

# Promoting colorectal cancer screening among South Asian populations: Strategies to promote access

by Joanne Crawford

## ABSTRACT

*The acceptance of colorectal cancer screening may be challenging for some South Asian groups in Canada. As oncology nurses, it is important to recognize barriers to screening, and be cognizant of culturally appropriate strategies to promote access in practice. This paper presents current research that was undertaken to understand population-based colorectal cancer screening among South Asian immigrants, and uses an access framework to outline strategies that minimize access barriers. Cultural safety principles and cultural assessment tools to support practice are also discussed.*

## INTRODUCTION

The uptake of population-based cancer screening (breast, cervical, and colorectal) is lower among South Asian (SA) populations in Western countries (Crawford, Ahmad, Beaton, & Bierman, 2015a), and a greater understanding of barriers is fundamental to facilitating access. Two studies were undertaken to understand factors that influenced cancer screening overall, and colorectal cancer screening among SAs (Crawford et al., 2015a; Crawford, Ahmad, Beaton, & Bierman, 2015b). Atkinson and colleagues (2001) access framework was used to focus evidence-informed strategies, and cultural safety to inform oncology nursing practice.

## CANCER SCREENING AMONG SOUTH ASIANS

Despite implementation of population-based colorectal cancer (CRC)

screening programs across Canada and modest increases in screening rates, some populations experience health disparities in accessing screening services (Singh, Bernstein, Samadder, & Ahmed, 2015). Breast, cervical and CRC screening among SA groups is reportedly lower than Canadian-born populations (Quan et al., 2006; Lofters, Hwang, Moineddin, & Glazier, 2010; Lofters, Gozdyra, & Lobb, 2013). Numerous access barriers have been identified.

## BARRIERS TO SCREENING

A scoping study reported individual barriers to cancer screening among SA populations in the United Kingdom, the United States, and Canada, including language proficiency, low knowledge, low self-perceived risk, and fear; whereas system barriers included lack of physician recommendation, physician gender, lack of culturally sensitive education, and lack of local access to screening (Crawford et al., 2015a). A focus group study exploring CRC screening behaviours among SA immigrants in Canada uncovered barriers of not believing screening was necessary, fear, differing levels of knowledge and awareness, and varied support and accessibility to information and screening by the physician (Crawford et al., 2015b). Access expands beyond health service provision in relation to CRC screening. According to Atkinson et al. (2001), it includes (a) access to appropriate information, (b) culturally relevant and sensitive services, (c) ease of use, and (d) respectful treatment.

instrumental in promoting CRC screening and can benefit from learning about culturally relevant strategies.

**Access to appropriate information.** The assessment of literacy and English language proficiency are important to gauge a client's ability to understand information and test instructions. Teach back, a useful technique, checks a client's understanding, where the client is encouraged to repeat information received in their own words (Agency for Healthcare Research and Quality, 2015; see Appendix A). Clients who are literate in their own language may benefit from FOBT instruction sheets available in SA languages (Ministry of Health and Long-Term Care, 2016). Alternatively, interpreters may be required to translate information in the client's preferred language (Crawford et al., 2015b). Availability of interpreters enables access, and oncology nurses play a pivotal role to advocate for them in practice settings to meet SAs unique needs.

Limited knowledge of cancer risk among SA populations, also a barrier, is often due to low self-perceived risk of common cancers prevalent in Western countries (Crawford et al., 2015a, b). With time since settlement in the host country, SA CRC risk becomes similar to Canadian-born populations (Hislop, Bajdik, Saroa, Yeole, & Barroetavena, 2007). Additionally, beliefs by some SA groups that cancer is to be feared should be acknowledged. To accommodate for SA beliefs, oncology nurses may frame CRC screening as a way to maintain health within a holistic lens, so the rationale for prevention is understood. Holistic views of healthcare were beliefs reported by SAs, particularly in Canada (Crawford et al., 2015a). Given the collectivist values of SA populations, oncology nurses also need to include family members in discussing screening, as they are integral to decision-making (Crawford et al., 2015a, b).

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## STRATEGIES THAT ENABLE ACCESS

Both the scoping and focus group studies (Crawford et al., 2015a, b) can inform the thinking about culturally relevant strategies for SA populations to enable access. Oncology nurses in community, diagnostic assessment, cancer prevention, and ambulatory care are

**Culturally relevant and sensitive services and ease of use.** Oncology nurses on multidisciplinary teams enable access to screening information using culturally appropriate strategies. For instance, to address gender issues, female nurses are ideally suited to provide screening information and access to other female care providers (Crawford et al., 2015a, b). Group education and multi-component strategies by peer health educators are recommended to promote CRC screening (Brouwers et al., 2011; Crawford et al., 2015a, b). Oncology nurses provide leadership and consultation in developing group education and also mentoring peer health workers to deliver culturally appropriate information and facilitate access to screening (Crawford, Frisina, Hack, & Parascandalo, 2015).

For ease of access, nurse-led mobile vans have been successful at increasing breast and CRC screening rates in select communities (Baron et al., 2008). Currently, mobile units promote breast, cervical and CRC screening to reduce local access barriers among under-screened communities, including SA (Cancer Care Ontario, 2015). Collectively, these strategies accommodate and respect client needs through culturally sensitive and safe services.

**Respectful treatment and culturally safe care.** System access barriers identified in the literature included the lack of valuing or accommodating for cultural beliefs and traditions, and lack of respectful behaviours from physicians (Crawford et al., 2015a, b). An important recommendation was to have nurses provide CRC

screening, as they were perceived to “listen” (Crawford et al., 2015b) and, in turn, demonstrate respect.

Cultural safety considers the socio-cultural context of unique individuals, and how this influences perceptions of health and access to care (Browne et al., 2009). Embracing cultural safety means being aware of unequal distribution of power within healthcare settings and working to equalize power in order to develop a respectful mutual relationship with the client and family (Bearskin, 2011; Browne et al., 2009).

**Cultural safety incorporates cultural competence.** Cultural competence is self-assessed by nurses, as an ongoing goal of becoming competent, while cultural safety is evaluated by the client through verbalization of feeling culturally safe during the communication encounter. Tools and skills required for cultural competence and cultural safety are somewhat similar in that they enable self-assessment and the use of communication skills during nurse-client encounters. There are a number of helpful tools nurses may use in self-assessment, for example: the ASKED tool to assess cultural competence (Campinha-Bacote, 2002); and, the Health Professional’s Self-assessment of Cultural Competency Questionnaire to reflect on individual ability to provide culturally competent care and identify areas of improvement (Vaugh, Szafran, Triscott, & Parent, 2014). See Appendix A.

Nurse-client communication encounters enable nurses to gain information

about beliefs, values, and health practices that address perceptions of health, illness, and disease. There are several valuable tools available to enhance this type of communication: the LEARN tool may be used to gain knowledge about cultural issues, and collaboratively work with clients to engage in screening (Berlin & Fowkes, 1983), and the BRIDGES tool promotes greater understanding of the cultural context of the individual required to meet their needs (Vaugh et al., 2014). See Appendix A. In using these tools, oncology nurses may also become an advocate for culturally appropriate services and social justice, particularly when racism or prejudice is evident in healthcare settings (Browne et al., 2009).

## CONCLUSION

To promote CRC screening for SA populations, an understanding of access barriers and strategies assist oncology nurses in improving access. Given the growing number of SA populations in Canada, it is imperative that oncology nurses engage in cross-cultural encounters that enable full access to meet the needs of clients. Self-assessment and communication tools are valuable and can support nurses to be culturally competent and safe in their practice.

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Appendix A: Cultural Assessment and Communication Tools		
Name	Reference	Link
Teach Back Tool #5	Agency for Healthcare Research and Quality, (2015). Use the Teach-Back Method: Tool #5. In <i>Health Literacy Universal Precautions Toolkit</i> (2nd Edition), Rockville, MD.	<a href="http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthlitoolkit2-tool5.html">http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthlitoolkit2-tool5.html</a>
ASKED Tool A – awareness S – skill K – knowledge E – encounters D – desire	Campinha-Bacote, J. (2002). The process of cultural competence in the delivery of healthcare services: A model of care. <i>J Transcult Nurs</i> , 13, 181. doi:10.1177/10459602013003003	<a href="http://coe.stanford.edu/courses/ethmedreadings10/Process%20of%20Cultural%20Competence.pdf">http://coe.stanford.edu/courses/ethmedreadings10/Process%20of%20Cultural%20Competence.pdf</a>
Health Professional's self-assessment of cultural competency (HPSACC) Questionnaire  7 Scales using 6-point Likert response categories	Waugh, E., Szafran, O., Triscott, J.A.C., Parent, R. (2015). <i>Cultural competency skills for health professionals: A workbook for caring across cultures</i> . Brush Education (Bridges Tool, HPSACC Tool).	<a href="https://www.ualberta.ca/medicine/departments/family-medicine/research/areas-of-research/centre-for-health-and-culture/cultural-competency-skills-modules">https://www.ualberta.ca/medicine/departments/family-medicine/research/areas-of-research/centre-for-health-and-culture/cultural-competency-skills-modules</a>
BRIDGES Tool B – beliefs, values and norms R – roles and relationships I – identify language, literacy, communication D – decision-making practices G – group, community, organizations E – extraordinary health issues S – share understanding of each other's culture, and reach common ground/compromise	Waugh, E., Szafran, O., Triscott, J.A.C., Parent, R. (2015). <i>Cultural competency skills for health professionals: A workbook for caring across cultures</i> . Brush Education.	<a href="https://www.ualberta.ca/medicine/departments/family-medicine/research/areas-of-research/centre-for-health-and-culture/cultural-competency-skills-modules">https://www.ualberta.ca/medicine/departments/family-medicine/research/areas-of-research/centre-for-health-and-culture/cultural-competency-skills-modules</a>
LEARN Model of Cross-cultural communication L – listen with cultural sensitivity E – explain your perceptions of health issue A – acknowledge similar and diverse perspectives R – recommend interventions in a respectful and sensitive manner N – negotiate a decision/agreement	Berlin, E.A., & Fowkes, W.C. (1982). A teaching framework for cross-cultural health care: Application in family practice. <i>Western Journal of Medicine</i> , 139(6), 934–938.	<a href="https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1011028/">https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1011028/</a>