Low rates of cervical cancer screening among urban immigrants: a population-based study in Ontario, Canada.

FOCUS OF THE STUDY:
We were interested in whether appropriate cervical cancer screening rates (i.e. at least 1 Pap test every 3 years, until age 70) vary among women living in Ontario according to age, neighborhood income, and immigrant status. We used several large databases (e.g. physicians' claims, 2001 Census) to access data on more than 2.2 million screening-eligible women aged 25-69 who lived in Ontario's urban areas 2003-2005. Recent registration with Ontario's universal health insurance plan was used as a proxy for immigration.

KEY FINDINGS:
- Women who are older, immigrants, and/or live in poor areas are significantly less likely to have a regular Pap test.
  - Older women (50+) were much less likely than younger women to have a regular Pap test.
  - Among older women, testing rates were lowest for recent immigrants.
  - For all women - especially long-term resident women - testing rates increased as neighbourhood income increased.
- Rates were lowest for the group with all three of the above risk factors. Only 31% of older, recent immigrant women who lived in the poorest areas had a regular Pap test (compared to 70% of younger, long-term Ontario resident women who lived in the wealthiest areas).
- Overall, just 61% of all women in Ontario were screened appropriately. This number is much lower than described in previous studies based on self reports.

IMPLICATIONS FOR HEALTH POLICY AND PRACTICE:
Programs to reduce cervical cancer screening inequities should be targeted at the neighbourhood level as well as the patient/physician level. Self reports may not be sufficient to guide decision-making; administrative data may be more reliable.

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Universal health insurance and health care access for homeless persons.

FOCUS OF THE STUDY:
Canada has a publicly-funded system of universal health insurance. Our goal was to determine the extent of unmet needs for health care among homeless people within this system. We conducted face-to-face interviews with 1,169 homeless people (about 50% single men, 25% single women, and 25% women with dependent children) recruited at shelters and meal programs in Toronto.

KEY FINDINGS:
- 1 in 6 homeless people in Toronto - and 1 in 5 homeless women - aren't getting the health care they need.
- Unmet health care needs were most common among homeless single women (22%), followed by women with children (17%), and single men (14%).
- The disparity between Toronto's general population and homeless population was greatest for women with children; unmet needs were more than twice as common in the homeless group.
- Factors associated with having unmet health care needs were: being physically assaulted at least once in the past year (more common among women); having a higher need for health care (i.e. poor physical or mental health status); and being younger.

IMPLICATIONS FOR HEALTH POLICY AND PRACTICE:
Strategies to reduce important non-financial barriers faced by homeless women with children, younger adults, and recent victims of physical assault may include primary prevention of physical assault (e.g. universal screening in health care settings for domestic violence), an emphasis on non-stigmatizing attitudes towards homeless people among health care trainees and workers, and specialized primary care programs that are tailored to improve access for homeless patients.

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**Cost-effectiveness of strategies to improve HIV testing and receipt of results: economic analysis of a randomized controlled trial.**


**FOCUS OF THE STUDY:**

New approaches to HIV counseling and testing are available: “routine screening” (i.e. all patients in all health care settings are routinely offered an HIV test), “rapid testing” (i.e. pre-test counseling, testing, results, and referrals are all provided in a single visit), and “streamlined counseling” (i.e. 7 minutes of pre-test counseling, as opposed to the traditional 20 minutes). A 2008 randomized control trial* compared:

1. Traditional HIV counseling and testing
2. Nurse-initiated routine screening with traditional HIV testing and counseling
3. Nurse-initiated routine screening with rapid HIV testing and streamlined counseling

The trial found that strategy 3 resulted in substantially higher testing rates, and higher rates of receiving test results. Our goal was to find out whether the most effective model was also cost effective. We looked at testing, return rates, and related short- and long-term costs in a randomized trial of 251 primary-care patients in the US with unknown HIV status. The cohort and strategies in our analysis reflected those in the 2008 study.

**KEY FINDINGS:**

- The most effective strategy, nurse-initiated routine screening with rapid HIV testing and streamlined counseling (strategy 3), was also cost effective.
- All three elements of this strategy contributed to its effectiveness and cost effectiveness:
  - The use of non-physician providers and streamlined counseling greatly reduced per-person costs. The benefits for patients were the same.
  - With rapid testing, many more patients who tested HIV negative received their results: 90% compared to 35-36% for the other strategies.

**IMPLICATIONS FOR HEALTH POLICY AND PRACTICE:**

The US Centre for Disease Control recommends universal HIV screening, but the best way to implement these recommendations is uncertain. Nurse-initiated routine screening with rapid HIV testing and streamlined counseling has significant promise as an approach for integrating routine HIV screening into primary care practice.

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**Are we asking the right questions?**

A review of Canadian REB practices in relation to community-based participatory research.


**FOCUS OF THE STUDY:**

Community-based participatory research (CBPR) blurs the lines between research, advocacy, intervention, and community development. We conducted a Canada-wide assessment of REB ethics review protocols and guidelines to gauge their sensitivity to CBPR approaches, processes, and outcomes. We also looked at whether CBPR sensitivity varied according to an organization’s region, type (i.e. university or health care), primary language (i.e. English or French), and national ranking as a research intensive institution. Our sample comprised 278 REBs in 4 categories (behavioural, biomedical, social sciences, humanities) that were likely to review CBPR. We evaluated ethics review documents using 30 CBPR-related criteria.

**KEY FINDINGS:**

- Few REB documents explicitly take CBPR principles into account. This means that innovative CBPR designs may be blocked, and CBPR projects may be approved without reviewers asking the right questions.
- Highly ranked, research intensive organizations tended to be more sensitive to CBPR. An organization’s region, type, or primary language did not predict its CBPR sensitivity.

**BEST PRACTICES:**

We recommend that REBs:

- **Expand their definition of risk and vulnerability** to include risk at the community level (e.g. risk of stigmatizing marginalized communities) as well as the individual level (e.g. risk of miscarriage among pregnant women).
- **Provide enough space on forms for researchers to justify any deviations from standard research processes.** This will likely result in fewer reviewer comments and researcher revisions.
- **Ask for a terms of reference** from CBPR teams. This will encourage CBPR teams to outline roles and responsibilities in advance, and anticipate how conflicts will be addressed.
- **Suggest ways that data could be made available to participants, communities, and other relevant stakeholders** (e.g. assess and support community capacity to manage data, stewardship models).
- Consider developing an ethics review model for CBPR that would encourage researchers to consult with REB staff throughout the lives of their projects. This would result in mutual learning, and promote the benefits of ethics review.

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