Introduction
This report is to share the project experiences and lessons learned from the Scarborough Breast Health Community Action Project. This project was offered by St. Paul’s L’Amoreaux Centre (St. Paul’s) in partnership with Agincourt Community Services Association, Immigrant Women’s Health Centre, Quantum Medical Imaging Services, Inc., Toronto Public Health, and West Hill Community Services from October 2007 to March 2010. The Canadian Breast Cancer Foundation – Ontario Chapter (CBCF), provided the financial support for the implementation, evaluation, and knowledge sharing of the project.

Project Goal
The goal of the Scarborough Breast Health Community Action Project was to increase participation in breast cancer prevention and screening among immigrant and low income women over the age of 40 from the Chinese, English, Somali, Tamil and Urdu-speaking communities in Scarborough.

To achieve the project goal, a detailed work plan was developed based on former project experiences, community needs, breast health promotion best practices, and approval of the CBCF.

Project Team
The team was composed of one project lead person, seven advisory committee members, one full time project coordinator, ten part-time contract peer leaders, and ten volunteers. The advisory committee, with expertise and experience in breast health and community outreach, provided training, guidance, and linkages with other community organizations. They also contributed to the development, monitoring, and evaluation of the project.

Peer leaders were hired and trained to deliver culturally sensitive and language specific breast cancer screening promotion, education, and support.

Project Activities:

Training
The project kicked off with a media launch after the project team was formed. The Toronto Public Health nurse played an additional role by providing important training on breast health within the team. In addition to the Toronto Public Health training, the team received a series of trainings to ensure a competent, professional team:

- Basic facts on breast cancer
- Benefits of early detection
- Ontario breast screening guidelines
- Ontario Breast Screening Program (OBSP)
- Health promotion communication
- Evaluating health promotion
- Clear language and design
- Client & staff safety – privacy & confidentiality, infection control, and handling emergency situations

Project key messages were developed with the input of the team and translated in the languages served. Through project pamphlets, workshop sessions, interactive displays, media, and peer leaders’ contacts, the following important and consistent messages were disseminated among the target communities:

- When breast cancer is found and treated early, there is a good chance for it to be cured
- The chance of getting breast cancer increases with age, especially after the age 50
- Women over 40 years old should have a yearly clinical breast examination (CBE) by a health professional
- Women 50 years old and over should have a mammogram (breast x-ray) every two years
- A mammogram can detect small cancers before they can be felt
- Women over forty years old can get free support from this project such as, booking appointments at Ontario Breast Screening Program (eligible women), getting TTC tokens, and interpretation on-site.

Workshops and interactive displays were conducted in a culturally sensitive and language specific manner in easy to access locations in Scarborough. Peer leaders led discussions about breast cancer statistics, risk factors, breast screening techniques, benefits of early detection, the Ontario Breast Screening Program (OBSP), and regular screening according to Ontario Breast Screening Guidelines.
Tools included presentation charts, pictures, models of lump sizes, a wheel game and quiz were used to increase the incentive for learning. Participants who answered a question correctly at the end of the workshop session or one on one conversations received a key chain. The key chain is composed of different sizes of beads which represent different sizes of breast lumps.

Participants who needed support to attend the OBSP were invited to sign up for appointment bookings.
Informal outreach was also conducted by peer leaders to groups that did not have enough time for a formal workshop but could accommodate a 15 – 20 minute brief session about the program.

Breast screening support was offered to women who signed up for a mammogram. With the signed consent of the participants, peer leaders collected all the information as required by OBSP to book the appointment. Appointments were booked based on clients’ choice of location and a convenient time. The client would then be informed of the location, date, and time for the mammogram. Depending on the client’s request, services, such as interpretation or group escort, and TTC tickets were provided. Clinical breast examinations (CBE) with Immigrant Women’s Health Centre Mobile Health Clinic were conducted especially for women under 50 years of age.

Evaluation
The evaluation tools were developed right at the start of the project in the main languages served. Both qualitative and quantitative data were collected through formal and informal methods from project participants, staff, volunteers and the involved social and health service providers. A variety of data collection tools were developed to identify evidence on the program activities’ results and impacts. Other evaluation methods for example surveys, direct observation and review of project documents, records and statistics were also used.

Workshop participants were invited to:
• complete a feedback form at the end of the session
• answer a telephone survey four months after workshop
• answer a telephone survey two months after the OBSP appointment

Data analysis
Quantitative and qualitative data collected from workshops was translated and then entered online into Survey Monkey, an online survey tool. Data was sorted and filtered for in-depth data analysis purposes. Some of the statistical results were generated from Survey Monkey. Numerical data gathered was encoded, categorized, tabulated and described according to percentage.

Limitations
The data collected relies on the self-report and voluntary participation of workshops and OBSP participants. For a number of reasons, not all participants completed the workshop feedback forms or responded to the follow-up telephone survey four months after the workshops – for example, responses include lack of time, uninterested, low literacy level / illiteracy, or poor memory. About 60% of workshop participants completed the feedback forms. Approximately 65% responded to the phone follow-up survey conducted.

Project Results

Exhibit 1

<table>
<thead>
<tr>
<th>Language Group</th>
<th>Cantonese</th>
<th>Mandarin</th>
<th>Somali</th>
<th>Tamil</th>
<th>Urdu</th>
<th>Total</th>
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<tr>
<td>English / ESL</td>
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<td>500</td>
<td>134</td>
<td>23</td>
<td>200</td>
<td>92</td>
</tr>
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<td>1000</td>
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<td>108</td>
<td>745</td>
<td>122</td>
</tr>
<tr>
<td>Total</td>
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<td>1500</td>
<td>1134</td>
<td>131</td>
<td>945</td>
<td>214</td>
</tr>
<tr>
<td></td>
<td>33%</td>
<td>26%</td>
<td>19%</td>
<td>2%</td>
<td>16%</td>
<td>4%</td>
</tr>
</tbody>
</table>

The project has outreached to nearly 6,000 participants through 96 workshops and 58 interactive displays in over 100 easy to access locations in Scarborough (see Exhibit 1, 2).

The majority participants was non-native English speaking (over 67%).

45% of the participants were from the Chinese speaking community.

Outreach was lowest in the Somali speaking community owing to disparate location of residences and challenges in hiring competent and dedicated peer leaders.
Exhibit 2

The project received 883 completed workshop surveys (50%) from the 1,760 workshop participants. 70% of the respondents self-reported over 40 years of age (see Exhibit 3). Most of the participants under 40 years of age were ESL students among the community groups of the project served.

Exhibit 3

Workshop Response % by Age Group

- Under 40: 28%
- 40 - 49: 14%
- 50 - 59: 16%
- 60 - 69: 18%
- 70 and older: 22%
- N/A: 1%

Exhibit 4

Self-Reported Breast Screening Practices

- Need Assistance: 19% / 44%
- Mammogram: 27% / 75%
- CBE: 38% / 78%
- BSE: 34% / 66%

65% (1,130 out of 1,760 who attended workshops from Apr 2008 – Nov 2009) were reached for a post-workshop phone survey.

Some respondents who did not attend breast screening (19% - 44%) indicated the 'need assistance' to attend OBSP (see Exhibit 4).

The workshop response also showed that at least 27% of the respondents had regular breast screenings (BSE, CBE, and mammogram) before the workshop session.

Much higher breast screening participation was reported at the four months post workshop phone survey (BSE - 66%, CBE – 78%, mammogram - 75%). It therefore showed that workshops are effective in convincing women of the value of having regular breast screenings.

Likewise, fewer women relied on breast self-examinations (BSE) as compared to the other screening methods showing the fact that women trusted the other two methods more which could have been imparted to them during the workshop.
Respondents in both surveys reported learning a lot from the workshop - 71% of the workshop survey response, 90% of the 4 months post workshop phone survey response. The new learning described by respondents was categorized as risk factors, breast screening, OBSP services, importance of mammograms, CBE, breast cancer, and BSE (see Exhibit 5). Apparently, the key project messages learned during the workshop seemed to be retained very well. Knowledge on risk factors undoubtedly prompted women to go for breast screening which has a very positive impact on women’s attitude in taking charge of their health.

Four months after the workshop, phone survey respondents (156) described their reasons for not having regular breast screening:

- **BSE is inaccurate.** This is actually more on a positive note because it means women rely more on other screening methods i.e. CBE and mammograms.
- **CBE is uncomfortable.** This would need further clarification as to what exactly makes the process uncomfortable. Has it got to do with cultural issues, physical discomfort, doctor performing the exam or just a matter of not getting used to it?
- **CBEs and mammograms are unnecessary.** This is the main reason for women refusing CBE and mammogram screening, even after attending the workshop. Such reasoning could also be the other reasons mentioned by other respondents like: their own family physician did not recommend it, they are too old to get cancer, or they believe in fate, etc.
- **I will have it later /Pain /Too old/ Radiation.** Follow-up or additional workshop for these participants might help them to make better screening decisions.
About 300 project participants attended the OBSP with project support. 28% of the participants were first timers to mammograms and 62% were first timers to the OBSP (see Exhibit 7).

192 participants were reached for the phone survey after they attended the OBSP with project support (68%). Most of the respondents shared positive experiences about their OBSP appointment: 45% felt comfortable with the female staff; 45% appreciated the project support - appointment booking, TTC tokens, interpretation services; and 22% - not as painful as expected (see Exhibit 8). What is very significant among the experiences mentioned by the respondents was their motivation to encourage their female friends to go for mammograms under OBSP. Ninety percent of women claimed that they will return for mammogram screening under OBSP every two years.

Obviously, displays appear to be a very effective way to recruit women for mammogram screening as evidenced by 40% of the participants who attended a mammogram came from displays (see Exhibit 9). The displays create a chance to reach people who are not connected formally to the social or health services. Also, there was more one on one contact when a woman approached the peer leader. The peer leader could explain at length about breast health individually.
Addressing Challenges
The project has proven to be quite an educational experience for the team. Training sessions and regular team meetings enabled the team to come up with strategies to overcome barriers and gain support and confidence in breast health promotion.

Workshops
- Rebutting myths and misconceptions
  - Peer leaders were able to clarify that breast compression does not cause cancer, neither does the small dose of radiation used for mammograms.
  - Some women 70 and over considered themselves immune to the disease until they were told that higher age was a risk factor. This was a jolt since even their family doctor had not suggested that they go for a mammogram.
  - Women who had heard that mammograms were very painful had to be made to consider which was worse - momentary pain or life-long misery.
- Overcoming cultural barriers
  - In some cultures, women felt too embarrassed to talk about breast health. To make women more comfortable in a group discussion, the peer leaders would switch to using “chest” in place of “breast” and “women’s health” to “breast health.”
  - Derived from religious or cultural practices, some women entrusted everything in God’s hands and negated the responsibility of taking care of their own health. Peer leaders would convince women that it is part of the divine plan that people help and support each other and that’s why there are doctors, nurses, pharmacists and skilled workers.
- Facilitating group workshops
  - The difficulty arose in workshops conducted in LINC or ESL classes when there were women whose English level was extremely low. Pictures and models were more than helpful in bringing home the message. Gaining the support of the ESL program coordinator was extremely helpful.
  - Not all groups of women agreed to the presence of men in the workshops. Peer leaders couldn’t include men in their groups if there was even one dissenting voice. Men’s participation in workshops would be an asset to the promotion of the project’s objectives since they would be sure to encourage the females of their family to go for a mammogram. On the other hand, men’s presence would somehow curtail the openness of some women in discussing breast health.
  - Some organizations have not been able to set aside a sufficient amount of time for the workshops. Presentations had to be condensed so that the most important messages were prioritized.

- Some centres, for reasons of confidentiality, wouldn’t allow their clients to give out their names and other particulars. The centre would only provide an aggregate workshop attendance.
- Some workshop sites were not conducive for learning. The noise level was quite disruptive in some places. Some participants were obviously not interested and talked to their neighbours. The peer leader could only pause and politely ask for the participants’ attention.
- The greatest challenge was reaching out to the Somali community. It was difficult to have someone from the community committed to the project as a few active community members moved out of the Scarborough during the project period. Linking with the service providers was not very successful. Some declined because they are still in the process of organizing a structured group while some claimed that they too have difficulty in connecting with the community.

Mammograms
- Some participants would not take a step in any direction without consulting their family first. It is important that they first know which one of their relatives would be able to take them to the OBSP site and before committing to a time, the relative’s agenda had to be considered.
- Some participants could not give the needed information to the OBSP, such as postal code and OHIP number. Some did not understand directions, like going to the screening sites. Peer leaders called a member of the participant’s family to the phone to take or give the required information.
- In response to women’s preference to have CBE performed by a female health care professional, OBSP appointments were arranged at the only one OBSP site in Scarborough that offers CBEs.
Testimonials

Ya Xiu Lei:
"I did not really know anything about mammograms until I attended the workshop."
"I'll look more into information on breast health."
"I've shared and discussed the information with family and friends."

Oluyinka Sekoni:
"In Nigeria, the media told us women to check our breasts for lumps which I found very cumbersome."
"The most useful information was the discovery of the place to go for a mammogram ...... a free, hassle-free OBSP mammogram."
"I feel faith in the OBSP because the government monitors it."
"They prepared me for the mammogram saying that I would feel some pain, not much. They also said the pain would be only a few seconds and would not be everlasting. They convinced me so that I would not be afraid."

Lee Pui Kwan:
"I will pass on what I learned and encourage my friends and family to have regular examinations and do breast self examinations as well."
"By getting my booking done, you saved me time."
"Escorting to the mammogram site made me feel safe [and] translation provided by the program during the mammogram was very useful."

Pei Zhen Shi:
"Mammograms are safe and important. They can detect lumps the size of a pinhead."
"I will tell others to go for a mammogram as early as possible."
"I'm going to perform more physical activity... and eat healthier-less red meat, more vegetables, such as carrots, pumpkins, and have more fruits."

Sulogini Sothynathan:
"I have told all my friends about the benefits of a mammogram and the assistance St. Paul's provides in this respect."
"I experienced great peace of mind after the mammogram."
"I have also spoken with the women in my seniors' group. I encouraged 4 women to go for breast screening"
Conclusion

The Scarborough Breast Health Community Action Project has successfully achieved its expected results. Outreach to under-screened immigrant and low-income women was well received by 1,760 workshop participants and 4,077 interactive displays participants. About 300 women were motivated to attend the OBSP with project support which removed information, language, social, cultural, and transportation barriers.

Peer leaders were able to transfer basic breast health knowledge learned from the training provided by Toronto Public Health nurse to their respective communities in a culturally sensitive and language specific manner. They were able to spread simple and clear breast health messages through verbal, written, and visual communication formats through workshops, interactive displays, and media.

Most of the OBSP project participants also reported their first screening experiences at the OBSP positively. Participants' were very satisfied with the OBSP appointment booking and on-site support provided by peer leaders.

However, more innovative strategies are needed to address the various concerns of the 25% of the eligible workshop participants who decided not to attend regular breast screenings.

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