PROMOTING REGULAR SCREENING MAMMOGRAPHY IN AN AMERICAN INDIAN COMMUNITY IN OKLAHOMA

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Introduction: American Indian/Alaska Native (AI/AN) women are less likely than white women to have received a mammogram within the past 2 years. A currently funded 3-year study is a continuation of a series of preliminary studies that have taken place at a tribal clinic in Oklahoma since 2005. We hypothesize that a sustained multi-component (clinical and community) intervention based on a sound theoretical model will yield improved rates of mammography uptake and clinical outcomes.

Methods: A Community Steering Committee representing the clinic, the tribal government and community members was formed. The priority population consists of healthy AI women without a history of breast cancer between the ages of 40-65. The study has three aims: 1) Conduct a needs and resource assessment of the priority population through focus groups, key informant interviews and quantitative data analysis based on the administration of the Women’s Health Survey, b) Utilize the needs and resource assessment data to refine the overarching intervention Logic Model and develop a community-driven intervention program, and c) Pilot-test the intervention, and upon the completion of the pilot, refine the proposed intervention and conduct an evaluation of the intervention by using a quasi-experimental evaluation design. The study utilizes a Community Based Participatory Research approach.

Results: We have just completed aim 1, and have partially completed aim 2. The results of the formative research (aim 1) indicated that: a) AI women still lack knowledge of mammograms, b) The inconsistency of mammogram guidelines add to this lack of knowledge, c) Many AI women felt that a holistic approach to their health is preferable, d) Physicians are the most influential individuals to women and therefore, communication between physician and patient should include an open dialog on mammograms, e) Social modeling is an important motivating factor and participants suggested that the Native community as a whole can encourage women to get mammograms where the Native “community” includes elder women and breast cancer survivors, tribal newspapers or tribal media, and tribal clinics, and f) Community Health Representatives (CHR) already present in the community can play an active role in dissemination of breast cancer and mammography information.

Conclusion: We have been able to build the infrastructure of the project through the provision of trainings, recruitment of project staff, and volunteers. We also have worked toward building a strong basis of collaboration and trust among the four major partners; OUHSC, the tribal clinic, the tribal government, and community members. This was accomplished by having monthly steering committee meetings, by taking time to explain research findings in lay language, and by allowing the steering committee members to reflect on the research results as we are moving forward with the project implementation. Finally, through our participation in various community/outreach projects we are continually gaining credibility within the local AI community and we are becoming more visible. These activities have further led to building trust and gaining entry into the community, both of which are critical steps to implementing an effective community-based participatory breast cancer screening program.