast, cervical and/or colorectal).
 - ♦ Offer cancer screening — and target messaging — as part of a “one stop,” integrated, team-based approach.
 - ♦ Provide cancer screening as part of a holistic wellness program based on chronic disease prevention, education and management (e.g., blood pressure, heart rate, diabetes, and cancer screening according to clinically relevant age groups).
- Develop programs that aim to help women improve, and increase control over, their own health by:
 - ♦ Enhancing their ability to be full participants in making informed decisions about their own healthcare by providing them with access to accurate and up-to-date information about cancer and cancer screening — including when and how to get screened
 - ♦ Identifying and addressing perceptions regarding susceptibility, seriousness, benefits, barriers and self-efficacy related to breast, cervical and/or colorectal cancer and screening

- ♦ Supporting and encouraging women to talk to their healthcare providers about cancer screening and, when necessary, to advocate for their health needs, and
- ♦ Enabling women to tell and share their own stories and gain social support.
- Make it as easy as possible for women to make an appointment and to get screened by:
 - ♦ Accommodating women’s needs (e.g., booking appointments; accompanying women to screening; providing transportation, language translation, childcare, etc.)
 - ♦ Providing a toll-free number or central booking service (ideally, to access all screening services)
 - ♦ Bringing services to women (i.e., through mobile programs), and
 - ♦ Providing services at convenient times (including evening and weekend hours).
- Recognize and program for differences between and within populations (e.g., do not assume that campaigns targeted to women who have sex with women will be effective in reaching trans men; women with physical disabilities may require different accommodations and practical and ethical considerations than women with developmental disabilities).

PROGRAM DESIGN

- Consult relevant literature, theories and programs for adaptation toward evidence-based practice.
- Consider using theoretical models (e.g., transtheoretical stages of change model, community development and health belief model) to determine outcome measures and to guide your program development, implementation and evaluation.
- Be clear about program goals and objectives and match the activities to the expected or desired goals.
- Consider a comprehensive range of strategies to reach the broadest audience (e.g., lay health educator programs; mobile health units; incentive campaigns; group screenings; toolkits and resources, including brochures, DVDs, newspaper and journal articles, etc.).
- Ensure that processes and approaches are sensitive to a range of barriers to screening, including physical, geographic, cultural, socioeconomic and systemic barriers.
- Go to where your target community congregates (e.g., community centres, places of worships, ESL classes, public housing and workplaces) to promote participant engagement and recruitment, and/or provide services.
- Include a comprehensive range of program components, such as awareness raising, education, assistance with booking screening appointments, on-site support and appropriate follow-up of abnormal results and clinical findings.
- Make programs fun and informal:
 - ♦ Social elements, such as refreshments, parties, group-screening bus trips that include shopping, and unconventional settings such as beauty salons and shopping malls can make interventions more inviting for women (e.g., in some Aboriginal communities, visiting, tea and socialization are a sign of respect and are critical to the consultation process and participation in the outreach program).
 - ♦ Giveaways and incentives such as coupons and keychains can help boost participation rates.
- Consider engaging nontraditional information providers (e.g., lay health educators, peer educators, mall vendors, beauty salon owners and stylists, pharmacists, actors) who can help promote awareness and screening uptake among your target population.
 - ♦ Men and younger women can serve as ambassadors for cancer screening for eligible female family members.

PROGRAM EVALUATION

- Account for evaluation in the early stages of program planning and clearly link evaluation with program goals and objectives.
- Whenever possible, consult professionals with expertise in evaluation design.
- Understand that it is difficult to evaluate screening rates and/or behaviour changes, particularly during limited funding terms.
- Allow extra time to conduct evaluation with women of low literacy and/or whose first language is not English.
- Create effective and efficient ways to track activities and outcomes.

ENGAGING HEALTHCARE PROVIDERS

- Many women who are seldom or never screened feel more comfortable with — or will only attend screening with — a female healthcare provider.
- Consider expanding the role of female nurse practitioners to include cancer education and screening.
- Whenever possible, acknowledge family physicians as key influencers and engage them throughout the process to garner support and buy-in.
- Educate healthcare providers about the importance of cancer screening for all eligible populations.
 - ◆ Some physicians do not include referrals to screening as part of their everyday practices.
 - ◆ Some seldom or never screened populations are not being referred for screening at the same rates as the general population (e.g., disabled women, women having sex with women, and trans men)
- Support and encourage doctors to talk to their patients about cancer screening.
 - ◆ Equip healthcare providers with up-to-date information, as well as tools and resources to promote, inform and facilitate discussions about screening (e.g., provincial screening guidelines, a listing of accessible screening centres, tool kits, videos and reading materials for waiting rooms, etc.).
 - ◆ Encourage healthcare providers to find ways to provide their female patients with enough time to discuss their health-related needs without feeling rushed.

DATA AND TECHNOLOGY

- Ensure access to information sources, such as databases and contact lists, are complete, reliable, accurate and up to date.
- Have adequate and efficient data systems in place (e.g., consider the potential of electronic medical records and GIS technology to survey activities and to identify seldom or never screened women, and for site-specific planning).

HUMAN RESOURCES

- Recruit staff from diverse backgrounds reflective of the target population(s).
- When necessary and possible, hire full-time program staff and provide training and support (e.g., cultural competency training).
- It can be difficult to find and hire lay health educators or peer educators with skills and experience to deliver programs; compensate lay health educators for their time, experience and expertise, and provide them with ongoing support and information.



ROLE OF FUNDERS AND SUSTAINABILITY PLANNING

- Governmental and non-governmental funding (monetary and in-kind) are available to support programs aimed at engaging seldom or never screened women in cancer screening (e.g., national non-profit organizations, cancer boards, corporate donors/sponsors).
 - ◆ Recognize that a lack of adequate funding (e.g., to hire dedicated staff) and difficulty working within funders' timelines are among the top challenges reported by programs.
 - ◆ It is important for funders to consider providing multi-year funding to allow time to build longer-term, trusting and meaningful relationships; conduct more rigorous evaluation; better integrate practices in core community and health services; and strengthen agencies' abilities to plan for the long term.
- Keep sustainability in mind from the beginning: funding and resources are essential but must be complemented by cultivating trust with the community, building effective partnerships and ongoing support from policymakers.



Conclusion



This compendium highlights the trends apparent in the research — and showcases an impressive array of customized, community-based Canadian promising practices to engage seldom or never screened women in cancer screening. The practices span diverse agencies, provinces and territories, and urban versus rural settings, and include and respond to the needs of their target population(s). While the Pan-Canadian Best and Promising Practices to Engage Seldom or Never Screened Women in Cancer Screening project may not have reached everyone who could have provided valuable input, this resource is rich in Canadian wisdom and experience — and relevant to and translatable across this country's landscape. Together, the programs discussed in this compendium provide the information and guidance required to support evidence-based decision-making and to develop best practices to engage women who are seldom or never screened.

This compendium — including 61 promising practices and literature review findings — demonstrates that Canadian (and international) agencies, researchers and funders are concerned about closing the gap in health equity for a broad range of underserved and often marginalized populations. Program providers are eager to share and learn about their own and others' successes, harness and adapt practices, and expand and strengthen their networks. Opportunities for collaboration are encouraging and exciting.

Seldom or never screened populations are at increased risk of unfavourable outcomes if diagnosed for breast, cervical and colorectal cancer. By addressing equity issues in cancer screening, we can greatly enhance women's ability to be full participants in making informed decisions about their own healthcare — and to improve, and increase control over, their own health. It is hoped that this compendium will serve as a springboard for continued, long-term investment in and discussion about effective, best and promising practices to engage seldom or never screened populations in cancer screening across the country — and that it will lead to better health for all Canadian women.



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PROMISING PRACTICES

By cancer site:

Breast cancer	26, 30, 34, 36, 38, 40, 42, 44, 46, 48, 50, 52, 54, 58, 60, 62, 64, 66, 68, 74, 78, 80, 82, 84, 86, 90, 92, 94, 96, 98, 100, 102, 106, 108, 110, 112, 114, 116, 118, 122, 124, 126, 128, 130, 132, 134, 136, 138, 142, 146, 148, 152
Cervical cancer	28, 32, 42, 50, 52, 68, 70, 72, 76, 78, 80, 82, 84, 86, 92, 94, 102, 112, 114, 116, 124, 128, 130, 134, 136, 138, 140, 144, 146, 148, 150, 152
Colorectal cancer	42, 52, 68, 78, 80, 84, 86, 94, 102, 104, 114, 116, 130, 134, 138, 140, 146, 148, 152
Breast and cervical cancer	50, 82, 92, 112 (and ovarian), 124, 128, 136
Breast, cervical and colorectal cancer	42, 52, 68, 78, 80, 84, 86, 94, 102, 114, 116, 130, 134 (and prostate), 138, 146, 148, 152
Cervical and colorectal cancer	140
All cancers, including breast, cervical and colorectal cancer	42, 78

By target population:

Aboriginal women	26, 28, 30, 34, 38, 40, 42, 46, 48, 52, 58, 68, 76, 94, 102, 104, 110, 132, 142, 146, 150, 152
Disabled women	36, 78, 80, 82, 84, 102
Low-income women	32, 40, 46, 48, 62, 66, 68, 76, 92, 96, 98, 102, 118, 124, 136, 150, 152
Newcomers to Canada and immigrant women	30, 36, 46, 50, 52, 64, 66, 68, 76, 90, 92, 94, 96, 98, 100, 106, 108, 112, 116, 118, 122, 124, 126, 128, 130, 142, 146
Older women	38, 48, 68, 92, 102, 106, 118, 152
Rural and geographically isolated women	28, 30, 38, 40, 48, 54, 64, 76, 102, 110, 132, 134, 136, 140, 142, 144, 146, 148, 150, 152
Trans men	70
Women of low literacy or whose first language is not English	32, 36, 46, 48, 52, 66, 68, 76, 90, 92, 94, 96, 98, 100, 106, 112, 116, 118, 122, 124, 126, 128, 130, 150

Women who self-identify as lesbian, bisexual, queer, questioning or two-spirit

62, 72, 108, 152

Other populations:

All eligible women

60, 62, 66, 136, 142

At-risk populations

46, 150

Breast cancer survivors

38, 40, 42, 90, 106, 110, 118

**Community/
frontline workers,
community health
facilitators/workers**

52, 58, 98, 116

Disadvantaged women

74

**District health authority
administrators**

144

General public

52, 68, 134

Hard-to-reach women

(including women living in abusive situations and survivors of violence; sex trade workers; women living in poverty; women with mental illness and addiction; women with no fixed address, or who are homeless or marginally housed; women without transportation)

32, 60, 62, 66, 76, 102, 130, 142, 146, 152

Health promoters

114, 116

Healthcare providers

34, 38 (and health organizations and agencies), 64, 70, 72, 78, 80, 86, 104, 114, 116, 148

Low education

46, 62, 136

**Never screened or
unscreened women**

54, 76, 110, 138, 146

**Seldom or underscreened
women**

44, 46, 62, 68, 76, 96, 98, 110, 136, 138, 146, 150

Underserved women

60, 66, 90, 102, 146, 150

Younger women

38

