

COMMUNITY HEALTH ADVISORS EFFECTIVELY PROMOTE CANCER SCREENING

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INTRODUCTION

As the second leading cause of death in the United States, cancer, and the suffering and death it causes, continues to be a national health priority.¹ This is especially true for racial/ethnic minorities; compared to non-Hispanic Whites, minorities have lower 5-year survival rates.² Reducing and eliminating this unequal cancer burden will require multiple approaches, including the establishment of partnerships with minority communities.

One way to establish partnerships in the community is through developing relationships with Community Health Advisors (CHAs). As trusted natural helpers, CHAs provide emotional support, advice, and tangible aid to members of their social network. Their understanding of community culture (eg, behaviors, beliefs systems, and attitudes) allows CHAs to provide culturally appropriate, informal, and spontaneous assistance to community members, often reaching individuals considered underserved or "hard to reach." Various descriptors, including community health advisors, lay health advisors, community health workers, indigenous volunteers, and community health advocates, are terms used interchangeably to describe these natural helpers. This paper will provide further definition on CHA roles, highlight examples of successful CHA interventions to promote cancer screening, and conclude with considerations for future programs.

COMMUNITY HEALTH ADVISORS DEFINED

There are many models that define CHAs. The World Health Organization (WHO) defines community health workers (CHWs) as individuals who re-

side in the community they serve, are chosen by the community, and are accountable to the community. While WHO recognizes that CHWs might be trained, training is viewed as brief and focused. According to this definition, CHAs are not necessarily associated with a formal institution.³ In the work by Rosenthal,⁴ seven core roles for CHWs were identified: 1) individual and community capacity building; 2) counseling and social support; 3) direct services; 4) culturally appropriate health education; 5) ensuring delivery of services to individuals; 6) cultural mediation; and 7) advocacy on behalf of themselves and their communities. As reflected in these descriptions, CHAs can play an essential role in community health and empowerment.

COMMUNITY HEALTH ADVISORS: CANCER SCREENING PROGRAMS

One strategy to reduce the burden of cancer in minority populations is to increase participation in regular cancer screenings. Approximately half of all new cancer cases in the United States are among cancers that could be detected early through screening. Early detection of cancer improves overall survival rates for patients.¹ The efficacy of CHA interventions to increase cancer screening has been demonstrated across many racial/ethnic minority groups. The majority of these interventions have focused on breast and cervical cancer screening.

In a study among North American Chinese women who are considered to under-utilize Pap tests,⁵ women were randomized to one of three groups: 1) outreach worker intervention; 2) direct mail; or 3) usual care. In the outreach worker intervention, during a home vis-

Cancer is the second leading cause of death in the United States. Across many cancers, racial and ethnic minorities bear an unequal burden of disease (eg, lower 5-year survival rates). Concerted efforts to reach minority communities and address these disparities are needed. Community Health Advisors (CHAs) are trusted natural helpers from within the community who provide emotional support, advice, and tangible aid to members of their social network. Their understanding of community culture allows them to provide culturally appropriate, informal, and spontaneous assistance to community members. Using various approaches and across a number of racial/ethnic groups, CHA interventions have demonstrated success in increasing cancer screening. This paper highlights some of those intervention programs and concludes with considerations for future projects. (*Ethn Dis.* 2005; 15[suppl 2]:S2-14–S2-16)

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it, outreach workers provided tailored counseling to overcoming barriers, used visual aids to describe pap testing (eg, a speculum and pap testing kit), and provided educational materials (eg, a video about cervical cancer done in a culturally appropriate, soap-opera format; a motivational pamphlet; and an informational brochure). Women in this group also received a follow-up phone call. Women in the direct mail intervention had no contact with an outreach worker, but did receive the educational materials in the mail. The intervention was effective, 39% of the women in the outreach worker intervention, 25% in direct mail group, and 15% in usual care had a pap test within the 6 month follow-up. The outreach intervention was significantly more effective than direct mail and usual care.

Among Latinas, the *Por La Vida* model was successful in increasing the use of cancer screening tests.⁶ In this program, groups of women were randomized to a 12-week CHA-led cancer screening, accessing care, and nutrition course or were assigned to a comparison condition that highlighted community living skills. Although the study did not increase pap testing, the intervention increased breast self examination and mammography use.

Two studies conducted among Vietnamese Americans also found increased rates of cancer screening after interventions. In the study by Bird et al,⁷ the primary intervention utilized indigenous lay health workers who held neighborhood meetings that addressed breast and cervical cancer prevention. In addition, culturally appropriate materials promoting screening were distributed at the neighborhood meetings, and were distributed in the community including placement at Vietnamese physician offices, health fairs, stores, and service agencies. Uniquely, the program included an incentive contest wherein women up-to-date with their cancer screenings were automatically eligible to win a prize and women not up-to-date with

screenings became eligible if they kept a screening appointment. The intervention also consisted of health fairs held in conjunction with Vietnamese holidays and health days conducted at places of worship. Compared to women in the control community, those in the intervention group were more likely to recognize cancer screening tests and more likely to receive both mammograms and pap tests. In a second program with Vietnamese women,⁸ a lay health worker intervention (ie, group sessions that highlighted how to access care and information on pap testing) combined with a media intervention (ie, print, radio, and television media) was more effective in increasing pap tests when compared to the media-only intervention.

Older African-American women are at particular risk for underutilization of cancer screening services. Recognizing this, Zhu and colleagues delivered an intervention to older, single, African-American women residing in public housing complexes.⁹ Complexes were randomized to a lay health educator intervention or control condition. During a home session, lay health educators (when at all possible from the same public housing complex) addressed cognitive barriers to breast cancer screening (eg, knowledge, attitudes, experiences), psychological barriers related to single status (eg, loneliness, depression), and social network barriers. Educators engaged women in role-play scenarios to practice skills necessary to overcoming barriers to screening. An innovative aspect of the intervention was its inclusion of a significant other, if present, in the intervention. Although this study did not find significant results between the intervention and control condition, the effect of the intervention was in favor of increased breast self-examination and breast cancer screening. Moreover, the effect was stronger for women who had a significant other participate in the intervention.

In another study with African-American women,¹⁰ lay health advisors

participated in a variety of intervention activities in rural communities. Lay health advisors promoted referrals for mammograms by training physician offices, health centers, and health departments to refer women for testing; made community presentations (eg, in beauty salons, churches); assisted women in overcoming barriers to screening (eg, providing transportation and negotiating lower fees for mammograms); conducted one-to-one information sessions using culturally sensitive materials; and participated in community events (eg, mobile mammography programs, health fairs). Compared to women in the comparison counties, women in the intervention counties self-reported an increase in mammography screening. Moreover, the greatest effect was among lower-income women.

In a racially diverse group of women comprised primarily of African-American, Southeast Asian, Native American, and non-Hispanic White women, women were assigned to either usual care or a lay health advisor intervention.¹¹ The intervention consisted of providing recommendations for cancer screening on behalf of physicians and providing women a convenient way to be screened by a nurse practitioner. Women in the usual-care group were not contacted again until follow-up. Women in the intervention group had higher screening rates for both mammograms (60% vs 50%) and pap smears (63% vs 50%) compared to women in usual care, with the greatest effect observed for women who were not up-to-date with their screenings.

These studies underscore the effectiveness and robustness of CHA-based interventions to promote cancer screening. As reviewed, a variety of approaches are effective in increasing screening across a variety of racial/ethnic groups. The effectiveness of CHAs in promoting cancer screening suggests that cancer prevention and control efforts should include a component that is community-based and in partnership with community health advisors.

CONSIDERATIONS AND FUTURE DIRECTIONS

The demonstrated effectiveness of CHA interventions to increase cancer screening suggests that CHAs may also be effective in other cancer prevention and control initiatives. The American Cancer Society estimated that one-third of the expected cancer deaths in 2004 would be related to lifestyle factors such as obesity, diet, and physical inactivity. Other behaviors that can reduce risk of developing cancer include decreasing sun exposure, avoiding heavy alcohol use and smoking initiation, and modifying sexual behavior to reduce the risk of acquiring viruses associated with cancer. Whether CHAs can make a significant impact in addressing these behaviors in the context of cancer prevention is relatively unexplored.

Beyond encouraging and supporting behavior change among their peers, CHAs can contribute in other important ways. The National Cancer Institute's Deep South Network for Cancer Control (DSN) has already funded innovative projects utilizing the community health advisor model. In these projects, CHAs have: 1) modified the National Cancer Institute's 5-a-day message to be more effective for southern African Americans; 2) served as key informants to identify factors that influence cancer information seeking among African Americans; 3) developed skills to conduct quality Internet searches on colon cancer; 4) co-developed a CHA smoking cessation curriculum; 5) learned how to administer a tailored, computerized cervical cancer risk assessment tool to community members and; 6) trained resident physicians communication skills related to mammography screening in African-American women. These projects illustrate unique ways in which CHAs make important and novel contributions to cancer prevention and control.

In addition to expanding the roles of CHAs, the evaluation of CHA programs

represents both an opportunity and a challenge. Challenges include the ability to fully capture the informal, spontaneous interactions that take place between a CHA and a community member (eg, discussing mammograms with a friend in the grocery store). The nature of these encounters may make them difficult to recall and/or arduous to describe and document. An opportunity for evaluation lies in programs that seek to understand the mechanisms that make CHA programs effective. Rauscher and colleagues¹² examined whether exposure to an intervention, which could have included a discussion with a lay health advisor (LHA), effectively changed attitudes about mammography and breast cancer and whether changes were related to mammography screening. In this study, women exposed to the intervention experienced positive attitude change and, in fact, mammography attitude change was more likely among women who indicated that they received LHA advice (58%) vs those who did not report LHA advice (38%). Changes in mammography attitude, but not breast cancer attitude, were related to mammography use for those who received lay health advisor advice. Because understanding how CHAs affect change has implications for the recruitment and training of CHAs as well as the design of CHA interventions, future studies should continue to explore the CHA helping process.

CONCLUSION

Community involvement is important to achieving the American Cancer Society's goal of eliminating cancer disparities by the year 2015. Partnering with natural helpers is an effective way to deliver culturally appropriate, cancer prevention and control programs. Moreover, because natural helpers are indigenous to their communities, the community health advisor model of health promotion may be a sustainable ap-

proach to community health. Public health programs have significantly benefited from the CHA model and future programs should continue to foster this important partnership.

REFERENCES

1. American Cancer Society. *Cancer Fact and Figures*. Atlanta, Ga: American Cancer Society; 2004.
2. Singh GK, Miller BA, Hankey BF, Edwards BK. *Area Socioeconomic Variations in US Cancer Incidence, Mortality, Stage, Treatment, and Survival, 1975-1999*. NCI Cancer Surveillance Monograph Series, No. 4. Bethesda, Md: National Cancer Institute; 2003. NIH Publication No. 03-5417.
3. World Health Organization (WHO). *Community Health Worker: Working Document for the WHO Study Group*. Geneva, Switzerland: WHO; 1987.
4. Rosenthal E. *A Summary of the National Community Health Advisor Study*. Baltimore, Md: Ann E. Casey Foundation; 1998.
5. Taylor VM, Hislop TG, Jackson JC, et al. A randomized controlled trial of interventions to promote cervical cancer screening among Chinese women in North America. *J Natl Cancer Inst*. 2002;94(9):670-677.
6. Navarro AM, Senn KL, McNicholas LJ, Kaplan RM, Roppe B, Campo MC. Por La Vida model intervention enhances use of cancer screening tests among Latinas. *Am J Prev Med*. 1998;15(1):32-41.
7. Bird JA, McPhee SJ, Ha NT, Le B, Davis T, Jenkins CN. Opening pathways to cancer screening for Vietnamese-American women: lay health workers hold a key. *Prev Med*. 1998;27(6):821-829.
8. Lam TK, McPhee SJ, Mock J, et al. Encouraging Vietnamese-American women to obtain Pap tests through lay health worker outreach and media education. *J Gen Intern Med*. 2003;18(7):516-524.
9. Zhu K, Hunter S, Bernard LJ, et al. An intervention study on screening for breast cancer among single African-American women aged 65 and older. *Prev Med*. 2002;34(5):536-545.
10. Earp JA, Eng E, O'Malley MS, et al. Increasing use of mammography among older, rural African-American women: results from a community trial. *Am J Public Health*. 2002;92(4):646-654.
11. Margolis KL, Lurie N, McGovern PG, Tyrrell M, Slater JS. Increasing breast and cervical cancer screening in low-income women. *J Gen Intern Med*. 1998;13(8):515-521.
12. Rauscher GH, Earp JA, O'Malley M. Relation between intervention exposures, changes in attitudes, and mammography use in the North Carolina Breast Cancer Screening Program. *Cancer Epidemiol Biomarkers Prev*. 2004;13(5):741-747.