Pacific Island Jurisdictions Comprehensive Cancer Control Technical Assistance Workshop

May 23-25 · Honolulu, Hawaii
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EXECUTIVE SUMMARY

The Centers for Disease Control and Prevention’s (CDC) National Comprehensive Cancer Control Program (NCCCP) supports comprehensive cancer control (CCC) in all 50 states, Washington, D.C., seven tribes and tribal organizations and seven Pacific Island Jurisdictions (PIJs) and territories. With support from CDC, the American Cancer Society (ACS), National Cancer Institute, the University of Hawaii John Burns School of Medicine and the American College of Surgeons Commission on Cancer, NCCCP grantees from six PIJs – American Samoa; Commonwealth of Northern Mariana Islands (CNMI); Federated States of Micronesia (FSM) that include the states of Chuuk, Kosrae, Pohnpei and Yap; Guam; Republic of the Marshall Islands (RMI); and Republic of Palau—gathered for a two-and-a-half-day technical assistance workshop May 23-25 in Honolulu, Hawaii.

The workshop goal was to explore strategies and build capacity for community action through effective CCC coalitions in PIJs to achieve the following priorities:

1. Improve human papillomavirus (HPV) vaccination uptake
2. Assess and address colorectal cancer
3. Assess and address cancer survivorship
4. Assess and address palliation needs

The workshop objectives were for PIJs to:

- Identify relevant and adaptable evidence-based interventions on the priorities
- Hear about cultural and resource-appropriate approaches and PIJ-specific efforts related to the priorities
- Develop an action plan on the priority topics for the following 12 months that was complementary to their CDC program work plans

Presenters provided information and insight throughout the workshop on the priority topics, which provided the foundation for successful discussions and action planning among PIJ teams. Key takeaways for each priority included the following:
Improve HPV Vaccination Uptake

- Some PIJs have the highest rates of cervical cancer in the world, but cervical cancer screening coverage remains low
- Primary prevention and achieving high HPV vaccination completion rates in the PIJs are important
- Children under age 15 should be vaccinated in two doses, six months apart, in accordance with Advisory Committee on Immunization Practices (ACIP) guidelines

Assess and Address Colorectal Cancer

- Colorectal cancer screening should be prioritized second only to cervical cancer screening in PIJs, especially when considering ways to maximize resources
- Existing evidence-based programs, such as Screen to Save, could be leveraged to provide educational information on colorectal cancer incidence, risk factors and prevention

Assess and Address Cancer Survivorship

- Patient navigation is important to provide linguistically appropriate, culturally grounded supportive services to patients and improve health outcomes
- Existing patient navigation training could be leveraged to support the needs of cancer survivors

Assess and Address Palliation Needs

- Integrating palliative care into the spectrum of cancer care experience is an important consideration for survivorship and compassionate care

Workshop evaluation revealed that the workshop provided an opportunity for PIJ cancer and immunization programs, coalitions, CDC staff and stakeholders to network, share experiences and discuss and plan activities to reduce the burden of cancer in PIJs.

This report, developed by the George Washington University (GW) Cancer Center, summarizes workshop proceedings, presentation highlights and key decisions made by attendees, as well as evaluation results completed and generated by attendees.
FOREWORD FROM CDC

The U.S.-Affiliated Pacific Island Jurisdictions (USAPIJs) consist of Flag Territories and Freely Associated States (FAS). The Flag Territories include: American Samoa, Guam and the Commonwealth of the Northern Mariana Islands (CNMI). The FAS include the Federated States of Micronesia (FSM), which consist of Yap, Pohnpei, Kosrae and Chuuk; the Republic of Marshall Islands (RMI) and the Republic of Palau.

The health status of the islanders and the challenges faced by the health care systems naturally vary within and among the jurisdictions. In general, almost all health indicators for the islanders are worse than those of mainland Americans. These significant health disparities have led to lower life expectancies and higher infant mortality among the islanders. However, many chronic diseases, including cancer, can be prevented or mitigated by culturally relevant, community driven policies, systems, and environmental improvements that support healthy choices and behaviors.

In an effort to address these issues, CDC works with USAPIJs to promote health, prevent disease, reduce health disparities and strengthen connections to culture and behaviors that improve health and wellness. CDC’s National Center for Chronic Disease Prevention and Health Promotion has a significant investment in health and wellness in USAPIJs.

Through the National Breast and Cervical Cancer Early Detection Program, CDC provides low-income, uninsured and underserved women access to timely breast and cervical cancer screening and diagnostic services, and referral to treatment programs in all 50 states, the District of Columbia, six U.S. territories, and 13 American Indian/Alaska Native tribes or tribal organizations to provide screening services for breast and cervical cancer.

The NCCCP helps all 50 states, the District of Columbia, seven tribes and tribal organizations and seven USAPIJs and territories to plan and prioritize strategic activities to prevent and control cancer. NCCCP grantees use an integrated and coordinated coalition-based approach to implement activities to reduce the burden of cancer in their communities by maintaining and supporting strong, statewide (or jurisdiction-wide) coalitions of cancer prevention and control stakeholders; and implementing statewide (or jurisdiction-wide) cancer control plans that emphasize the primary prevention of cancer, support people who have been diagnosed with cancer through treatment and beyond and increase access to quality health care for all people, including those in communities with a higher burden of cancer.

The purpose of CDC’s Colorectal Cancer Control Program, established in 2009, is to increase colorectal cancer screening rates among people between 50 and 75 years of age by implementing evidence-based interventions and other supporting strategies in partnership with health systems and providing colorectal cancer screening and follow-up services for a limited number of eligible people.

This report summarizes the outcomes and proceedings from the CDC- and CCC National Partnership-sponsored 2017 Pacific Island Jurisdictions CCC Technical Assistance Workshop. The workshop was convened to provide a forum for an open dialogue on topics of interest to all PIJ Programs, including
a review of the unique characteristics of USAPIJ programs and communities, chronic disease prevention and control (colorectal cancer screening, HPV vaccination, cancer survivorship); access to quality cancer screening, diagnostic, and treatment services; understanding the needs of cancer survivors and patient navigation. This workshop was designed to provide an opportunity for action teams from each jurisdiction to work together to collaboratively plan and review strategies to address programmatic priorities for the next five years.

Sincere appreciation is extended to meeting partners and supporters including CDC, the American Cancer Society, the GW Cancer Center, National Cancer Institute, the University of Hawaii John Burns School of Medicine, the American College of Surgeons Commission on Cancer and Strategic Health Concepts. We hope the 2017 Pacific Island Jurisdictions CCC Technical Assistance Workshop report encourages and inspires readers in planning and implementing cancer prevention and control activities in the USAPIJs.

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DAY 1: TUESDAY, MAY 23\textsuperscript{RD}

Agenda:

8:30 am – Opening prayer

8:35 am – Welcome and introductions

9:00 am – “Look How Far We’ve Come!” Large Group Exercise

9:30 am – Mobilizing Community Action Through Effective CCC Coalitions

10:30 am – What’s Working, What Can Be Improved in Mobilizing Community Action through Effective CCC Coalitions in Our Jurisdiction? Individual PIJ Team Assessment with Facilitator

11:00 am – Break and move to Coalition Experience Exchange Discussions

11:15 am – Coalition Experience Exchange Discussions

11:50 am – Debrief Discussion

12:00 pm – Prayer and Optional Discussion on Betel Nut during lunch

1:00 pm – Increasing HPV Vaccination in the PIJs

2:00 pm – What’s Working, What Can Be Improved in Increasing HPV Vaccination Rates in Our Jurisdiction? Individual PIJ Team Assessment with Facilitator

2:45 pm – Break and move to Coalition Experience Exchange Discussions

3:20 pm – Debrief Discussion

3:30 pm – Facilitated Individual PIJ Team Discussion Planning Instructions

3:45 pm – Facilitated Individual PIJ Team Discussion and Planning

4:30 pm – Adjourn

The first day of the workshop started with an opening prayer from Mr. Motusa Tuileama Nua, director of health from American Samoa. Ena Wanliss, MS, National Partnership project lead, CDC, officially welcomed participants and provided an overview of the workshop.
Following the overview, a coordinator from each of the PJIs gave an overview of their jurisdiction to the larger group.
Karin Hohman, RN, MBA, Strategic Health Concepts, introduced the first large group activity, “Look How Far We’ve Come!” The activity highlighted PIJ accomplishments in CCC over the past three to five years. Each PIJ had submitted key CCC successes they wanted to share with others prior to the workshop, and 19 of them were posted on easel paper throughout the room.

Participants took time to read the accomplishments and provide their best guess as to which PIJ reported each success. After making their guesses, Ms. Hohman revealed the correct PIJ associated with each accomplishment, which gave participants the opportunity to acknowledge PIJs’ progress in CCC. Accomplishments included:

1. Development and finalization of a cancer survivorship plan (RMI)
2. Development of a cancer resource guide (Palau)
3. Creation of a cancer survivors support group (American Samoa)
4. Integration of survivorship services in to the Homebound Program (Kosrae)
5. Increased number of women getting screened through a church-to-clinic cancer screening campaign (RMI)
6. Visual inspection with acetic acid (VIA) training conducted and currently delivered with 11 certified staff (Kosrae)
7. Implementation of an annual VIA refresher training for new health providers (Pohnpei)
8. Initiation of quarterly breast and cervical cancer screenings on the outer islands (CNMI)
9. Update and revision of breast and cervical cancer screening and treatment guidelines (FSM)
10. Development and implementation of a breast and cervical cancer screening algorithm (Palau)
11. Passage of Tobacco 21, tobacco tax parity between smokeless and smoked tobacco (Guam)
12. Passage of a 150-foot smoke-free zone from national government buildings (FSM)
13. Passage of a comprehensive smoke-free indoor act, which bans smoking in all government buildings, vehicles, restaurants and bars (Chuuk)
14. Passage of a law banning the sale of the betel nut to minors (CNMI)
15. Development of a physical education and health curricula in 2015 and distribution to all schools in 2016 (Pohnpei)
16. Implementation of a successful pilot of the HPV program in schools (American Samoa)
17. Successful collaboration with the non-communicable disease physical activity team to implement obesity prevention activities, such as Early Start Fit for Life initiative (Guam)
18. Partnership with the non-communicable disease program to change outer island medical referral feeding program from store food to local food using a coupon system (Yap)
19. Increased demand for local food due to promotional efforts with vendors and farmers selling local foods seven days a week (Yap)
“Look How Far We’ve Come!” Activity

Figure 1: Word cloud of cancer control accomplishments reported by PJ teams
MOBILIZING COMMUNITY ACTION THROUGH EFFECTIVE CCC COALITIONS

After the activity, several speakers presented on the topic of mobilizing community action through effective CCC coalitions.

Karin Hohman, RN, MBA, Strategic Health Concepts, presented on CCC. Ms. Hohman defined CCC as, “a group of people—including individuals, governments, organizations and communities—working together on cancer problems.” Ms. Hohman highlighted the importance of identifying and involving key stakeholders that can affect or be affected by the efforts of an initiative. Ms. Hohman discussed the types of stakeholders to consider and how their influence and support may vary based on the project or initiative. Ms. Hohman also presented strategies to obtain buy-in. For instance, in order to increase interest and support of a key stakeholder, it is essential to engage in one-on-one communication, develop a relationship and present data and a rationale to support the initiative. Ms. Hohman stressed the importance of presenting clear, simple, action-oriented, persuasive, compelling and relevant information when meeting and discussing an initiative with a stakeholder.

Leslie Given, BA, MPA, Strategic Health Concepts, presented the Nine Habits of Successful CCC Coalitions. The CCC National Partnership resource outlines the following “attributes of high-performing CCC programs:"

1. **Empowering Leadership:** “Strong coalition leaders show their leadership by welcoming decision making by their members.”
2. **Shared Decision Making:** “Shared decision making guides the coalition. Steps are put in place so that no one organization overpowers the decisions made by the coalition.”
3. **Value-Added Collaboration:** “Members acknowledge and appreciate the benefits of forging alliances and working on efforts that might not be prioritized without the coalition.”
4. **Dedicated Staff:** “Because the members of the coalition are volunteers, who often hold leadership positions within their own organizations, the burden of additional work for coalition members needs to be recognized and partially handled by dedicated staff.”
5. **Diversified Funding:** “Diversified funding can create wider support of and involvement in the coalition’s efforts by a greater number of stakeholders and can allow the coalition to remain viable if one source of funding disappears.”
6. **Effective Communication:** “Coalition communication is a consistent and purposeful dialogue that uses all appropriate channels for discussion and feedback, including email, websites, phone calls, meetings and newsletters.”
7. **Clear Roles and Accountability:** “Coalition members understand their roles and feel accountable for accomplishing agreed-upon tasks. Members understand the mission of the coalition and how they, as individuals, can help achieve that mission. Coalition member roles are defined and communicated both verbally and in written documents.”

8. **Flexible Structure:** “The coalition structure is flexible, adapts to challenges and facilitates implementation of the cancer plan. The coalition strives to operate in a way that maximizes the effective and efficient work of its coalition members.”

9. **Priority Work Plans:** “Priorities are chosen and work plans are developed around evidence-based strategies. Work plans clearly articulate the expected outcomes, methods to reach those outcomes, responsibilities and timelines. The work plans are used to guide actions and are revised as challenges and opportunities arise.”

Following the discussion of the *Nine Habits of Successful Cancer Coalitions*, Ms. Given discussed the common ground between cancer and other non-communicable diseases and highlighted the benefits of collaboration, including:

- Reaching similar groups of people or work with the same community partners
- Identifying common problems and gaps in services and finding new ways to address them
- Solving similar problems together and more effectively and efficiently
- Defining roles and responsibilities more clearly to prevent duplications of effort
- Learning from each other

Angela Moore, MPH, program evaluation and partnership team lead, CDC, presented on “Harnessing the Power of CCC Coalitions: Implementing CCC Strategies.” Ms. Moore highlighted priority areas for CDC, which include reducing cancer risk and promoting a healthy lifestyle, promoting screening and early detection, improving quality of life among cancer survivors and addressing cancer disparities. Ms. Moore outlined evidence-based approaches to addressing priority areas, particularly policy, systems and environmental change and community-clinical linkages.

Policy, systems and environmental change “supports the improved health and wellbeing of individuals and families through a comprehensive and practical approach” (American Cancer Society, 2015). Policy, systems and environmental changes are public health strategies that “enable healthy options and allow the healthy choice to become the easy choice” (Truss, 2013). Examples include worksite wellness programs, creation of policy and guidelines that expand the role of allied health
professionals and reimbursement policies for community health workers so they can help people manage chronic conditions such as heart disease, stroke and diabetes.

Community-clinical linkage strategies develop and support relationships between communities and clinics so that patients are referred to disease management programs that will help them manage and reduce their risk, such as through patient navigators or community health workers.

During the “What’s Working and What Can Be Improved in Mobilizing Community Action Through Effective CCC Coalitions in Our Jurisdiction” session, PJJs worked with an assigned facilitator to determine which of the nine habits to focus on. PJJs also brainstormed the approach (policy, systems and environmental change or community-clinical linkages) and leadership support needed to address their priorities.

After the individual jurisdiction discussions, Ms. Hohman introduced the “Coalition Experience Exchange Discussions.” Participants sat at three different roundtables, each with representatives from Pohnpei, Palau and Guam, who led group discussions on mobilizing community action through effective CCC coalitions.

Pohnpei’s CCC coalition finalized and implemented coalition bylaws and certification; created sub-groups within their coalition focused on improving cancer treatment, early detection and screening; and implemented policy, systems and environmental change strategies in partnership with other non-communicable disease programs. A major challenge Pohnpei reported was obtaining community and political leadership buy-in to support their cancer efforts.

Palau conducted a coalition workshop to re-organize and set priorities for plan implementation. Palau is currently implementing policy, systems and environmental changes—aligned with the non-communicable disease strategic plan—with other non-communicable disease programs and community partners. For example, Palau passed a law to allocate 10% of alcohol and tobacco tax to fund non-communicable disease prevention activities.
Palau is also currently working to establish a provider reminder system for breast and cervical cancer screenings.

Guam is mobilizing and collaborating with coalition action teams to implement strategies that meet their cancer plan objective, which is to “engage and support the Guam Comprehensive Cancer Control Coalition and Non-Communicable Disease Consortium by maintaining the number of [policy, systems and environmental change] activities to four per project year.” Guam also collaborated with partners in the passage of policies such as Tobacco 21; Strengthening Guam’s Clean Indoor Air Act; Tobacco Tax Party; and the Elimination of Tobacco Discount Schemes. Guam’s initiatives were supported by several community champions, including local senators and prominent figures within the community. A challenge for Guam is limited human and financial resources.

As part of efforts to evaluate the workshop, participants were asked a different question after each session. Qualitative feedback was provided by writing on large sticky notes later displayed around the room. After the first session on Day 1, the posed question was: “What barriers and challenges exist to be an effective CCC coalition?” (Figure 2). Specific responses in participants’ own words were as follows:

- “Keeping engagement”
- “Lack of shared ownership”
- “Communication involving the outer islands”
- “The local cancer coalition lacks giving the opportunity for the community to get involved in the decision making”
- “Lack of flexible structure/bylaws”
- “Lack of collaborative initiatives”
- “Need more members from the community other than business people”
- “Work within coalitions and identify roles using the 9 Habits resource”
- “Lack of incentive for volunteer members of the coalition. At least provide funding for refreshments during meetings”
- “Limited financial and human resources”
- “Membership commitment (and burnout)”
- “Competing priorities”

Figure 2: Workshop participants’ responses to the question: “What barriers and challenges exist to be an effective CCC coalition?”
ORAL CANCER/BETEL QUID AND ARECA NUT

An optional discussion on “Oral Cancer/Betel Quid (BQ) and Areca Nut (AN)” (referenced as “betel nut” by PJIs) was offered to workshop participants during lunch hour. According to CDC, BQ is “a combination of betel leaf, areca nut and slaked lime,” and in “many countries, tobacco is also added, and the product known as gutka” (CDC, 2016). BQ and gutka use have been associated with negative health outcomes, including oral and esophagus cancers and oral precancerous lesions (CDC, 2016).

Participants from FSM including the states of Yap, Kosrae, Pohnpei, Chuuk; RMI; Palau; and Guam participated in the discussion. The following is a list of questions and summary notes:

1. **What current data are available to describe the prevalence of BQ/AN use, including data on who uses it, why and in what form in your country?**
   - Data are somewhat limited, or out-of-date.
   - Palau uses the World Health Organization 2011 STEPwise approach to surveillance (STEPS) survey. Palau has also conducted focus groups with audiences of different ages and are currently analyzing the data.
   - Guam mentioned that the University of Guam is conducting surveillance/research projects for the Pacific region.
   - Kosrae indicated that 49 percent of high school students use betel nut.

2. **What BQ/AN control policies or activities are you aware of in your country?**
   - Palau has banned betel nut in all schools and some workplaces.
   - Participants mentioned that the CNMI recently banned betel nut use under age 18.
   - RMI has banned betel nut import, but it has not been effective, as it can be grown easily.
   - Chuuk has banned betel nut use in one high school.
   - Pohnpei has banned betel nut chewing in public places.
   - Yap Department of Health Services has banned betel nut chewing in patient service areas in a bid to slowly get staff weaned off chewing while attending to patients. This workplace wellness initiative is also designed for health care staff to set an example and get patients to adhere to recommendations to stop chewing.

3. **Are there different patterns of BQ/AN use across distinct populations characterized in your country? (i.e. male versus female; specific subpopulations)**
   - Yap reports that there are no differences across age groups.
   - Guam reports that youth use betel nut more.
   - Palau reports that older populations tend to use betel nut, while youths smoke.
• Kosrae reports that younger populations use betel nut more.

4. **Are BQ/AN used in combination with tobacco? How are BQ/AN use behaviors similar to or different from those of tobacco use in your country?**
   • Generally, older people use BQ/AN in a traditional way, independent from tobacco, while younger people add tobacco. There is a general trend toward adding flavorings among youth, as well.

5. **Is BQ/AN control seen as a high priority in oral cancer prevention efforts in your country? Why or why not?**
   • Most jurisdictions indicate it is a high priority to prevent use.
   • In Yap, chewing is a cultural practice that is used to start conversations, as a sign of friendship or as a way to get time out to search for wisdom in the basket when tough decisions have to be made. It is a form of income and exchange in times such as marriage, death and peace offering. It is also used to stave off hunger, awaken the tired and sleepy senses and to calm nerves. Therefore, any open or active attempt to stop its use will naturally be met with resistance. Yap’s only option has been to slowly, but diplomatically, educate people over the last 10 years. They have done this by communicating its cancer-causing effect, sharing oral cancer data and organizing radio advertisements. Yap also includes health education about the dangers of betel nut during outreach presentations at community events and gatherings. They have also instituted partial chew bans at the hospital. More people are aware of betel nuts’ health effects now, and have openly tried quitting and stated they want to, but it is hard to quit and relapse is an issue.
   • In Yap, betel nut prevention is a high priority on the health services and public health side, but to engage the community and get buy-in, they have to use the soft approach (described above) especially since most of their traditional and elected officials and government leaders are all chewers. This is where they look to other PIJs to see what they are doing and how, and assess how best to adapt and create a best practice approach in Yap.

6. **Are there current BQ/AN (with or without tobacco) prevention and cessation programs in your country? If so, are you aware of any research or evaluation around those programs?**
   • Very few betel nut-specific and standalone programs for prevention exist. Most are in conjunction with tobacco control efforts. There is little to no focus on betel nut cessation.
   • Majority of research is conducted through University of Guam. They are currently conducting a pilot cessation program.
   • Kosrae has a school-based prevention program.

7. **Are there non-governmental key persons or organizations that focus on BQ/AN issues (with or without tobacco)?**
   • Primary non-governmental organizations involved are women’s councils and CCC coalitions, as well as University of Guam.
8. **What are some obstacles to implementing stronger effective BQ/AN control in your country?**
   - Anyone can grow it, so control/importation bans are difficult.
   - There is a lack of leadership, and many policy makers use it.
   - There is no funding or focal person to lead betel nut initiatives.
   - There is a lack of understanding about how to conduct betel nut-specific cessation programs.

9. **Is there a key contact or office in the national government that is responsible for BQ/AN issues?**
   - Not specifically for betel nut—reaching out to tobacco or cancer contacts would be best.

10. **What are your greatest needs related to betel nut prevention/cessation?**
    - Need help building the evidence base for prevention and cessation.
    - Need some basic funding and guidance about evidence-based approaches for betel nut prevention/cessation.
    - Need help getting political buy-in.
    - Need help with data: improving the quality of data and analyzing data.
    - Need ideas about how to overcome betel nut use that is congruent with the “Pacific Islander” identity.

**INCREASING HPV VACCINATION IN PIJS**

During the second half of the first day, the workshop focused on HPV vaccination efforts in the PIJs. Lee Buenconsejo-Lum, MD, professor at the University of Hawaii’s John A. Burns School of Medicine, presented, “HPV Vaccination Overview: How it Works and Why We Should Give it to Our Children”. Dr. Buenconsejo-Lum described the burden of HPV in PIJs, the etiology of certain cancers caused by HPV, how the HPV vaccine works and [ACIP recommendations](#) for HPV vaccination in adolescents. Some PIJs have the highest rates of cervical cancer in the world, but cervical cancer screening coverage remains low; therefore, it is critical to achieve high completion rates of the HPV vaccine in PIJs. Workshop participants were encouraged to vaccinate children under age 15 in two doses, six months apart, in accordance with ACIP guidelines. This schedule is also convenient for the many school-based HPV vaccination programs in the PIJs.
Mimi Eckert, MPH and Charnetta Williams, MD, National Center for Immunization and Respiratory Disease, CDC, focused on “Using Data to Increase HPV Coverage.” Due to high cervical cancer rates in PIJs and obstacles to conducting appropriate screening such as low health literacy, financial constraints and lack of resources, Ms. Eckert and Dr. Williams stressed the importance of primary prevention by vaccinating adolescents with the HPV vaccine.

Ms. Eckert and Dr. Williams introduced WebIZ, an immunization information system that can identify adolescents who are missing HPV doses, identify coverage rates by location and provide clinic/provider-specific reports of missing doses (WebIZ is not open-source). Ms. Eckert and Dr. Williams walked participants through the portal illustrating how to use the system. They also explained ways programs could use school rosters and HPV vaccine distribution data to calculate the proportion of HPV vaccines distributed to each student. This proportion is calculated by assessing the number of vaccines administered before the age of 15 per student. The goal is to have administered 2 vaccines per student, 2:1.

Marcie Fisher-Borne, MPH, MSW, PhD, director of HPV vaccination at the American Cancer Society, presented on “Core Messages to Increase HPV Vaccination”. Dr. Fisher-Borne provided participants with clear, concise and factual messages about HPV vaccination to combat common myths. One of the main reasons parents do not initiate HPV vaccination for their children is a lack of provider recommendation. In response to this finding, Dr. Fisher-Borne provided examples of ways to make an effective recommendation based on the “Same Way, Same Day” principle.

For instance, providers should recommend the HPV vaccine the same way and the same day that they would recommend tetanus, diphtheria and pertussis (Tdap) and meningococcal vaccines: “your preteen needs three vaccines today, to protect against meningitis, HPV cancer and pertussis.” Dr. Fisher-Borne highlighted lessons learned from Hawaii’s HPV vaccination initiative, including the need to make messaging stronger by emphasizing the connection between HPV and cancer, linking the HPV vaccine to other adolescent vaccines and targeting provider groups.
The “What’s Working and What Can Be Improved to Increase HPV Vaccination Rates in Our Jurisdiction” session focused on ways PJIs could approach transitioning from a three-dose to the newly recommended two-dose strategy. In doing so, PJIs considered ways they could use available data to (1) identify those who have completed two versus just one dose of the HPV vaccine; and (2) educate stakeholders to ensure they understand the rationale behind the updated recommendation.

During the second round of “Coalition Experience Exchange Discussions,” Kosrae, CNMI and Chuuk shared successes and challenges surrounding HPV vaccination initiatives. CNMI discussed their successful 2008 HPV vaccination campaign, where 94% of their target age group was vaccinated. CNMI discussed challenges they encountered once their school-based campaign was transferred to a clinic-based setting, where they have struggled to duplicate campaign popularity. Kosrae discussed challenges of improving HPV vaccination rates, including widespread misinformation, which has led to many parents not consenting for their children to receive the vaccine.

Misconceptions include the idea that the vaccine will cause infertility later in life and that it prompts adolescents to engage in sexual activity. Chuuk’s Immunization Program is working to vaccinate all fifth graders in their jurisdiction against HPV. The initiative includes awareness education in schools and throughout the broader community to obtain acceptance and consent from parents, community members and political leaders. Lack of transportation and access to HPV vaccines remain a challenge for outer islands.
Attendees were asked again to provide qualitative feedback by writing on large sticky notes to put up on display. After the session on HPV vaccination, the posed question was, “What additional programming/resources are needed to increase HPV vaccination in PIJs?” (Figure 3). Specific responses in participants’ own words were as follows:

- “Different funding source aside from CDC”
- “Include HPV in school vaccination policy mandatory”
- “Staff coordination on immunization WebIZ”
- “Funding support on media campaigns”
- “Funding”
- “Consent form”
- “Approach the HPV vaccine coverage and two-dose”
- “Started registering target population of three outer islands”
- “Work and public school service to draft Memorandum of Understanding between Public School System and Ministry of Health on vaccination enrollment and consent”
- “Work with the office of the president for full support”
- “Ongoing: comprehensive public health community outreach”
- “Next five-year project is a hard-hitting video on HPV vaccine (Did You Know?) and community outreach to schools and hospitals”
- “Internal memo from Ministry of Health on discharged physical examinations referred to public health”
At the end of the first day, PJJs worked closely with their facilitator to discuss takeaways from the day’s presentations and group discussions. Attendees brainstormed ways to build and improve their CCC coalitions and increase HPV vaccination in their PJJ. They began developing an action plan with specific tasks, dates, people responsible, important contacts, resources needed and measures of success. The action planning sessions were scheduled throughout the workshop and finalized plans were shared with the large group at the end of the workshop.
DAY 2: WEDNESDAY, MAY 24TH

Agenda:

8:30 am – Opening prayer; Welcome Back and Agenda for the Day

8:40am – Colorectal Cancer Assessment and Planning

9:55am – What’s Working, What Can Be Improved in Colorectal Cancer Assessment and Planning in Our Jurisdiction? Individual Jurisdiction Team Assessment with Facilitator

10:15am – Break and move to Coalition Experience Exchange Discussions

10:30am – Coalition Experience Exchange Discussions

11:00am – Cancer Survivorship

12:00pm – What’s Working, What Can Be Improved in Cancer Survivorship in Our Jurisdiction? Individual Jurisdiction Team Assessment with Facilitator

12:30pm – Prayer and Lunch

1:30pm – Palliative Care

2:00pm – What’s Working, What Can Be Improved in Palliative Care in Our Jurisdiction? Individual Jurisdiction Team Assessment with Facilitator

2:30pm – Break and move to Coalition Experience Exchange Discussions

2:45pm – Coalition Exchange Discussions

3:15pm – Debrief Discussion

3:30pm – Facilitated Individual PIJ Team Discussions and Planning

4:30pm – Adjourn

The second day of the workshop began with a prayer from Ms. Pertina Albert from Pohnpei in her local dialect. Ena Wanliss then welcomed the group back and presented the agenda for day 2.
COLORECTAL CANCER ASSESSMENT AND PLANNING IN PIJS

The topic for the morning of day 2 focused on “Colorectal Cancer Assessment and Planning in PIJs.”

Haley Cash, PhD, MPH, non-communicable disease regional epidemiologist for USA Pacific Islands at CDC and Pacific Island Health Officers’ Association (PIHOA), presented “Colorectal Cancer Data in the USAPIs”. The main data sources in PIJs are the Cancer Registry, adult population-based surveys and Health Information System (HIS)/Electronic Health Records (EHRs). Data indicate higher incidence of colorectal cancer, poorer rates of colorectal cancer survival and lower screening rates in PIJs compared to the United States as well as the need for increased surveillance. Increased surveillance is necessary in order to obtain baselines of adult screening rates for goal-setting and prioritization of interventions.

Mark Durand, MD, MPH, PIHOA, focused on “Colorectal Cancer Screening for the USAPIs: Current Issues.” Dr. Durand presented a series of questions for PIJs to consider when strategizing about ways to improve colorectal cancer screening in their jurisdiction:

- What is the payoff?
- How big is the task?
- What are the tradeoffs?

With limited public health resources allocated to PIJs compared to the United States, it is important to consider tradeoffs in cancer screening. For example, despite its proven effectiveness, cervical cancer screening rates remain low despite its high incidence compared to colorectal cancer. Therefore, Dr. Durand argued that colorectal cancer screening should be prioritized only second to cervical cancer screening in PIJs, especially when considering ways to maximize resources.

Nikki Hayes, MPH, branch chief, CDC, outlined CDC’s priorities for “Colorectal Cancer Assessment and Planning.” Priority topics include elimination of preventable cancers; access to the right screening at the right time; providing the best possible cancer care and outcomes; and longer, healthier lives for cancer survivors. Ms. Hayes provided information on coverage for colorectal screening tests through the Patient Protection and Affordable Care Act (ACA) of 2010, as well as the 2016 United States Preventive Services Task Force recommendations for colorectal cancer screening. Ms. Hayes also highlighted the Cancer Moonshot Prevention and Diagnosis Workgroup priorities, which includes improving colorectal cancer screening rates.
Kevin Cassel, DrPH, assistant professor, University of Hawaii Cancer Center, presented information on the Screen to Save program to illustrate outreach strategies for colorectal cancer screening. The purpose of Screen to Save is to implement an evidence-based outreach and colorectal cancer screening initiative that provides educational information on colorectal cancer incidence, risk factors and prevention. Partners for the initiative include faith-based organizations; libraries; pharmacies; health departments; and salons and barbershops.

Community health educators are charged with conducting quarterly education outreach using the Screen to Save materials that are culturally appropriate for the population. Three activity formats were used as part of primary outreach: 1) an inflatable colon; 2) PowerPoint presentation; and 3) flip books and flip charts. Community health workers then self-selected the format(s) most appropriate to use for their health site.

As an example, Dr. Cassel highlighted a colon cancer screening intervention in Hawaii. Data collected for this initiative revealed that more than 58% of Native Hawaiian men over age 50 have never been screened for colon cancer. Research demonstrated that community-based social networks may help Hawaiian men adopt healthy behaviors including colon cancer screening. However, there is little focus on using existing social networks to promote colon cancer screening among Native Hawaiian men. The screening initiative in Hawaii used the Hawaiian practice of “hale mua” (men’s house) in order to promote colon cancer screening among Hawaiian men (kāne).

Cultural considerations such as language, ancestral understanding and practices related to food preparation and beliefs associated with major organs (e.g. na’ua, or small intestine, is also believed to be a spiritual area of the body) were important factors to consider when initiating the screening program. In addition, Dr. Cassel discussed how colon cancer screening should never be considered without having the necessary treatment available to those who are screened. Further, data should be collected and analyzed concerning the burden (number of newly diagnosed cases and number of deaths) of colon cancers before considering implementation of a screening program.

This analysis can include subgroup stratification (e.g. ethnic groups, gender group and geographic location), which is essential in prioritizing the types of cancer screening implemented in a particular jurisdiction. Based on need and resources available, colorectal cancer screening may come second to other cancer screenings.

There are also a multitude of evidence-based colorectal cancer screening education programs available on the National Cancer Institute website, such as the Filipino-American Health Study, which is “designed to increase colorectal cancer screening among Filipino Americans,” and the Kukui Ahi.
(Light the Way): Patient Navigation, which is “designed to promote cancer screening among [Pacific Islander] adults.” Such programs should be further tailored to suit populations of interest.

During the “What’s Working and What Can Be Improved in Colorectal Cancer Assessment and Planning in Our Jurisdiction” session, PIJs and their facilitators discussed their current capacity to address colorectal cancer prevention, screening, diagnosis, follow-up and treatment. PIJs also considered available data sources and additional data and resources needed to plan and monitor colorectal cancer interventions.

The third round of “Coalition Experience Exchange Discussions” focused on colorectal cancer and was led by FSM, Yap and RMI. Yap shared their experience of providing a free screening program for men and women 18 years and older during National Women’s and Men’s Health Weeks. Fecal occult blood tests (FOBTs) were provided to men and women who met the age and risk requirements. RMI shared their experience of successfully updating their resource-stratified colorectal cancer guidelines and plans to implement a colonoscopy training program for physicians. RMI discussed the lack of clinical support and champions for men’s health as a major challenge.

Attendees were again asked to provide qualitative feedback by writing on large sticky notes to put up on display. After the later session on day two, the posed question was: “What policy, systems and environmental strategies could be implemented to increase colorectal cancer screening in your community?” (Figure 4). Specific responses in participants’ own words were as follows:

- “Improving what we can: reminder systems, etc.”
- “Creation of colorectal cancer program via trust fund monies that cover FIT and colonoscopy/sigmoidoscopy”
- “Connecting current health systems”
- “Why do the territories have to push the colorectal initiative, i.e. education/screening and not concentrating on what is the top killer in their communities?”
- “Sounds like the Roundtable is dictating what we do and not assessing the territories with our needs…”
- “Standardize procedures in clinics to mandate colorectal screening and referral and report”
- “Previous education on colorectal cancer”
- “Assessment and feasibility study”
- “Identify colorectal cancer resources, continue screening and community awareness on colorectal cancers”
- “Currently we have a) CT-scan b) colonoscope and c) fecal occult blood test; [next steps are to establish a palliative care committee, re-training on palliative care; draft standard operating procedure on pain management; hire a new patient navigator”
- “Establish data base in the laboratory: strengthen our [Chronic Disease Electronic Management Systems] CDEMs; review cancer registry for colorectal cancer, revisit the law on cancer registry data for doctors”
During the second half of day two, the workshop focused on “Cancer Survivorship Efforts in PIJs.”

Lana Sue Ka’opua, PhD, DCSW, LSW, professor at the Myron B. Thompson School of Social Work and associate member of the University of Hawaii Cancer Center, presented on “Cancer Patient Navigation.” Dr. Ka’opua highlighted the Tautai Lavea’i program (tautai refers to steering or navigating a canoe and lavea’i refers to preventing harm). It is a patient navigator program designed to reduce loss to follow-up and increase timely receipt of cancer services for breast cancer survivors. Tautai Lavea’i was tailored to provide linguistically appropriate, culturally grounded supportive services for Samoans living in American Samoa.

Figure 4: Workshop participants’ responses to the question: “What policy, systems and environmental strategies could be implemented to increase colorectal cancer screening in your community?”

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The hospital-based patient navigator program was able to identify and support women with breast cancer and their families. Partnerships with the Lyndon B. Johnson Tropical Medical Center and the American Samoa Cancer Community Network proved critical for infrastructure support. In forging such partnerships, Dr. Ka’opua noted that it is important to weave indigenous Pacific Islander ways of knowing with Western-derived evidence-based practice. Such integration offers the best prospect of health equity for all.

Amanda Allison, community health worker certificate program instructor at Kapi’olani Community College, former education and training coordinator at Papa Ola Lokahi, and project specialist (patient navigation) at ‘Imi Hale Native Hawaiian Cancer Network (a program of Papa Ola Lokahi), presented on “Cancer Survivorship.” Ms. Allison presented information on the physical, social, psychological, emotional and economic burdens that many cancer survivors face. Ms. Allison highlighted the importance of survivorship care planning and ways they could be developed and used in PIJs. Survivorship care plans developed in PIJs need to be simple, portable and applicable to PIJs’ specific population needs.

Neiar Kabua, RMI CCC program coordinator and Dr. Helentina (Aina) Garstang, MO, DCHMS, RMI Cancer Council of the Pacific Islands (CCPI) medical director of public health, presented on “Cancer Survivorship Assessment and Plan for the RMI Cancer Program.” The goals of the program were to improve cancer prevention, screening and early detection and provide adequate and culturally appropriate support for cancer survivors.

Overall, the assessment found that there is a significant disconnect between patients and providers about aspects of survivorship care that need to be developed or prioritized. Specifically, the assessment found that 1) providers perceived survivorship care plans as a high priority, but patients did not; 2) providers did not perceive education on the late effects of cancer and treatment as a high priority, but patients did; and 3) providers did not perceive family and support groups as high priority, but patients did. Based on these findings, RMI shared their six priority recommendations for cancer survivorship, including:

1. Develop training and education on cancer survivorship
2. Encourage use of survivorship care plans
3. Enhance human resources and staffing for survivorship care
4. Develop culturally and geographically appropriate services for cancer survivors
5. Promote evidence-based clinical care guidelines related to survivorship care among primary care providers
6. Enhance resources for cancer survivorship care
The “What’s Working and What Can Be Improved in Cancer Survivorship in Our Jurisdiction” session gave PIJs the opportunity to brainstorm approaches to enhance patient navigation efforts. They considered specific services along the cancer care continuum for various types of cancers and populations. PIJs also discussed strategies to increase the number of cancer survivors that receive survivorship care plans in their jurisdictions.

PALLIATIVE CARE

The final presentation focused on palliative care in PIJs. Patricia Winck Nishimoto, DNS, FAAN, Tripler Army Medical Center, began her presentation on palliative care with a group activity. All participants lined up in the middle of the room. Ms. Nishimoto stood at the front of the line facing the group and shouted out two options from which the group should choose (bananas or oranges, sharks or dolphins, etc.). Participants made a choice and the line split in two. The activity illustrated the decisions people make every day based on personal preferences, much like the way patient preferences influence treatment decisions and palliative care. Ms. Nishimoto stressed the importance of integrating palliative care into the spectrum of the cancer care experience.

During the “What’s Working and What Can Be Improved in Palliative Care in Our Jurisdiction” session, participants were asked to individually recall and reflect on an example of a family or friend’s medical care experience where palliative care was or was not used. In addition, members identified barriers
that their family or friend experienced if they did not receive palliative care or factors that facilitated their family or friend to receive palliative care. As a group, participants discussed whether most people in their jurisdiction share a similar experience to that of their family or friend and potential strategies to integrate palliative care into the cancer care experience.

The fourth and final round of “Coalition Experience Exchange Discussions” were led by American Samoa, Yap and RMI. These jurisdictions shared their successes and challenges related to cancer survivorship and palliative care. American Samoa discussed their Cancer Survivor Support Group and ways they successfully increased membership from zero to 20 members. Yap discussed the challenges in maintaining a support group for survivors, including limited staff and competing priorities. RMI’s cancer survivor support groups continue to be offered at hospitals and homes for patients and their families and they are making progress in cancer survivorship planning, palliative care and pain management.

Again, attendees were asked to provide qualitative feedback by writing on large sticky notes to put up on display. After the first session on day 2, the posed question was: “What is the biggest need for PIJ cancer survivors?” (Figure 5). Specific responses in participants’ own words were as follows:

- “Oncologist on the island”
- “Cancer treatment (radiology, chemotherapy, radiation)”
- “Medical/pharmacy, palliative care, pain medication”
- “Hiring of patient navigator”
- “Follow the cancer survivorship plan”
- “Survivorship summary care plan from off- or in-island referrals”
- “Adopt other countries’ success stories and guidelines on palliative care and patient navigation”
- “Incorporate care in home bound and hospital settings”

**Figure 5**: Workshop participants’ responses to the question: “What is the biggest need for PIJ cancer survivors?”
At the end of the second day, jurisdictions worked with their facilitator and individual team members to discuss takeaways from the first and second days' presentations and group discussions. PIJs brainstormed their specific needs in colorectal cancer, cancer survivorship and palliative care. PIJs continued developing their action plan defining priorities, goals, objectives and specific tasks to accomplish their priorities.
DAY 3: THURSDAY, MAY 25TH

Agenda:

8:30 am – Opening prayer; Welcome Back and Agenda for the Day

8:40 am – Answering Questions and Addressing Technical Assistance Needs

9:30 am – Final Facilitated Individual PIJ Team Discussion and Planning

10:15 am – Action Plan Sharing

11:00 am – Workshop Wrap-Up and Next Steps

11:30 am – Closing Prayer and Lunch

12:30 pm – CDC Program Meetings Throughout the Afternoon

The third and final day of the Pacific Island Jurisdiction Workshop opened with a prayer from Ms. Irish Tutii from Palau. Ena Wanliss then welcomed the group back and presented the agenda for day three.

Angela Moore, MPH, program evaluation and partnership lead, CCC and Jamila Fonseka, MPH, CHES, public health advisor, both from CDC, facilitated a question and answer session with participants. Ms. Moore and Ms. Fonseka then provided information on schedules for the afternoon CDC program meetings with individual jurisdictions.
ACTION PLANS

Following the question and answer session, jurisdictions worked with their facilitators to finalize their action plans. After finalizing their plans, Ms. Hohman facilitated the action plan sharing session. Each jurisdiction shared their topline priorities with the larger group:

American Samoa
- Create a strategic plan for palliative care for cancer patients and their families
- Integrate prevention strategies into primary care practice in American Samoa
- Expand existing HPV vaccination program

Guam
- Engage survivorship work group in developing plans for people “beyond cancer” and survivorship plans

FSM National
- Amend the current Immunization Act to include HPV vaccine
- Implement the existing Cancer-Immunization Collaborative action plan
- Clarify roles of the National Cancer Steering Committee
- Develop protocol/guidelines for colorectal cancer
- Conduct palliative care training
- Create a survivor care plan template

Chuuk
- Set up a permanent system (procurement and budget) to obtain nitrous oxide or carbon dioxide in order to treat women using cryotherapy immediately for abnormal Pap smears or VIA test
- Create a Chuuk Survivorship Workgroup
- Hire a Chuuk Cancer Registrar
- Identify and implement the Community Health Worker curriculum that fits best for Chuuk

Kosrae
- Coalition: Empower leadership
- Colorectal Cancer: Conduct an assessment and explore feasibility
- HPV: Bust myths
- Survivorship: Train health workers

Pohnpei
- Increase HPV vaccination rates in 5th and 6th grade girls and boys in Pohnpei
- Review 9 Habits of Effective Coalitions with coalition and identify the habits that need work
o Colorectal cancer:
  o Increase awareness of colorectal cancer risk, prevention, symptoms
  o Consider integrating some colorectal cancer screening into the community outreach protocol
  o Reorganize and revitalize palliative care team

Yap

  o Revise the Immunization School Health Certificate to include HPV vaccine
  o Plan a “Screen to Save” FOBT education and awareness campaign
  o Strengthen survivorship support in the PEP clinic services

Palau

  - Patient Navigation: Create a protocol to fill in the gap between diagnosis and treatment
  - Effective CCC Coalition: Create a membership packet

RMI

  - Increase HPV [vaccination] coverage rate
  - Increase cervical cancer screening and HPV [screening] in the outer islands
  - Improve survivorship coordination and referral
  - Conduct physician palliative care training
  - Re-establish the palliative care committee
  - Improve colorectal cancer screening

CNMI

  - No action plan submitted (CNMI’s CCC program coordinator could not attend the workshop)
Jurisdictions sharing their topline priorities
The action plan sharing session was followed by a recap of the accomplishments of the last three days, a brief discussion on key takeaways and next steps. At the end of the workshop, a final closing prayer was offered by Dr. Livingston Taulung, director of health from Kosrae.
EVALUATION

The PIJ Workshop Planning Committee administered paper and electronic surveys at the end of the workshop to assess (1) participant satisfaction, (2) outcomes of the workshop and (3) ways to improve similar meetings in the future. Of the 29 participants who completed the survey, ten represented PIJ CCC programs (35.7%), nine represented PIJ coalitions (32.1%), eight represented CCC National Partnership Organizations (28.6%) and two represented State CCC Programs (7.1%) (Figure 6).

Eleven respondents were program coordinators/managers/directors (39.3%), eight were PIJ coalition members (28.6%), three were immunization program managers (10.7%), and ten had other roles, including a University of Hawaii faculty member, a fiscal officer, public health department staff, a marketing and community outreach manager and a Department of Education representative (17.9%). The vast majority of respondents (20) have held their role for over two years (71.3%), five for less than 12 months (17.9%) and three for 12-24 months (10.7%).
Participants were also asked in the survey to rate their satisfaction with and the process of the workshop from 1 (strongly disagree) to 5 (strongly agree). On average, workshop attendees agreed that they were satisfied with the workshop process (Table 1).

<table>
<thead>
<tr>
<th>Table 1: Average ratings for process and satisfaction evaluation questions (1=strongly disagree, 5=strongly agree) (n=29)</th>
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</thead>
<tbody>
<tr>
<td>I was able to network during the workshop</td>
</tr>
<tr>
<td>The workshop objectives were clearly stated</td>
</tr>
<tr>
<td>The workshop agenda aligned with the objectives</td>
</tr>
<tr>
<td>Time allotted to each agenda item was appropriate</td>
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<tr>
<td>Issues being discussed during breakout sessions were pertinent to my interests</td>
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<tr>
<td>The “Look How Far We’ve Come!” large group exercise improved my understanding of PIJs’ progress and accomplishments in cancer over the past several years</td>
</tr>
<tr>
<td>The priorities discussed during the “Individual Jurisdiction Team Assessment” were satisfactory and actionable</td>
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<tr>
<td>The “Coalition Experience Exchange” discussions increased my understanding of PIJ successes and challenges in cancer survivorship, colorectal cancer, HPV vaccination and comprehensive cancer control coalitions</td>
</tr>
<tr>
<td>The priorities established during the “Facilitated Individual PIJ Team Discussion and Planning” were satisfactory and actionable</td>
</tr>
<tr>
<td>Average level of satisfaction with the process</td>
</tr>
</tbody>
</table>

To assess short-term outcomes of the workshop, the survey asked participants whether they intended to practice what they learned and implement action plans. On average, workshop attendees agreed that they do (Table 2).

<table>
<thead>
<tr>
<th>Table 2: Average ratings for short-term outcomes evaluation questions (1=strongly disagree, 5=strongly agree) (n=28)</th>
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<tbody>
<tr>
<td>I intend to identify evidence-based interventions to mobilize community action through effective comprehensive cancer control coalitions</td>
</tr>
<tr>
<td>I intend to identify evidence-based interventions to increase HPV vaccination uptake</td>
</tr>
<tr>
<td>I intend to identify evidence-based interventions to address cancer survivors’ needs</td>
</tr>
<tr>
<td>I intend to assess colorectal cancer needs in my community</td>
</tr>
<tr>
<td>I intend to provide evidence-based interventions to address colorectal cancer in my community</td>
</tr>
<tr>
<td>I intend to make policy, systems and environmental changes in my community</td>
</tr>
<tr>
<td>I intend to implement the priority action plans created during the workshop</td>
</tr>
<tr>
<td>Average level of intention to apply workshop outcomes</td>
</tr>
</tbody>
</table>
The most valuable components of the workshop, as reported in free responses by attendees, included:

- **Coalition Experience Exchange Sessions** (n=12): Selected PIJ representatives shared their successes during group discussion session on predetermined topics such as coalition functioning, HPV vaccination, colorectal cancer assessment and planning, cancer survivorship and palliative care. One participant said, “I truly appreciated the coalition experience exchange discussions as it gave an insight to the different ways countries were implementing their programs.”

- **Action Planning** (n=4): Individual PIJ teams had time throughout the workshop to discuss and build consensus on the contents of their action plans. One participant said, “Our team was able to work closely to put things together effectively.”

- **Facilitated PIJ Team Discussion and Planning** (n=4): Individual PIJ teams had time throughout the workshop to 1) debrief on materials presented by speakers; 2) hear about successes and challenges from other participants; and 3) plan actions to implement back in their home jurisdictions with help from a facilitator. One participant said, “Group discussions on subject after each presentation was most valuable to our team.”

- **Facilitation** (n=4): A facilitator sat with individual PIJ teams to guide discussion throughout the workshop. One participant said, “Having a strong facilitator to help us with strategic planning” was meaningful.

- **Presentations** (n=2): Subject matter experts gave talks throughout the workshop to lay the foundation for discussions thereafter. One participant said, “Presenters [were the] right people.”

The least valuable components of the workshop, as reported in free responses by attendees, included:

- **Lack of Time** (n=1): One participant said that “time allotted for the workshop…was limited.”

- **Coalition Experience Exchange** (n=1): One participant said that while the exchanges were interesting to hear, some of the experiences of the other islands will just not be feasible in my jurisdiction.”

- **Presentations** (n=1): One participants said that some content of the presentations were rudimentary, but understood that “perhaps it was to ensure everyone have [sic] the same 101 understanding.”

Areas for improvement for future workshops include:

- Providing meals (n=5): One participant said, “Lunch and snacks MUST be included—best practice for PIJs.”

- **Venue** (n=3): One participant said that the venue was “too cold and no windows/natural light—makes you want to sleep.”

- **Make travel to the workshop easier** (n=3): One participant said, “Consider doing half day on the first day in the afternoons. With travel time and time zone differences, folks will be more rested.” Another suggested conducting the workshop in “the PIJ, especially if CDC is participating for their own understanding.”
More group work (n=2)  
More time (n=2)  
Securing separate rooms for discussion (n=1)  
Providing trainings during the workshop, such as strengthening coalition partnerships (n=1)

Stakeholders that attendees indicated they would like to see at the next workshop included:

- More PIJ coalition members (n=7)  
- Survivors (n=6)  
- Immunization Program staff (n=6)  
- Clinicians (n=5)  
- Local and community PIJ programs (n=4)  
- Decision- and policy-makers (n=3)  
- Additional CCC National Partnership organizations, including National Association of Chronic Disease Directors, American Cancer Society and CDC Immunization Officers (n=3)  
- World Health Organization (n=1)

Technical assistance needs as identified by participants are:

- Trainings, including for community health workers and on coalition functioning, palliative care, colorectal cancer screening and “101-type” trainings on cancer and related issues (n=10)  
- Site visits and on-site technical assistance (n=3)  
- Identifying opportunities for and sources of funding (n=2)  
- Creating and maintaining coalitions (n=2)  
- Information technology and Immunization Information Systems (n=1)  
- Communication and prevention messages (n=1)  
- Policy development (n=1)  
- Survivorship care plans (n=1)

As the evaluation results show, the workshop provided an opportunity for PIJ cancer and immunization programs, coalitions, CDC staff and stakeholders to network, share experiences and discuss and plan activities to reduce the burden of cancer in PIJs. Over the next six months, ACS will provide tailored follow-up to help workshop attendees and stakeholders evaluate the implementation of their action plans, identify challenges, and address technical assistance needs. PIJs seek further support with additional trainings and on-site technical assistance for topics including coalition functioning and palliative care.
RESOURCES

Mobilizing Community Action through Effective CCC Coalitions

- **Nine Habits of Successful CCC Coalitions** identifies “attributes of high-performing CCC programs with input from CCC coalition members and many CCC experts throughout the nation.”
- **Comp Cancer 101 Wiki** summarizes the nuts and bolts of CCC coalition tasks. There are sections on **Coalition Organization and Leadership Structure; Membership, Communication and Engagement**; and **CCC Plan Development**.
- **The Grants and Funding: Diversifying and Securing Resources for Cancer Control webinar recording** guides CCC coalitions on finding funding sources and completing grant applications and features case studies from Kentucky, Georgia and Virginia.
- **The notes from the Ask-the-Expert session on CCC Coalition Membership and Leadership** summarizes key points of discussion and ways to establish and maintain effective structures and features of coalition membership and leadership.
- **Commission on Cancer State Chair Toolkit** provides State Chairs with guidance for participation with their state’s coalition.
- **Collaboration and Team Science: A Field Guide** can be applied to the structure of CCC coalitions, using the strengths of each member.

Increasing HPV Vaccinations in the PIJs

- **The HPV Vaccination Resource Clearinghouse** contains more than 400 resources from national organizations.
- **HPV Vaccination Partner Toolkit** includes “resources for state and local organizations interested in enhancing HPV vaccination at the clinician, patient and partnership levels.”
- **The HPV Myth Busting for Health Care Providers Social Media Toolkit** is designed to help public health professionals establish a “Myth Busting” social media strategy to encourage providers to effectively talk to parents and adolescents about the HPV vaccine.
- **The HPV Vaccination Resource Book** is a primer on HPV to help prepare you to facilitate professional education and provider outreach to increase HPV vaccination rates in your area.
- **The Using Immunization Information Systems (IIS) to Increase HPV Vaccination Uptake webinar recording** and **slides** identify ways health care providers IIS can be leveraged to support programs.
- **The HPV Vaccination Initiative Contact Map** provides contact information for various HPV vaccination initiatives by state/territory, organization and project type.
- **The Steps for Increasing HPV Vaccination in Practice: An Action Guide to Implement Evidence-based Strategies for Clinicians** provides detailed steps, evidence-based strategies, and tools to increase HPV vaccination through system changes in the clinical setting.
- **Hospitals and Cancer Centers: Vaccinate Adolescents against Cancers** details strategies for hospitals and cancer centers to increase HPV vaccination coverage.
Colorectal Cancer Assessment and Planning

- **United States Cancer Statistics and Data Visualization website** is a user-friendly tool that provides easily accessible cancer surveillance data, as well as the Cancer Moonshot Prevention and Diagnosis Workgroup priorities, which includes improving colorectal cancer screening rates.
- **Screening for Colorectal Cancer: Optimizing Quality** is a “continuing education activity that provides guidance and tools for clinicians on the optimal ways to implement screening for colorectal cancer to help ensure that patients receive maximum benefit.”
- **80% by 2018 Communications Guidebook: Recommended messaging to reach the unscreened** is designed to help educate, empower and mobilize key audiences who are not getting screened for colorectal cancer.
- **What can Comprehensive Cancer Control Coalitions Do to Advance 80% by 2018, What can Communities Do to Advance 80% by 2018 and What Can Survivors & Families Do to Advance 80% by 2018** provide strategies to support the initiative to increase colorectal cancer screenings.
- **Management of Colon Cancer: Resource-Stratified Guidelines from the Asian Oncology Summit 2012** outlines strategies that can be implemented “in Asian countries with different levels of health care resources and economic development, stratified by basic, limited, enhanced and maximum resource levels.”
- **Colorectal Cancer Awareness Month Social Media Toolkit 2017** is designed to help public health professionals establish a Colorectal Cancer Awareness Month social media strategy, manage social media accounts, implement Facebook and Twitter best practices, disseminate Colorectal Cancer Awareness Month messaging and evaluate their social media efforts.
- **Screen to Save** is a culturally sensitive, evidence-based outreach and colorectal cancer screening initiative that provides educational information on colorectal cancer incidence, risk factors and prevention.

Cancer Survivorship and Palliative Care

- **Supporting Cancer Survivors through Comprehensive Cancer Control Programs** report presents a national snapshot of the current state of cancer survivorship in the United States, including what we know about the health status, needs and disparities among survivors.
- **Cancer Survivorship E-Learning Series for Primary Care Providers** is a continuing education program offered at no cost that provides a forum to educate primary care providers on how to care for survivors.
- **Oncology Patient Navigator Training: The Fundamentals** is a no-cost competency-based training that uses interactive web-based presentations to discuss evidence-based information and case studies to prepare patient navigators to effectively address barriers to care for cancer patients and survivors.
- **Advancing the Field of Cancer Patient Navigation: A Toolkit for Comprehensive Cancer Control Professionals** guides states in advancing patient navigation by educating and training patient...
navigators; providing technical assistance to members of the coalition; building navigation networks at the state level; and identifying policy approaches to sustain patient navigation.

- Kokua Mau Hawaii Hospice and Palliative Care Organization provides resources on Advance Directives.
- The National Coalition for Cancer Survivorship provides resources on cancer survivorship care plans.

For more resources, visit GW Cancer Center’s Cancer Control Technical Assistance Portal’s (TAP) searchable Resource Repository of tools and resources, including reports, toolkits, fact sheets, infographics and trainings. New resources are added regularly, and readers are also encouraged to submit resources to be added to the repository.
REFERENCES

