IMPROVEMENT OF QUALITY OF THE NATIONAL CANCER SCREENING PROGRAMMES IMPLEMENTATION (CRO SCREENING)
Communication strategies to improve participation in screening programmes

Communication strategy in Program Svit – experiences from Slovenia

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• **Communication strategy** needs to be a part of every public health program.

• Communication is not about being pleasant, witty or nice – it is about reaching the goals.

• Communication needs to be planned, targeted, systematic, theory and evidence based.

• Interventions need to be **constantly monitored**, evaluated and adapted to current situation.
SVIT
Slovenian National Population Based Colorectal Cancer Screening Program

2007 - Preparation Phase (graphic symbol, logo, media strategy for preparation phase created by LUNA TBWA)

2008 - Pilot (Three cities in Slovenia - June-December; Creation of strategic communication plan and tools)

2009 - in April National Population Based Colorectal Cancer Screening Program starts
The person is invited to participate in the Svit program

The person confirms the participation in writing

The participant receives a kit for taking stool samples by mail

The participant does not return the test

Written reminder

The participant returns the test to the Central laboratory

Written reminder

Test results

Positive

Colonoscopy

Negative

The participant receives another invitation for screening after 2 years

PROGRAM SVIT ALGORYTHM

Created in 2007

Communication tools designed in spring 2008
WE WANT TO IMPROVE THE SCREENING UPTAKE.

But – what does this really mean?

What *exactly* do we want to achieve?

OBJECTIVES:
- At least 60% of invited people sign participation form
- 90% of test kits returned to the lab
- Minimum of mistakes in all procedures
- All FOBT + patients undergo colonoscopy

*If you don’t know where you’re going, any road will get you there.*

~ Cheshire Cat
PLANNING COMMUNICATION STRATEGY

• Choosing theoretical basis
• Analysis of status quo, of target audiences, of obstacles, possible supporters and channels of communication
• Gathering evidence
• Setting realistic objectives
• Designing interventions
• Designing tools for these interventions
• Designing training for communicators
• Creating evaluation methodology
WHERE WE ARE NOW

WHERE WE WANT TO BE
• Analysis of screening algorithm
• Analysis of target populations
• Defining obstacles
• Research mechanisms
• Evaluation mechanisms
• Resources
• Time scale
• THEORY

• What do they need to know?
• What do they need to do?
• What skills are necessary?
• What about people with special needs?
• Designer’s work
• Channels and tools

• Monitoring (all stages of) uptake on national, regional and local level
• Monitoring procedural mistakes
• Monitoring colonoscopy experiences
• Target interventions
• Campaigns with defined goals

• Changes and adaptations of the strategy

• Planning and Strategy Development
• Developing and Pretesting Concepts, Messages, and Materials
• Implementing the Program
• Assessing Effectiveness and Making Refinements

• Training healthcare workers
• Recruiting volunteers
• Training volunteers
• Activating channels
• Dissemination of tools
• Motivation of communicators

• Monitoring (all stages of) uptake on national, regional and local level
• Monitoring procedural mistakes
• Monitoring colonoscopy experiences
• Target interventions
• Campaigns with defined goals

• Changes and adaptations of the strategy
GENERAL OBSTACLES - TARGET POPULATION (people over 50)

- Very low trust in healthcare system
- High trust in general practitioners – but they have no time
- Low health literacy
- Little knowledge about colorectal cancer
- Stigma and taboo
- Fear of cancer
- Disgust
- A lot of tasks to be performed by patients at home
- Relatively complicated tasks and procedures
- Low self esteem
- Need of repeating participation in testing
- Unpleasant (painful) colonoscopy performed without sedation
- Test kit to be delivered to a post-office
- Time consuming visits to general practitioner and pharmacy in case of FOBT+
- Demanding preparation for colonoscopy
EVIDENCE

Metastudy – what influences CRC screening – by National Health Service - Centre for Reviews and Dissemination together with experts from York University, UK:

• Older people are more willing to be tested
• Women are more willing to participate in screening than men
• More educated people are more willing to be tested
• People who participated in screening before and had positive experience are more willing to do it again
• Information allone is not enough to effect behaviour.
• Call centre is essential
• Personal contact and interactive, interpretive communication is essential


http://www.hta.ac.uk/fullmono/mon414.pdf
<table>
<thead>
<tr>
<th>SUPPORTING PARTICIPATION</th>
<th>OBSTACLES TO PARTICIPATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication and support of the chosen general practicioner</td>
<td>Individual obstacles (handicap, distance, literacy…)</td>
</tr>
<tr>
<td>High self esteem, sense of control, capability, freedom of choice</td>
<td>Fear of cancer</td>
</tr>
<tr>
<td>Living together with someone who has participated</td>
<td>Fear of being seriously ill</td>
</tr>
<tr>
<td>Family support</td>
<td>Low self esteem</td>
</tr>
<tr>
<td></td>
<td>Sense of not being able to perform all the tasks independently and successfully</td>
</tr>
<tr>
<td>Noticing alarming symptoms</td>
<td>Low trust</td>
</tr>
<tr>
<td>Communication interventions in local community, work environment</td>
<td>Lack of support from healthcare workers</td>
</tr>
<tr>
<td>Peer advise</td>
<td></td>
</tr>
<tr>
<td>Personalized letters and other messages; reminders; call centre</td>
<td></td>
</tr>
</tbody>
</table>
Main obstacles mentioned by the participants in the 2000 survey:

- **fear of cancer diagnosis** (»It is better not to know!“ „As long as I do not know, I am healthy.“)

- **high opinion on personal health** (»I feel perfectly well – so I do not need any tests!«)

- **no support from family and peers** (»Nobody gets tested – so I will not participate either!“)

- **no cases of cancer in the family** (»Cancer is not a problem in my family – we die of other causes.“)

- **disgust** (»I will not handle my poo – if my physician sends me directly to colonoscopy, I will think about it. «)

- **personal obstacles** (financial, distance, language, literacy…)

- **other serious problems prevailing** (»I have so many grave problems at the moment that I can not cope with another one!«)
• QUESTIONS ABOUT PARTICIPATION FORMS – criteria for exclusion
• FOBT+ WITHOUT RESPONSE
• COLONOSCOPY CENTRES

CALL CENTRE
Phone, e-mail, fax

MAIL TERMINAL
Letters, parcels

• INVITATION LETTERS
• TEST KITS
• REMINDERS
• FINDINGS
• REFERRALS

• PARTICIPATION AGREEMENTS
• TEST KITS
• Personal letters
• POST COLONOSCOPY SURVEY

MOTIVATION
Community Preventive Healthcare Centres in Slovenia

- Svit contact points
- Coordination on local level
- Local Svit events
- Local ambassadors and supporters

VITAL - but very, very busy!
Communication interventions have different goals:

TO INFORM ON FACTS:
What is the problem
What is the solution
HOW DOES SVIT WORK

TO GIVE CLEAR INSTRUCTIONS

TO CREATE AND SUSTAIN TRUST

TO REMOVE OBSTACLES TO PARTICIPATION IN SCREENING

TO MOTIVATE FOR PARTICIPATION

TO INVITE SUPPORTERS AND AMBASSADORS
THEORETICAL FRAME FOR COMMUNICATION STRATEGY

Health belief model
Transteoretical model (Prochaska-DiClemente)
Social cognitive theory (Bandura)
**Theory of planned behaviour (Ajzen)**
Targeted communication tools and channels
DOBRODOŠLI!

Program Svit je Državni program presejanja in zgodnjega odkrivanja predračnih sprememb in raka na debelem črevesu in danki. Sodelovanje v Programu Svit rešuje življenja!

Več o programu »

ČAS JE, DA POMISLITE NASE.

O PROGRAMU SVIT
Preberi več o tem »

VIZIJA IN POSLANSTVO
Preberi več o tem »

ČASTNI POKROVITELJ
Preberi več o tem »
KAKO SE PRIPRAVIMO NA KOLONOSKOPIJO
DON‘T BE AFRAID OF THE WORLD INSIDE YOU! TAKE A TEST IN PROGRAM SVIT!
“You know what? Everyone is a little scared of places where the sun never shines. But it is much better to be checked early than to die early!”

Viktor Grošelj, mountain climber
The Strategy was systematically implemented from 2009 to 2014.
Clinical pathway is a multidisciplinary management tool based on evidence-based practice for a specific group of patients with a predictable clinical course, in which the different tasks (interventions) by the professionals involved in the patient care are defined, optimized and sequenced either by hour (ED), day (acute care) or visit (homecare). Outcomes are tied to specific interventions.
• CALGARY-CAMBRIDGE MODEL OF CLINICAL CONVERSATION
• MOTIVATIONAL INTERVIEW
• CULTURALLY COMPETENT COMMUNICATION

• TOOLS
• MANUALS
• TRAINING
Motivational Interview

- Spirit of MI:
  - Agape
  - Collaborative (patient as a partner)
  - Evocative (evoking patient’s strength and will)
  - Honoring patient authonomy

Forcing people to adopt „official“ values, behaviour and conduct

MOTIVATIONAL INTERVIEW

What causes conflict, defensive reaction and objection:
• Orders, imposing, forcing, warning, threat
• Advises, pushing, forcing one’s own opinion
• „sermons“, mentioning science and guidelines as highest authority
• Judging, criticising, accusing

What supports behavioural change:
• Exploring different points of view, opinions, values and possibilities
• High self esteem
• Confidence in one’s abilities
• Freedom of choice
• Acknowledging that there is more than just one way to the main goal
Communication interventions budget per year: on average 120,000,0 €

## Results in 2014:

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
<th>all</th>
<th>men</th>
<th>women</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of invitations sent out</strong></td>
<td>253,335</td>
<td>94,71%</td>
<td>94,39%</td>
<td>95,03%</td>
</tr>
<tr>
<td><strong>Number of letters received</strong></td>
<td>252,305</td>
<td>99,59%</td>
<td>99,38%</td>
<td>99,80%</td>
</tr>
<tr>
<td><strong>Returned signed agreement to participate in screening</strong></td>
<td>152,475</td>
<td><strong>60,43%</strong></td>
<td>55,22%</td>
<td>65,53%</td>
</tr>
<tr>
<td><strong>Excluded on the basis of clinical criteria</strong></td>
<td>8,289</td>
<td>5,44%</td>
<td>5,61%</td>
<td>5,29%</td>
</tr>
<tr>
<td><strong>Number of test kits sent out – without repeated sendings</strong></td>
<td>144,144</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>People who sent samples unsuitable for analysis</strong></td>
<td>4,119</td>
<td>2,85%</td>
<td>2,65%</td>
<td>3,01%</td>
</tr>
<tr>
<td><strong>Number of people screened with FOBT test</strong></td>
<td>138,214</td>
<td><strong>56,64%</strong></td>
<td>50,91%</td>
<td>62,27%</td>
</tr>
<tr>
<td><strong>FOBT -</strong></td>
<td>129,693</td>
<td>94,12%</td>
<td>92,73%</td>
<td>95,23%</td>
</tr>
<tr>
<td><strong>FOBT +</strong></td>
<td>8,108</td>
<td>5,88%</td>
<td>7,27%</td>
<td>4,77%</td>
</tr>
<tr>
<td><strong>Colonoscopy adherence</strong></td>
<td></td>
<td>&gt; 90%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Percentage of people who signed participation form in 2014 by region

- %63,12
- 64,31%
- 61,94%
- 62,49%
- 55,55%
- 60,19%
- 60,10%
- 60,43%
- 57,75%
- 57,59%

55,22% 65,53%