

# Afrocentric screening program for breast, colorectal, and cervical cancer among immigrant patients in Ontario

Onye Nnorom MD MPH CCFP FRCPC Antonia Sapping-Kumankumah MD CCFP  
 Oluwatobi R. Olaiya MD Mervin Burnett MBBS Nancy Akor RN  
 Nan Shi PA Patricia Wright NP Abel Gebreyesus MHI  
 Liben Gebremikael MA Aisha Lofters MD CCFP PhD

## Abstract

**Problem addressed** Black and immigrant populations across Canada have lower screening rates than Canadian-born white populations, predisposing them to increased cancer morbidity and mortality. Effective interventions are required to increase cancer screening rates among these populations.

**Objective of program** To improve breast, colorectal, and cervical cancer screening rates at TAIBU Community Health Centre, which has a mandate to provide primary health care services to the Black and immigrant community in the greater Toronto area.

**Program description** An Afrocentric quality improvement program was developed and implemented, consisting of provider audits, cancer screening education programs, a patient call-back program, and a mammography promotion day.

**Conclusion** TAIBU Community Health Centre's continuous quality improvement approach was successful in engaging health care providers and patients to increase cancer screening participation sustainably in a racially and socioeconomically diverse setting. Rates of breast, colorectal, and cervical cancer screening offered to eligible patients increased from 17% to 72%, 18% to 67%, and 59% to 70%, respectively, between 2011 and 2018.

## Editor's key points

- ▶ Immigrant and racialized populations in Canada are not being screened at a rate comparable to the rate for white Canadian populations, predisposing them to increased cancer morbidity and mortality.
- ▶ Engagement of the community throughout the quality improvement process was of paramount importance in sustaining participation in cancer screening. TAIBU Community Health Centre used information from surveys and focus groups to tailor its educational content to address important barriers to screening.
- ▶ TAIBU Community Health Centre's Afrocentric quality improvement program for cancer screening was successful in increasing cancer screening rates sustainably in a racially and socioeconomically diverse clinic.

### Points de repère du rédacteur

- ▶ Les populations immigrantes et racialisées au Canada ne font pas l'objet de dépistages dans la même mesure que les populations canadiennes de race blanche, ce qui les prédispose à une morbidité et à une mortalité liées au cancer accrues.
- ▶ La mobilisation de la communauté durant tout le processus d'amélioration de la qualité était d'une importance cruciale pour le maintien de la participation au dépistage du cancer. Le Centre de santé communautaire TAIBU a utilisé des renseignements tirés de sondages et de groupes témoins pour adapter son contenu éducatif dans le but d'éliminer d'importants obstacles au dépistage.
- ▶ Le programme afrocentriste d'amélioration de la qualité pour le dépistage du cancer a réussi à accroître les taux de dépistage du cancer de manière durable dans une clinique caractérisée par la diversité raciale et socioéconomique.

# Programme de dépistage afrocentriste du cancer colorectal, du sein et du col chez des patients immigrants en Ontario

Onye Nnorom MD MPH CCFP FRCPC Antonia Sappong-Kumankumah MD CCFP  
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### Résumé

**Problème à l'étude** Les populations immigrantes et de race noire au Canada ont des taux de dépistage plus bas que ceux des populations de race blanche nées au pays, ce qui les prédispose à une morbidité et à une mortalité accrues. Des interventions efficaces sont nécessaires pour augmenter les taux de dépistage du cancer dans ces populations.

**Objectif du programme** Améliorer les taux de dépistage du cancer colorectal, du sein et du col au Centre de santé communautaire TAIBU, qui a pour mandat d'offrir des services de soins primaires à la communauté noire et immigrante dans la région du Grand Toronto.

**Description du programme** Un programme afrocentriste d'amélioration de la qualité a été élaboré et mis en œuvre, comprenant des vérifications auprès des professionnels, des programmes d'éducation sur le dépistage du cancer, un programme de rappel des patients et une journée de promotion de la mammographie.

**Conclusion** L'approche d'amélioration continue de la qualité adoptée par le Centre de santé communautaire AIBU a réussi à mobiliser les professionnels de la santé et les patients pour augmenter la participation au dépistage du cancer de manière durable dans un milieu caractérisé par la diversité raciale et socioéconomique. Les taux de dépistage du cancer du sein, colorectal et du col offert aux patients admissibles se sont accrus, respectivement, de 17 à 72 %, de 18 à 67 % et de 59 à 70 % entre 2011 et 2018.

Cancer is the leading cause of death in Canada.<sup>1</sup> In Ontario, breast, colorectal, and cervical cancer screening programs have been implemented.<sup>2-4</sup>

Widespread application of these organized cancer screening programs has been shown to reduce cancer incidence and mortality.<sup>5-7</sup> Unfortunately, access and adherence to screening programs is inequitable across Canada, with lower cancer screening rates among visible minorities and immigrant populations.<sup>8-14</sup> These disparities in cancer screening are unethical, and also deeply worrisome given that delayed or decreased screening is associated with later stage diagnosis and increased mortality.<sup>5,6,14-16</sup> Clearly, increasing screening rates among minority and immigrant groups is a logical step toward reducing disparities.

It is incumbent upon health care providers to develop strategies to mitigate barriers to screening and improve health outcomes for these vulnerable populations. Commonly identified barriers to screening include fear of the testing method, perceptions of reduced importance of cancer screening, cultural differences, and perceived stigmatization.<sup>17-19</sup> Interventions to increase screening uptake in visible minority and immigrant populations have included peer-led outreach and education groups, language-specific services and information, transportation programs, and patient call-back or reminder letter programs.<sup>20-22</sup>

### Program objective

TAIBU Community Health Centre (CHC) provides primary health care services to the Black population in the greater Toronto area, as well as the largely immigrant population in the Malvern area (Scarborough, Ont). TAIBU CHC's patient population is 85% foreign-born and 59% Black (**Table 1**); Afrocentricity is one of its core values (ie, anchored in African values of cooperation, focusing on the collective for input). Most patients in the area live below the poverty line. Despite 45% of patients reporting completion of postsecondary education (or equivalent), 30% of patients make less than \$15 000 yearly, and 55% earn less than \$35 000 yearly.

TAIBU CHC was established in 2008 in response to community advocacy for a centre that focuses on Black

population health. As part of its mission, TAIBU CHC recognizes that

systemic oppression has fostered conditions of ill-health with Black communities. [They] strive to deliver these services through intersectional, equity-based and culturally affirming practices which promote holistic wellness, health education, and prevention.<sup>23</sup>

Most staff and practitioners working at TAIBU are racialized, reside locally, and represent the demographic characteristics of the population they serve.

Given the focus on community health, recognition of low cancer screening rates among the target population prompted a desire to develop effective, community-focused interventions to promote screening. This study describes these initiatives and evaluates the screening program's effect on TAIBU CHC's cancer screening rates. We hope that, through developing and sharing effective cancer screening promotion activities among Black and immigrant populations, we will better equip our health care system to address inequities faced by these populations.

### Program description

In 2013, TAIBU CHC conducted a review of its breast, colorectal, and cervical screening rates (17%, 22%, and 54% in 2012, respectively), all of which were substantially lower than provincial averages. For the purpose of this article, cancer screening rates refer to services offered, rather than completed, as this is how all CHCs in Ontario report their cancer screening data to the Alliance for Healthier Communities. The use of "screening offered" rates as a proxy for completed screening rates was validated using a chart audit process, the details of which can be found below in the section on "Assessing the effect of TAIBU CHC's cancer screening task force."

In response to the low screening rates, a cancer screening task force was established, comprising TAIBU CHC staff: 2 family doctors, a physician assistant (PA), a nurse practitioner, and a registered nurse (RN). The task force developed a culturally competent, multifaceted quality improvement (QI) program that was also Afrocentric to design and implement interventions effective in increasing TAIBU's cancer screening rates.

### Components of the QI program

**Assessment of barriers.** After a discussion of experiential barriers to screening, the task force conducted a rapid review to identify barriers to screening among Black and immigrant patient populations, barriers to screening for primary care providers, health implications of underscreening in Black and immigrant populations, and ways to improve screening rates.

**Centre-level data audit of cancer screening in the electronic medical record (EMR).** One of the key challenges

**Table 1. Race and sex among TAIBU CHC patients, 2017-2018 fiscal year**

RACE	SEX, N (%)		TOTAL*
	FEMALE	MALE	
Black	2491 (62)	1527 (38)	4038 (59)
South Asian	1118 (56)	558 (28)	1976 (29)
White	239 (62)	149 (38)	388 (6)
Other	263 (58)	174 (42)	487 (6)

CHC—community health centre.  
\*Sex was not recorded for all patients.

the task force identified was that providers did not believe the screening data. Many believed that the data were inaccurate and underestimated the true screening rates. Hence, we conducted an audit of all patient charts. The audit confirmed that the EMR underestimated the proportion of patients screened, largely because providers' reports of when cancer screening had been offered were inconsistent. A member of the task force manually corrected these data entry errors, and a guide to use of the EMR and "refresher" EMR education sessions were offered to all providers. All providers were also given a report of their screening practices and a list of their own patients who were overdue for screening. Despite these corrective actions, screening rates remained low, providing the impetus to motivate providers to increase the "true" cancer screening rates. Provider audits are now performed quarterly, helping to maintain awareness and motivation to improve cancer screening.

**Provider education program.** The task force identified a need for provider education about lower cancer screening among Canadian immigrants and about poorer cancer health outcomes among African Americans (Canadian cancer racial disparity data are unavailable). Provider educational sessions were provided to increase awareness of TAIBU's screening disparities, gaps in provider practice, and provincial screening guidelines. Specific to primary care physicians, a provider guideline review package was created, and a regional primary care lead from Cancer Care Ontario and a community researcher provided a staffwide education session to review provincial screening guidelines and promising practices in screening immigrant populations. Cancer screening information sessions are now provided annually to clinical staff through the Central East Regional Cancer Program.

**Cancer screening call-back program.** To address the large number of patients overdue for screening, the task force pilot-tested a call-back program in 2013 to streamline cancer screening processes. Before the program was implemented, a medical directive was signed by all TAIBU primary care physicians to permit a trained RN or PA to order mammography and fecal occult blood tests (FOBTs), and to perform Papanicolaou tests on behalf of patients' physicians.

Administrative assistants were responsible for calling and offering screening to all patients who were eligible for, but not up-to-date with, breast, colorectal, or cervical cancer screening. The calls were managed in a culturally safe way, avoiding the word *cancer* over the telephone (based on feedback from previous consultations with community members for a church- and community-based cancer education program).<sup>20</sup> If a patient consented to screening, an RN and PA were then responsible for providing education on cancer screening (using the term *cancer* in the clinical setting), performing

Pap tests, ordering FOBTs, and ordering mammography. Patients who were identified during the clinical encounter as not meeting the low-risk eligibility criteria set out by Cancer Care Ontario, or who were otherwise deemed inappropriate for the call-back program by their primary care provider, were not seen by the RN or PA but were booked with their provider for cancer screening. The initial pilot test was successful, and a full-scale call-back program took place annually (with the exception of 2016).

**Patient education program.** Based on feedback elicited from patients,<sup>20</sup> educational pamphlets about cancer screening were developed by TAIBU using a culturally appropriate approach to reflect the racial diversity of patients and staff. TAIBU staff volunteered to develop a screening pamphlet with photos of vocationally, racially, and gender-diverse TAIBU providers, and the heading: "We are up-to-date on our screening. Are you?" The RN and PA involved in the call-back program distributed these pamphlets and provided in-person information about breast, colorectal, and cervical cancers and their respective screening tests.

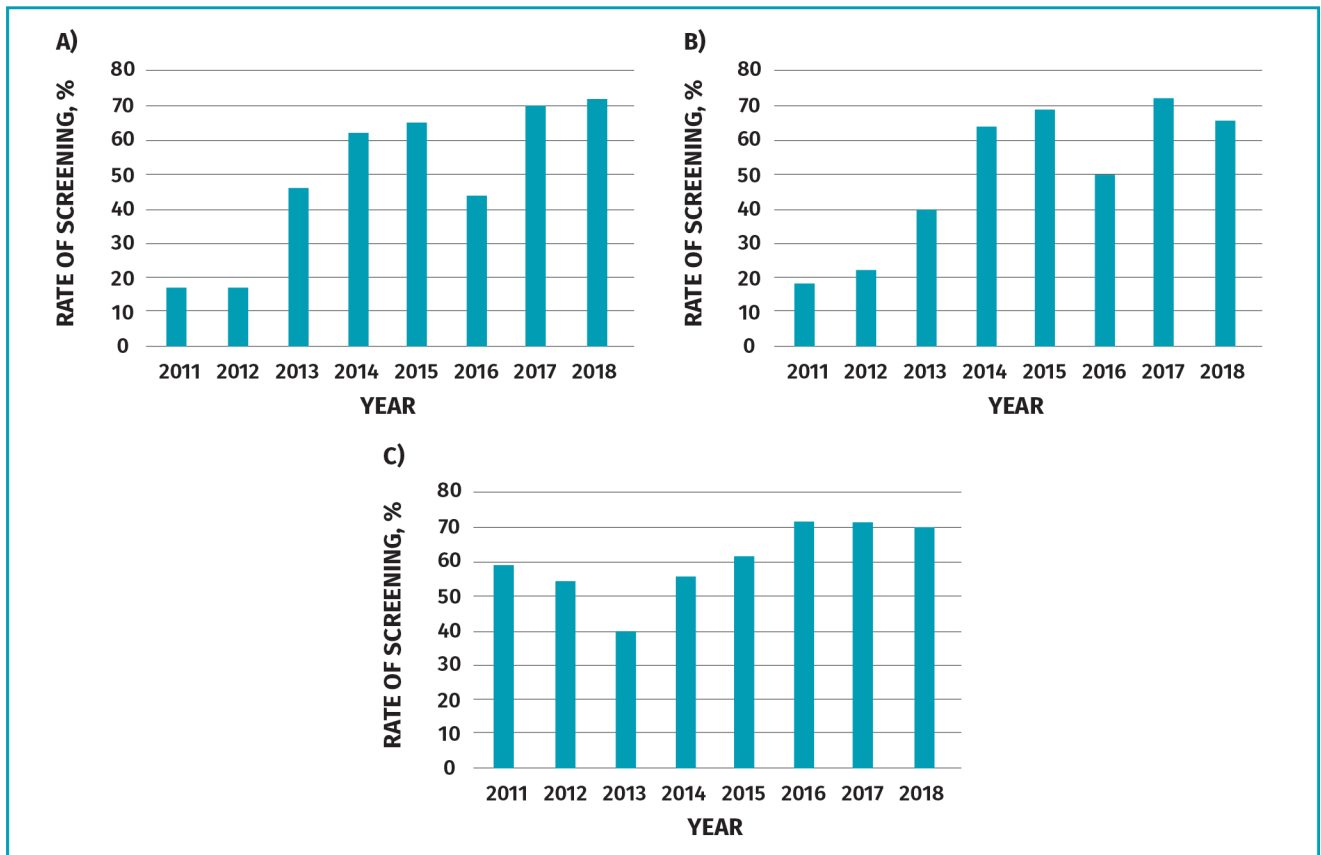
**Speak Up for Health! mammogram patient engagement project.** TAIBU CHC successfully applied for a QI grant through the Central East Regional Cancer Program in 2015. A multimethod, Afrocentric approach was used to aid in the development and implementation of effective interventions to improve breast cancer screening rates at TAIBU CHC, which included focus groups that assessed current knowledge, exploration of cultural beliefs and concerns, and interventions to improve breast cancer screening rates. In the spring of 2015, clinical patients and nonclinical TAIBU CHC clients were recruited (via posters) for surveys and focus groups; clerical, nursing, and health promotion staff also notified clients of survey and focus group sessions.

From October 2015 to February 2016, TAIBU used community feedback to develop and implement breast cancer screening posters featuring Black and racialized people, educational sessions, breast cancer screening videos in the waiting room, cancer screening pamphlets, and a local mammography "Just Book It" day, all of which featured women of colour. The mammography day included screening questionnaires, Afrocentric pamphlets, information on the nearest mammography site, and refreshments.

### Assessing the effect of TAIBU CHC's cancer screening task force

A retrospective analysis of TAIBU's cancer screening indicators was conducted to determine the annual cancer screening rates beginning in the 2011-2012 fiscal year until the 2017-2018 fiscal year (Figure 1). Research ethics board approval for the retrospective analysis was granted by the University of Toronto. The required data were collected and compiled from the aggregate data provided by TAIBU to the Alliance For Healthier Communities

**Figure 1.** Rates of cancer screening offered to patients at the TAIBU Community Health Centre from the 2011-2012 fiscal year to the 2017-2018 fiscal year: A) Breast cancer screening, B) colorectal cancer screening, and C) cervical cancer screening.



on the proportion of eligible patients offered each type of cancer screening. All CHCs in Ontario report their aggregated cancer screening data to the alliance as a standard practice. Data were analyzed using Microsoft Excel.

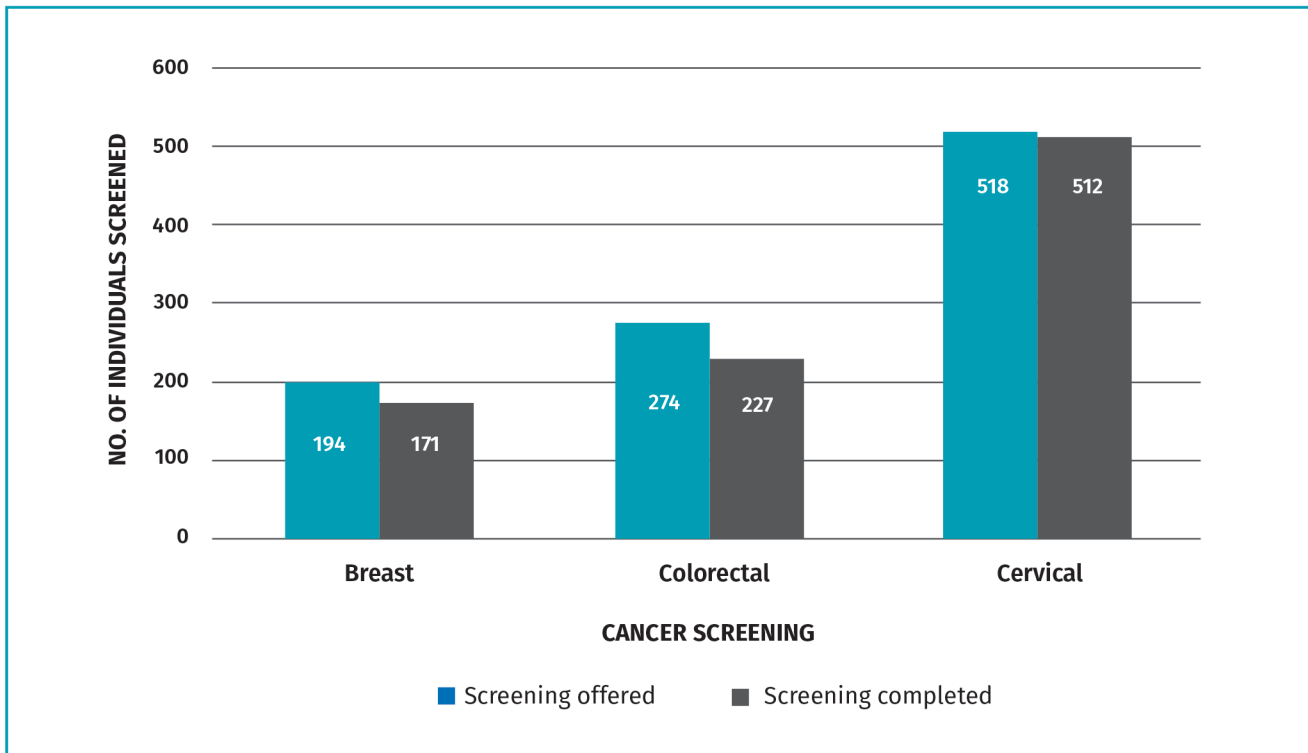
The rates of breast, colorectal, and cervical cancer screening offered to eligible patients increased from 17% to 72%, 18% to 67%, and 59% to 70%, respectively, between 2011 and 2018 (Figure 1). At CHCs in Ontario, clinical screening indicator data are based on services offered, not completed. Hence, a cross-sectional chart review of the 2017-2018 fiscal year was also conducted to validate the use of the rates of services offered as proxies for screening test completion rates. A total of 708 charts were reviewed to determine whether a screening result was received for each screening test offered by health care providers; 88% of mammograms offered, 83% of FOBTs offered, and 99% of Pap tests offered were completed, respectively (Figure 2).

The success of this QI program likely lies in its multifaceted approach (Figure 3). Previous systematic reviews of strategies to improve cancer screening in immigrant and minority populations suggest that a combination of culturally sensitive education initiatives for patients and providers, administrative support of scheduling, and media campaigns are most effective in increasing cancer screening rates.<sup>21</sup>

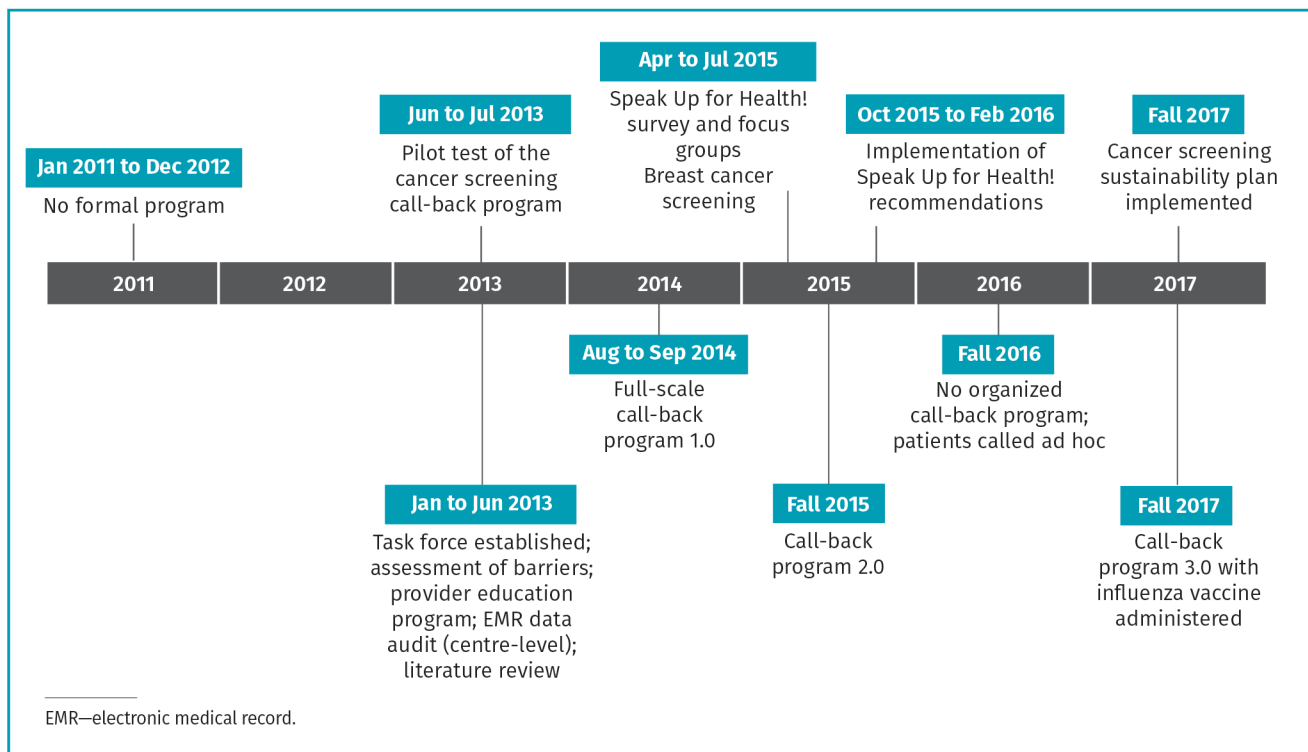
**Continuous QI approach.** Although screening rates generally increased over time, rates of breast and colorectal cancer screening decreased during the first and second quarter of 2016. This decrease can be attributed to initial process and human resource oversights during the design and implementation of the patient call-back program. In 2014, all patients due for FOBTs and mammograms were called within a period of several weeks, leading to an uptake in screening for a large number of patients at essentially the same time. Unfortunately, the initial personnel that were involved in running the call-back program were unavailable when the 2014 patient cohorts were due for repeat breast and colorectal screening 2 years later. Consequently, the call-back reminders were delayed and completion of mammograms and FOBTs was similarly delayed.

Using a continuous QI approach, the call-back program has since been modified to be completed on an annual rolling basis to ensure that there is sufficient time between the call-back reminder and when the patient becomes overdue for screening. We found calls (which used to be completed during the summer) often conflicted with Ramadan, so that Muslim patients could not participate. The call-back program now operates in the fall to coincide with influenza vaccinations (which has had the added benefit of increasing TAIBU's

**Figure 2.** Comparison between individuals offered cancer screening and individuals who completed cancer screening in the 2017-2018 fiscal year



**Figure 3.** Cancer screening initiatives by the TAIBU Community Health Centre cancer screening task force, 2013 to 2017



influenza vaccination rates). Cancer screening rates have remained stable since we rescheduled the calls.

## Conclusion

TAIBU's cancer screening task force has been highly effective in increasing cancer screening rates to above Ontario's provincial screening rates.<sup>24</sup> The success of TAIBU's task force lies within the multifaceted and community-centred QI approach. The leadership and resources invested by the executive director, empowerment of RNs and PAs to provide patient education and order screening tests, and provision of education to all TAIBU staff (including clerical staff) served to create a strong organizational commitment to improve cancer screening.

Engagement of the community throughout the QI process has been of paramount importance in sustaining participation in cancer screening. TAIBU CHC has used information from surveys and focus groups to tailor its educational content to address important barriers to screening, such as patients' perceived invulnerability to cancer and apprehension of pain and discomfort during testing. Our Afrocentric approach is best captured by a common African principle: *Ubuntu*. The term is from the Bantu language and means "I am because we are"; our entire approach is grounded in valuing our collective well-being; the community wanted posters with racialized clinicians promoting screening; the community wanted culturally appropriate messaging; the community wanted to be heard. We listened—in the clinic and in the community. And we continuously sought feedback. As a result, we observed improved outcomes. Educational posters, videos, and information pamphlets now contain culturally representative images and information to increase the perceived relevance of these strategies. Ultimately, involvement of the community has fostered a sense of members' ownership in their health care experiences.

The success of TAIBU CHC's cancer screening program provides a road map to engaging staff, health care providers, and patients to increase screening participation sustainably. Such a multimodal approach will likely prove beneficial in other Canadian family medicine centres serving racially and socioeconomically diverse communities, enabling us to achieve improved health outcomes for all. 🌿

**Dr Onye Nnorom** is a family physician and Public Health and Preventive Medicine Specialist in Toronto, Ont, Associate Program Director of the Public Health and Preventive Medicine Residency Program at the Dalla Lana School of Public Health, Black Health Theme Lead in the Faculty of Medicine, and Equity, Diversity and Inclusion Lead for the Department of Family and Community Medicine, all at the University of Toronto. **Dr Antonia Sappong-Kumankumah** is a family doctor at Inner City Health Associates in Toronto. **Dr Oluwatobi R. Olaiya** is a resident in the Michael G. DeGroot School of Medicine at McMaster University in Hamilton, Ont. **Dr Mervin Burnett** is a research assistant in the Department of Laboratory Medicine and Pathology at the University of Alberta in Edmonton. **Nancy Akor** is a registered nurse at TAIBU Community Health Centre (CHC) in Toronto and Coordinator for the Ontario Telemedicine Network. **Nan Shi** is a physician assistant in the University Health Network in Toronto. **Patricia Wright** is a nurse practitioner at TAIBU CHC. **Abel Gebreyesus** is Data Management Coordinator at TAIBU CHC and Data Coach (E-QIP) at Addictions and Mental Health Ontario. **Liben Gebremikael** is Executive Director of TAIBU CHC. **Dr Aisha Lofters** is a family doctor and Chair in Implementation Science at Women's College Hospital, Associate Professor in the Department of Family and Community Medicine at the University of Toronto, Senior Scientist at ICES, and Provincial Primary Care Lead for the Ontario Health (Cancer Care Ontario) Cancer Screening Portfolio.

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## Contributors

All authors discussed the results and contributed to the final manuscript. **Dr Onye Nnorom** led the project, conceived the idea for the paper, led the evaluation, and wrote the manuscript. **Dr Antonia Sappong-Kumankumah** collected and analyzed the data, assisted with the evaluation, and wrote the manuscript. **Dr Oluwatobi R. Olaiya** collected and analyzed data, and wrote the manuscript. **Dr Mervin Burnett** contributed to data analysis and wrote the manuscript. **Nancy Akor** contributed to the design of the project and co-implemented the project. **Nan Shi** contributed to the design of the project, co-implemented the project, and assisted with the evaluation. **Patricia Wright** contributed to the design of the project. **Abel Gebreyesus** compiled the data. **Liben Gebremikael** supervised the project and evaluation. **Dr Aisha Lofters** helped to supervise the evaluation and supervised development of the manuscript.

## Competing interests

At the time this research work took place, **Dr Aisha Lofters** and **Onye Nnorom** were both working as primary care leads for Cancer Care Ontario.

## Correspondence

**Dr Onye Nnorom**; e-mail [onye.nnorom@utoronto.ca](mailto:onye.nnorom@utoronto.ca)

## References

1. Table 13-10-0394-01. *Leading causes of death, total population, by age group*. Ottawa, ON: Statistics Canada; 2020. Available from: <http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/hlth36a-eng.htm>. Accessed 2021 Oct 15.
2. *ColonCancerCheck (CCC). Guide to average risk screening with the fecal immunochemical test (FIT) in Ontario*. Toronto, ON: Ontario Health, Cancer Care Ontario; 2019. Available from: [https://www.cancercareontario.ca/sites/cocancercare/files/assets/H-FIT\\_PCC\\_2742\\_ClinicalToolForProviders.pdf](https://www.cancercareontario.ca/sites/cocancercare/files/assets/H-FIT_PCC_2742_ClinicalToolForProviders.pdf). Accessed 2019 Sep 19.
3. *Ontario Breast Screening Program (OBSP). Guidelines summary*. Toronto, ON: Cancer Care Ontario; 2015. Available from: <https://www.cancercareontario.ca/sites/cocancercare/files/assets/OBSPGuidelinesSummary.pdf>. Accessed 2019 Sep 19.
4. *Ontario Cervical Screening Program (OCSP). Screening recommendations summary*. Toronto, ON: Ontario Health, Cancer Care Ontario; 2020. Available from: [https://www.cancercareontario.ca/en/system/files\\_force/derivative/OCSPScreeningGuidelines.pdf](https://www.cancercareontario.ca/en/system/files_force/derivative/OCSPScreeningGuidelines.pdf). Accessed 2021 Oct 15.
5. Canadian Task Force on Preventive Health Care. Recommendations on screening for colorectal cancer in primary care. *CMAJ* 2016;188(5):340-8. Epub 2016 Feb 22.
6. Tonelli M, Connor Gorber S, Joffes M, Dickinson J, Singh H, Lewin G, et al. Recommendations on screening for breast cancer in average-risk women aged 40-74 years. *CMAJ* 2011;183(17):1991-2001. Erratum in: *CMAJ* 2011;183(18):2147.
7. Murphy J, Kennedy EB, Dunn S, McLachlin CM, Fung MFK, Gzik D, et al. Cervical screening: a guideline for clinical practice in Ontario. *J Obstet Gynaecol Can* 2012;34(5):453-8.
8. Lofters AK, Moineddin R, Hwang SW, Glazier RH. Predictors of low cervical cancer screening among immigrant women in Ontario, Canada. *BMC Womens Health* 2011;11:20.
9. Lofters AK, Moineddin R, Hwang SW, Glazier RH. Low rates of cervical cancer screening among urban immigrants: a population-based study in Ontario, Canada. *Med Care* 2010;48(7):611-8.
10. Kerner J, Liu J, Wang K, Fung S, Landry C, Lockwood G, et al. Canadian cancer screening disparities: a recent historical perspective. *Curr Oncol* 2015;22(2):156-63.
11. Nestel S. *Colour coded health care: the impact of race and racism on Canadians' health*. Toronto, ON: Wellesley Institute; 2012.
12. Johnston GM, Boyd CJ, MacIsaac MA. Community-based cultural predictors of Pap smear screening in Nova Scotia. *Can J Public Health* 2004;95(2):95-8.
13. Quan H, Fong A, De Coster C, Wang J, Musto R, Noseworthy TW, et al. Variation in health services utilization among ethnic populations. *CMAJ* 2006;174(6):787-91.
14. Buchman S, Rozmowitz L, Glazier RH. Equity and practice issues in colorectal cancer screening. Mixed-methods study. *Can Fam Physician* 2016;62:e186-93. Available from: <https://www.cfp.ca/content/cfp/62/4/e186.full.pdf>. Accessed 2021 Oct 15.
15. Smith-Bindman R, Miglioretti DL, Lurie N, Abraham L, Barbash RB, Strzelczyk J, et al. Does utilization of screening mammography explain racial and ethnic differences in breast cancer? *Ann Intern Med* 2006;144(8):541-53.
16. Dickinson J, Tsakonias E, Conner Gorber S, Lewin G, Shaw E, Singh H, et al. Recommendations on screening for cervical cancer. *CMAJ* 2013;185(1):35-45.
17. Decker KM, Singh H. Reducing inequities in colorectal cancer screening in North America. *J Carcinog* 2014;13(1):12.
18. Amankwah E, Ngwakongwi E, Quan H. Why many visible minority women in Canada do not participate in cervical cancer screening. *Ethn Health* 2009;14(4):337-49.
19. Vahabi M, Lofters A, Kumar M, Glazier RH. Breast cancer screening disparities among immigrant women by world region of origin: a population-based study in Ontario, Canada. *Cancer Med* 2016;5(7):1670-86. Epub 2016 Apr 22.
20. Lofters A, Jain A, Siu W, Kyte M, Lee-Foon N, Scott F, et al. Ko-Pamoja: the feasibility of a lay health educator-led breast and cervical screening program for Black women in Ontario, Canada (short report). *Cancer Causes Control* 2017;28(11):1207-18. Epub 2017 Jul 6.
21. Schoueri-Mychasiw N, Campbell S, Mai V. Increasing screening mammography among immigrant and minority women in Canada: a review of past interventions. *J Immigr Minor Health* 2013;15(1):149-58.
22. Dunn SF, Lofters AK, Ginsburg OM, Meany CA, Ahmad F, Moravac MC, et al. Cervical and breast cancer screening after CARES: a community program for immigrant and marginalized women. *Am J Prev Med* 2016;52(5):589-97. Epub 2017 Jan 13.
23. *RISE. Excellence in Black community based health. Strategic plan 2017-2022*. Toronto, ON: TAIBU Community Health Centre; 2017. Available from: <https://taibuchc.ca/wp-content/uploads/2019/02/TAIBU-CHC-2017-2022-Strategic-Plan-RISE.pdf>. Accessed 2021 Oct 15.
24. *Ontario cancer screening performance report 2016*. Toronto, ON: Cancer Care Ontario; 2016. Available from: <https://www.cancercareontario.ca/sites/cocancercare/files/assets/CCOCancerScreeningPerformanceReport.pdf>. Accessed 2019 Sep 19.

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