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   Beverly D. Taylor, M.D.

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   Morehouse School of Medicine
   Atlanta, Georgia 30310-1495

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13. ABSTRACT (Maximum 200)
    Morehouse School of Medicine has developed a Breast Health Education Study that focuses on two groups:
    1) minority, underserved women who are residents of Atlanta Housing Authority communities, and
    2) primary care physicians and other health care providers who care for the medically underserved.
    The study seeks to determine and validate the efficacy of community-based educational program initiatives in promoting breast health in this population by educating and motivating target women to seek mammograms and perform breast self-examinations on a regular basis. We also seek to determine and validate the efficacy of an innovative educational initiative in encouraging other health professionals to discuss and promote clinical breast exams, mammographies and breast self-examinations to their female patients.
    During the second year of the study (FY 95-96), seven communities within the Atlanta Housing Authority were identified, along with community leaders, and informed of the project and encouraged to participate. Community Lay Health Workers (CLHW) who are also residents of the communities selected were hired, trained and are working in the community. Morehouse School of Medicine students in the Masters of Public Health Program as well as medical students were hired to assist the CLHW in the conduction of the breast health education community health needs assessment and baseline breast cancer knowledge, attitudes and practices assessment in each community. Two hundred men and women of various ages were randomly selected from community clusters to participate in the survey.
    INFODRAMA presentations (The Education Initiative for Health Professionals) were conducted at the Annual Meeting of the Atlanta Chapter of National Black Nurses Association and the 6th Annual Meeting of the National Black Leadership Initiative on Cancer, Southern Region.
    Preliminary results of the community assessment substantiate the need for breast health education programs if we are ever going to favorably impact the health of these communities.

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Atlanta, Georgia 30310-1495

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Beverly T. Taylor, M.D. 7/30/97
PI = Signature Date
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INTRODUCTION

The Breast Health Education Study at Morehouse School of Medicine, received funding for a three year cycle, by the Department of Defense in 1994.

The purpose of the currently funded project is: to seek to determine and validate the efficacy of a community-based educational program initiative in promoting breast health in minority, medically undeserved women by educating and motivating them to seek mammograms and perform breast self-examination on a regular basis.

The study focuses on two groups to achieve its goals:

1) minority and undeserved women, in the metropolitan Atlanta area, and

2) family and primary care physicians and other health care providers who care for the medically undeserved

Nature of the problem:

African American women are more likely than white women to have advanced breast cancer and to have poor survival from those cancers.\(^1,2,3,4\) Although the incidence rate of breast cancer is lower in African American women than White women (94.0/100,000 vs 113.20/100,000), the mortality rate in this population is higher (31.2 vs 27.2).\(^5\) Further, once diagnosed with breast cancer, African American women tend to have lower survival rates than White-American women. The five year survival rate is 81.6% for whites but only 65.8% for Black women.\(^5\) This is thought to be due primarily to the more advanced stage of the disease at the time of diagnosis.\(^6,7,8,9\)

Reasons for this advanced stage of disease has included limited access to health care and decreased use of mammographic screening\(^8\) as well as some socioeconomic and hormonal issues.

Many studies have been done to determine the reasons for low mammography use among
African American women. Results have revealed that many women do not get mammograms because their physicians don’t tell them that they need one, nor make any references to them.\textsuperscript{9,10,11,12} Lack of knowledge about the screening recommendations is another barrier to complying with recommendations.\textsuperscript{13,14,15,16} From these studies, it becomes clear that a two-tiered approach to promoting mammography screening among women is indicated.

This breast cancer education and prevention project attempts to address the three overall goals of Healthy People 2000: to increase the span of healthy life, to reduce health disparities, and to achieve access to preventive services for all Americans. Two preventive service objectives are also addressed: \textbf{Objective 16.3}-- to reduce breast cancer mortality, and \textbf{Objective 16.11}-- to increase the proportion of women age 40 and older who received a clinical breast examination and mammogram. At least two Educational and Community-Based Program objectives are addressed: \textbf{Objective 8.1} which seeks to increase the years of healthy life of black people and \textbf{Objective 8.11} which emphasizes increasing culturally appropriate community health promotion programs for minority populations.\textsuperscript{17}

\textbf{Background of previous work:}

The Atlanta Coalition on Breast Health was established in August 1990 by the Southern Region of the National Black Leadership Initiative on Cancer (NBLIC) to focus on the problem of breast cancer among black women in the Atlanta area. The Coalition has implemented as its major project, the Black Women’s Mammography and Screening Project, a community education model developed by the National Medical Association’s Council on Concerns of Women Physicians in cooperation with the Minority Health Education Program, Office of Cancer Communications, National Cancer Institute. A long term goal of the NBLIC is to replicate the structure and activities of the Atlanta Coalition in other parts of Georgia and the region.

Since its establishment in August 1990, the Coalition has accomplished a number of important initiatives including:

- conducted over 12 mini Breast Health Education Workshops throughout Metro Atlanta and some parts of south Georgia. These workshops were attended by over 200 women between the ages of 12 and 65 years of age.

- development of a facility guide of ACR approved mammography screening sites in the Atlanta area

- development of a training curriculum for Coalition members. This “train the trainer” curriculum is designed to equip members with the skills needed to train community leaders and community members in breast cancer prevention

- assist in the training of Community Lay Health Workers assigned to the targeted
The Atlanta Coalition remains actively involved in the planning and development of the Breast Health Education Study.

**Purpose of the present work:**

The purpose of this project is to impact favorably, the breast health of low income, undeserved minority women. As stated previously, the project addresses three of the overall goals of *Healthy People 2000*:

- to increase the span of healthy life
- to reduce health disparities, and
- to achieve access to preventive services for all Americans

Two preventive services objectives are addressed:

- **Objective 16.3**: to reduce breast cancer mortality,
  and
- **Objective 16.11**: to increase the proportion of women age 40 and older who have received a clinical breast examination and mammogram.

And, two Educational and Community-based program objectives:

- **Objective 8.1a**: which seeks to increase the years of healthy life of black people,
  and
- **Objective 8.11**: which emphasizes increasing culturally appropriate community health promotion programs for minority populations.

We believe that a culturally appropriate, comprehensive breast cancer screening intervention in a low-income public housing community will increase rates at which women obtain clinical breast examinations and mammograms. If we are successful, these rates will approach the frequencies recommended by the National Cancer Institute.

**Methods of approach:**

A review of recent literature and studies on promoting breast health makes it apparent that
effective breast cancer prevention and early detection requires education of both health professionals and clients. For example, in the Morehouse Cancer Screening Project entitled, "Avoidable Mortality from Cancer in Black Populations (AMCBP) targeted black women in the inner-city. The study sought to determine if an in-home educational intervention conducted by a Lay Health Worker could increase adherence among low-income black women to breast cancer screening schedules as well as increase the women's knowledge and change their attitudes regarding these cancers. The results of the study showed a 2.9% increase in Pap smear screening, and a 34.5% increase in breast screening. AMCBP's study method of educational intervention differs from those in the proposed project (in-home vs. community group); however, the target group is the same, and the proposed study emphasizes culturally appropriateness and is based on a philosophy of empowering low-income (blacks) to help themselves and one another.

The approach to community organization and development for health promotion for the communities in this study is based on the theories of Braithwaite, Lythcott et al., and call for the following steps:

- Learn the community
- Document the community ecology
- Organize a community coalition board
- Share the results with the community
- Design an intervention
- Implement the intervention

The current methodology calls for a community cluster comparison between the cases and comparison groups who reside in high-rise complexes within the Atlanta Housing Authority (AHA); and case and comparison groups who reside in low-rise complexes. Each community within the cluster of communities will experience each step listed above. Since this is a disease-specific study, the intervention was designed along with the earlier steps. It will, however, be adjusted to accommodate the differences within each community.

**BODY**

**Methods**

**Background, Sample and Data Collection**

The Breast Health Education Study is designed to focus on the consumers and the providers of breast cancer screening practices. It utilizes lay health workers to recruit and provide individual instruction to Black women on breast cancer prevention; and an Infodrama (dramatic presentation of information on breast cancer screening practices geared for the health care provider).
The women invited to participate in this project were residents of six public housing facilities (intervention communities) in Atlanta, Georgia. Women were eligible to participate if they were aged 35-79, a current resident of an intervention community, and had no personal history of breast cancer or breast surgery.

Specific objectives of the study were to:

1. **Organize each intervention community around the problem of breast cancer**

   Communities within the Atlanta Housing Authority each have a Tenant’s Association. This organization is composed of residents within the community for the purpose of identifying and resolving issues related to safe and efficient living conditions. The residents of the community elect a Tenant’s Association President who serves as the point of entry into the community. The Tenant’s Association President is a very powerful person who has been given the “authority” to represent the community.

   The Tenant Association President of each community received a visit by the study team to present the Breast Health Education Project and solicit their support. They were all receptive but differed in their approach to presenting the project to their constituents. In each case we were invited to attend a Tenant Association meeting where the president introduced us to the community. We were available to answer any questions that might arise.

   We advertised for Community Lay Health Workers (CLHW) in each community. We successfully recruited six women to work with us. Their ages ranged from 35-79. They came from three of the six communities (two of the original six workers were discontinued and replaced from the pool of applications received during recruitment). These workers received training in breast cancer prevention through workshops conducted by the Atlanta Coalition on Breast Health. CLHW’s assisted by our staff, began to develop community coalitions, or groups of residents interested in breast cancer prevention, who would also receive the training and assist the CLHW’s in providing support for other women within the community.

   The CLHW was also responsible for assisting in the survey of 200 community members. Each CLHW served as the point person to recruit survey participants from our list of randomly selected candidates, and was paired with a trained interviewer to attend each interview. A presentation of the data obtained during this phase of the study will appear later in this report.
2. **Conduct programs to improve breast cancer knowledge, attitudes, and screening practices among members of the intervention communities at large, health care providers serving these communities, and women aged 35-79 residing in these communities.**

The second phase of the project at the community level was a series of workshops on breast health that are to be presented in the various communities. The workshops are designed to empower participants to become pro-active in preventing breast cancer. We seek to instill confidence in their knowledge about the disease; by teaching them what to do to assist in the early detection of the disease; and teaching them ways to effectively communicate with their health care provider. Efforts are made to dispel the myths and misconceptions that some of them have about the disease. A Training Manual was developed in conjunction with the National Black Leadership Initiative on Cancer for the purpose of providing the education in a consistent manner. A copy of the manuscript for the manual is in the appendix.

The second component of the Breast Health Education Study is the implementation and evaluation of an intervention that educates and motivates primary care physicians to discuss breast health issues with their patients. In the form of an Infodrama, an interactive dramatic production based on actual case histories, the intervention encourages primary care physicians to recommend regular breast self-examinations, clinical breast examinations and screening mammograms to their patients. The Infodrama is produced by a local playwright in Atlanta, GA and is presented by four professional actors. The script for the presentation is based on research studies, information obtained from provider and consumer focus groups, and information pertaining to the social and cultural issues being explored. The impact of the presentation is assessed through pre- and post- intervention questionnaires that measure physician’s knowledge, attitudes, and practices regarding breast health care. The pretest is given immediately prior to the Infodrama and the post-test is delivered via mailed questionnaire six months afterwards. This intervention has been presented to 46 providers (including family physicians, internists, OB-GYN physicians, surgeons, and nurses). We are in the process of retrieving post intervention data from these participants to evaluate the impact, if any, that the intervention had on their breast cancer prevention strategies.

3. **Evaluate the impact of the comprehensive intervention on breast cancer screening, knowledge, attitudes, and practices.**

The bulk of our work this year was done during the administration of the questionnaires and in the analysis of the data retrieved. We simultaneously conducted workshops on breast education to community participants. We have requested a no cost extension to provide us with the opportunity to finalize the data collected during the workshops and
during the Infodrama presentations.

Person-to-person interviews were conducted between the spring of 1996 and the beginning of 1997. A random sample of 200 men and women were selected using the Atlanta Housing Authority’s tenants occupancy list. Men were not excluded if they were members of the randomly selected household. A separate analysis of their responses will be done to determine the effect that an involved male family member may have on breast screening practices. The sample included 160 women. This sample of study participants was representative of what we initially sought to achieve.

Measures

A brief 20-30 minute structured questionnaire was administered by graduate students of the Morehouse School of Medicine. Each student received interviewing skills training prior to participation in the study. We paired each student with a Community Lay health Worker (also a participant in the interviewing skills training) who served as a facilitator for the interviewing process. The Community Lay Health Worker (CLHW) was responsible for setting up the interview, reminding the participant of the interview appointment and was present, but not obtrusive, during the time of the interview.

The questions assessed sociodemographic characteristics, medical and family history, preventive health practices, insurance characteristics, level of exercise, weight control, tobacco use, alcohol use, cancer knowledge, attitudes, and beliefs, and history of breast cancer screening.

- **Sociodemographic** questions addressed marital status, level of education, employment history, what they believed to be the most important aspect of life, religious preference, income level and their opinion of their own personal health.

- **Knowledge and attitude** questions addressed personal susceptibility to breast cancer, whether a woman can have breast cancer with/without certain symptoms, whether cancer was a health problem in the community, and the likelihood of their attendance in breast health educational workshops.

- **History of breast cancer screening** addressed the frequency of study participant’s receiving breast self-examinations, clinical breast examinations, and mammography.

Data Analysis

Surveys were completed for 202 African-American women 30 years of age and older
1) ever having a clinical breast exam (CBE)
2) ever having a mammogram
3) receiving the last CBE within the past year and
4) receiving a mammogram within the past year.

The association between participants’ knowledge and attitudes about breast cancer and their previous breast cancer screening practices was also assessed. Using the SAS software package, logistic regression was performed to calculate the association between the specified variables while controlling for potential confounders.

Participants’ knowledge and attitudes about breast cancer prevention and control was assessed by asking a series of yes/no questions about breast cancer risks and screening. Summary scores were developed for each participant as the total number of correct answers to 20 questions. Correct responses to these questions were divided into two categories - scores of less than 13 and scores of 13 and greater. Women who had scores of less than 13 are reported as those who have low knowledge and negative attitudes about breast cancer prevention and control. Women who had scores of 13 and greater are reported as having high knowledge and positive attitudes.

Knowledge variables included in the knowledge/attitude score pertain to risk factors (or perceived risk factors) for breast cancer and are as follows:

1) age 40 years or older
2) bruising/bumping the breast
3) having a family member with breast cancer
4) being overweight
5) being around someone who has breast cancer
6) having a first child after the age of 30 years
7) menopause after the age of 50 years
8) menstruation before the age of 12 years
9) having a high fat diet and
10) cigarette smoking.

Other knowledge variables pertain to being able to name the correct screening tests for breast cancer and include:

1) the pap smear
2) the chest x-ray
3) breast self-examination
4) clinical breast examination and
5) mammography.
The attitude variables included in the knowledge/attitude score include:

1) breast cancer can be prevented
2) it is silly to have a breast exam when one is feeling fine
3) it is not a good idea to talk about breast cancer
4) breast cancer can be found early and
5) early treatment of breast cancer can save a woman’s life.

Preliminary results of the association between selected demographic factors and screening practices are presented in Tables 1 - 4. Of the women 30 - 50 years old, 85.7% report ever receiving a CBE as compared to only 55.6% of women 50-65 years and 67.7% of women 65 years and older (p=0.01, Table 1). There is no significant association between women who report ever receiving a CBE and the other specified demographics - education, marital status, employment status, income level, and insurance status. As revealed in Table 2, there is no association between selected demographic characteristics and receiving a CBE within the past year. Of unemployed women in the study, 58% report ever receiving a mammogram as compared to only 41.2% of employed women, and 25.0% of women who were housekeepers or students (p=0.05, Table 3). There is no association between ever receiving a mammogram and other selected demographics. Finally, Table 4 reveals that there is no association between receiving a mammogram within the past year and selected demographic characteristics.

Table 5 shows the association between study participants’ overall knowledge and attitudes about breast cancer and their breast cancer screening practices. Women with high scores (13 or greater) are more likely to have ever had a CBE as compared to women with low scores (90.8% vs. 60.3%, p=0.001). Furthermore, 79.4% of women with high knowledge and positive attitudes report to ever receiving a mammogram as compared to only 43.8% of women with low knowledge and negative scores (p = 0.001). Finally, women with high knowledge and positive attitudes are more likely to have had a mammogram within the past year as compared to women with low knowledge and negative attitudes (64.7% vs. 20.2%, p=0.001). There is no difference in knowledge and attitude scores in terms of receiving a CBE within the past year.

Tables 6 - 9 show the association between individual knowledge/attitude variables and breast cancer screening practices. As seen in Table 6, specific factors significantly associated with ever having a CBE include the knowledge that: 1) family history is a risk factor for breast cancer and 2) CBE and mammography are screening tests to detect breast cancer. Women who know that the pap smear is not a test to detect breast cancer are more likely to report ever having a CBE than women who think that the pap smear is a screening test. In addition, women are more likely to have ever had a CBE if they: 1) do not believe that bumping or bruising the breast is a risk factor for breast cancer and 2) do not believe that being around someone with breast cancer is a risk factor for breast
cancer. In terms of attitudes, ever having a CBE is associated with the belief that: 1) it is not silly to have a mammogram even when one is feeling fine 2) it is a good idea to talk about breast cancer 3) breast cancer can be found early and 4) the early treatment of breast cancer can save a woman's life. As seen in Table 7, there are no specific knowledge/attitude factors that are significantly associated with having a CBE within the past year.

Table 8 shows the association between knowledge/attitude variables and mammography utilization. Specific factors associated with ever having a mammogram include the knowledge that: 1) age 40 years or older is a risk factor for breast cancer 2) family history is a risk factor for breast cancer and 3) mammography is a screening test to detect breast cancer. Women who know that having a child after the age of 30 is a risk factor for breast cancer are less likely to have ever had a mammogram as compared to women who do not know this.

As seen in Table 9, specific factors significantly associated with having a mammogram within the past year include the knowledge that:

1) age 40 years or older, family history, obesity, and a high fat diet are risk factors for breast cancer and

2) mammography is a screening test to detect breast cancer.

Table 10 shows the results of logistic regression. Of significance, women who received their last CBE within the past year are 3.9 times more likely to have high knowledge and positive attitudes about breast cancer prevention and control as compared to women who did not receive a CBE within the past year (95% confidence interval - 1.5,9.9). In addition, women who received a mammogram within the past year are 4.2 times more likely to have high knowledge and positive attitudes as compared to women who did not receive a mammogram within the past year (95% confidence interval - 1.4,12.8).

Bivariate and multivariate analysis for this study is still in progress. We have requested and have been approved for a one-year no cost extension for this study. During this time, we will complete analysis of this data and will submit a manuscript for publication.
Table 1:
SOCIODEMOGRAPHIC FACTORS OF WOMEN WHO HAVE EVER HAD A CLINICAL BREAST EXAM BY A HEALTH PROFESSIONAL

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<td><strong>Pap test by schedule</strong></td>
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Table 3:

SOCIODEMOGRAPHIC FACTORS OF WOMEN WHO HAVE EVER HAD A MAMMOGRAM

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<td><strong>Education yrs.</strong></td>
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<td>52.0</td>
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<td></td>
<td>52.8</td>
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<td>Housekeeper/Student</td>
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<td>75.0</td>
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<td>40</td>
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<td>50.7</td>
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<td>57.7</td>
<td>42.3</td>
<td>0.37</td>
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<tr>
<td>Agree</td>
<td>50.6</td>
<td>69.4</td>
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<td>0.41</td>
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<td>Medicare/Medicaid</td>
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<td>52.2</td>
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<tr>
<td>Private</td>
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<td>44.4</td>
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<td>37.8</td>
<td>0.32</td>
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Table 4:
SOCIOECONOMIC FACTORS AND MAMMOGRAPHY BY SCHEDULE*

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<td>13 years</td>
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<td>12 years</td>
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<td>&lt;12 years</td>
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<td>&lt;15,000</td>
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<td>n=98</td>
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<tr>
<td>No</td>
<td>n=100</td>
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<tr>
<td><strong>Breast cancer is preventable</strong></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>n=98</td>
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<tr>
<td>No</td>
<td>n=100</td>
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<tr>
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</tr>
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<td>Medicare/Medicaid</td>
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*According to the Guidelines of the American Cancer Society (ASC)
Table 5:
ASSOCIATION BETWEEN BREAST CANCER SCREENING HISTORY
AND THE KNOWLEDGE/ATTITUDE SCORE

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<th>EXAM</th>
<th>Knowledge and Attitude Score</th>
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<td>≥13</td>
<td>&lt;13</td>
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<tr>
<td></td>
<td>n(%)</td>
<td>n(%)</td>
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<td>Ever Clinical Ex</td>
<td>n=76</td>
<td>n=126</td>
</tr>
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<td>Yes</td>
<td>69(90.8)</td>
<td>76(60.3)</td>
</tr>
<tr>
<td>No</td>
<td>7(9.2)</td>
<td>50(39.7)</td>
</tr>
<tr>
<td>Last breast exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>By Schedule*</td>
<td>63(82.9)</td>
<td>97(77.0)</td>
</tr>
<tr>
<td>No</td>
<td>13(17.1)</td>
<td>29(33.0)</td>
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<tr>
<td>Ever had Mammogram</td>
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<td>n=89</td>
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<td>Yes</td>
<td>27(79.4)</td>
<td>39(43.8)</td>
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<td>No</td>
<td>7(20.6)</td>
<td>50(56.2)</td>
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<tr>
<td>Mammogram</td>
<td></td>
<td></td>
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<tr>
<td>By schedule</td>
<td>22(64.7)</td>
<td>18(20.2)</td>
</tr>
<tr>
<td>No</td>
<td>12(35.3)</td>
<td>71(79.8)</td>
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*ACS Guidelines
Table 6: Knowledge, Attitude and Those Who Have Ever Had A Clinical Breast Exam

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<th>Ever Had a Clinical Breast Exam</th>
<th>Total</th>
<th>P-Value</th>
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<tbody>
<tr>
<td></td>
<td>n(%)</td>
<td>n(%)</td>
<td>n(%)</td>
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<tr>
<td>Age 40 years or older associate with breast cancer</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>No</td>
<td>40(28.8)</td>
<td>99(71.2)</td>
<td>139(100)</td>
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<tr>
<td>Yes</td>
<td>17(27.0)</td>
<td>46(73.0)</td>
<td>63(100)</td>
</tr>
<tr>
<td>Bruising/bumping the breast associate with breast cancer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>52(32.5)</td>
<td>108(67.5)</td>
<td>160(100)</td>
</tr>
<tr>
<td>No</td>
<td>5(11.9)</td>
<td>37(88.1)</td>
<td>42(100)</td>
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<tr>
<td>Family hx is a risk factor for breast cancer</td>
<td></td>
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<td></td>
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<tr>
<td>No</td>
<td>37(39.4)</td>
<td>57(60.4)</td>
<td>94(100)</td>
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<tr>
<td>Yes</td>
<td>20(18.5)</td>
<td>88(81.5)</td>
<td>108(100)</td>
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<tr>
<td>Being overweight</td>
<td>No</td>
<td>39(27.7)</td>
<td>102(72.3)</td>
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<td>Yes</td>
<td>18(29.5)</td>
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<td>61(100)</td>
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<tr>
<td>Being around someone who has breast cancer</td>
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<tr>
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<td>137(77.8)</td>
<td>176(100)</td>
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<tr>
<td>Yes</td>
<td>18(69.2)</td>
<td>8(30.8)</td>
<td>26(100)</td>
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<tr>
<td>Having first child after age 30</td>
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<td>119(68.4)</td>
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<td>Yes</td>
<td>2(71)</td>
<td>26(92.9)</td>
<td>28(100)</td>
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<tr>
<td>Menopause after age 50</td>
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<td>110(70.1)</td>
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<td>35(77.8)</td>
<td>45(100)</td>
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<tr>
<td>Menstrual before age 12</td>
<td>No</td>
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<td>130(71.8)</td>
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<td>15(71.4)</td>
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<tr>
<td>High fat diet</td>
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<td>87(69.6)</td>
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<td>19(24.7)</td>
<td>58(75.3)</td>
<td>77(100)</td>
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(Con’t table 6)

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<th>P-Value</th>
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<td>Yes</td>
<td></td>
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<td>Cigarette smoking</td>
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<td>33(70.2)</td>
<td>47(100)</td>
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<td></td>
<td>43(27.7)</td>
<td>112(72.3)</td>
<td>145(100)</td>
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<td>34(32.7)</td>
<td>70(67.3)</td>
<td>104(100)</td>
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<td></td>
<td>23(23.5)</td>
<td>75(76.5)</td>
<td>98(100)</td>
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<td>Breast self exam finds breast cancer in the very early stages</td>
<td>6(46.2)</td>
<td>7(53.9)</td>
<td>13(100)</td>
</tr>
<tr>
<td></td>
<td>51(27.0)</td>
<td>138(73.0)</td>
<td>189(100)</td>
</tr>
<tr>
<td>Pap Smear finds breast cancer</td>
<td>9(15.8)</td>
<td>48(84.2)</td>
<td>57(100)</td>
</tr>
<tr>
<td></td>
<td>48(33.1)</td>
<td>97(66.9)</td>
<td>145(100)</td>
</tr>
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<td>6(31.6)</td>
<td>19(100)</td>
</tr>
<tr>
<td></td>
<td>44(24.0)</td>
<td>139(76.0)</td>
<td>183(100)</td>
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<td>127(72.2)</td>
<td>176(100)</td>
</tr>
<tr>
<td></td>
<td>8(30.8)</td>
<td>18(69.2)</td>
<td>26(100)</td>
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<td>Mammography finds breast cancer in its very early stages</td>
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<td></td>
<td>29(18.0)</td>
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<td>161(100)</td>
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<td>Silly to have breast exam when feeling fine</td>
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<td>21(50.0)</td>
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<td></td>
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<td>124(77.5)</td>
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(Con’t table 6)

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<th>P-Value</th>
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<td></td>
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<td>22(57.9)</td>
<td>38(100)</td>
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<tr>
<td></td>
<td>Agree</td>
<td>Disagree</td>
<td></td>
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<td></td>
<td>41(25.0)</td>
<td>123(75.0)</td>
<td>164(100)</td>
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<td>Breast cancer can be found early</td>
<td>14(56.0)</td>
<td>11(44.0)</td>
<td>25(100)</td>
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<td></td>
<td>No</td>
<td>Yes</td>
<td></td>
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<td>43(24.3)</td>
<td>134(75.7)</td>
<td>177(100)</td>
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<td>8(44.4)</td>
<td>18(100)</td>
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<td>Yes</td>
<td></td>
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<td></td>
<td>47(22.5)</td>
<td>137(74.5)</td>
<td>184(100)</td>
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<td>68(100)</td>
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<td>3(2.2)</td>
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<td>134(100)</td>
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<td>Frequency of breast self exam</td>
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<td>110(100)</td>
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<td>Other</td>
<td>One at Least</td>
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<td>4(4.4)</td>
<td>88(95.7)</td>
<td>92(100)</td>
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Table 7:

Knowledge, Attitude and last clinical breast exam by schedule*

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<td>n(%)</td>
<td>n(%)</td>
<td>n(%)</td>
<td>P-Value</td>
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<td>Age 40 years or older associate with breast cancer</td>
<td>No</td>
<td>29(20.9)</td>
<td>110(79.1)</td>
<td>139(100)</td>
<td>0.97</td>
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<td>Yes</td>
<td>13(20.6)</td>
<td>50(79.4)</td>
<td>63(100)</td>
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</tr>
<tr>
<td>Bruising/bumping the breast associate with breast cancer</td>
<td>Yes</td>
<td>31(19.4)</td>
<td>129(80.6)</td>
<td>160(100)</td>
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<td>31(73.8)</td>
<td>42(100)</td>
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<td>76(80.8)</td>
<td>94(100)</td>
<td>0.59</td>
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<td></td>
<td>Yes</td>
<td>24(22.2)</td>
<td>84(77.8)</td>
<td>108(100)</td>
<td></td>
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<tr>
<td>Being overweight</td>
<td>No</td>
<td>33(23.4)</td>
<td>108(76.6)</td>
<td>141(100)</td>
<td>0.15</td>
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*ACS Guidelines
(Con't table 7)

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"By Schedule" means according to ACS Guidelines
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*ACS Guidelines*
Table 8: Knowledge and Attitudes that are associated with ever having Mammography

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(Con’t table 8)

Knowledge and Attitudes that are associated with ever having Mammography

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Table 9: Knowledge, Attitude and having Mammography by schedule

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*According to American Cancer Society’s Guidelines
(Con't table 9)

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<th>Total</th>
<th>P-Value</th>
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<td></td>
<td>n(%)</td>
<td>n(%)</td>
<td>n(%)</td>
<td></td>
</tr>
<tr>
<td>Cigarette smoking</td>
<td>7(25.0)</td>
<td>21(75.0)</td>
<td>28(100)</td>
<td>0.46</td>
</tr>
<tr>
<td>Yes</td>
<td>33(34.7)</td>
<td>62(65.3)</td>
<td>95(100)</td>
<td></td>
</tr>
<tr>
<td>Breast Cancer can be prevented</td>
<td>23(31.5)</td>
<td>50(68.5)</td>
<td>73(100)</td>
<td>0.77</td>
</tr>
<tr>
<td>No</td>
<td>17(34.0)</td>
<td>33(66.0)</td>
<td>50(100)</td>
<td></td>
</tr>
<tr>
<td>Breast self exam finds breast cancer in its very early stages</td>
<td>39(83.0)</td>
<td>79(67.0)</td>
<td>118(100)</td>
<td>0.90</td>
</tr>
<tr>
<td>Yes</td>
<td>1(20.0)</td>
<td>4(80.0)</td>
<td>5(100)</td>
<td></td>
</tr>
<tr>
<td>Pap smear finds breast exam</td>
<td>31(32.3)</td>
<td>65(67.7)</td>
<td>96(100)</td>
<td>1.0</td>
</tr>
<tr>
<td>No</td>
<td>9(33.3)</td>
<td>18(66.7)</td>
<td>27(100)</td>
<td></td>
</tr>
<tr>
<td>Clinical breast exam finds breast cancer in its very early stages</td>
<td>3(20.0)</td>
<td>12(80.0)</td>
<td>15(100)</td>
<td>0.42</td>
</tr>
<tr>
<td>Yes</td>
<td>37(34.3)</td>
<td>71(65.7)</td>
<td>108(100)</td>
<td></td>
</tr>
<tr>
<td>Chest x-rays finds breast cancer</td>
<td>35(33.2)</td>
<td>70(66.7)</td>
<td>105(100)</td>
<td>0.85</td>
</tr>
<tr>
<td>No</td>
<td>5(27.8)</td>
<td>13(72.2)</td>
<td>18(100)</td>
<td></td>
</tr>
<tr>
<td>Mammography finds breast cancer in its very early stages</td>
<td>1(2.9)</td>
<td>33(97.1)</td>
<td>34(100)</td>
<td>0.001</td>
</tr>
<tr>
<td>No</td>
<td>39(43.8)</td>
<td>50(56.2)</td>
<td>89(100)</td>
<td></td>
</tr>
<tr>
<td>Silly to have breast exam when feeling fine</td>
<td>9(25.7)</td>
<td>26(74.3)</td>
<td>35(100)</td>
<td>0.42</td>
</tr>
<tr>
<td>Agree</td>
<td>31(35.2)</td>
<td>57(64.8)</td>
<td>88(100)</td>
<td></td>
</tr>
<tr>
<td>Not good idea to talk about breast cancer</td>
<td>9(29.0)</td>
<td>22(71.0)</td>
<td>31(100)</td>
<td>0.80</td>
</tr>
<tr>
<td>Agree</td>
<td>31(33.7)</td>
<td>61(66.3)</td>
<td>92(100)</td>
<td></td>
</tr>
</tbody>
</table>

*According to ACS Guidelines
(Con't table 9)

<table>
<thead>
<tr>
<th>Knowledge or Attitude Variable</th>
<th>No</th>
<th>Ever had Mammography</th>
<th>Total</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n(%)</td>
<td>n(%)</td>
<td>n(%)</td>
<td></td>
</tr>
<tr>
<td>Breast cancer have been found early</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>2(8.0)</td>
<td>23(92.0)</td>
<td>25(100)</td>
<td>0.12</td>
</tr>
<tr>
<td>Yes</td>
<td>43(24.3)</td>
<td>134(75.7)</td>
<td>177(100)</td>
<td></td>
</tr>
<tr>
<td>Early treatment of breast cancer</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>2(16.7)</td>
<td>10(83.3)</td>
<td>12(100)</td>
<td>0.36</td>
</tr>
<tr>
<td>Yes</td>
<td>38(34.2)</td>
<td>73(65.8)</td>
<td>111(100)</td>
<td></td>
</tr>
<tr>
<td>Last breast exam was a routine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>6(11.5)</td>
<td>46(88.5)</td>
<td>52(100)</td>
<td>0.001</td>
</tr>
<tr>
<td>Yes</td>
<td>34(47.9)</td>
<td>37(52.1)</td>
<td>71(100)</td>
<td></td>
</tr>
<tr>
<td>Frequency of breast self exam</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>15(19.0)</td>
<td>64(81.0)</td>
<td>79(100)</td>
<td></td>
</tr>
<tr>
<td>One at least</td>
<td>25(56.8)</td>
<td>19(43.2)</td>
<td>44(100)</td>
<td>0.001</td>
</tr>
</tbody>
</table>

*According to ACS Guidelines*
Table 10:

Adjusted odds ratio comparing women having the selected screening practice to women who did not.

<table>
<thead>
<tr>
<th>Knowledge, Attitude, Practice</th>
<th>Ever clinical Breast exam O.R. (95% CZ)</th>
<th>Clinical breast exam by schedule O.R. (95% CZ)</th>
<th>Ever Mammogram O.R. (95% CZ)</th>
<th>Mammogram by Schedule O.R. (95% CZ)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have had Pap test by schedule*</td>
<td>0.9 (0.2, 3.3)</td>
<td>0.9 (0.5, 2.3)</td>
<td>0.6 (0.2-1.8)</td>
<td>1.6 (0.6-4.1)</td>
</tr>
<tr>
<td>Knew having first child after age 30 at higher risk of breast cancer</td>
<td>6.1 (20-76.3)</td>
<td>2.4 (0.6-9.0)</td>
<td>6.7 (0.9-46.0)</td>
<td>1.4 (0.3-5.7)</td>
</tr>
<tr>
<td>Knew bruising/bumping the breast not associated with breast cancer</td>
<td>3.8 (1.5-21.4)</td>
<td>1.6 (0.7-3.3)</td>
<td>1.2 (0.3-5.1)</td>
<td>4.4 (1.0-21.0)</td>
</tr>
<tr>
<td>Have had last breast exam as a routine</td>
<td>143.0 (33.0-577.0)</td>
<td>7.1 (0.4-18.9)</td>
<td>13.5 (4.8-38.4)</td>
<td>4.4 (0.7-13.6)</td>
</tr>
<tr>
<td>Knew frequency of self-breast exam</td>
<td>14.1 (3.1-64.3)</td>
<td>1.4 (0.7-3.5)</td>
<td>2.9 (0.9-9.3)</td>
<td>2.7 (0.9-21.0)</td>
</tr>
<tr>
<td>Have had good knowledge and attitude about breast cancer and prevention</td>
<td>1.4 (0.2-79)</td>
<td>3.9 (1.5-9.9)</td>
<td>1.4 (0.2-2.7)</td>
<td>4.2 (1.4-12.8)</td>
</tr>
</tbody>
</table>

*According to ACS Guidelines
Problems: We’ve had numerous challenges with the implementation of this study. With each problem we requested and received permission to adjust the study to accommodate the communities that participated. The major difficulty encountered was the dismantling of the communities under the Atlanta Housing Authority. These communities have traditionally housed tenants who have very low or no income. Atlanta now has a commitment to integrate residents of middle to high income levels with those who are poor. As a result, the housing communities as they existed in 1994 will no longer exist. Community housing in these areas will be upgraded to improve existing properties and to include homes that cost hundreds of thousands of dollars. Current residents are being moved to Section VIII housing throughout the metropolitan area. Senior citizens and the disabled will have first option on remaining.

We were impacted to such a degree early in the study that one community had to be dropped due to the difficulty we had in contacting participants for the interview. We did identify another community with similar characteristics. We repeated the process of identifying the leadership of the community, introducing them to our goals and objectives, and assigning them to a trained Community Lay Health Worker. This delayed our progress in achieving the activities listed on our pert chart.

Problems encountered when working with our communities:

- Atlanta Housing Authority is dismantling and boarding up many of the communities we had selected for the study
- Some participants moved out of the community with no forwarding address of telephone number
- Some participants (approx. 6) are now deceased
- Some participants now reside in a nursing home
- Apathy, especially in the younger population prohibited women from participating
- Politics, internal and external to the community

The changes we’ve encountered in the administration of low rent housing communities by the Atlanta Housing Authority are being seen in communities throughout the country. This will certainly have an effect on community leadership and community based research in the future.

We also experienced a set-back when one of our more cooperative Tenants Association Presidents became ill and subsequently died. Her community had provided us with the largest number of participants for the initial intervention. This was due largely to her working closely with the CLHW and the Lay Health Worker Supervisor to inform the residents of the workshops and to encourage them to participate. It has been more difficult to get participants for the post-intervention evaluation since her death.

A recurring theme for us when we approached community residents to participate in any aspect of the study was the “What’s in it for me?” question. The grant made no provisions for participants to receive incentives. However, increasingly, the lack of incentives for community based research is a problem. We circumvented the problem during the survey by providing participants with cancer prevention pamphlets, cookbooks and other paraphernalia and “T” shirts that were provided by non-grant contributions.
Taylor, Beverly D.  

We had increasing concern for the safety of our workers as they entered the various communities over the three year period of funding. Some of the areas were heavy drug traffic areas. Residents were suspicious of our actions initially. Workers were paired off with each group being inclusive of at least one of the two male team members.

Problems encountered in the "Provider Phase" of the Study: The INFODRAMA is an innovative method of providing medical information to provider audiences. We developed the presentation in such a way that participants could obtain CME credits by attending. We did not anticipate however, the reluctance of conference planners to schedule something as unusual as this. As a result, we found that we were scheduled either during the preconference schedule or during the end of the conference. Attendance was not what was expected in most instances. However, in a focus group format after each presentation, providers were quite open with us regarding why they chose to come and what almost prevented them from coming.

When listed as an INFODRAMA, participants stated that they were hesitant to participate because they were afraid that they would have to be part of the drama; the time that the presentation was offered was a factor; and an uncertainty as to what material would be presented were all factors.

Additionally, we encountered difficulty in obtaining post intervention feed back from providers after repeated attempts through mailed questionnaires. During the next year (we requested and received a one year extension at no cost) we plan to follow up with telephone interviews. Hopefully that data will be presented in the next final report.

Conclusions:.

As stated earlier, we are continuing to evaluate the data so final conclusions are not possible at this time. Previous studies have shown that the overall breast cancer screening rates are greatly influenced by attitudes, knowledge and beliefs; and that encouragement to receive breast cancer screening by the patient's physician or provider influences a woman's decision to get a mammogram. Our finding so far, show a strong correlation between a woman's practice of getting a mammogram within the past year if she scores high in knowledge and positive attitude. These women would also be more positive about breast cancer prevention and control in general. We can also see an association in breast cancer screening rates with marital status, employment history, one's opinion of their own health and family history of the disease. This indicates that women who have a strong support system get encouragement to do regular screens.

Lifetime history of clinical breast examination was not significantly associated with many of the independent variables in this study. The three variables associated with clinical breast exams were: familial history of breast cancer, likelihood of breast cancer, and belief in breast cancer prevention. Women who were not sure of their familial breast cancer history, who thought they had little chance of getting breast cancer, and who only moderately believed in breast cancer prevention were most likely to have never had a clinical breast examination in their lifetime. This directly disputes Tarpin, et al., who found that a family history of breast cancer or little knowledge of the fact was associated with greater participation in a breast cancer screening program. Price, et. al., on the other hand, found that economically disadvantaged Black women with a low perception of breast cancer susceptibility were least likely to receive screening than those without this perception.
It is apparent that in this population the effects of poverty, single parenthood, employment history and lack of knowledge about the prevention of breast cancer are key barriers that we must face in order to improve mammography utilization.
References

1. American Cancer Society, Cancer Facts and figures - 1995


Morehouse School of Medicine

Breast Health Education Study
Training Manual

Prepared by:
The National Black Leadership Initiative on Cancer - Southern Region
Atlanta Coalition on Breast Health
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Resources
Over the years many women, especially black American women, have died needlessly of a dreadful disease. It has robbed many families of their mothers, grandmothers, sisters, and aunts. It paid no mind to the sorrow it caused, and made many tributes to the deaths it delivered. It will continue to strike until a cure is found, but it doesn’t have to be devastating. We know this disease as breast cancer.

Breast Cancer is hardly a woman’s best friend, but it is an enemy she can beat.

Long ago when breast cancer struck generations of women from the same family, they expected and accepted it. No longer does a woman have to allow breast cancer to take its toll. Simply knowing about early detection and good breast health practices is half the battle. The National Black Leadership Initiative on Cancer (NBLIC) Southern Region, Atlanta Coalition on Breast Health has devoted its time and efforts into the development of a user friendly manual. This manual will be used as a guide to educate minority underserved women about breast health and give them knowledge about early detection. We want to "Spread the Word." Ultimately community leaders can replicate the process of spreading the word and help to save lives in their community.

"The Battle Against Breast Cancer Can Be Won"

In memory of all the women who have lost their lives to breast cancer
ACKNOWLEDGMENTS

The National Black Leadership Initiative on Cancer (NBLIC) Southern Region is grateful to its staff and the Atlanta Coalition on Breast Health members who contributed to the development and successful completion of the Breast Health Education Study Manual.

A personal thanks to the following members, whose individual input was endowed by their expertise and commitment to this project:

Beverly D. Taylor, MD
Co-Chairperson
Atlanta Coalition on Breast Health

Ruby Ivery-Brown, MPH
Program Specialist
NBLIC Southern Regional Office

Mary Glenn, MMSc, RD, LD
Chairperson
Atlanta Coalition on Breast Health

Angela Payne, BSN, RN
Coalition Volunteer
Atlanta Coalition on Breast Health

Melanie Dowdell
Secretary
Atlanta Coalition on Breast Health

Bridget J. Toodle
Administrative Secretary
NBLIC Southern Regional Office

A special thanks to our partner, the American Cancer Society, Georgia Division for allowing NBLIC to adapt much of its training material for the manual. All material will be used for education purposes only. Materials such as diagrams, questions and answers taken from other divisions of ACS have been stated and referenced.
PURPOSE

The purpose of this training manual is to educate minority and underserved women about their breasts. It is designed to be culturally sensitive. The content includes materials for appropriate reading levels, information on the incidence of breast cancer among black women, risk factors for breast cancer including diet and the importance of early detection and screening guidelines. This manual encourages replication for the purpose of community based cancer education and screening programs.

GOALS

The goal of the training manual is to:

- Empower minority and underserved women to rely on themselves and each other as well as community resources for early detection of breast cancer.

- Teach Breast Self Examination technique

- Clarify and discuss common barriers, myths, and misconceptions about breast cancer and mammography.

- Identify the relationship between diet and risks of developing cancer.
Breast Cancer Overview
Breast cancer is the most common major cancer among women in the United States. Each year more than 180,000 women in this country will learn they have breast cancer. Over all ages combined, white women are more likely to develop breast cancer than African American women. However, African American women are more likely to die from the disease; probably due to diagnosis in a more advanced stage. African American women are also more likely to develop breast cancer younger than 45 years of age. Women of higher socioeconomic status, married women, women living in urban versus rural areas, and women of northern states have the highest rates. Breast cancer not only occurs in women; although rare, it affects more than 1,000 men in this country each year. It is estimated that 46,300 people will die from breast cancer each year; 300 of those deaths will be men.

All women are at risk of developing breast cancer. One out of eight women in the United States will develop breast cancer during her life time, including those with no family history of the disease. Overall, the risk tends to increase with age. According to the American Cancer Society (ACS), older women are at a much higher risk of developing breast cancer and dying from it than younger women. ACS reports that 77 percent of the new diagnosis of Breast cancer each year, occur in women over the age of 50. Despite the fact that older women are at a higher risk, breast cancer screening rates decline with increasing age.

Other risk factors for developing breast cancer include:

- History of breast cancer in close family relatives (grandmother, mother, sister, aunt)
- Late age menopause
- Onset of menses before age 12
- Never given birth
- Obesity (40% above normal weight)
- More than 30 years old at the birth of first child
- A personal history of breast cancer (has had it before)

It is important to keep in mind that these factors do not cause breast cancer but are merely associations that may increase cancer risks. Having one or more of these risks factors, does not mean a woman is certain to develop breast cancer. There is no way to prevent breast cancer, therefore, finding the disease as early as possible is the primary goal. When breast cancer is detected and treated early, the chances of survival increases. Women also have more of a choice, for example: a lumpectomy as opposed to a mastectomy.
According to the most recent available data, the overall five year relative survival rate for breast cancer by stage of disease at diagnosis for all women are specifically: 97 percent when diagnosed at a local stage (confined to the breast). 76 percent when diagnosis include regional spreading (cancer has spread to surrounding tissue). 20 percent when cancer is diagnosed at a distant stage (cancer has spread or metastasized to surrounding and distant tissue).

The five year relative survival rates are used to monitor progress in early detection and treatment of cancer and includes persons who are living five years after diagnosis, whether in remission, disease free, or under treatment. The survival rate is observed among a group of cancer patients, compared with the survival rates of persons in the general population, who are similar to the patient group with respect to age, gender, race and the calendar year of observation.

The National Cancer Institute’s latest finding suggests, a decline in the breast cancer death rate among American women through 1993. These findings indicate improved breast cancer management from early detection to treatment is having a beneficial effect. The mortality rate in white women has improved markedly in the 1990’s compared to the 1980’s. As for black women, increased mortality persists especially among older women. However, the overall increase has slowed significantly.

<table>
<thead>
<tr>
<th>Who is less likely to be Screened?</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Women with less than a high school education</td>
</tr>
<tr>
<td>* Poorer Women (household income less than 15,000)</td>
</tr>
<tr>
<td>* Older women (age 70 and older)</td>
</tr>
<tr>
<td>* Women who have never had a complete breast exam (these women are very unlikely to have had a mammogram or to perform breast self examination)</td>
</tr>
<tr>
<td>* Women with no regular source of medical care</td>
</tr>
</tbody>
</table>

According to NCI, racial differences in mortality rates in the United States depend on several factors including: risk of developing breast cancer, access to screening and early detection, treatment and medical follow-up and supportive care.

Breast cancer mortality rates:
Deaths per 100,000
- African Americans: 31
- White: 27
- Hispanic: 17

Breast cancer incidence rates:
Cases per 100,000
- African Americans: 95
- White: 112
- Hispanic: 70

National Cancer Institute
Breast Cancer Incidence by Age, 1988-1992

Average annual incidence rates per 100,000 women, age-adjusted to 1970 U.S. standard population.


Rates represent American Indians in New Mexico only.

Average annual incidence rates per 100,000 women, age-adjusted to 1970 U.S. standard population.

Breast Cancer 5-Year Relative Survival Rates for U.S. Women

Relative survival rates are adjusted for expected deaths from other causes and are higher than observed survival rates. **Data Source:** National Cancer Institute Surveillance, Epidemiology and End Results Program, 1995 (Whites and African Americans). NCI Initiatives for Special Populations, 1973-1994 (Hispanics, New Mexico only.)

84% of White women diagnosed and treated with breast cancer, are living 5 years after diagnosis either in remission, disease-free, or under treatment; compared to 70% of Hispanic women and only 69% of African-American women.
Barriers/Myths/Misconceptions
BARRIERS: BELIEFS: MYTHS: MISCONCEPTIONS

Black American women are less likely to develop breast cancer than white American women. However, they are more than likely to die from the disease. There is no one answer to this problem, but there are major factors that contribute to it, such as barriers, beliefs, myths and misconceptions. We will take a closer look at each of these factors.

BARRIERS

In the black community, there are many barriers that get in the way of health care delivery that are very often over looked; some of which are deeply rooted. Historically blacks had little to no access into the health care system. As a result they relied mostly on home remedies, some worked and some didn’t. They made many self diagnosis and relied heavily on their religion. Illnesses such as cancer (the big C) were considered taboo and kept hush-hush. In obtaining some access into the health care system, they were often misrepresented. After the Tuskegee experiment, they learned not to trust white physicians. Those who had physicians they could trust, did not venture out for second opinions because of the strong sense of loyalty. Many of these barriers still exist in the black community. Today even in acquiring access into the health care system, “access” is still denied, due to even more barriers.

Fear is perhaps the most common barrier that is shared by everyone. Among blacks as well as the poor, early medical attention will not be sought because of fear of learning of a deadly disease which will become another burden in their lives. Such fears can be approached by constantly reinforcing the benefits of early detection. Across the board, family structure is changing in America, creating many households led by single parents; mainly black American women. Many of these women fall in a low socioeconomic status, which means they are more likely to lack health insurance, less likely to have access to screening tests and good medical care and more likely to have over burdened lives, which leaves them little to no time for themselves. The “if it’s not broken don’t fix it” attitude infiltrates. Such barriers have been detrimental to black American women with breast cancer.

Another barrier includes lack of information in the black community. According to a survey conducted by the American Cancer Society, awareness and the use of cancer screening tests are lower among blacks than whites, leaving blacks less know-ledgeable about cancer and its warning signs. Few existing cancer education material feature blacks, as a result cancer is viewed as a disease not likely to affect them. They do not see it as their problem. It can be concluded that information needs to be ethnically and culturally sensitive and suited for various reading levels.
BELIEFS

Belief systems play an important role in every culture. They can be very strong and many of them are centered around religion. Unfortunately, some can become barriers. Encountering a dreadful disease such as cancer, blacks tend to perpetuate a belief, that a diagnosis of cancer is a death sentence (Why bother with treatment, when it’s your time to die it’s going to happen anyway). As if it were a destiny to die with such a disease. Treatment is a long and painful process, but life can prevail. Sadly, many see only death. It is not realized that cancer can be cured if it’s detected early, offering more options.

MYTHS

Myths and beliefs are closely related. Like beliefs, they can be culturally inclined or community confined. They can also become barriers. One such myth that is confined to a community is “cancer is a curse.” This type of attitude leaves no place for hope, only despair as it submits to death. Another myth which is culturally inclined “cancer is contagious”, is one of alienation. This myth was probably the reason why the disease was kept hush-hush in black cultures. When a family member becomes a victim of cancer, the bonds between family, friends and relatives are most important. This is the time when all should come together to promote courage and explore all options. Cancer is not a curse nor is it contagious. It is one of the many challenges in life to overcome.

MISCONCEPTIONS

A misconception is an incorrect interpretation or understanding. Misconceptions are found in all socio-economic classes and vary from culture to culture. It can be general, religious, or medical. When it is medically inclined, it can be very harmful because it becomes a barrier, which gets in the way of health care delivery. A common misconception about breast cancer, “I won’t get breast cancer because it doesn’t run in my family.” The truth is that 80 percent of the women who develop breast cancer, have no family history of the disease. While chances of getting breast cancer increases if a close family member has it (grandmother, mother, sister, aunt), this does not mean that a woman is free of all risks. Another common misconception, “Cancer spreads as soon as it’s exposed to air.” The fact is, many black American women are most often detected with breast cancer in its later stages, when it has already begun to spread. Recent studies also suggests that breast cancer appear to be more aggressive among black American women, reflecting a faster rate of tumor growth and is more likely to be estrogen receptor negative and difficult to treat. Given these factors, early detection and a good breast health plan is even more vital to black women.
Beliefs, myths and misconceptions are all barriers which create attitudes that get in the way of health care delivery. Such barriers can be removed over a gradual process. Implementing education and raising awareness via workshops, health fairs and the media are key tools. Additionally, cancer control and screening programs which are affordable must also be provided. Otherwise, they will not be utilized. The black community has become very cautious and is not very receptive to those who are not apart of the community. In reaching the population, activities and programs must somehow be coordinated into their lifestyles. This means, working with the churches they attend, the schools their children attend and working with identified community leaders.
Diet, Nutrition and Cancer Prevention
CANCER PREVENTION: DIET AND NUTRITION

The most effective way to avoid developing cancer is to lower the risk factors. A risk factor is defined as any behavior or condition that increases the likelihood of developing cancer. Diet and nutritional risk factors are among the easiest to manage by the individual. The American Cancer Society has the following recommendations on diet and nutrition:

1. Maintain a low-fat and high fiber diet
   and
2. Follow the 5-A-Day For Better Health Program

The 5-A-Day For Better Health Program is one of the first national nutrition programs to approach Americans with a simple and positive message to eat 5 or more servings of fruits and vegetables every day for better health. The program is jointly sponsored by the National Cancer Institute and the Produce for Better Health Foundation, a non-profit consumer education foundation representing the fruit and vegetable industry. Their goals are to increase the average consumption of fruits and vegetables to 5 servings daily by the year 2000.

Maintaining a low fat diet is helpful because high fat diets and obesity are associated with an increased risk of breast cancer development. Fruits and vegetables are lower in calories and fat, and high in vitamins, minerals and fiber. It has been demonstrated that women who eat at least five servings of fruits and vegetables per day are generally in better health, have stronger immune systems, and have a lower risk of developing breast cancer. Numerous studies have shown a link between certain foods and the risk of developing certain cancers. Some experts believe that about 35 percent of cancer deaths may be related to what we eat.
Three Reasons Why High-Fat Diets Are Associated With Breast Cancer Development

1) High fat diets produce large amounts of sterol chemicals and bile acids which the body is able to convert into carcinogenic estrogens and other harmful compounds.

2) Diets high in animal fat weaken the immune system by lowering antibody production.

3) Consumption of high levels of polyunsaturated fats may increase the levels of prolactin, a hormone possibly associated with breast cancer development.

To determine grams of fat and saturated fatty acids for any caloric level, use the following calculations:

- Multiply calories per day by 0.30 (30%) to get calories from total fat per day (2000 calories * 0.30 = 600 calories from fat).

- Divide the calories from total fat by 9 (calories in each gram of fat) to get grams of total fat per day (600 divided by 9 = 65 grams of total fat).

- Divide the grams of total fat per day by 3 to get grams of saturated fatty acids providing 10% of calories (65 divided by 3 = 21.6 (22)).

In addition to lowering fat intake, women should also avoid foods that are high in cholesterol. High blood cholesterol levels increase the amount of cholesterol epoxide, a carcinogen found in breast fluid. In contrast to fat and cholesterol which are dietary components that should be lowered; vitamin E and fiber should be increased. It is believed that cells become cancerous when free radical producers like radiation and cigarette smoke damage the genetic machinery that controls cell division, causing cells to multiply out of control. Particularly vulnerable are the cells fat. It is thought that by protecting them, vitamin E keeps the cancer process from starting. Vitamin E would probably be more effective in tissues associated with fats, such as the breasts, lungs, and colon.

Fiber or roughage, will not cure or prevent all disease, but it should be a part of a healthy diet. It is found only in plants and varies from one kind of plant to another and may vary within a species or variety. By eating a variety of fruits, vegetables and legumes (a pod such as that of a pea or bean), all the different types of fibers are
incorporated into the diet. Water **insoluble** fibers act like sponges holding water and cleaning your intestines as they pass through. This cleaning action may prevent cancer causing substances from remaining in the intestines long enough to cause cancer. Water **soluble** fibers lowers blood cholesterol, decreasing the risk of heart disease. They also help control blood sugar by slowing down the rate food leaves the stomach.

Fiber is a very important part of the diet and cancer prevention puzzle. Eating 5-7 servings of fruits and vegetables per day will help insure the recommended amount of fiber and all the other potential beneficial substances in fruits and vegetables. Yet the average person in this country does not eat the recommended number of servings of fruits and vegetables. The average is just slightly over 3 servings per day. The reasons given why includes:

- Cost of fresh produce especially out of season
- Perceived lower nutrient value of canned vegetable
- Feeling that vitamin supplements give everything needed
- Foods don't taste as good as they use to
- Chewing problems
- Special restricted diets
- Lack of knowledge about the importance of eating fruits and vegetables
- Difficulty preparing fresh fruits and vegetables (ie. individuals with arthritis)

**Three Reasons to Maintain a High Fiber Diet**

1) Fiber binds and helps to inactivate bile acids, cholesterol and other carcinogens, thereby acting as a protective agent for the body.

2) Fiber also helps to maintain healthy intestinal flora (bacteria) to prevent the secretion of carcinogenic compounds.

3) Fiber increases the weight of stool and the rate at which carcinogens are excreted from the body.
NUTRITION SOURCES

Foods that are high in fiber:

- Brussels sprout
- Broccoli
- Cabbage
- Whole-wheat pasta
- Whole-wheat cereals/crackers
- Whole grain
- Rice
- Carrots
- Unsweetened fruit juices
- All bran cereals
- Dried peas and beans
- Prunes
- Raisins
- Yams
- Apples
- Bananas
- Grapefruits
- Oranges
- Pears

Foods that are Vitamin E rich:

- Leafy vegetables
- Wheat germ
- Whole grain cereals
- Vegetable oils
- Milk
- Eggs

Vitamin E (alpha tocopherol) is a vital component of the blood. It is an oxygen conservator and an anti-oxidant. These properties suggest that vitamin E possess the ability to improve the cell’s life and its function. As an anti-oxidant, vitamin E delays the oxidative process which turns cells rancid, and prevents oxygen from combining with cellular wastes that form the poisonous hydrogen peroxide (H2O2), which is deadly to cells. Hydrogen peroxide among others, rapidly destroys red blood cells as well as the enzyme “catalase” which is vital to the aeration (exposure to the circulation of air for purification) of cells.
DO'S AND DON'TS TO REDUCE RISKS OF BREAST CANCER

Top 9 Dietary Factors To Avoid:

1. Fried and high fat foods
2. High cholesterol foods
3. Foods cooked over charcoals, smoked or pickled
4. Fruits and vegetables exposed to pesticides (wash them thoroughly)
5. Processed foods including luncheon meats
6. Overcooking vegetables (overcooking may eliminate vital nutrients)
7. Red meats
8. Caffeine (coffee, tea, colas)
9. Over eating

Top 9 Dietary Factors To Do:

1. Eat low fat and low cholesterol foods (keep fat intake to 30% of calories)
2. Eat at least 5 servings of fruits and vegetables per day
3. Eat foods that are high in fiber (try for 25-30mg per day)
4. Eat baked/broiled meats and steamed vegetables
5. Eat more poultry and fish (except for shellfish, sardines, mackerel and other fish canned in oil)
6. Consume adequate amounts of vitamin E
7. Exercise regularly to balance caloric intake and avoid obesity
8. Eat a variety of foods
9. Limit consumption of salt cured, smoked, and nitrate preserved foods

Nutrition can play a role in lowering your risks of cancer. It is one very important piece of a very large puzzle.
PHYTOCHEMICALS

- Phytochemicals are other chemicals in food that may play a role in cancer prevention.

- Soy products contain Phytochemicals called phytoestrogens and these are being studied because Asian women, whose diets are high in soy products, have very low rates of breast cancer.

- There are many different Phytochemicals found in fruits and vegetables.

- Quite a bit of research is being done on Phytochemicals in food absorption and utilization.

SULPHOROPHANE

- Sulphoraphane is one of a group of compounds found naturally in food called, isothiocyanates.

- Isothiocyanates are high in cruciferous vegetables such as broccoli, cauliflower, Brussels sprout and cabbage.

- Some research has shown isothiocyanates to increase the activity of enzymes involved in the detoxification of carcinogens and other foreign compounds.

- Sulphoraphane is one isothiocyanate that appear to be an exceptionally potent inducer of detoxification enzymes.

- Sulphoraphane is an organosulfur compound. It is said to have kept laboratory animals from getting breast cancer by boosting synthesis of anticancer enzymes. After entering the blood stream, it circulates and triggers one of the body's defense systems by activating a group of proteins called phase 2 enzymes.
ALCOHOL

Excessive alcohol consumption can contribute to many problems including cancer of the head, neck, liver, breast and pancreas. Excessive drinking of alcohol, combined with cigarette smoking, greatly increases the risk of cancer of the mouth, larynx, esophagus and respiratory tract. Heavy drinking alone can double or triple the risk of oral cancer, but when combined with heavy smoking, the risk is as high as 15 times that of nonsmokers and nondrinkers.

In place of drinking alcohol try drinking:

* Water
* Vegetable Juices
* Fruit punches
* Club soda
* Sparkling fruit juices
* Plain fruit juices

One of the most encouraging facts to emerge from cancer research in this decade is the accumulating evidence, that nutrition may be a factor in the development of certain cancers. These facts are encouraging because what we put in our mouths is one of the few things we can control and change. Based on hundreds of studies, the National Cancer Institute estimates that about one third of all cancers are in some way linked to diet. Yet many Americans remain either unaware of the diet disease connection or unsure of what action to take.

We don’t have to give up any of the foods we like to protect against cancer risks. The idea is to choose more often the foods that may help decrease the risks of cancer and to choose less often the foods that may increase the risks of cancer. Changing the way favorite foods are prepared can also help. Start with the changes that are easiest. Changes don’t have to be made over night. By taking enough time to think and plan each day before buying, preparing and serving foods, we can help protect ourselves and our families from certain cancers and from heart disease, high blood pressure and other chronic diseases.
The Food Guide Pyramid is an outline of what to eat each day. It's not a rigid prescription, but a general guide that lets you choose a healthy diet that's right for you. The Pyramid calls for eating a variety of foods to get the nutrients you need and at the same time the right amount of calories to maintain a healthy weight.

The Food Guide Pyramid emphasizes foods from the five food groups shown in the three lower sections of the Pyramid.

Each of these food groups provides some, but not all, of the nutrients you need. Foods in one group can't replace those in another. No one food group is more important than another—for good health, you need them all.


Provided by: The Education Department of the National Live Stock and Meat Board.
How Many Servings Do You Need?

The Food Guide Pyramid shows a range of servings for each food group. The number of servings that are right for you depends on how many calories you need. Calories are a way to measure food energy. The energy your body needs depends on your age, sex and size. It also depends on how active you are.

In general, daily intake should be:

- 1,600 calories for most women and older adults;
- 2,200 calories for kids, teen girls, active women and most men; and
- 2,800 calories for teen boys and active men.

The amount of food that counts as one serving is listed below. If you eat a larger portion it is more than one serving. For example, a slice of bread is one serving, so a sandwich for lunch would equal two servings.

For mixed foods, estimate the food group servings of the main ingredients. For example, a large piece of sausage pizza would count in the bread group (crust), the milk group (cheese), the meat group (sausage) and the vegetable group (tomato sauce). Likewise, a helping of beef stew would count in the meat group and the vegetable group.

What Counts as a Serving?

<table>
<thead>
<tr>
<th>Bread, Cereal, Rice &amp; Pasta Group</th>
<th>Vegetable Group</th>
<th>Fruit Group</th>
<th>Milk, Yogurt &amp; Cheese Group</th>
<th>Meat, Poultry, Fish, Dry Beans, Eggs &amp; Nuts Group</th>
<th>Fats, Oils &amp; Sweets</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 slice bread</td>
<td>½ cup chopped</td>
<td>1 piece fruit or melon wedge</td>
<td>1 cup milk or yogurt</td>
<td>2½ to 3 ounces cooked meat, fish, poultry, or seafood</td>
<td></td>
</tr>
<tr>
<td>1 tortilla</td>
<td>cooked vegetables</td>
<td>¼ cup fruit juice</td>
<td>½ ounces natural cheese</td>
<td>lean beef, pork, lamb, veal, poultry or fish</td>
<td></td>
</tr>
<tr>
<td>½ cup cooked rice, pasta or</td>
<td>1 cup row,</td>
<td>¼ cup chopped, cooked or canned fruit</td>
<td>2 ounces process cheese</td>
<td>Count ½ cup cooked beans or 1 egg or 2 tablespoons peanut butter or % cup nuts</td>
<td></td>
</tr>
<tr>
<td>cereal</td>
<td>leafy vegetables</td>
<td></td>
<td>2 cups cottage cheese</td>
<td>as 1 ounce of meat</td>
<td></td>
</tr>
<tr>
<td>1 ounce ready-to-eat</td>
<td>¼ cup vegetable juice</td>
<td>1½ cups ice cream or ice milk</td>
<td>1 cup frozen yogurt</td>
<td></td>
<td></td>
</tr>
<tr>
<td>cereal</td>
<td>¼ cup scalloped potatoes</td>
<td>1 cup frozen yogurt</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>½ hamburger roll, bagel or</td>
<td>½ cup potato salad</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>English muffin</td>
<td>10 French fries</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3-4 plain crackers (small)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 pancake (4-inch)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>¼ croissant (large)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>¼ doughnut or danish (medium)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>¼ cake (average)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 cookies (medium)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>¼ pie (2-crust, 8&quot;)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Adapted from the Food Guide Pyramid, Home and Garden Bulletin Number 252. U.S. Department of Agriculture, Human Nutrition Information Service. FOOD MODELS courtesy of NATIONAL DAIRY COUNCIL. Published by the Education Department NATIONAL LIVE STOCK AND MEAT BOARD 444 NORTH MICHIGAN AVENUE CHICAGO, ILLINOIS 60611

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How much fat is that?

It’s hard to visualize a gram of fat; but we can see teaspoons of fat. Look at the teaspoons of fat in a few foods from the “Primer.” (Count 1 teaspoon for each 4 grams of fat.)

Now try to visualize fat in other foods in the Primer or when you read food labels.

<table>
<thead>
<tr>
<th>FATS, OILS, SWEETS</th>
<th>Total fat (grams)</th>
<th>Saturated fatty acids (grams)</th>
<th>Cholesterol (milligrams)</th>
<th>Calories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Butter, 1 tbsp.</td>
<td>12</td>
<td>7</td>
<td>31</td>
<td>100</td>
</tr>
<tr>
<td>Butter-margarine blend, 1 tbsp.</td>
<td>12</td>
<td>5</td>
<td>16</td>
<td>100</td>
</tr>
<tr>
<td>Margarine, 1 tbsp.</td>
<td>12</td>
<td>2</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>Salad dressing, 1 tbsp.</td>
<td>12</td>
<td>2</td>
<td>7</td>
<td>100</td>
</tr>
<tr>
<td>Mayonnaise (regular)</td>
<td>5</td>
<td>1</td>
<td>5</td>
<td>50</td>
</tr>
<tr>
<td>Mayonnaise, reduced-calorie</td>
<td>7</td>
<td>1</td>
<td>4</td>
<td>70</td>
</tr>
<tr>
<td>Mayonnaise-type, reduced-calorie</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td>45</td>
</tr>
<tr>
<td>Italian, low-calorie</td>
<td>1</td>
<td>trace</td>
<td>0</td>
<td>15</td>
</tr>
<tr>
<td>Italian</td>
<td>7</td>
<td>1</td>
<td>0</td>
<td>70</td>
</tr>
<tr>
<td>Cream, 1 tbsp.</td>
<td>3</td>
<td>2</td>
<td>6</td>
<td>30</td>
</tr>
<tr>
<td>Sour</td>
<td>3</td>
<td>2</td>
<td>10</td>
<td>30</td>
</tr>
<tr>
<td>Light (table)</td>
<td>3</td>
<td>2</td>
<td>10</td>
<td>30</td>
</tr>
<tr>
<td>Nondairy, frozen</td>
<td>1</td>
<td>trace</td>
<td>0</td>
<td>20</td>
</tr>
<tr>
<td>Cream cheese</td>
<td>5</td>
<td>3</td>
<td>16</td>
<td>50</td>
</tr>
<tr>
<td>Cake, devil’s-food, frosted, 1/12 8-inch</td>
<td>16</td>
<td>5</td>
<td>32</td>
<td>405</td>
</tr>
<tr>
<td>Brownie, 1</td>
<td>9</td>
<td>3</td>
<td>23</td>
<td>175</td>
</tr>
<tr>
<td>Pie, apple, 1/8 9-inch</td>
<td>22</td>
<td>5</td>
<td>0</td>
<td>455</td>
</tr>
<tr>
<td>Cheesecake, 1/12 9-inch</td>
<td>25</td>
<td>10</td>
<td>86</td>
<td>405</td>
</tr>
<tr>
<td>Sherbet, 1/2 cup</td>
<td>2</td>
<td>1</td>
<td>7</td>
<td>135</td>
</tr>
<tr>
<td>Chocolate bar, 1 oz.</td>
<td>9</td>
<td>5</td>
<td>6</td>
<td>145</td>
</tr>
</tbody>
</table>
### Breads; Cereals, Rice, Pasta

<table>
<thead>
<tr>
<th></th>
<th>Total fat (grams)</th>
<th>Saturated fatty acids (grams)</th>
<th>Cholesterol (milligrams)</th>
<th>Calories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bread, 1 slice</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>1</td>
<td>trace</td>
<td>trace</td>
<td>70</td>
</tr>
<tr>
<td>Whole-wheat</td>
<td>1</td>
<td>trace</td>
<td>0</td>
<td>65</td>
</tr>
<tr>
<td>Bagel, with egg, 1</td>
<td>1</td>
<td>trace</td>
<td>14</td>
<td>155</td>
</tr>
<tr>
<td>Biscuit, 1 medium</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>105</td>
</tr>
<tr>
<td>Roll, dinner, 1</td>
<td>2</td>
<td>trace</td>
<td>0</td>
<td>85</td>
</tr>
<tr>
<td>Croissant, 1 medium</td>
<td>12</td>
<td>7</td>
<td>62</td>
<td>230</td>
</tr>
<tr>
<td>Muffin, 1 large</td>
<td>6</td>
<td>2</td>
<td>44</td>
<td>185</td>
</tr>
<tr>
<td>Pancake, 1 medium</td>
<td>3</td>
<td>1</td>
<td>26</td>
<td>90</td>
</tr>
<tr>
<td>Waffle, 1 medium</td>
<td>5</td>
<td>2</td>
<td>39</td>
<td>205</td>
</tr>
<tr>
<td>Doughnut, yeast, 1</td>
<td>14</td>
<td>5</td>
<td>21</td>
<td>245</td>
</tr>
<tr>
<td>Danish pastry, 1 (2 oz.)</td>
<td>13</td>
<td>4</td>
<td>49</td>
<td>240</td>
</tr>
<tr>
<td>Oatmeal, cooked, 1/2 cup</td>
<td>1</td>
<td>trace</td>
<td>0</td>
<td>70</td>
</tr>
<tr>
<td>Shredded wheat,</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 large biscuit</td>
<td>trace</td>
<td>trace</td>
<td>0</td>
<td>85</td>
</tr>
<tr>
<td>Granola, 1/3 cup</td>
<td>10</td>
<td>2</td>
<td>0</td>
<td>180</td>
</tr>
<tr>
<td>Rice, white, cooked</td>
<td>1/2 cup</td>
<td>trace</td>
<td>0</td>
<td>110</td>
</tr>
<tr>
<td>Fried rice (with egg and vegetables), 1/2 cup</td>
<td>6</td>
<td>1</td>
<td>21</td>
<td>120</td>
</tr>
<tr>
<td>Cookie, 1 medium</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oatmeal</td>
<td>3</td>
<td>1</td>
<td>5</td>
<td>60</td>
</tr>
<tr>
<td>Chocolate chip</td>
<td>4</td>
<td>1</td>
<td>6</td>
<td>70</td>
</tr>
</tbody>
</table>

### Vegetables

<table>
<thead>
<tr>
<th></th>
<th>Total fat (grams)</th>
<th>Saturated fatty acids (grams)</th>
<th>Cholesterol (milligrams)</th>
<th>Calories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potatoes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boiled, 1/2 cup</td>
<td>trace</td>
<td>trace</td>
<td>0</td>
<td>65</td>
</tr>
<tr>
<td>Potato salad, 1/2 cup</td>
<td>8</td>
<td>1</td>
<td>50</td>
<td>135</td>
</tr>
<tr>
<td>French fries, 10 strips</td>
<td>8</td>
<td>3</td>
<td>0</td>
<td>160</td>
</tr>
<tr>
<td>Au gratin, 1/2 cup</td>
<td>9</td>
<td>4</td>
<td>19</td>
<td>175</td>
</tr>
<tr>
<td>Chips, 1 oz</td>
<td>10</td>
<td>3</td>
<td>0</td>
<td>150</td>
</tr>
<tr>
<td>Cabbage, 1/2 cup</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cooked</td>
<td>trace</td>
<td>trace</td>
<td>0</td>
<td>15</td>
</tr>
<tr>
<td>Creamy coleslaw</td>
<td>11</td>
<td>2</td>
<td>6</td>
<td>125</td>
</tr>
<tr>
<td>Celery and carrot sticks, 8</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Stir fried vegetables, 1/2 cup</td>
<td>trace</td>
<td>trace</td>
<td>0</td>
<td>45</td>
</tr>
</tbody>
</table>

### Meats, Poultry, Fish, Alternates

<table>
<thead>
<tr>
<th></th>
<th>Total fat (grams)</th>
<th>Saturated fatty acids (grams)</th>
<th>Cholesterol (milligrams)</th>
<th>Calories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beef</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lean cut (eye of round), roasted, 3 oz.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lean and fat</td>
<td>11</td>
<td>4</td>
<td>61</td>
<td>195</td>
</tr>
<tr>
<td>Lean only</td>
<td>4</td>
<td>2</td>
<td>59</td>
<td>145</td>
</tr>
<tr>
<td>Fattier cut (chuck blade), braised, 3 oz.</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Lean and fat</td>
<td>22</td>
<td>9</td>
<td>88</td>
<td>295</td>
</tr>
<tr>
<td>Lean only</td>
<td>11</td>
<td>4</td>
<td>90</td>
<td>215</td>
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<tr>
<td>Ground, cooked, 3 oz. patty</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regular</td>
<td>17</td>
<td>7</td>
<td>76</td>
<td>245</td>
</tr>
<tr>
<td>Lean</td>
<td>16</td>
<td>6</td>
<td>73</td>
<td>230</td>
</tr>
<tr>
<td>Extra lean</td>
<td>14</td>
<td>5</td>
<td>71</td>
<td>215</td>
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<tr>
<td>Pork center loin, roasted, 3 oz.</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Lean and fat</td>
<td>11</td>
<td>4</td>
<td>68</td>
<td>180</td>
</tr>
<tr>
<td>Lean</td>
<td>8</td>
<td>3</td>
<td>67</td>
<td>150</td>
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<tr>
<td>Beef liver, braised, 3 oz.</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With skin</td>
<td>12</td>
<td>3</td>
<td>74</td>
<td>200</td>
</tr>
<tr>
<td>Without skin</td>
<td>6</td>
<td>2</td>
<td>75</td>
<td>160</td>
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<tr>
<td>Halibut fillets, baked, 3 oz.</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In oil</td>
<td>7</td>
<td>1</td>
<td>25</td>
<td>170</td>
</tr>
<tr>
<td>In water</td>
<td>1</td>
<td>trace</td>
<td>25</td>
<td>115</td>
</tr>
<tr>
<td>Crabs, hardshell, steamed, 2 medium</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shrimp, steamed or boiled, 8 extra large</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frankfurters</td>
<td>2</td>
<td>2</td>
<td>47</td>
<td>300</td>
</tr>
<tr>
<td>Dry beans, cooked, 1/2 cup</td>
<td>trace</td>
<td>trace</td>
<td>0</td>
<td>110</td>
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<tr>
<td>Peanut butter, 2 tbsp.</td>
<td>16</td>
<td>3</td>
<td>0</td>
<td>190</td>
</tr>
<tr>
<td>Sunflower seeds, 2 tbsp.</td>
<td>10</td>
<td>1</td>
<td>0</td>
<td>105</td>
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<tr>
<td>Egg, large, cooked, 1</td>
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<tr>
<td>Yolk</td>
<td>5</td>
<td>2</td>
<td>213</td>
<td>60</td>
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<tr>
<td>White</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>15</td>
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</tbody>
</table>
EAT LESS FAT
It may lower your chances of getting some kinds of cancer.
Here’s How...

1 Cut extra fat from your meat and throw the fat away.

2 Before you eat chicken, take off the skin and throw it away.

3 Use less fat to cook vegetables.
   • Cut a piece of fat meat the size you normally use when you cook vegetables.
   • Then cut this piece in half.
   • Now cut it in half again.
   • Use only one piece of this fat meat to cook your vegetables. You will be using 1/4 the fat you usually use.

4 Cook vegetables with:
   • Fresh turkey parts without skin.
   • Fresh garlic, onions, celery, and bell peppers.
   • Lemon juice.

5 Pour the fat from the frying pan before you make gravy. Throw the fat away.

6 Broil, boil, bake, or pan broil your meat instead of frying it.
   This is how you pan broil it:
   • Spray nonstick spray in the bottom of a frying pan. Let it get medium hot.
   • Put the meat in the pan. Do not add any more nonstick spray.
   • Turn meat often.
   • Pour the fat from the pan as the meat cooks. Throw the fat away.

When will you cut down on fat? How about starting today!
## Nutrient Values of Sample Fast-Food Meals

<table>
<thead>
<tr>
<th>SAMPLE MEAL</th>
<th>% FAT</th>
<th>CALORIES</th>
<th>CHOLESTEROL (mg)</th>
<th>SODIUM (mg)</th>
<th>VITAMIN A</th>
<th>VITAMIN C</th>
<th>CALCIUM</th>
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<tbody>
<tr>
<td>Double burger with sauce, milk shake, french fries, regular</td>
<td>46</td>
<td>1,275</td>
<td>155</td>
<td>1,190</td>
<td>10</td>
<td>30</td>
<td>80</td>
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<tr>
<td>Chicken nuggets (6), apple pie, coffee with cream</td>
<td>55</td>
<td>655</td>
<td>95</td>
<td>1,115</td>
<td>2</td>
<td>20</td>
<td>9</td>
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<tr>
<td>Fish sandwich with cheese and tartar sauce, soda (12 oz.), french fries,</td>
<td>53</td>
<td>885</td>
<td>73</td>
<td>811</td>
<td>2</td>
<td>20</td>
<td>19</td>
</tr>
<tr>
<td>regular</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beef tacos (2), low-fat milk (8 oz.)</td>
<td>40</td>
<td>495</td>
<td>60</td>
<td>690</td>
<td>18</td>
<td>3</td>
<td>61</td>
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<tr>
<td>Single burger, tossed salad, low-fat milk</td>
<td>32</td>
<td>445</td>
<td>55</td>
<td>1,005</td>
<td>28</td>
<td>75</td>
<td>50</td>
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<tr>
<td>Baked potato, plain margarine (1 pat), tossed salad with low-calorie</td>
<td>18</td>
<td>340</td>
<td>10</td>
<td>620</td>
<td>28</td>
<td>120</td>
<td>45</td>
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<tr>
<td>dressing, low-fat milk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cheese pizza (1 slice), tossed salad with low-calorie dressing, orange</td>
<td>30</td>
<td>310</td>
<td>40</td>
<td>500</td>
<td>27</td>
<td>233</td>
<td>26</td>
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<tr>
<td>juice (8 oz.)</td>
<td></td>
<td></td>
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</tbody>
</table>
Conducting A Successful Workshop
CONDUCTING A SUCCESSFUL WORKSHOP

Introduction

All successful workshops should meet the three 'Ts' in criteria:

- Intention
- Informative
- Interactive

Intention

The workshop's intention is to present established goals and implement them via a Breast Health training. The idea is to provide women with information and skills that will aid them in adopting lifesaving behaviors.

Informative

The Breast Health Education Workshop (BHEW) will provide women with information on barriers, myths and misconceptions, risks and incidence as well as prevention and early detection. The core of the workshop will be the Breast Self Examination (BSE) Training. The terminology of the BHEW should be catered to the participants so that views can be communicated clearly and the language is comfortable.

Interactive

The BHEW should be interactive to the extent that participants are encouraged to ask questions and present feedback on the instructions. When participants are allowed to share their thoughts, feelings and concerns on breast cancer, and also have fun in the process, they are more likely to remember what they have learned. In addition, they are more than likely to share the information with a friend or relative; the dissemination of the information is the ultimate goal.
BREAST HEALTH EDUCATION WORKSHOP FORMAT

Equipment and Workshop Aids

- Markers and marker board
- Easel
- Video tapes
- Flip chart or an overhead projector
- Breast models (ideally 1 model per 3 participants)
- Handouts
- Pencils
- Pretest / Post test

Number of participants

Keeping in mind the level of competency of the participants:

- up to 10 is considered a small and manageable group
- more than 10 is somewhat large, plan for an assistant
Part 1 - Introduction

**Time Allotment**
20 minutes

**Content**

I. **Self Introduction**

Introduce yourself as a volunteer for the National Black Leadership Initiative on Cancer (NBLIC).

II. **Summarize Goals of BHEW**

The BHEW's goal is to provide women with a good breast health plan that includes:

1. Routine breast self examination
2. Clinical breast examination
3. Mammography when appropriate

III. **Administer breast health pretest**

The purpose of the pretest is to find out the participants' knowledge of breast health, so that areas of concentration can be determined.

IV. **Begin discussion with ice breakers**

Icebreakers are used to initiate interaction and participation.

**Icebreaker #1 - Cancer Word Association**

- Ask participants what thoughts come to mind when they hear the word "cancer".

- Document their response on the marker board (Hint: Separate negative and positive comments, then respond by reminding participants that cancer can have positive outcomes, and that the key is early detection).
Icebreaker #2 - Question and Answer

- Does anyone here know someone who has been touched by breast cancer? Ask for the ages of the women touched by breast cancer, then respond by saying; breast cancer can affect women of all ages, etc.

Icebreaker #3 - Video (08 - 10 min.)

- Show breast self examination video. Have participants write their questions down and hold them until the question/answer session (questions may be answered throughout the workshop).

Part 2 - Statistics and Risk Factors

Time Allotment
5 minutes

Content

I. Discuss Breast Cancer Statistics

Briefly present the following facts and statistics on breast cancer:

- Breast cancer is the most common form of cancer diagnosed in women

- Breast cancer is the second leading cause of cancer deaths in women (lung cancer is #1)

- 1 out of 8 women will develop breast cancer in her lifetime

II. Discuss Risk Factors for Breast Cancer

Briefly discuss the following risk factors:

1. Gender - all women are at risk of developing breast cancer

2. Age - breast cancer risk increases with age

3. Family history - risk increases in daughters or sisters of women with breast cancer
4. Early menses, late menopause
5. Reproductive history - more than 30 years old at the birth of first child
6. Diet - obesity (40% above normal weight)
7. Hormones - should be discussed in depth with your doctor

Part 3 - Anatomy of the Breast

Time Allotment
5 minutes

Content

I. Display illustrations on flip chart or overhead

II. Review terminology on diagrams

Part 4 - BSE Instructions with Flip Chart/Overhead Projector

Time Allotment
30 minutes

Content

I. BSE Technique Demonstrated

- Looking: Things to be done in the mirror:
  - Have participants stand and follow flip chart/overhead illustrations

- Feeling: Things to be done lying down:
  - Demonstrate BSE on yourself over clothes or on breast model (choice depends on the selection of participants). Participants may want to follow over their clothes as each element is demonstrated.
- Discuss areas to feel:
  - Underarm to lower bra line
  - Across the breast bone
  - Up to the collar bone
  - Back to the armpit

- Use the pads of the three middle fingers (encourage participation)

- Use three levels of pressure:
  - Light
  - Medium
  - Firm

  Note: for the elderly, if there is difficulty in feeling with the finger tips, using the palm of the hand is better than not doing BSE at all.

- Examine the entire breast using the most comfortable technique:
  - The Vertical Strip Pattern (studies show this method to be more effective)
  - The Circular Pattern
  - The Wedge Pattern

  Note: lotion or powder may be used to help the fingers (palm) slide easier across the skin.

---

**Part 5 - Breast Health Plan**

**Time Allotment**
10 minutes

**Content**

I. **Wrap-up the Workshop**

- Point out the three components of a good breast health plan:
  - Breast Self Examination (BSE)
  - Clinical Examination
  - Mammography

- Discuss guidelines for early detection:
a) Breast Self Examination at age 20 and over:
- should be done monthly
- at least one week after period when breast are less tender
- if there is no longer a period plan to examine the breast monthly on the same day
- for women on replacement hormones, do BSE when starting a new cycle of pills

b) Clinical Breast Exam:
- should be done by a doctor every 3 years between the ages of 20 and 40, if there are no symptoms and you do not fall into a high risk profile and, if you do not use birth control pills or hormones
- should be done yearly by a doctor or nurse (preferably when it's time for a pap smear) over the age of 40

c) Mammography:
- Have your baseline mammogram by age 40 and then once every year.
- Some women may need mammograms more often, check with your healthcare provider to find out what is best for you.

Part 6 - Conclusion

Time Allotment
As time permits

Content
I. Questions and Answers (give out prizes)
II. Administer post test
III. Pass out literature to reinforce training
IV. Thank participants for coming
Breast Self-Examination Training
BREAST SELF-EXAMINATION PROGRAM GOALS

The BSE Training Program is designed to help each woman:

- Identify three components of a good breast health plan: breast self-examination, clinical breast examination and mammography.
- Follow recommended breast cancer screening guidelines.
- Perform breast self-examination with confidence.
- Act promptly if any breast changes are found

The BSE Training Program was developed to:

- Recruit and retain well-trained volunteers.
- Present current information on breast health and breast cancer detection.
- Provide an opportunity for participants to become knowledgeable about the importance of mammography, clinical breast exam and breast self-examination.
- Teach women how to perform a proficient breast self-examination.

Each woman who attends the Training should become more knowledgeable about her breast and understand the value of early detection. She should be capable in deciding her breast health.
Breast cancer is the most common form of cancer diagnosed in women.

Breast cancer is the second leading cause of deaths in women (lung cancer is #1).

Breast cancer is the leading cause of cancer death for Black American women.

1 out of 8 women will develop breast cancer in her lifetime.

Up to 90% of women whose breast cancer is found early, before it spreads beyond the breast, will survive.
Breast Cancer Risks

All Women are at risk

PRIMARY
- Age
- Family History
- Diet?

SECONDARY
- Reproductive History
- Menstrual History
- Hormones?
BREAST CANCER RISK FACTORS

Every woman is at risk of getting breast cancer. There is probably no single cause of the disease. Research has shown that several different factors working together appear to increase the risk of breast cancer. Because of genetic and lifestyle differences, some women are more likely to get the disease than others.

Primary Risk Factors

- Gender

- Age
  - risk increases over 50 years of age

Family history of breast cancer

- Risk may be increased in daughters or sisters of women with breast cancer, especially if the women had premenopausal, bilateral breast cancer.

- Risk may also be increased with a positive paternal family history.

- BRCA1 is one of several genes that contribute to hereditary breast cancer risk. Studies on these genes suggest that approximately 5% of breast cancers are hereditary.

Secondary Risk Factor

- Reproductive history
  - Risks are increased in women who have never had children.
  - Women who have a first child after the age of 30 may be at even greater risk than the women who remain childless.

- Menstrual history
  - Risk increases somewhat in women who begin menstruating early and/or experience menopause late.

The relationship between breast cancer and hormones is unclear. The decision to use hormones or hormone replacement therapy should be made on an individual basis, in consultation with your physician/health care professional.
Diet

Obesity or high dietary fat intake may be a contributor to breast cancer risks. Therefore, the American Cancer Society recommends eating a nutritionally balanced diet, emphasizes low fat, high fiber foods and increased physical activity.

Breast cancer is NOT associated with trauma, fondling, or fibrocystic changes in the breast, and it is not contagious.

**Remember:** It should be emphasized that all women are at risk for breast cancer and should discuss their risk factor profile with their health care provider to determine an appropriate early detection plan.
Anatomy of the Breast
Cancers of the breast develop more often in certain areas of the breast. For example, 50% occur in the upper outer quadrant; 15% percent develop in the upper inner quadrant; 6% develop in the lower inner quadrant, 11% develop in the lower outer quadrant; while 18% occur in and around the nipple.
Each breast has 15-20 sections called lobes. Within each lobe are many smaller lobules, which end in dozens of tiny bulbs that can produce milk. The lobes, lobules and bulbs are all linked by tiny tubes called ducts. These ducts lead to the nipple in the center of a dark area of skin called the areola. Fat fills the spaces around the lobules and ducts. There are no muscles in the breast, but muscles lie under each breast and cover the ribs.
BREAST SELF EXAMINATION TRAINING

Most lumps are found by women themselves. It is therefore important that BSE is done at the same time each month, to look and feel for changes in the breast.

There are two parts to BSE: *Looking and Feeling*

**LOOKING FOR CHANGES**

Stand in front of the mirror to look at your breast, compare for symmetry (both breasts are in proportion with each other). Keep in mind that it is not unusual for one breast to be slightly larger than the other.

1) With your hands at your side, look for changes in:
   ♦ Shape
   ♦ Color

   Check for:
   ♦ Puckering
   ♦ Dimpling
   ♦ Skin Changes
   ♦ Nipple Discharge

Continue to check, turning to your right side and then to your left, check for the same changes on each side.

2) Place your hands behind your head, check for:
   ♦ Symmetry
   ♦ Puckering
   ♦ Dimpling

Turn to both your right and left side, check for the same changes on each side.
3) Place your hands on your hips, press down and bend forward, check for:
- Symmetry
- Nipple Direction
- General Appearance

Turn to your right side and then to your left, check for the same changes on each side. (Note if both breasts fall freely)

FEELING FOR CHANGES

1) Lie down. Place a pillow or a folded towel under your right shoulder with right arm raised above your head. This will flatten breast tissue and allow it to spread evenly over the chest. Repeat for left breast.

2) Examine area from:
- Underarm to lower bra line
- Across to the breast bone
- Up to the collar bone
- Back to the armpit

3) Use the sensitive pads of the three middle fingers on the left hand.
- Keep fingers close together, holding the hand in a bow position
- Place the left hand on the right breast
- Move fingers in dime size circles

4) Use three levels of pressure:
- Light - to feel just below the skin
- Medium - to feel the mid section of the breast
- Firm - to feel down to the chest wall
5) Examine the entire breast area using the search pattern you are most comfortable with:

A. Circular pattern

B. Verticle strip pattern

C. Wedge Pattern
There is evidence that proves the vertical strip method ensures a more complete examination

**VERTICAL STRIP METHOD**

Begin the vertical strips under the arm (remember to use the three finger pads and three levels of pressure and move in dime like circles):

♦ Move down one finger breadth at a time.

♦ Do not remove the fingers from the breast once the examination has begun. You have completed one strip when you reach the bottom of the bra line.

♦ Move over one finger breadth toward the breast bone and repeat strips until you come to the nipple.

♦ Make sure the area around and under the nipple is examined thoroughly.

♦ The average number of strips will be between 10 and 16; it will take about 30 seconds to complete each strip.

♦ If you have large breasts, remove the pillow or towel from under your shoulder once the nipple area has been examined, so that the breast tissue will flatten on the inner half of the breast. Repeat this procedure on the opposite breast, comparing both of them with each other.

♦ If you find any lumps, knots, or changes, tell your doctor immediately. 80% of breast lumps are benign but every lump should be evaluated.

You may also want to examine your breasts while showering, when the skin is wet and lumps may be easily palpated (this can not be adequately done by women with larger breast). BSE in the shower is not recommended by all programs, however, it can be suggested, since some women only examine their breasts in the shower; some form of BSE is better than none at all. BSE lying down should be strongly encouraged.
GUIDE LINES FOR EARLY DETECTION

Breast Self Examination

Examine your breast once a month starting at age 20 and over

♦ at least one week after your period, when breasts are less lumpy and tender

♦ if you don't have a period, plan to examine your breasts every month on the same day

♦ for women on replacement hormones, do BSE when starting a new cycle of pills

Clinical Breast Examination

Have your breasts examined by your healthcare provider every three years between the ages of 20 and 40, if there are no symptoms and you do not fall into a high risk profile and, if you do not use birth control pills or hormones

Have your breasts examined by your doctor every year (preferably when it is time for a papsmear) if over the age of 40

Mammography

♦ Have your baseline mammogram by age 40 and then once every year.

♦ Some women may need mammograms more often, check with your healthcare provider to find out what is best for you.
Questions And Answers About Breast Cancer

1. If I'm at a higher risk of developing breast cancer, how often shall I see my doctor?
   Based upon the risk factors in your individual situation, your doctor will recommend how often you should be checked and what special tests are indicated.

2. I normally have lumpy breasts. How can I determine the difference between my normal condition and an abnormal lump?
   You can't. Regular breast examination will lead you to become very familiar with the pattern of lumps in your breast; any variation in this pattern should be evaluated by a physician. Your doctor may want to see you as often as every three months if you have this condition.

3. I have inverted nipples. Is there any cause for concern?
   Generally speaking, no. They are however, subject to infection if not kept clean and dry, but do not seem to be related to an increase risk of breast cancer.

4. Can mammography replace BSE?
   No. Although mammography is an essential element to early detection, since it can pick up cancer to small to be felt, it is not a replacement for monthly breast self examination where women help protect themselves between professional checkups. Women should consult their physicians on the recommended frequency of mammography.

5. Can the use of hormones which relieves symptoms of menopause cause breast cancer?
   There is currently some controversy about the use of female hormones during and after menopause. Most authorities agree that using replacement hormones need thorough investigation for suitability. Discuss this with your physician. Of course women who take replacement hormones should continue to do breast self examination. Hormones may be recommended for reasons such as prevention of osteoporosis and heart disease, which has a far greater incidence and morbidity than breast cancer.

6. Has diet been linked to breast cancer?
   Yes. Countries that have a diet high in animal fat also have a high rate of breast cancer. This relationship is being studied more by epidemiologist.

7. Do very large breast increase the risk of getting breast cancer?
   Size of the breast is not related to the development of breast cancer. However, a large breasted women should be certain to have a regular physician checkup.
since a small mass is sometimes difficult to detect. This should be in addition to doing BSE.

8. Is breast cancer transmitted from the mother’s or father’s side?
As far as we know, breast cancer is “familial” or hereditary through both sides, but risks are greater when the occurrence of breast cancer is on the mother’s side.

9. If I had a biopsy that turned out benign, will any other tumor I get be benign?
This can not be predicted in individual cases. Statistically, about 8 out of 10 breast lumps are pathologically benign.

10. Is a cyst ever malignant?
Almost all cysts are benign and remain benign; the problem lies in distinguishing a fluid filled cyst from a solid cancer. Also, cancers can occur adjacent to cysts or may develop cysts in the middle of them. Very rarely a benign cyst may develop into cancer, but that is an extremely rare occurrence.

11. What are the possible benefits or risks of breast cancer reconstruction after a mastectomy?
With assistance from her physician, each woman must decide what is right for herself. Some women wish to have the breast contour restored. Benefits include the following: 1) physical comfort, 2) increased pleasure in the style and variety of clothes that may be worn, and 3) psychological adjustment made easier since the woman may feel more confident and pleased with how she looks both dressed and undressed, less often reminded of her disease. Risks might include those that can follow any surgical operation; bleeding, infection, and heavy scar formation. Additional operations may be required if heavy bleeding occurs, if tissues contract or hardens around an implant when the nipple and areola are reconstructed or partial loss of the skin graft occurs.

Source: American Cancer Society, Washington Division
1. Are X-rays harmful?
X-rays for diagnostic purposes are not harmful. However, radiation itself is cumulative and unnecessary; X-ray exposure should be avoided. There is no problem with the type of exposure that is received with routine X-rays.

2. When there is a cancerous lump in the breast, is the lump removed only or is the breast also removed?
Depending on the type and size of the cancer and the women’s choice of treatment, either a part or the whole breast is removed.

3. Do all lumps have to be removed?
No. It depends on the age of the women and the appearance and type of lump.

4. How are most cancerous lumps discovered?
More than 80% of the lumps are discovered by women themselves.

5. If something is felt other than a lump, what might it be?
Sometimes a glandular tissue of the breast itself will feel like a lump. Sometimes a rib may also be mistaken for a lump in the breast. A cyst of the breast is fairly common and may present itself as a lump. Most lumps that are found turn out to be something other than cancer.

6. Can men get lumps in the breast?
Yes, and it is possible for men to develop breast cancer although it is very rare. Breast cancer in men may present itself as a hard lump under the nipple.

7. What is done for pregnant women with breast cancer?
Treatment depends on many factors including: stage in the pregnancy; location and size of the cancer; and whether it has spread or is localized. Each case is decided on an individual basis.

8. Do you continue to examine your breast during pregnancy?
It is a good idea to examine your breast during pregnancy, although the breast are usually more tender and is uncomfortable to do. Usually, the doctor examines the breast to be sure there are no unusual lumps early in the pregnancy. If there is ever a question as to a lump being present, he or she would re-exam the breast. As long as it is comfortable, BSE should be performed during pregnancy.
9. **Does cigarette smoking cause breast cancer?**
   No, it has not been proven that cigarette smoking causes breast cancer. Cigarette smoking definitely causes lung cancer and it is associated with other cancers such as cancer of the mouth, tongue, throat, esophagus and urinary bladder.

10. **Can a bruise or a blow to the breast cause a lump?**
    It is possible that a lump could occur following an injury to the breast, but the lump itself would be related to the blood clot to the tissue. This would be reabsorbed by the body and eventually disappear. Sometimes a bruise may cause an individual to examine herself more frequently and she may find a lump that had been there previously. However, the bruise of the breast itself was not the cause of the lump or the tumor.

11. **Is cancer hereditary?**
    Some forms of cancer do seem to be more prevalent in some families. Predispositions to certain types of cancer may run in families. A history of breast cancer in the family increases the chance that a women may develop it.

*Source: American Cancer Society*
Mammography Backgrounder
Mammography
MAMMOGRAPHY OVERVIEW

Breast cancer is one of the leading causes of death in women, second only to lung cancer. Despite evidence that mammography is the most effective method of detecting early stage breast cancer, use of this technology is low. According to 1987 data from the National Health Interview Survey, only about 17 percent of women age 40 and older reported they had a mammogram within the past year. Trends indicate that one time use of mammography is increasing significantly, but few women follow frequency guidelines.

Women and physicians lack accurate information about screening mammography. Studies of women age 40 and older indicate that the main reasons women give for not having a mammogram are “no need” and lack of physician referral. Cost is also an issue, especially for repeat mammograms. Surveys of physicians indicate their reasons for non-compliance with screening guidelines are: cost to the patient, reliability of a mammogram, availability of qualified radiologist, low chance of finding a breast abnormality, availability of breast x-ray machine and exposure of patients to radiation.

The National Cancer Institute has launched a national education program to target both women and physicians. Information will be disseminated through media, women’s organizations, and physicians societies.

There is concern about how much radiation is dispensed from a mammogram. By the late 1970's, radiation from a mammogram was down one rad per exam. Today's, equipment provides doses as low as 0.3 rad per exam. The risk of something happening at that dosage is equal in comparison to: 1) 400 miles of travel by air, 2) 60 miles of travel by car, 3) smoking 3/4 of one cigarette, and 4) 20 minutes of being a male age 60. The theoretical risk at that exposure level has been estimated at one death per 1 million women per year. The American Cancer Society's position on radiation risk states: “Available information suggests that the risks of inducing breast cancer from low dose modern mammography is minimal, if it exists at all. Because of the detection of some small and palpable breast cancers, and also the reduction of radiation exposure which is now possible with optimum mammogram techniques and carefully monitored equipment, a favorable benefit/risk ratio can be expected in women beginning at age 40 or older.”

There are presently about 18,000 radiologist is the United States, however, only a small percentage are proficient in mammography. In 1990, the oral examination of the American Board of Radiology began including a section specifically on mammography. The two most important issues in choosing a mammography facility are quality and cost. One sign of quality is the American College of Radiology (ACR) voluntary accreditation.
program for mammography facilities. More than 2,800 facilities have been accredited since the program began in 1987.
Mammography Rates Among Women Ages 50 and Older

Percent Screened Within Last Year

51% of White women between the ages of 50-64 received screening mammograms within the last year, compared to 45% of Hispanic women and 40% of African-American women. 42% of White women age 65 and over received screening mammograms within the last year, compared to 32% of African-American women and 30% of Hispanic women.

MAMMOGRAMS

The most important piece of information women need to know about mammography is that it is the single most powerful tool to detect breast cancer early. It can detect breast cancers too small to be seen or felt by physical examination. Mammography screening done at regular intervals, together with clinical breast exams, and monthly breast self-examination are the three techniques that provide the best means of protection for women.

What is mammography?

Mammography is the process of taking an x-ray picture of the breast. Each breast is placed between two plastic plates and, for a clear picture, the breasts are slightly flattened. Usually, two views of each breast are taken, one from the side and one from above. If an area on the mammogram is not clear or looks suspicious, additional views may be needed. The procedure is not painful; understanding what happens during a mammogram will help reduce the anxieties. A squeezing-type pressure may feel a bit uncomfortable, but lasts only a few seconds, so try to relax. This test is extremely safe, since modern mammography uses very low amounts of radiation. A specially trained radiologic technologist administers the test and a specially trained physician (a radiologist) reads the mammogram.

Preparation for a mammogram

These points should be kept in mind on the day of the procedure:

1) You will need to undress above the waist for the exam, so wear a blouse with a skirt or slacks, rather than a dress to the facility.

2) Don’t wear any deodorant, perfume, powders or ointments of any sort in the underarm area or on the breasts on the day of the exam. These products may cause shadows to appear on the mammogram.

3) If possible, don’t schedule a mammogram near the time of your menstrual period, since breasts may be more tender than usual at this time.

4) Bring the name, address, and phone number of your doctor or other health care provider.

5) Bring a list of the places and dates of mammograms, biopsies, or other breast treatment you have had before.
6) Ask the facility where you had mammograms before to release them to you, and bring them with you if possible. Your new mammogram can be compared with the earlier ones to see if there have been any changes.

It is also helpful to:

• Bring a list of any questions you may have about mammography and your mammograms.

• If you think you may have trouble hearing or understanding the instructions, consider bringing a friend or family member to help you.

• If you are worried about discomfort, you may want to take a mild over-the-counter pain reliever about an hour before your mammogram. This will not affect the mammogram.

• If there is something you do not understand, ask. And keep asking until all your questions are answered.

• If you do not hear from your physician within 10 days, do not assume that your mammogram was normal. Confirm this by calling your health care provider or the facility.

Recommendations for screenings:

1) By age 40, have your first baseline mammogram and then once every year

2) Some women may need mammograms more often, check with your health care provider to find out what is best for you

Choosing a mammography facility:

If a mammography facility is accredited by the American College of Radiology, its machines and staff has met specific quality standards and is issued an FDA certification. To insure that a facility is of a high quality staff, "yes" should be answered to all of the following questions:

• Does the facility use machines specifically designed for mammography?

• Is the person who takes the mammograms a registered technologist?

• Is the radiologist who reads the mammograms specifically trained to do so?
• Does the facility provide mammograms as part of its regular practice?

• Is the mammography machine calibrated at least once a year?

Cost

A mammography screening can cost as little as $65.00, up to $225.00. If cost is a concern, various health agencies, organizations, and women's groups provide referrals to low-cost or free mammography services (see Resource section). Many insurance companies provide some form of mammography coverage and Medicare pays a limited amount toward mammography screening for its beneficiaries.
### Size of Tumors Found by Mammography and Breast Self-Exam

- **3 mm or .3 cm**
  - Average-size lump found by getting regular mammograms.
- **5 mm or .5 cm**
  - Average-size lump found by first mammogram.
- **11 mm or 1.1 cm**
  - Average-size lump found by women practicing regular breast self-examination (BSE).
- **25 mm or 2.5 cm**
  - Average-size lump found by women practicing occasional BSE.
- **38 mm or 3.8 cm**
  - Average-size lump found by women untrained in BSE.

Source: The Breast Health Program of New York

Physicians describe lumps in terms of millimeters (mm), centimeters (cm), and inches (in).

10 mm = 1 cm  \hspace{1cm} 2.54 cm = 1 in
**MYTHS ABOUT MAMMOGRAPHY AND BREAST CANCER**

Myth 1: I don’t need a mammogram if I don’t have any symptoms.

**FACT:** Mammography can detect breast cancer up to two years before you or your doctor can feel a lump.

Myth 2: There’s no history of breast cancer in my family, so I don’t need to worry about getting it.

**FACT:** Eight out of ten women who develop breast cancer have no family history of the disease.

Myth 3: I had one normal mammogram, so I don’t need another.

**FACT:** Once is not enough. Women age 40-49 should have a mammogram every year or two; from age 50 on, they need a mammogram once a year.

Myth 4: Mammograms are painful.

**FACT:** A mammogram is simply an x-ray of your breast. Although the procedure may cause slight discomfort, it doesn’t hurt. And the amount of radiation is very low.

Myth 5: If a mammogram does find something, it’s too late.

**FACT:** In nine cases out of ten, women whose breast cancer is found and treated early, before it has spread beyond the breast, will survive.

Myth 6: I just found a lump in my breast; but since I had a mammogram recently I don’t have to worry.

**FACT:** Anytime you find a lump it must be seen by a doctor.
1. What is a mammogram?
   It is an x-ray of the breast that gives a picture of the inside of the breast.

2. Is there any risk in having a mammogram?
   You will get a very small dose of radiation that is not harmful. Experts
tell us that there is only a small risk from these low dose x-rays.

3. My doctor has not recommended that I have a mammogram.
   Maybe your doctor was seeing you for something else and just did not
think about it. As we grow older, our risk of breast cancer rises quickly.
So, the American Cancer Society recommends that all women 40 and older
have regular mammograms. You may want to call your doctor and talk to
him/her about having a mammogram.

4. Who takes the mammogram?
   An x-ray technologist. She is trained to keep you comfortable, use the
mammography machine safely and to answer questions you may have. The
mammogram will be read by a specially trained doctor.

5. Should I have a mammogram even if I have no symptoms?
   Yes. A mammogram can find breast cancer very early, up to 1 to 2 years
before it can be felt by a doctor.

6. Does a mammogram find all cancers?
   No test is 100% effective. The American Cancer Society advises that a
doctor or other health care provider check your breasts once a year. You
should check our own breast once a month.

7. How much does a mammogram cost?
   The cost usually range from $65.00 to $225.00. Many insurance plans
cover the cost of a mammogram. If you are not covered by insurance,
some hospitals and health clinics offer low fee or free mammograms. Also,
*Medicare covers mammograms for women 65 and older* (Note: look at
your Unit Mammogram Resource Guide for cost in your area).

8. Will the mammogram hurt?
   You will feel some pressure during the x-ray, but it should not be painful.
Any discomfots will only last a few seconds. Your breasts may be more
sensitive just before your period. If you have periods, plan to have your
mammogram 7 to 10 days after the start of your period. Also, eliminating caffeine from your diet will help to alleviate persistent pain from the breast. If you are concerned, talk with the x-ray technician before the test.

9. **Where could I get a mammogram?**
You may want to arrange an appointment with your doctor or clinic. The American College of Radiology provides a list of facilities that are approved for mammograms (Note: look at your Unit Mammogram Resource Guide for a list of these facilities in your area).

* * Medicare cost is covered every two years.*
FDA's Mammography Program

By October 1, 1994, all mammography facilities in the U.S. (except those of the Department of Veterans Affairs) will have to be certified by the U.S. Food and Drug Administration (FDA) as providing quality mammography in order to lawfully continue to provide mammography services. The new certification requirement is a result of legislation enacted by Congress in 1992 that requires national, uniform quality and safety standards for mammography facilities. The legislation is titled the Mammography Quality Standards Act of 1992 (MQSA).

MQSA Requirements

The key features of MQSA are:

- To operate lawfully after October 1, 1994, a mammography facility must be certified by FDA as providing quality mammography services.

- For a facility to be certified, it must be accredited by a federally-approved private nonprofit or state accreditation body. As of September 22, 1994, FDA had approved the American College of Radiology (ACR) and the States of Arkansas, California, and Iowa as accreditation bodies. If other States are approved as accreditation bodies, FDA will announce their names in its quarterly newsletter, Mammography Matters.

- To be accredited, the facility must apply to an FDA-approved accreditation body, undergo periodic review of its clinical images, have an annual survey by a medical physicist, and meet federally-developed quality standards for personnel qualifications; quality assurance programs, and recordkeeping and reporting.

- The facility must also undergo an annual inspection conducted by federally-trained and certified federal or state personnel.

Who Will Have To Meet MQSA Requirements?

- All mammography facilities (any facility that produces, processes, or interprets mammograms), except those of the Department of Veterans Affairs. Requirements will cover personnel, equipment, radiation dose, quality assurance programs, and recordkeeping and reporting.

- Accreditation bodies (state or private nonprofit organizations)

- The following personnel who are involved in the production, processing, or interpretation of mammograms:
  - Physicians who interpret mammographic images
  - Radiologic technologists who perform mammographic procedures
  - Medical physicists who survey mammography equipment

(continued on other side)
FDA Implementation of MQSA

FDA is responsible for implementing MQSA. This entails certifying by October 1, 1994, all U.S. mammography facilities that have received accreditation by an approved accreditation body; training and certifying federal and state inspectors; inspecting all mammography facilities annually; overseeing facility efforts to correct deficiencies; and educating mammography facilities and the public about quality mammography.

In order to meet the October 1994 deadline, Congress amended MQSA to streamline the process for issuing regulations that describe the facility quality standards and the standards to be met by the accrediting bodies. The amendments gave FDA authority to issue interim regulations and exempted the agency from the requirement to consult with an advisory committee during their development.

The interim standards were published in the December 21, 1993, Federal Register and mailed to mammography facilities during the first week of January 1994. The National Mammography Quality Assurance Advisory Committee also has been formed. The advisory committee met on February 17-18, May 2-4, and July 12-15, 1994. After FDA consults again with the committee and considers comments received in response to the interim regulations, it will develop more comprehensive final regulations to replace the interim regulations.

After October 1, 1994, uncertified mammography facilities that continue in operation will be in violation of the law and subject to civil penalties.

For additional information:

FDA will issue periodic announcements regarding MQSA requirements and implementation strategies in its quarterly newsletter, Mammography Matters. To receive copies of the newsletter, write to:

Food and Drug Administration  
Center for Devices and Radiological Health  
Office of Health and Industry Programs  
Division of Mammography Quality and Radiation Programs (HFZ-240)  
1350 Piccard Drive  
Rockville, MD 20850

Fax: 301-594-3306

Also, please let us know what types of articles you'd like to see in our newsletter and what questions you'd like to have answered by sending us a Fax.

9/22/94
Glossary of Terms

Areola (a-REE-oe-la): The area of dark colored skin that surrounds the nipple.

Axilla (ak-SIL-a): Area under the arm.

Benign (bee-NINE): Not cancerous; does not invade nearby tissue or spread to other parts of the body.

Biopsy (BY-op-see): The removal of a sample of tissue, which is then examined under a microscope to check for cancer cells. Excisional biopsy is surgery to remove an entire lump and an area of normal tissue around it. In incisional biopsy, the surgeon removes just part of the lump. Removal of tissue with a needle is called a needle biopsy.

Cancer: A term for more than 100 diseases in which abnormal cells can spread through the bloodstream and lymphatic system to other parts of the body.

Carcinoma (kar-sin-OE-ma): Cancer that begins in the lining or covering of an organ.

Cyst (siist): A closed sac or capsule filled with fluid.

Duct: A small channel in the breast through which milk passes from the lobules to the nipple. Cancer that begins in a duct is called ductal carcinoma.

Estrogen (ES-troe-jin): A female hormone.

Gynecologist (guy-ni-KOL-o-jist): A doctor who specializes in treating diseases of the female reproductive organ.

Hormonal therapy: Treatment of cancer by removing, blocking, or adding hormones.

Hormones: Chemicals produced by glands in the body. Hormones control the actions of certain cells or organs.

Incidence: The frequency of occurrence of new cases (ex: breast cancer) during a period of time.

Lobe: A part of the breast; each breast contains 15-20 lobes.

Lobule (LOB-yood): A subdivision of the lobes of the breast. Cancer that begins in a
lobule is called lobular carcinoma.

Lumpectomy (*lump-EK-toe-mee*): Surgery to remove only the cancerous breast lump; usually followed by radiation therapy.

Lymph (*limf*): The almost colorless fluid that travels through the lymphatic system and carries cells that help fight infection and disease.

Lymph nodes: Small bean-shaped structure located along the channels of the lymphatic system. Bacteria or cancer cells that enter the lymphatic system may be found in the nodes. Also called lymph glands.

Lymphatic systems (*lim-FAT-ik*): The tissue and organs (including the bone marrow, spleen, thymus, and lymph nodes) that produce and store cells that fight infection and disease. The channels that carry lymph also are part of this system.

Malignant (*Ma-LIG-nant*): Cancerous; can spread to other parts of the body.

Mammogram (*MAM-o-gram*): An x-ray of the breast.

Mammography (*MAM-OG-ra-fee*): The use of x-rays to create a picture of the breast.

Mastectomy (*mas-TEK-to-mee*): Surgery to remove the breast (or as much of the breast as possible).

Menopause: The time of a woman’s life when menstruation ends; also called a change of life.

Menstrual cycle (*Men-stroo-al*): The hormone changes that lead up to a woman having a period. For most women, one cycle takes 28 days.

Metastasis (*meh-TAS-tas*): The spread of cancer from one part of the body to another. Cells in the metastatic (secondary) tumor are like those in the original (primary) tumor.

Mortality: Frequency of the number of deaths (death rate) in proportion to a population (ex: there were 31 breast cancer deaths per 100,000 African-American women between 1988-1992).

Oncologist (*on-KOL-o-jist*): A doctor who specializes in treating cancer.

Palpation (*pal-PAY-shun*): A simple technique in which a doctor presses on the surface
of the body with his or her fingers to feel the organs or tissues underneath.

Pathologist (pa-THOL-o-jist): A doctor who identifies diseases by studying cells and tissues under a microscopic.

Prognosis (prog-NOE-sis): The probable outcome or course of a disease; the chance of recovery.

Prosthesis (pros-THEE-sis): An artificial replacement of a part of the body. A breast prosthesis is a breast form worn under clothing.

Rad: A measurement that is used for the amount of radiation absorbed by the body.

Radiation therapy (ray-dee-AY-shun): Treatment with high energy rays to kill cancer cells. Radiation therapy that uses a machine located outside the body to aim high energy rays at the cancer is called external radiation. When radioactive material is placed in the breast in thin plastic tubes, the treatment is called implant radiation.

Radiologist: A doctor who specializes in creating and interpreting pictures of areas inside the body. The pictures are produce with x-rays, sound waves, or other types of energy.

Remission: Disappearance of the signs and symptoms of cancer. When this happens, the disease is said to be “in remission.” A remission can be temporary or permanent.

Risk factor: Something that increases a person’s chance of developing a disease.

Screening: Checking for disease when there are no symptoms.

Stage: The extent of the cancer. The stage of breast cancer depends on the size of the cancer and whether it has spread.

Stem cells: The cells from which all blood cells develop.

Surgery: An operation.

Tissue (TISH-oo): A group or layer of cells that performs a specific function.

Tumor: An abnormal mass of tissue.

Ultrasonography (UL-tra-son-OG-ra-fee): A test in which high frequency sound waves
that cannot be heard by humans, are bounced off tissues and the echoes are converted into a picture (sonogram). These pictures are shown on a monitor like a TV screen. Tissues of different densities look different in the picture because they reflect sound waves differently. A sonogram can often show whether a breast lump is a fluid-filled cyst or a solid mass.

**Xeroradiography** *(Zee-ore-ray-dee-OG-ra-fee)*: A type of mammography in which a picture of the breast is recorded on paper rather than on film.

**X-ray**: High-energy radiation. It is used in low doses to diagnose diseases and in high doses to treat cancer.
MPRIS
The Mammography Program Reporting and Information System
State Facilities Listing

List Current as of: 11/15/95

State: GA
Accreditation Status: Fully Accredited

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# MPRIS
The Mammography Program Reporting and Information System

## State Facilities Listing

List Current as of: 11/15/95

State: GA  
Accreditation Status: Fully Accredited

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### MPRIS

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# MPRIS

The Mammography Program Reporting and Information System

## State Facilities Listing

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List Current as of: 11/15/95

State: GA

Accreditation Status: Fully Accredited

Questions regarding certification status should be directed to 800-838-7715, or FAX 410-229-2335.
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The Mammography Program Reporting and Information System

## State Facilities Listing

**List Current as of: 11/15/95**

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**Accreditation Status:** Fully Accredited

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# MPRIS

The Mammography Program Reporting and Information System

## State Facilities Listing

List Current as of: 11/15/95

**State:** GA  
**Accreditation Status:** Fully Accredited

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**MPRIS**
The Mammography Program Reporting and Information System

**State Facilities Listing**

*List Current as of: 11/15/95*

**State:** GA  
**Accreditation Status:** Fully Accredited

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<th>Facility ID</th>
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| 145944      | William H. Holbrook, M.D.  
Mammography Services | 1010 Prince Avenue,                           | Athens        | 4043531212 | 07/21/1999 |
| 176445      | Winn Army Community Hospital               | Radio Service                                  | Fort Stewart  | 9127676725 | 03/01/1999 |
| 147371      | WomanCare                                  | 1455 Montreal Road, Suite 202                 | Tucker        | 4044916668 | 07/24/1999 |
| 195735      | Women'S Center                             | University Hospital Medical Ce, 4106          | Martinez      | 7068683200 | 03/11/1999 |
| 159301      | Women's Diagnostics of Albany              | 419 Fifth Avenue                               | Albany        | 9128835211 | 10/08/1999 |
| 187484      | Womans Center of Piedmont Hospital         | 324 Stevens Entry,                             | Peachtree City | 4044876543 | 06/07/1999 |
| 201376      | Woodstock Imaging Center                   | 2000 Professional Way, Bldg. 100 - Suite A    | Woodstock    | 4045919711 | 05/20/1999 |
| 203604      | Yvonne Scott, M.D. Mammography Center      | 5430 Jimmy Carter Blvd., Suite 100            | Nocross       | 4047349353 | 04/20/1996 |

**Accreditation Status:** Provisionally Accredited

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**Number of Facilities:** 267
# MPRIS

The Mammography Program Reporting and Information System

State Facilities Listing

List Current as of: 11/15/95

## State: GA

### Accreditation Status: No Longer Practicing Mammography

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Number of Facilities: 8

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| 4451 Paulsen Street, 849 Peachtree Ne, Suite 202B, 719 Scenic Highway, Suite C, Mobile
| 199869      | South Dekalb Diagnostic Center         | 3424 Flat Shoals Road, Ste. C/D  | Decatur 30034      | 4042128357     | 11/03/1995   |
| 195834      | Worth County Hospital, Inc.            | Camilla Hwy, P.O. Box 545        | Sylvester 31791     | 912766561      | 06/30/1995   |

Number of Facilities: 3

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<td>4451 Paulsen Street,</td>
<td>Savannah 31405</td>
<td>9123507500</td>
<td>04/28/1995</td>
</tr>
<tr>
<td>199877</td>
<td>Midtown Diagnostic Center</td>
<td>849 Peachtree Ne, Suite 202B</td>
<td>Atlanta 30308</td>
<td>404873423</td>
<td>11/03/1995</td>
</tr>
</tbody>
</table>
| 205633      | Primary Care Diagnostics Center, Inc.- | 719 Scenic Highway, Suite C, Mobile
| 199869      | South Dekalb Diagnostic Center         | 3424 Flat Shoals Road, Ste. C/D  | Decatur 30034      | 4042128357     | 11/03/1995   |
| 195834      | Worth County Hospital, Inc.            | Camilla Hwy, P.O. Box 545        | Sylvester 31791     | 912766561      | 06/30/1995   |

Number of Facilities: 5

### Accreditation Status: Provisional Reinstatement of Accreditation

<table>
<thead>
<tr>
<th>Facility ID</th>
<th>Facility Name</th>
<th>Facility Address</th>
<th>Facility City/ZIP</th>
<th>Telephone</th>
<th>Expiration</th>
</tr>
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<tbody>
<tr>
<td>189233</td>
<td>Complete Health Care Center, Inc.</td>
<td>1013 Main Street, Ste. A</td>
<td>Perry 31069</td>
<td>9129875080</td>
<td>02/18/1996</td>
</tr>
<tr>
<td>179218</td>
<td>Internal Medicine Associates, P.C.</td>
<td>618 Orange Street,</td>
<td>Macon 31298-5999</td>
<td>9127451191</td>
<td>01/07/1996</td>
</tr>
<tr>
<td>203018</td>
<td>La Grange Internal Medicine</td>
<td>301 Medical Drive,</td>
<td>La Grange 30240</td>
<td>706885341</td>
<td>02/04/1996</td>
</tr>
<tr>
<td>164798</td>
<td>Middle Georgia Urgent Care</td>
<td>818 Forsyth Street,</td>
<td>Macon 31201</td>
<td>9127415051</td>
<td>12/10/1995</td>
</tr>
<tr>
<td>185159</td>
<td>Minnie G. Boswell Memorial Hospital</td>
<td>1201 Siloam Highway, P.O. Box 329</td>
<td>Greensboro 30642</td>
<td>7064537331</td>
<td>01/05/1996</td>
</tr>
<tr>
<td>196952</td>
<td>Mitchell County Hospital</td>
<td>90 Stephens Street, P.O. Box 639</td>
<td>Camilla 31730</td>
<td>9123365284</td>
<td>01/12/1996</td>
</tr>
<tr>
<td>136713</td>
<td>South Atlanta Radiology Associates, P.C.</td>
<td>119 Upper Riverside Road,</td>
<td>Riverdale 30274</td>
<td>7709911010</td>
<td>04/19/1996</td>
</tr>
</tbody>
</table>

Number of Facilities: 6
MPRIS
The Mammography Program Reporting and Information System

State Facilities Listing

List Current as of: 11/15/95

State: GA
Accreditation Status: Provisional Reinstatement of Accreditation

<table>
<thead>
<tr>
<th>Facility ID</th>
<th>Facility Name</th>
<th>Facility Address</th>
<th>Facility City/ZIP</th>
<th>Telephone</th>
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<tbody>
<tr>
<td>139329</td>
<td>St. Joseph's Hospital of Atlanta - MOBILE</td>
<td>Women's Breast Health Center, 5665 Peachtree Dunwoody Road Suite 100</td>
<td>Atlanta 30342</td>
<td>4048517470</td>
<td>01/07/1996</td>
</tr>
<tr>
<td>178160</td>
<td>Wills Memorial Hospital</td>
<td>Radiology Department, Gordon Street P.O. Box 370</td>
<td>Washington 30673</td>
<td>7066782151</td>
<td>12/28/1995</td>
</tr>
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</table>

Accreditation Status: Failed to Complete Accreditation

<table>
<thead>
<tr>
<th>Facility ID</th>
<th>Facility Name</th>
<th>Facility Address</th>
<th>Facility City/ZIP</th>
<th>Telephone</th>
<th>Expiration</th>
</tr>
</thead>
<tbody>
<tr>
<td>202739</td>
<td>Diagnostic Center Ltd.</td>
<td>993 Johnson Ferry Road, Suite C-130</td>
<td>Atlanta 30342</td>
<td>4042529511</td>
<td>04/07/1995</td>
</tr>
<tr>
<td>199174</td>
<td>Scandinavian Diagnostic Center, Inc.</td>
<td>730 Peachtree Street, NE, Suite 900</td>
<td>Atlanta 30308</td>
<td>4048723436</td>
<td>04/07/1995</td>
</tr>
<tr>
<td>193463</td>
<td>Telfair County Hospital</td>
<td>Hwy 341 South, P.O. Box 150</td>
<td>Morrow 31055</td>
<td>9128685621</td>
<td>04/07/1995</td>
</tr>
</tbody>
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Accreditation Status: Duplicate Accreditation

<table>
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<tr>
<th>Facility ID</th>
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<th>Facility Address</th>
<th>Facility City/ZIP</th>
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<th>Expiration</th>
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<tbody>
<tr>
<td>175869</td>
<td>Moody Air Force Base</td>
<td>347 Medical Group / Sghr, 3278 Mitchell Boulevard</td>
<td>Moody Afb 31599-1500</td>
<td>9123333295</td>
<td>10/06/1995</td>
</tr>
<tr>
<td>205856</td>
<td>South Fulton Medical Center, Breast Health Center</td>
<td>1100 Cleveland Avenue,</td>
<td>East Point 30344</td>
<td>4047675359</td>
<td>06/20/1995</td>
</tr>
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</table>

Accreditation Status: Accreditation Expired

<table>
<thead>
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<th>Facility ID</th>
<th>Facility Name</th>
<th>Facility Address</th>
<th>Facility City/ZIP</th>
<th>Telephone</th>
<th>Expiration</th>
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<tbody>
<tr>
<td>111229</td>
<td>East Cobb Women's Diagnostic Center, Inc.</td>
<td>1121 Johnson Ferry Road, Suite 235</td>
<td>Marietta 30068</td>
<td>4049716975</td>
<td>08/09/1995</td>
</tr>
<tr>
<td>200220</td>
<td>Southeastern Diagnostic Center Corporation</td>
<td>3009 Rainbow Drive, Suite 146</td>
<td>Decatur 30034</td>
<td>4012415766</td>
<td>07/02/1995</td>
</tr>
</tbody>
</table>

Number of Facilities: 9
Number of Facilities: 3
Number of Facilities: 2

Total Facilities in State as of Above Date: 307
GEOGRAPHICAL ROSTER
MAMMOGRAPHY FACILITIES
February 2, 1997

All facilities which have an active application for accreditation with the American College of Radiology are listed. Those in bold type are accredited.

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Indian River Radiology
North River Office Center
1485 37th Street
Suite 107
Vero Beach, FL 32960
(407) 569-8745

Indian River Memorial Hospital
1000 36th Street
Vero Beach, FL 32960
(407) 567-4311

Indian River Radiology
Indian River Medical Center
777 37th Street
Suite B106
Vero Beach, FL 32960
(407) 562-3391

West Palm Beach
Drs. Hudson, Jabour, Goldmann & Muschkin, P.A.
1411 North Flagler Dr.
Suite 6800
West Palm Beach, FL 33401-3412
(407) 835-1900

West Palm Beach V.A. Medical Center
7305 N. Military Trail
West Palm Beach, FL 33410-6400
(407) 882-6756

Lawrence Rothenberg, M.D.
3915 Haverhill Road
Suite 119
West Palm Beach, FL 33417
(407) 697-4646

Center for Breast Care
Columbia Medical Plaza
4700 North Congress Ave
Suite 201
West Palm Beach, FL 33407
(407) 881-9200

St. Mary’s Hospital, Inc.
901 45th Street
P.O. Box 24620
Atn: Pete Schweers
West Palm Beach, FL 33416-4620
(407) 881-2726

Berry Simon, M.D., P.A.
2161 Palm Beach Lake Blvd.
Suite 100
West Palm Beach, FL 33409
(407) 478-0101

Mammography Center of the Palm Beaches
3537 Forest Hill Boulevard
Suite B
West Palm Beach, FL 33406
(407) 965-1199

Ultrasound and Mammography Associates
603 Village Boulevard
Suite 202
West Palm Beach, FL 33409
(561) 687-9633

Wellington Regional Medical Center
10101 Forest Hill Blvd.
West Palm Beach, FL 33414
(407) 798-8514

OB
GYN Specialists of the Palm Beaches, P.A.
2611 N. Dixie Highway
West Palm Beach, FL 33401
(407) 655-3331

Good Samaritan Medical Center
P.O. Box 3166
Figueroa Drive @ Palm Beach Lakes Blvd.
West Palm Beach, FL 33402
(407) 650-6441

Drs. Rattinger, Steinberg, et al
2801 N. Flagler Drive
West Palm Beach, FL 33407
(407) 659-7411

Midtown Imaging, P.A.
5405 Okeechobee Boulevard
Suite 101
West Palm Beach, FL 33417
(561) 697-3001

The Magnet of Palm Beach, LTD
4477 Medical Center Way
West Palm Beach, FL 33409
(407) 840-9400

Weston
Cleveland Clinic Weston
1825 North Corporate Lakes Blvd.
Weston, FL 33326
(954) 978-5113

Tufts Mammography Center
1601 Town Center Boulevard
Suite B
Weston, FL 33336
(305) 349-7510

Williston
Nature Coast Regional Hospital
125 S.W. 7th Street
P.O. Box 550
Williston, FL 32696
(352) 528-2801

Winter Haven
Winter Haven Hospital
Radiology Department
200 Avenue F N.E.
Winter Haven, FL 33881
(813) 297-1811

Regency Medical Center
Radiology Department
101 Avenue O S.E.
Winter Haven, FL 33880
(941) 294-1885

Gessler Clinic, P.A.
635 First Street, North
Winter Haven, FL 33881
(813) 294-0670

Bond Clinic, P.A.
500 East Central Avenue
Winter Haven, FL 33880
(813) 293-1191

Winter Park
Aloma Winter Park Medical Center
3027 Aloma Avenue
Winter Park, FL 32792
(407) 678-6466

Lee Road Radiology
2566 Lee Road
Winter Park, FL 32701
(407) 830-6420

Linville, Adcock & Dexter, M.D. MOBILE
120 University Park Drive
Ste. 140
Winter Park, FL 32792
(407) 322-6241

Central Florida Center for Diagnostic Imaging
1285 Orange Avenue
Suite 200
Winter Park, FL 32789-4909
(407) 628-5051

The Breast Care Center, P.A.
1561 West Fairbanks Avenue
Suite 200
Winter Park, FL 32789-4601
(407) 647-4288

NMC Diagnostic Services, Inc. - MOBILE
6912 Aloma Avenue
Winter Park, FL 32792
(407) 679-2022

Park Health Corporation
Winter Park Memorial Hospital
200 N. Lakemont Avenue
Winter Park, FL 32792
(407) 646-7629

Park Health Corporation
Winter Park Women’s Center
133 S. Benmore Drive
Winter Park, FL 32792
(407) 646-7629

Winter Park Memorial Hospital Mobile Unit
200 North Lakemont Avenue
Winter Park, FL 32792
(407) 646-7020

University Imaging
120 University Park Drive
Suite 140
Winter Park, FL 32792
(407) 679-7772

Frazz, Lucas & Bernstein, M.D., P.A.
1925 Mizell Avenue
Suite 104
Winter Park, FL 32792
(407) 644-6771

NMC Diagnostic Services, Inc. - MOBILE
6912 Aloma Avenue
Winter Park, FL 32792
(407) 679-2022

Zephyrhills
Florida Medical Clinic
38135 Market Square
Zephyrhills, FL 33540
(813) 782-8829

East Pasco Imaging Center
38035 Medical Center Drive
Zephyrhills, FL 33540
(813) 783-6150

East Pasco Medical Center
7050 Gall Blvd.
Zephyrhills, FL 33541
(813) 788-0411

February 2, 1997 edition
Mammography Facilities

Atlanta Medical Associates
100 10th Street
Atlanta, GA 30309
(404) 897-1010

Southwest Hospital & Medical Center
501 Fairburn Road, S.W.
Atlanta, GA 30331
(404) 689-1111

St. Joseph’s Hospital of Atlanta
Women’s Breast Health Center
5665 Peachtree-Dunwoody Road
Atlanta, GA 30342
(404) 851-7470

Kaiser Permanente - Glentlake Medical Facility
20 Glentlake Parkway
Atlanta, GA 30328
(770) 677-5810

Peachtree Women’s Clinic
980 Johnson Ferry Road
Suite 220
Atlanta, GA 30342
(404) 255-8022

Southside Healthcare, Inc.
1039 Ridge Avenue S.W.
Atlanta, GA 30315
(404) 688-1330

Drs. Johnston, Croft & Wiskind
105 Collier Road
Suite 2030
Atlanta, GA 30309
(404) 552-1235

Atlanta Women’s Specialists, P.C.
980 Johnson Ferry Road, NE
Suite 510
Atlanta, GA 30342
(404) 252-5196

OB-GYN of Atlanta, P.C.
975 Johnson Ferry Road N.E.
Suite 400
Atlanta, GA 30342
(404) 252-1137

Ratchford & McDaniel, P.C.
115 Collier Road
Suite 1080
Atlanta, GA 30309
(404) 352-2850

North Atlanta OBGYN, P.A.
980 Johnson Ferry Road
Suite 8410
Atlanta, GA 30342
(404) 255-0621

Grady Health System
Radiology Department, Mammography
80 Butler Street, SE; PO Box 276
Atlanta, GA 30335-3801
(404) 716-4530

Southeastern Health Services/Prucare
3200 Downwood Circle
Suite 300
Atlanta, GA 30327
(404) 609-5678

Del Mazo Medical Services
478 Peachtree Street, NE
Suite 107A
Atlanta, GA 30308-3124
(404) 577-1112

Atlanta Women’s OB-GYN Associates
2001 Peachtree Road, NW
Suite 640
Atlanta, GA 30309
(404) 352-3616

Atlantic
Southside Healthcare, Inc. - MOBILE
1039 Ridge Avenue, S.W.
Atlanta, GA 30315

Augusta
Brown and Radiology Associates
The Imaging Center
818 St. Sebastian Way
Suite 100
Augusta, GA 30901
(706) 722-3974

Drs. Williams, Eaker, Speese & Associates, P.C.
2258 Wightsboro Road
Suite 400
Augusta, GA 30910
(706) 733-4427

Radiology & Imaging Associates, P.C.
1450 Winter Street
Augusta, GA 30901
(706) 736-6626

University Hospital
1350 Walton Way
Augusta, GA 30910-3599
(706) 823-5000

Brown and Radiology Associates - MOBILE
818 St. Sebastian Way
Suite 100
Augusta, GA 30901
(706) 722-3974

Obstetrics and Gynecology Associates
1430 Harper Street
Augusta, GA 30910
(706) 724-2261

Brown and Radiology Associates
1500 Johns Road
Suite 7
Augusta, GA 30904
(706) 733-9445

Medical College of Georgia
Department of Radiology
1120 Fifteenth Street
Augusta, GA 30912
(706) 721-3251

Augusta Reproductive Biology Associates
812 Chafee Avenue
Augusta, GA 30904
(706) 724-0228

St. Joseph Hospital
2260 Wightsboro Road
Augusta, GA 30910
(706) 737-7400

Augusta Regional Medical Center
3624 J. Dewey Gray Circle
Suite 100
Augusta, GA 30909
(706) 650-6761

Drs. Goldsmith, Byars & McCreedy, M.D., P.C.
1126 Medical Center Drive
Augusta, GA 30909
(706) 863-5082

Reproductive Endocrinologists, P.C.
903 15th Street
Augusta, GA 30910
(706) 724-8878

Austell
Northwest Mobile Health Service-MOBILE @ Promina Cobb Hospital
3950 Austell Road
Austell, GA 30001
(404) 732-3500

Cobb Hospital and Medical Center
3950 Austell Road
Austell, GA 30001
(404) 944-5000

Bainbridge
Memorial Hospital & Manor
1500 E. Shotwell Street
Bainbridge, GA 31931
(912) 246-3500

Baxley
Applying General Hospital
301 East Tullison Street
Baxley, GA 31513
(912) 367-9841

Blairsville
Union General Hospital
714 Hospital Drive
ATN: PAM COLLINS, R.T.(R)
Blairsville, GA 30512
(404) 745-2111

Blakely
Early Memorial Hospital
Radiology Department
630 Columbia Road
Blakely, GA 31723
(912) 723-4241

Blue Ridge
Fannin Regional Hospital
P.O. Box 1549
Highway 5 North
Blue Ridge, GA 30513
(404) 632-3711

Bowdon
Bowdon Area Hospital
501 Mitchell Avenue
Bowdon, GA 30108
(770) 258-7207

Bremen
Higgins General Hospital
Radiology Department
200 Allen Memorial Drive
Bremen, GA 30110
(404) 537-5851
MAMMOGRAPHY FACILITIES

Datton
Hamilton Diagnostics
1407 Chattanooga Rd.
Datton, GA 30720
(706) 272-6565

Decatur
DeKalb Medical Center, Inc.
Diagnostic Breast & Osteoporosis Center
2701 N. Decatur Road
Decatur, GA 30033
(404) 501-5811

Southeastern Diagnostic Center Corporation
3009 Rainbow Drive
Ste. 146
Decatur, GA 30035
(404) 241-5756

Decatur Hospital
450 North Candler Street
Decatur, GA 30030
(404) 378-4982

DeKalb Medical Center Diagnostic - MOBILE
Breast Center
2701 N. Decatur Road
Decatur, GA 30033
(404) 501-5676

Rogbert F. Phillips, M.D.
Mammography Department
4150 Snapfinger Woods Drive
Suite 100
Decatur, GA 30035
(404) 289-5408

Carolyn Dudley, M.D., P.C.
X-ray, Mammography, Ultrasound
5040 Snapfinger Woods Drive
Suite 202
Decatur, GA 30035
(770) 322-1003

Atlanta Center for Medicine
2801 North Decatur Road
Suite 300
Decatur, GA 30033
(404) 296-3111

Demorest
Habersham County Medical Center
Highway 441
P.O. Box 37
Demorest, GA 30535
(706) 754-2161

Donaldsville
Donaldsville Hospital, Inc.
102 Hospital Circle
P.O. Box 677
Donaldsville, GA 31745
(912) 524-5217

Douglass
Coffee Regional Medical Center, Inc.
West Ward Street
PO Box 1248
Douglass, GA 31533-1248
(912) 384-1900

Douglasville
Promina Douglas Hospital
Radiology Department
8954 Hospital Drive
Douglasville, GA 30134
(404) 920-6340

Dublin
Southern Radiology Services - MOBILE
606 Academy Avenue
P.O. Box 1527
Dublin, GA 31040
(912) 274-1100

Fairview Park Hospital
200 Industrial Blvd.
Dublin, GA 31021
(912) 275-2000

Dublin Internal Medicine
104 Fairview Park Drive
Dublin, GA 31021
(912) 272-1366

Medical Center Family Practice
309 Bellevue Avenue
Dublin, GA 31021
(912) 272-7411

Duluth
Gwinnett Hospital System
3805 Pleasant Hill Road
Duluth, GA 30036
(404) 495-5100

Gwinnet Imaging, Inc.
3540 Duluth Park Lane
Suite 140
Duluth, GA 30036
(770) 629-5551

East Point
South Fulton Medical Center, Breast Health Center
1100 Cleveland Avenue
East Point, GA 30344
(404) 767-5359

South Fulton Medical Center
1170 Cleveland Avenue
East Point, GA 30344
(404) 630-5495

Eastman
Dodge County Hospital
715 Griffin Street
P.O. Box 4309
Eastman, GA 31023-4309
(912) 374-4000

Eatonon
Putnam General Hospital
Radiology Department
101 Greensboro Highway
P.O. Box 4330
Eatonon, GA 31024
(706) 485-2711

Elberton
Elbert Memorial Hospital
4 Medical Drive
Elberton, GA 30635
(706) 213-2573

Ellijay
North Georgia Medical Center
Jasper Road
Ellijay, GA 30540
(706) 275-4741

Fayetteville
Fayette Diagnostic Center
1250 Highway 54 West
Suite 102
Fayetteville, GA 30214
(770) 719-0386

Fayette Surgical Clinic & Breast Center
325 North Jeff Davis Dr.
Fayetteville, GA 30214
(404) 481-1357

Fayette Medical Clinic, P.C.
Department of Imaging
101 Yorktown Drive
Fayetteville, GA 30214
(404) 460-4318

Fitzgerald
Dorminy Medical Center
P.O. Box 1447
Perry House Road
Fitzgerald, GA 31750
(912) 423-5431

Folkston
Chariton Memorial Hospital
1203 N. Third Street
P.O. Box 188
Folkston, GA 31537
(912) 496-2531

Forest Park
First Family Care
528 A Forest Parkway
Forest Park, GA 30090
(404) 361-6272

Forsyth
Monroe County Hospital
88 Martin Luther King, Jr., Drive
P.O. Box 1068
Forsyth, GA 31029
(912) 994-2521

Fort Benning
Martin Army Community Hospital
9200 Marine Road
Building 9200
Fort Benning, GA 31905-6100
(706) 544-4051

Fort Gordon
Dwight David Eisenhower Army Medical Center
Radiology Department
Building 300
Chamberlain Avenue
Fort Gordon, GA 30905-5650
(706) 787-2245

Fort McPherson
Fort McPherson Army Health Clinic
USAHC Radiology Department
Fort McPherson, GA 30330-5600
(404) 752-2235

February 2, 1997 edition
Macon
Columbia Coliseum Medical Center
380 Hospital Drive
Suite 410
Macon, GA 31201
(912) 765-4836

Medical Center of Central Georgia
777 Hemlock Street
Macon, GA 31208-6000
(912) 853-1235

Focal Pointe Women
3200 Riverside Drive
Bldg. C
Macon, GA 31210

Internal Medicine Associates, P.C.
616 Orange Street
Macon, GA 31208
(912) 745-1191

Middle Georgia Urgent Care
816 Forthry Street
Macon, GA 31208
(912) 741-5051

Med Cross Diagnostic Center
1818 Forsyth Street
Macon, GA 31201
(912) 738-0099

Middle Georgia Hospital
886 Pine Street
Macon, GA 31297
(912) 751-0667

Macon Northside Hospital
Radiology Department
400 Charter Boulevard
Macon, GA 31210
(912) 757-6032

Regional Imaging Center
1650 Hardeman Avenue
Macon, GA 31201
(912) 749-9720

Marietta
The Breast Center
702 Canton Road
Marietta, GA 30060
(404) 428-4496

Quantum Radiology, Tower Road Imaging
70 Tower Road
Marietta, GA 30060
(770) 422-1930

Kennesaw Women's Center
30 South Medical Drive
Marietta, GA 30060
(404) 793-5574

PROMINA Windy Hill Hospital
2540 Windy Hill Road
Marietta, GA 30067
(404) 644-1240

Martinez
Women's Center
University Hospital Medical Center
4106 Columbia Road
Suite 201
Martinez, GA 30907
(706) 866-3200

Metter
Candler County Hospital
Cedar Road
P.O. Box 597
Metter, GA 30439
(912) 865-5741

Milledgeville
Milledgeville OB-GYN
750 North Cobb Street
Milledgeville, GA 31061
(912) 453-4511

Oconee Regional Medical Center
Radiology Department
821 North Cobb Street
Milledgeville, GA 31061
(912) 452-5021

Central State Hospital
Medical Surgical Division - Radiology
Culver Kidd Building
Vinson Highway
Milledgeville, GA 31062
(912) 453-5792

Monroe
Walton Medical Center
330 Alcovy Street
Monroe, GA 30655
(770) 267-1720

Montezuma
Flint River Community Hospital
Radiology Department-NANCY JUNKINS
509 Sumter Street
PO Box 770
Montezuma, GA 31063
(912) 472-3222

Morrow
Georgia Baptist Medical Group - MOBILE
Southlake/ATTN: DIXIE
1000 Corporate Center Drive
Suite 120
Morrow, GA 30260
(404) 968-2850

Moultrie
Colquitt Regional Medical Center
P.O. Box 40
3131 Thomasville Highway
Moultrie, GA 31776-0040
(912) 890-3500

Nashville
Barren County Hospital
Radiology Department
1221 East McPherson Avenue
Nashville, GA 31839
(912) 686-7471

Newnan
PAPP Clinic, P.C.
15 Cavender Street
Newnan, GA 30263
(404) 253-6616

Newnan Hospital
Radiology Department
80 Jackson Street
Newnan, GA 30263
(404) 254-3660

Peachtree Regional Hospital
Radiology Department
60 Hospital Road
Newnan, GA 30263
(404) 253-1912

Norcross
Peachtree Corners Medical Center
6920 Jimmy Carter Boulevard
Norcross, GA 30071
(770) 449-0930

Peachtree City
Peachtree City Gynecology Center
210 Clover Reach Drive
Peachtree City, GA 30269
(404) 487-9604

Women's Center of Piedmont Hospital @ Peachtree City
324 Stevens Entry
Peachtree City, GA 30269
(770) 487-6543

Perry
Complete Health Care Center, Inc.
1013 Main Street
Ste. A
Perry, GA 31069
(912) 987-5080

Perry Hospital
Radiology Department
1120 Morningside Drive
Perry, GA 31069
(912) 987-7667

Quintman
Brooks County Hospital
903 N. Court Street
PO Box 5000
Quintman, GA 31643
(912) 263-4171

Reidsville
Tattnall Memorial Hospital
Route 1, Box 256
Reidsville, GA 30453
(912) 557-4731

Riverdale
Breast Health Center
7365 Old National Highway
Ste. B
Riverdale, GA 30296
(404) 985-1183

South Atlanta Radiology Associates, P.C.
119 Upper Riverdale Road
Riverdale, GA 30274
(770) 991-1010

Joseph S. Levy, M.D., P.C.
189 Medical Way
Suite A
Riverdale, GA 30274
(770) 991-0970

Radiology Associates of Clayton, PC
33 Upper Riverdale Road, #105
Riverdale, GA 30274
(404) 991-9729

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MAMMOGRAPHY FACILITIES

Sugar Hill
North Gwinnett Medical Imaging
4700 Nelson Brogdon Blvd.
Suite 140
Sugar Hill, GA 30518
(404) 945-3929

Summerville
Chattooga Medical Center
Radiology Department
1010 Highland Avenue
Summerville, GA 30747
(706) 857-4761

Swainsboro
Emanuel County Hospital
117 Kite Road
Swainsboro, GA 30401
(912) 237-0267

Sylvania
Screven County Hospital
215 Mims Road
Sylvania, GA 30467
(912) 564-7426

Thomaston
Upson Regional Medical Center
801 W. Gordon Street
Thomaston, GA 30286
(706) 647-8111

Thomasville
Radiology Associates of Thomasville
113 West Hansell Street
PO Drawer 2450
Thomasville, GA 31799
(912) 226-6776

John D. Archbold Memorial Hospital
Gordon Avenue @ Mimosa Drive
Thomasville, GA 31792
(912) 228-2900

Thomson
McDuffie County Hospital
521 Hill Street, SW
Thomson, GA 30824
(706) 595-1411

Tifton
Affinity Health Group, LLC
712 E. 18th Street
Tifton, GA 31794
(912) 382-3814

Tifton General Hospital
Radiology Department
901 East 18th Street
Tifton, GA 31793
(912) 396-7500

Toccoa
Stephens County Hospital
Falls Road
PO Box 947
Toccoa, GA 30577
(706) 886-6841

Tucker
WomanCare
1455 Montreal Road
Suite 202
Tucker, GA 30084
(770) 270-3176

Radiology of MMC, Inc.
1462 Montreal Road
Suite 316
Tucker, GA 30084
(770) 939-2740

Kaiser Permanente - Crescent Centre
200 Crescent Centre Pkwy
Attn: Sandy Casaly
Tucker, GA 30084
(404) 496-3520

Valdosta
Radiology Associates of Valdosta, P.C.
2704-D North Oak Street
Post Office Box 3499
Valdosta, GA 31602-3499
(912) 333-9729

Southern OB-GYN Associates, P.C.
2841 North Patterson Street
Valdosta, GA 31602
(912) 241-2800

South Georgia Medical Center
Department of Radiology
2501 N. Patterson Street
Valdosta, GA 31603-1727
(912) 533-1000

Vidalia
Meadows Regional Medical Center
1703 Meadows Lane
PO Box 1048
Vidalia, GA 30474
(912) 537-6821

Vienna
Dooly Medical Center
Pitts Road
PO Box 278
Vienna, GA 31092
(912) 266-4141

Villa Rica
Tanner Medical Center Villa Rica
601 Dallas Road
Villa Rica, GA 30180
(404) 459-7174

Warm Springs
Georgia Baptist Meriwether Hospital
5995 Spring Street
PO Box 8
Warm Springs, GA 31830
(706) 655-3331

Warner Robins
Houston Health Pavilion Diagnostic & Education Center
233 N. Houston Road
Suite 140D
Warner Robins, GA 31093
(912) 923-0637

Houston Medical Center
Radiology Department
1601 Watson Boulevard
Warner Robins, GA 31093
(912) 922-4281

Radiology Associates of Houston Co., P.A.
102 Hospital Drive
Warner Robins, GA 31093
(912) 922-9314

G.V. Raghu, M.D. & M.H. Shah, M.D., P.C.
1021 North Houston Road
P.O. Box 2105
Warner Robins, GA 31093
(912) 922-9944

Heart of Georgia Womens Center
209 Green Street
PO Box 8288
Warner Robins, GA 31093
(912) 328-3590

Obstetrics & Gynecology, P.A.
105 Briarcliff Road
Warner Robins, GA 31086
(912) 922-3191

Waycross
Sattilla Regional Medical Center
410 Darlington Avenue
Waycross, GA 31501
(912) 287-2599

Waynesboro
Burke County Hospital - MOBILE unit
351 Liberty St.
Waynesboro, GA 30830
(706) 554-4435

Burke County Hospital
351 Liberty Street
Waynesboro, GA 30830
(706) 554-4435

Winder
Barrow Medical Center
316 N. Broad Street
Winder, GA 30680
(770) 307-5280

Woodstock
Imaging Center of Woodstock
Alpharetta-Woodstock OB/GYN
203 Woodpark Place
Suite A-200
Woodstock, GA 30186
(404) 924-7761

Woodstock Imaging Center
2000 Professional Way
Bldg. 100 - Suite A
Woodstock, GA 30186
(404) 591-9711

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Taylor, Beverly D.  DAMD17-94-J-4134

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Publications/Presentations/Manuscripts Developed as a Result of this Grant

Hill, CV. “An Exploratory Study: Demographic and Social Barriers To Breast Cancer Screening Among Low Income Black Women In Atlanta, Georgia.” Thesis manuscript. Master of Public Health Program, Morehouse School of Medicine, July 1997.

Taylor, BD, Sheats J, Murphy, F, et. al., Training Community Health Volunteers for Breast Health Education and Disease Prevention. American Journal of Health Promotion. Accepted subject to revision.

Presentations:
Taylor, BD, et. al., Breast Cancer screening Practices Amongst Primary Care Practitioners. Focus Group with Family Practice Residents, Morehouse School of Medicine, January, 1995

Taylor, BD, et. al. Nightmare, presented at the noon conference for Internal Medicine residents at Grady Memorial Hospital, Atlanta, Georgia, April 1995.


Taylor, BD, et. al. The Infodrama as an Effective Tool in Medical Education, presented at APHA, Women’s Health Section, New York, November 17-21, 1996.

**Community Presentation of the Breast Health Education Workshops:**

<table>
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<td>Nov. 6, 1996</td>
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<td>January 21, 1997</td>
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<td>John O. Chiles</td>
<td>April 24, 1997</td>
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<td>Antone Graves</td>
<td>July 8, 1997</td>
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Participants in the Breast Health Education Project who received funds from grant #DAMD17-94-J-4134 from June 30, 1994 through July 31, 1997.

<table>
<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Charlee Lambert</td>
<td>Consultant</td>
</tr>
<tr>
<td>Frederick Murphy</td>
<td>Consultant</td>
</tr>
<tr>
<td>Mable Densler</td>
<td>Outreach Coordinator</td>
</tr>
<tr>
<td>Mattie Kelly</td>
<td>Community Health Worker</td>
</tr>
<tr>
<td>Annie R. Cofer</td>
<td>Community Health Worker</td>
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<tr>
<td>Robin Hawkins</td>
<td>Community Health Worker</td>
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<tr>
<td>Eugenia Dickerson</td>
<td>Community Health Worker</td>
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<td>Catherine Epps</td>
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<td>Eva B. Davis</td>
<td>Community Health Worker</td>
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<tr>
<td>Joyce Sheats</td>
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<tr>
<td>Bridget Toodle</td>
<td>Administrative Secretary</td>
</tr>
<tr>
<td>Carl Hill</td>
<td>Student Research Assistant</td>
</tr>
<tr>
<td>Sherri Simpson</td>
<td>Student Research Assistant</td>
</tr>
</tbody>
</table>
Kenya Beverly  
Student Research Assistant

Germaine Cummings  
Student Research Assistant

Joyce Ellis  
Community Health Worker Trainee

Helen Heath  
Community Health Worker Trainee

Carol Dupree  
Community Health Worker Trainee