Chapter 17
Project Nana: Seasoning Our Seasoned Women

Vanessa L. Hill and Vinu Ilakkuvan

Abstract There are many public health campaigns targeting women's health. For women over 55, more prominent health campaigns tend to address issues to improve cardiovascular care, to prevent hip injuries, and to reduce the prevalence of dementias. However, it appears that health campaigns geared toward improving and maintaining gynecological health are mostly targeted to a younger audience concerned with reproductive health and fertility. This excludes a key demographic, given that postmenopausal women are at an increased risk for gynecological cancers. And while the rates of occurrence may be relatively the same among Caucasian and other women of color, black women tend to have a higher mortality rate. Black women are also disproportionately affected by sexually transmitted infections (STIs) and the human immunodeficiency virus (HIV). The impact of the lack of interventions to postmenopausal women and, specifically, to this high-risk group is not only late stage diagnosis of some preventable and treatable gynecological diseases, but also a reduction in longevity and quality of life. Addressing this concern, the non-profit organization, Project Nana, Inc. was established out of an ongoing research study titled *Project Nana: An Intervention to Increase the Utilization of Gynecological Services in Senior Women of Color.* The study assesses attitudes, beliefs, and knowledge of postmenopausal women as it relates to seeking and maintaining gynecological care. The subsequent intervention and service provided by the non-profit seeks to increase awareness, improve attitudes and beliefs, and ultimately increase gynecological care. Using a combination of educational workshops, visual and performing arts, collaborative community engagement, provider training, and peer-to-peer outreach, the goal of the intervention is to overcome educational, economic, and cultural barriers in order to reduce the late stage diagnoses of gynecological cancers and sexually transmitted infections. Since the population of senior women is expected to substantially increase in the next 30 years, prevention and early detection of disease will improve

V. L. Hill (✉)
Project Nana, Inc., Miramar, USA
e-mail: vhill@projectnana.org

V. Ilakkuvan
PoP Health, LLC, Fairfax, USA

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health outcomes, improve quality of life, decrease economic burdens, and decrease potential loss of valuable resources to the community—our seasoned women.

Keywords Primary care · Postmenopausal women · Geriatric gynecology · Women's cancers · Gynecology' health campaigns · Health Interventions · Project Nana · Social cognitive theory · Theory of planned behavior · Community workshops · Ovarian cancer · Cervical cancer · Endometrial cancer · Cancer of the uterus · Vaginal cancer · Vulvar cancer · Pelvic exam · Pap smears · Sexually transmitted infections · HIV · AIDS · STD · Sexually transmitted diseases · STI' · Menopause · Seniors · Post menopause · Vagina

There are many public health campaigns targeting women's health. For women over 55, more prominent campaigns tend to address issues to improve cardiovascular care, to prevent hip injuries and to reduce the prevalence of dementias. But why does it appear to be the case that campaigns geared toward improving and maintaining gynecological health mostly targeted to a younger demographic concerned with reproductive health and fertility? Postmenopausal women are at an increased risk for gynecological cancers. And while the rates of occurrence may be relatively the same among Caucasian and women of color, black women tend to have a higher mortality rate. Black women are also disproportionately affected by sexually transmitted infections (STIs) and the human immunodeficiency virus (HIV). The impact of the lack of interventions to postmenopausal women and, specifically, to this high-risk group is not only late stage diagnosis of some preventable and treatable gynecological diseases, but also a reduction in longevity and diminished quality of life. Addressing this concern, Project Nana, Inc. was established out of an ongoing research study titled *Project Nana: An Intervention to Increase the Utilization of Gynecological Services in Senior Women of Color*. The study assesses attitudes, beliefs, and knowledge of postmenopausal women as it relates to seeking and maintaining gynecological care. The subsequent intervention and service provided by the non-profit seeks to increase awareness, improve attitudes and beliefs, and ultimately increase self-efficacy in the ongoing care of gynecological issues. With the aid of the creative arts, Project Nana seeks to reimagine and fortify the humanity of our seasoned women, pulling them from the shadow of societal invisibility and supporting them to regain their own sense of agency and utility. Using a combination of educational workshops, visual and performing arts, collaborative community engagement, peer-to-peer outreach, and provider communication training, the goal of the intervention is to overcome educational, economic, and cultural barriers in order to reduce the late stage diagnosis of gynecological cancers and sexually transmitted infections. Specifically, the overall all health goal is to decrease the incidence rate of late stage diagnosis of cancers and sexually transmitted diseases in postmenopausal, black women, age 55 years and older in Hampton Roads, Virginia by 5% over 10 years. There are several objectives to meet in order to ultimately hit the program goal. The behavioral objective is to increase the utilization of gynecologists for annual screenings. Communication objectives include to increase knowledge of the benefits of gynecological care;

reduce perceive barriers to seeking gynecological care; increase positive attitudes toward seeking and continuing gynecological care; increase the belief that speaking with the gynecologist about issues relating to gynecological health, sexual issues, and overall health concerns can enhance quality of life; increase the confidence in talking about sex and their bodies with their physicians; and increase the comfort level in obtaining current information on gynecological issues from their gynecological care team. And finally, the self-efficacy objectives are to increase self-efficacy to seek gynecological care and increase support efforts to provide information on current gynecological issues such as risk of STIs, cancers, and need for routine pelvic exams by a gynecologist to their peer groups.

Since the population of senior women is expected to substantially increase in the next 30 years, prevention and early detection of disease will improve health outcomes, improve quality of life, decrease economic burdens for the patient and taxpayers, and decrease potential loss of valuable resources to the community—our senior—seasoned women.

Background

Seeking out and navigating the communal margins of society, on the surface, appear to be a statement wrought with hyperbole. However, globally, elder women are one of the most disenfranchised group. Before we can even address the idea of self-efficacy and their gynecological health, we must understand some contributing factors for mental and emotional barriers that may make it difficult for a seasoned woman to advocate for herself. A quick tour through headlines highlights this point: In a Korean Study titled Living Profiles of Older People Survey, the results suggested that emotional elder abuse was the most frequent type of abuse experienced by the elderly populations. Specifically, of the 10,184 respondents, 10.6% of the women stated they experienced abuse, compared with 8.8% of men. Of note, there was a significant correlation with poor self-rated health with elder abuse in women, than that of men (Jeon et al., 2019).

In other parts of the world, older women's voices are threatened, keeping the women locked in perpetual silence about daily experiences. A total of 75%, 83%, and 39% of women over 50 years of age in Mozambique, Peru, and Kyrgyzstan, respectively, stated that they have experienced violence. As a result, they may internalize the abuse and come to believe that their mental, emotional, and physical health is of little consequence and thus not seek help. According to HelpAge International, "Violence against older women is a severe human rights abuse. It is driven by both agism and sexism, and grounded in deep-rooted prejudices, dehumanizing stereotypes and social norms that tolerate and even condone awful acts of violence. An older woman may be the victim of verbal and physical abuse, be accused of 'witchcraft,' denied the right to land from her husband when he dies, and deprived autonomy in a [health]care setting, with other people making decisions for her that may not be her wish. Women may face many forms of sexual, physical, financial, and emotional

abuse, committed by various perpetrators and attacked or even murdered by members of her own community" (Rossman, 2017). With this understanding of the dehumanizing activities that are occurring at the intersection of sexism, agism and holistic health, it is incumbent on the public health advocate collective to amplify voices surrounding nuanced ideas and discussions on seasoned women's health.

There are moments within our life, nanoseconds, when you must respond to a significant emotional event. These moments tend to define or even redefine our character and may stretch our coping capacity beyond our preconceived limits. We either succumb to the gravity of the challenge at hand, or it becomes fuel that may launch other moments that have the potential to be more impactful than one can ever imagine. I experienced one of these life defining moments.

It was September 29, 2010, in hospital room 329 in Hampton Roads, Virginia, where my Nana, Merlice Yvonne McIntosh Henderson, was awaiting medical transport to take her home to hospice. Two weeks earlier, she had presented to the emergency department experiencing abdominal discomfort. After emergency surgery, she was diagnosed with stage IV cancer of the uterus. Now, she waited in pain which even morphine could not tame for the rainstorm to subside, so she could make it to the comfort of her own home. At the same time, my family also anticipated my granddaddy's arrival from the Veteran Affairs Hospital. Three weeks earlier and three days before my Nana was admitted to the hospital, Granddaddy had a stroke. My family did not tell him about Nana's health for fear that it would negatively impact his recovery. The plan was to bring them home together, so they could see each other for, however, long their last moments. The emergency medical technicians (EMTs) retrieved Nana, but the other transport company, citing safety concerns due to the stormy weather, would not bring Granddaddy home. Nana arrived safely, late on Wednesday. She died the next morning on September 30. My Granddaddy died 13 days later. During this period, I was in Miami teaching film serving as Director of a university graduate fine arts department. When I received the news of my Nana's diagnosis, she got on the phone with and made it clear that she wanted me to complete my preparation for my new incoming class and to not travel until after orientation. "We finish our work with excellence," I recall her saying. I booked my airline ticket to Virginia to see my Nana on Friday, October 1st. I was a day too late.

In the year that followed, I descended into a deep grief. I decided to move to Virginia, the epicenter of my life shattering moment in order to grieve…to fall apart. I could not make sense of how Nana could go so quickly. She was a breast cancer survivor and was seeing her primary care and oncologist on a regular basis. As I began my Google research, I discovered that uterine cancer exhibits visible symptoms. Why did not anyone notice? Why did not Nana say anything? The "but why" led me to uncover the growing power of advocacy within me. Through speaking with community and faith-based organizations, retelling Nana's story and educating citizens regarding issues, particularly healthcare issues, my call to action became clear. Soon I began developing the framework for an advocacy organization to be named Project Nana. I had no desire or will to return to my former life or work. I took every opportunity to talk about Project Nana and issues related to seasoned

women's health. I wanted to know more, to become an expert in order to earn the right to lead Project Nana.

I contacted The George Washington University (GWU) to express my interest in their medical program and was informed that one of the prerequisites needed to apply was direct patient care experience. It was suggested and I heeded the advice to become an EMT. I heeded that advice and completed my EMT training program and certification. Since I was still in Virginia at the time, I decided to apply to and was hired by the same hospital that diagnosed Nana. I knew it was going to be a major lifestyle transformation as it relates to finances and experience, especially since I was starting out at the entry level. But I was compelled by the opportunity to investigate my Nana's full experience by diving fully into what was her world. My first day on the job was horrendous. The work was physically challenging, and the emotional toll from navigating peer personalities to working with vulnerable patients made me question if I could continue. And at what was most definitely the proverbial fork in the road, when I had to decide on what type of human I wanted to become, I received a call offering me a job that would put my life in a much more comfortable position that paid more money and was more prestigious. Instinctively, I wanted to accept the offer, but instead I chose to remain at the hospital and learn from the grassroots experience. I knew that I needed to enrich my own limited understanding with the experience that can only come from true immersion.

During my time at the hospital, I was humbled with the privilege of caring for other Nanas. I also had an opportunity to finally set foot in room 329. Whether empty or occupied, that room became my fueling station. It made me view each patient engagement as though I was taking care of my Nana. I observed everything and asked many questions from a variety of perspectives—the patients, families, and medical providers. Most importantly I developed my ear for the patients with whom I was honored to engage. Each personal contact was a master class in how to present information while supporting their dignity as I participated in routine and critical care transport, in and out of hospitals, dialysis centers, nursing homes, etc.

My time at the hospital affirmed that I could use all my skill sets as an advocate, an educator, and a creative to amplify the voices of those who find themselves in the shadows and muted. With this realization, I decided to focus on public health and to attend a global virtual program. I graduated in 2018 with my masters from Milken Institute School of Public Health at GWU. My thesis further developed Project Nana, now a 501c3 non-profit, into an evidence-based intervention organization with the goals of overcoming communication, cultural, economic, and educational barriers to improve health outcomes, the healthcare experiences, and quality of lives of seasoned women, in honor of my Nana.

Rationale

During a woman's life span, critical biological set points are a major focus of concern that necessitate attention and further research. According to the Mayo Clinic, due to

the specific biological composition of a woman, the stages of her life are based on the reproductive season and are marked by hormonal changes. These stages include the menarche, the line of demarcation indicating the onset of puberty and the ability to procreate. Women are able and choose to may experience pregnancy. And the menopause occurs once the menses have ceased and continue beyond. Through further exploration, we will decipher the transformations that occur in a woman's body, and the medical needs required to support optimum health during the pivotal points of her life cycle to assist her in living life to the fullest (Mayo, 2019).

Heralded by the onset of her menstrual cycle, puberty is the first set point. Aside from one's mother, the gynecologist is the guide and teacher of the newly initiated. It is at that point that we pay close attention to the woman's body making sure that she strives for optimum health in preparation for the time and season of childbirth. Pregnancy is the second set point. The woman ensures that her body, mind, and spirit is in optimum condition by eating proper foods, engaging in exercise and healthy activities, and, if necessary, taking interventions in the form of fertility medicines. The gynecologist becomes a mainstay, during this period, and at times, becomes the primary care physician for the woman. The period when the menses cease or the initial menopausal years is the third set point. It is during this time when the woman's body goes through additional hormonal transformations. The gynecologist provides welcome relief to the hot flashes and mental and emotional misery that typically come when females go through "the change." But what happens to the body, mind, and spirit in postmenopausal period?—and—What role does the gynecologist have in the life of an older, seasoned woman?

Research has shown that women typically outlive men. According to the Population Reference Bureau, "the population of seniors who are 65 years or older will increase to almost 100 million by 2060 and will comprise 24% of the total population" (Mather, 2016). Although the gender gap is narrowing, women, since they statistically outlive men, will make up the majority of the older population (Mather, 2016). Project Nana is proactive in its vision toward the future of women's healthcare; the protocol for disease prevention for women should include gynecological care to complement optimum health screenings and improve health outcomes and quality of life. According to the Global Library of Women's Health, primary care physicians, with the focus on volume-based care, may not be addressing vital concerns relating to gynecological care. For example, 14% of women between the ages of 65 and 74 years and 39% of those older than 75 have never had a Papanicolaou (Pap) smear (Utian & Sultana, 2008). The Pap smear is critical in the early detection of cervical cancer. Primary care physicians (PCPs), in particular those not focused on women's health, tend not to perform critical pelvic exams, palpations of the vaginal cavity, abdomen, and in some cases, breasts, which are necessary to detect physiological irregularities that may be early indications of disease potential. PCPs may not ask the pertinent "basement issue" questions and/or investigate issues such as the level of or quality of sexual activity, the existence of mild incontinence, postmenopausal vaginal discharge, and pelvic pain or fullness, the latter which may be an indicator of a serious issue such as ovarian cancer (ACOG, 2017). In addition to not seeing the gynecologist, the other concern is the "official" recommended frequency of the

gynecological visit. According to the United States Preventative Services Task Force (USPST), it is no longer recommended for women over 65 years of age to have a Pap smear (USPST, 2018). This recommendation, or lack thereof, compelled the American College of Obstetricians and Gynecologists (ACOG) to release a statement reiterating the need for women to have an annual well-woman exam to include pelvic examinations, routine screenings for cancers or sexually transmitted diseases, and counseling by a gynecologist (ACOG, 2017).

Additionally, blatant health disparities persist between women of color and non-women of color from childbearing age to beyond postmenopause. According to a January 2017 Johns Hopkins report, black women and women over 65 years of age continue to exhibit health disparities. For example, when corrected for hysterectomies, the rates of mortality for cervical cancer for black women were 10.1 per 100,000 per year compared to 3.2 per 100,000 per year for white women. Older women are dying at higher rates than women younger than 65 years of age due to lack of screening (Johns Hopkins Bloomberg School of Public Health, 2017). There are also regional differences with the South having the highest incidence (8.5 per 100,000 persons) and mortality rates (2.7 per 100,000 persons) of any region of the US (Yoo et al., 2017). Black women are also at an increased risk for sexually transmitted diseases. According to the CDC, in 2018, the overall rate of reported chlamydia cases among blacks in the US was 1192.5 cases per 100,000 population and 392.6 cases per 100,000 population for Hispanic women or five times the rate and 1.9 times the rate of white women, respectively. "During 2014–2018, rates of reported cases of primary and secondary syphilis increased for all race/Hispanic ethnicity groups," (CDC, 2019). Thus, an older woman of color is at an increased disadvantage when it comes to health and well-being (Tang et al., 2011), especially as it relates to gynecological, women's health outcomes.

Community Analysis

Since the intervention was the response to a personal call to action, Project Nana started its first chapter and activities focused on Hampton Roads, Virginia, which is located in the southeast region of the state. It is comprised of seven cities: Portsmouth, Virginia Beach, Hampton, Norfolk, Newport News, Suffolk, and Chesapeake. According to the 2010 Census, the region is diverse with total population of 1.67 million people consisting of 59.6% white, 31.3% black, and 5.4% Hispanic. It has more females than males at a rate of 51–49%. A total of 22.7% of the population are 55 years of age and older (City of Norfolk, 2014).

In a first-time analysis spearheaded by the Virginia Healthcare Foundation, the Virginia Hospital and Healthcare Association published its community health assessment from all its hospital membership. Of particular interest, three of the hospitals serving the Hampton Roads region, Sentara Careplex Hospital (SCH), Sentara Norfolk General (SNG), and Sentara Virginia Beach General Hospital (SVBH) noted service gaps in aging/geriatric services, maternal health, and an exponential increase

in the senior population from 2012 through 2017, respectively (VHHA, 2016). Six years later, the gaps still exist. According to the 2019 Sentara Health Community Assessment, women's health, access, and prevention were three areas identified in the Hampton Roads regional survey that respondents noted needed strengthening and further surveillance (Sentara, 2019). The limited focus and resources devoted to healthcare disparities for women and aging services and the healthcare gaps related to access and preventative health care continues to fortify barriers against engagement about and improved health outcomes for postmenopausal health for services.

Historically, there has been a modicum of personal biased, at best, who has permeated health care as it relates to the intersection of women's health and aging. In his 1969 best-selling book, *Everything You Always Wanted to Know About Sex, But Were Afraid to Ask*, psychiatrist Dr. David Reuben declared that,

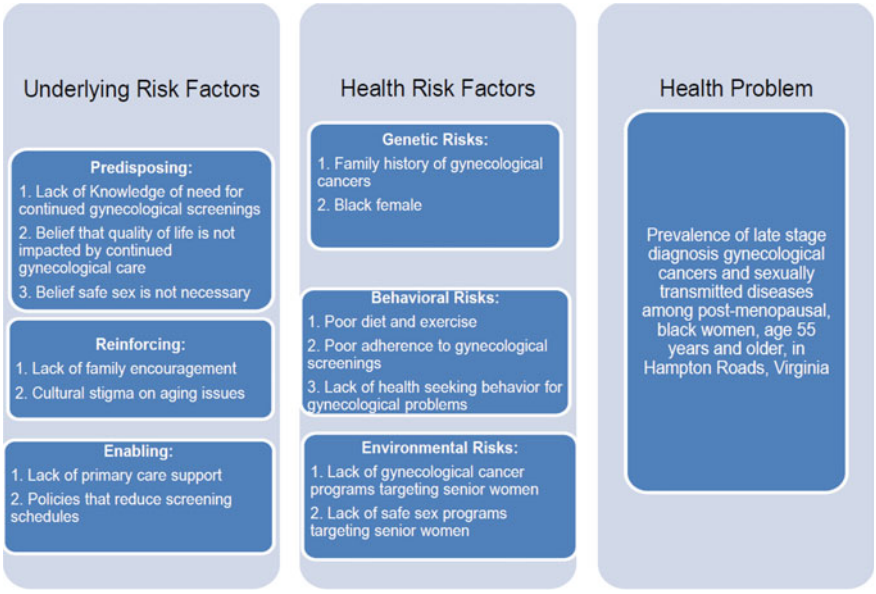
> as estrogen is shut off, a woman comes as close as she can to being a man. Increased facial hair, deepened voice, obesity, and the decline of breasts and female genitalia all contribute to a masculine appearance. Coarsened features, enlargement of the clitoris, and gradual baldness complete the picture. Not really a man, but no longer a functional woman, these individuals live in a world of intersex…sex no longer interests them. To many women the menopause marks the end of old age, the beginning of the end. They may be right. Having outlived their ovaries, they may have outlived their usefulness as human beings. The remaining years may be just marking time until they follow their glands into oblivion. (Reuben, 1969)

This book was adapted to film, by Woody Allen and released in 2000. We are not stating that these views are pervasive in healthcare. However, with the added use of mass media, these views have the potential to inform and impact implicit bias.

Several other barriers have been identified by our stakeholders (see Table 17.1). One barrier is patient experience and communication with primary care providers. Primary care providers are the gatekeepers, the central figures in ongoing healthcare. Their role in women's health should be to encourage continued gynecological screenings and address initial gynecological concerns for their patients who are in the target audience. However, due to perceived potential time constraints designated by health insurance mandates and a volume-based care modality, important discussions on postmenopausal women's health are not being addressed. Of the many discussions not tackled in the primary care setting, none have been mentioned more in the initial community interviews, than a need for clarifications of terms.

When faced with a deluge of mass media commercials regarding the latest recommendations for HPV and cervical screenings, there has been confusion between Pap smears and pelvic exams. While recommendations have changed in recent years regarding the screening intervals for Pap Smears, the need for annual pelvic exams have not changed. However, anecdotally noted, there is common confusion on the differences between the two. It is correct that if a woman no longer has a cervix through hysterectomy, or is over the age of 65, she no longer needs to have Pap smears, the standard screening for cervical cancer (USPST, 2018). However, pelvic exams, which are not just about Pap smears, but also include external visual observations, internal palpation of the pelvic cavity, and a general physical exam should occur annually and especially if there are any unexplained symptoms, such as postmenopausal bleeding, pain, and/or abdominal bloating (Mayo, 2019). Providers and

Table 17.1 Identifies the environmental and behavioral risk factors that may contribute to the late-stage gynecological cancer and STI diagnosis among postmenopausal, black women, age 55 years and older, in Hampton Roads, Virginia



patients alike need to be educated and made aware of the distinction between and importance of the two.

Additionally, some primary care physicians may opt to perform screenings rather than send patients to the gynecologist. As noted by gynecological oncologist Stacey Rogers, M.D., at times this lack or late referral could prove detrimental as some early warning signs may be missed and diagnosis may not be provided until late stage of the disease (S. Rogers, personal communication, February 15, 2018). Another barrier is the perception by some among the target audience that it is cost prohibitive to go the gynecologist since it is a specialist. According to gynecologist Keisha Burfoot, M.D., a common misperception is that insurance does not pay for gynecological care. However, every two years Medicare pays for a well-woman visit, and if there are any noted issues, it will also pay for gynecological visits. Even if a person has a physical exam at a primary care facility, as long as they decline the well-woman portion and have the primary care physician note that the patient intends to go the gynecologist, Medicare will also cover that visit (K. Burfoot, personal communication, January, 19, 2018).

Solutions to Meet the Needs

The chart below (Table 17.2) identifies environmental and behavioral risk factors which impact postmenopausal seasoned women when it comes to continued gynecological care. The societal, individual, more changeable, and less changeable categorization describes those factors that are easier to change via an intervention. The absence of the other previously identified factors does not negate their importance.

In order to increase knowledge of the benefits associated with continuing gynecological care and screenings, Project Nana presents education workshops targeting program participants. Initially, the educational workshops were only targeted to the research group of black women. However, after research and discussions with providers, advocates, and women within the community, it was decided that the workshops would be presented to all postmenopausal women, 55 years and older in Hampton Roads, Virginia. The gathered data would still look at the ethnic disparities in access, awareness, and care.

The various workshop topics are presented by a diverse group of healthcare providers and community advocates. Specifically, collaborative partnerships include Sentara Healthcare through their physicians and community cancer navigator program; local gynecological practices, pelvic floor physical therapists, Old Dominion University's School of Nursing, and the Lesbian, Gay, Trans, and Bisexual (LGTB) Life Center. Having presenters that represent various ethnicities, genders, ages, and sexual orientations ensures that the participants will be more engaged if they see someone with whom they can relate and perceive represents them. Workshops are presented in a creative way using a mix of interactive drama vignettes and monologs (what Project Nana refers to as Nanalogs) in order to reinforce information presented. Psychodramas are successfully used in depression interventions for their ability to allow participants to address issues in a creative way (Ahmet & Zeynep, 2016). Vignettes depicting a variety of situations that necessitate a gynecological screening are performed by actors, participants, and workshop leaders. This process of providing information in a way that will be easily understood and recognizable is known as knowledge, translation, and exchange (KTE) which has been shown to improve the comprehension and retention of health information (Ellen et al., 2017). The following sample Nanalog is presented to introduce the lecture topic clearly:

> Seasoned. What is seasoned? If it means my mind, my body and my heart marinating and maturating in a variety of experiences-some great, some not so bad, some challenging, then I guess I'm seasoned. Less sugar, more spice, but everything is nice.

Table 17.2 Identifies the changeability importance matrix for proposed solutions

	Individual	Societal
More changeable	Lack of knowledge of need for continued gynecological screenings	Lack of family/social encouragement
Less changeable	Lack of primary care support	Cultural stigma on aging issues

> Heck I'm getting all the mail and advertisements of a seasoned women. I got the AARP magazine. I got mail from the Alzheimer's Association, Social Security. Heck I even got something from Medicare. That made me feel over seasoned cause it is confusing. You got to know about Part A, Part B, Part C, Part D. One is for the hospital. One is for prescription drugs. One is for going to the regular doctor. One gives you an advantage, for what I do not know. I hope there's no E, F or G, cause I'm clueless.
>
> I see the commercials to make sure I get the pneumococcal and the flu shot. I got a checklist going. I see more commercials than enough about erectile disfunction and its saviors Cialis and Viagra. And let's be honest you know a man created that and made those over the top commercials that aren't true. You got a woman half my age, immediately turned on by a man twice my age and he acts all goofy and sweating. Viagra? The men I know see a woman like that they going to pass out before they even swallow that damn pill. They better hope she can do CPR. That's the only woman that's going to feel on that old man…a nurse.
>
> But what about women? The seasoned women like me? I'm over 55. I eat healthy. I go to my yoga class. I go to Zumba class. I even lift weights. I hike. I'm down for adventures. All adventures. You know a mission trip. I go to doctors and see all professionals like I'm supposed to. My internist, my dentist, my dermatologist. It's been a while, but I finally decided to go back to the gynecologist. You know to check things out, to make sure things are still working and haven't dried up too bad. You know in case I take some "mission" trips and don't accidentally bring back souvenirs. Thank God I can't get pregnant anymore. I tried calling a couple of doctors, but they said I need to go back to my primary because either I needed a referral, or they just flat out refused to see me because I had Medicare. That's the other alphabet, N for no. What am I supposed to do? I need to go to the type of doctor who can talk to me about my body, a woman's body. There's a difference you know. The primary care sees everyone but rushes me and never takes time to talk with me about my needs and specific experiences with an aging body. I need a specialist who really understands. After all I am special. Hey maybe I'll be heard if I make a commercial like the men do. Imagine with me you are driving a Bentley, a Mercedes, AN expensive car? And you have some maintenance issues to take care of. You have a choice to drive up to the specialist, or since we are using car references, the "dealer." OR you can get a 15 minute, in and out, checkup and oil change from the Jiffy Lube? Where would you take your most valuable possession? – © 2019 Vanessa LaTanya Hill

Another part of the intervention calls for increasing general and familial awareness of the need for gynecological care in postmenopausal women. The main way this occurs is through outreach and a social marketing campaign. Using a combination of printed material and audio/visual media, information is distributed through physicians' practices, faith-based and community organizations, as well as through commercials and public service announcements and in local print media (see Fig. 17.1). In addition to online media, specifically Facebook and Instagram, mass media, known as an effective compendium to program interventions, is used an advocacy approach, creating awareness for some and reinforcing information for others (Tabassum et al., 2018). Involving a more aware family and social network supports the participant in overcoming barriers.

Postmenopausal women are not always encouraged to utilize gynecologists for screenings as illustrated in the previous Nanalog. At times, primary care physicians include gynecological exams in routine physicals and well-woman exams. According to gynecological oncologist Stacey Rogers, M.D., although there are primary care physicians who are comprehensive when conducting exams on postmenopausal women, with increasing time constraints placed on primary care appointments, some

Fig. 17.1 Project Nana brochure, 2018

may not address gynecological concerns in routine exams; concentrating on seemingly more important issues such as hypertension, elevated cholesterol, and other cardiovascular issues. However, the primary care physician can be the entry point for some gynecological issues and need to know when to refer their patients to the gynecologist (S. Rogers, personal communication, 2/15/2018). Project Nana has engaged the Women's Health Nurse practitioner program at Old Dominion University to encourage nurse practitioners and other nurses to participate in the peer support advocate training in order to support and women who may not initially go to the gynecologists. The KTE method is also frequently used to increase the support of primary care providers and reinforcing the collaborative partnership necessary to provide the optimal treatment for their postmenopausal patients. KTE has been successfully utilized by providers in order to reinforce information and promote awareness and understanding on issues specific to marginalized populations (Tarasoff et al., 2014). Thus, this method is also used during the lunch and learns when presenting the program and communication techniques to physicians. Peer Support Advocates along with provider volunteers conduct training sessions with providers on how to better engage with patients. The addition of the communications training to physicians provides another opportunity to disseminate health information to reach a larger audience beyond the workshops.

The other less changeable, societal factors of the program has to do with changing cultural stigma on aging issues pertaining to postmenopausal women. Most have difficulty seeing seniors as sexual beings or engaging in sexual activity. In a study where students were asked to draw images of seniors, students overwhelming depicted the elders as genderless from a perception that seniors do not think about or engage in sexual activity (Barrett & Cantwell, 2007). This cultural stigma, though improving slightly over time, has historically been pervasive. The resulting exclusion of seniors in the safe sex discussions may lead to limited sexual healthcare (Syme & Cohn, 2016). According to the CDC, people 50 years and older are more likely than younger people to have a late-stage diagnosis of HIV. Specifically, in 2014, 40% of those people 55 years and older already had AIDS when the HIV infection was diagnosed (Center for Disease Control and Prevention, 2018). The following Nanalogs address this topic head-on as a lead in to the presentation by the LGTB Life Center:

> I did everything I was supposed to do. Ladies I'm sure you understand. At a certain time in our lives we reassess who we are, what we really want, and what we are willing to take.
>
> I've been married before and quite honestly, I didn't think I would marry again. But one day when I was at a church conference, I met a man. Of course, I didn't go with the intent of meeting a man. I'm there for a whole different reason. But this man…he was fine as wine. He came up to me and started a conversation. We talked about our jobs, our missions, travel…I mean he was interesting. He was really cool and funny. He didn't live far from me, so after the conference we kept in touch. He did everything right. Everything that I had been praying for he was. And honestly, I had already done the work on myself and was ready to be the woman, the friend, the wife. I did everything right.
>
> We got married after a year of courtship. And we consummated our relationship after the vows. And can I tell you, he didn't change. Everything he did to get me, he was doing to keep me. I didn't want for anything. He was caring not only to me but to my children, my parents, my family. He treated them as if they were his own. He didn't grow up with his

family. As a matter of fact, he had a rough childhood. So what he had always longed for he found in me and my family. We were very happy.

After about 3 years of marriage, a happy marriage, my husband got sick. It started as a flu that he could not get rid of. It wouldn't go away. I finally convinced him to go to the doctor – I don't know the last time he went. What is it with men and doctors? I would not take no for an answer so I took him myself, to my doctor.

After the exam and some tests, my doctor came in with a very stone face. There was a shift in the atmosphere. I knew something wasn't right. My husband took one look at the doctor and put his head down. The doctor just stared at him for a minute and then asked if I could give him some time alone to speak with my husband. My husband took my hand, never looking at me in my face and told the doctor that I was staying in the room.

The doctor revealed that my husband had AIDS. My husband did not look shocked. It was then that I found out my husband had been an IV drug user when he was younger. He was strong enough to get clean, turn his life around and give so much in the community. He wanted to forget all his mistakes of the past, so he decided to forget to remember that he should have told me this. He never had an HIV test.

I went through all the emotions. Anger, sadness, more anger. I prayed for what I should do. This man who devoted his time to the family, to the community, to his church. I realized that this man who was so good to me needed me. I did everything I right. Now I am a widow. A successful businesswoman. I serve my church and community. And I am HIV positive. – © 2019 Vanessa LaTanya Hill

Planning Procedures

Developing the Project Nana intervention has been a nine-year endeavor. Contacts were made to the National Institutes of Health's National Institute on Aging, American Association of Retired Persons (AARP), and Cleveland Clinic. Though formal letters of request for meetings and/or information was sent numerous times, concrete discussions did not happen right away. It was necessary to modify the communications strategy by focusing on local stakeholders. Productive meetings were held with local gynecology practices, the Virginia Oncology Association, local departments of health, aging advocates, and Sentara Women's Health Center at Sentara Virginia Beach General Hospital. These meetings resulted in vital background information and the development of key partnerships among community stakeholders. The main consensus was that research and data on postmenopausal women were limited, at best. There was general support to assist in the program intervention and to participate in the recruitment and research component.

Background research for evidence-based community education programs was conducted through reviews of Web searches using the key words women's health, gynecological oncology and sexually transmitted infections, links and other resources found at the Foundation for Women's Cancer Foundation Web site, and interviews with local gynecologists, gynecological oncologists, women's cancer advocates, and women's health advocates. The goal was to assess programs that were easily replicated in other locations, easy for the target demographic to understand, did not require too many resources to implement, and, most importantly, were deemed successful

in their respective goals to educate the constituency with information that could lead to behavior change. Three best-practice programs were chosen as models for the intervention.

The first program that was examined was the Alzheimer's Association's Peer-to-Peer Outreach program. This program pairs those living with early stage Alzheimer's and those who are newly diagnosed. Peer counselors share their experiences and encourage compliance with medications and other medical interventions. Assessment of the program shows that it has improved attitudes and created a support network for the patient and family (Alzheimer's Association, 2017). Another program is the Mammography Promotion and Facilitated Appointments Through Community-based Influenza Clinics. This program used a compressed time period to encourage the target audience to get a flu shot. While at the flu clinic, health educators took the opportunity to discuss breast cancer screenings and to make appointments for participants. The intervention has increased breast screenings among the target audience, even in the compressed, seasonal period of the intervention (Shenson et al., 2001). The other evidence-based program is the Peer Navigator Breast Cancer Screening Program for Korean-American Women. This is an education-based intervention designed to increase the amount of mammography and cervical cancer screenings. The program used faith-based organizations as the locations to hold the education workshops. The result was an 18% increase in the number of breast cancer screenings and over 13% increase in having both tests (Hae-Ra et al., 2017).

Theoretical Approach

The Project Nana intervention was influenced by two theories, the Theory of Planned Behavior and the Social Cognitive Theory, that have a collaborative effect on the intervention, including the social marketing campaign and social interactions, in order to change the target audience's behavior.

Theory of Planned Behavior

In 1985, Icek Ajzen developed the Theory of Planned Behavior based on his previous work, the Theory of Reasoned Action, which he developed along with his colleague Martin Fishbein. Theory of Planned Behavior takes the basic premise of TRA which is to explain the relationship between attitude and behavior, and further estimates the influence of perceived control in order to determine behavioral intention (Ajzen, 1991).

As the original conceptual framework, Theory of Reasoned Action posits that the best predictor of behavior is a person's intention to perform the behavior. The intention is not only influenced by a person's attitude toward the behavior, but also by a person's subjective norm, which is the perceived acceptable behavior (Ajzen, 1991).

In this framework, there is a strong correlation between attitude and belief. Thus, if there is a strong belief in a positive behavioral outcome, then there is positive attitude with regards to that behavior. Likewise, subjective norms are heavily influenced by the belief of acceptability of the behavior by those whom a person may seek to appease. Thus, if others approve of the behavior, then a person may hold a positive subjective norm toward the behavior (Glanz et al., 2008).

The inclusion of perceived control to the original framework is the differentiator that is the cornerstone for Theory of Planned Behavior. A person's perception of control can either facilitate or inhibit the ability to perform a behavior. Thus, a lack of agency can impede the intention to perform the behavior (Glanz et al., 2008).

The Theory of Planned Behavior has been used in various public health campaigns designed to predict and explain behaviors and intentions toward such interventions as smoking campaigns, promotion of breastfeeding, and the utilization of health services (Glanz et al., 2008). In 2017, the American Journal of Health Behavior published a study on the utilization of Theory of Planned Behavior in HIV testing intention. Previous studies on HIV prevention in sub-Saharan Africa focused on using this theory to address the intention to modify sexual behaviors. Evaluating prevention interventions from the standpoint of motivations to get tested for HIV, Ayodele used Theory of Planned Behavior in order to determine the intentions of a group of Nigerian college students with respect to HIV testing. Ayodele concluded that Theory of Planned Behavior was indeed effective in predicting HIV testing and prevention intentions (Ayodele, 2017).

Social Cognitive Theory

Originally known as the Social Learning Theory, Social Cognitive Theory posits that individuals learn and adapt behavior by observing the consequences of the behavior of others. Developed by Albert Bandura in 1986, Social Cognitive Theory integrates constructs from sociology, political science, and psychology to provide a comprehensive conceptual framework for how people learn from social experiences (Glanz et al., 2008). Social Cognitive Theory explores how people form and maintain behaviors through the lens of past experiences and the social environment. It introduces the concept of reciprocal confluence and interaction between behavior, the environment, and the individual (Glanz et al., 2008). Some key constructs of the Social Cognitive Theory include: reciprocal determinism (a change in either environmental factors or individual cognition or behavior affects the others); self-regulation (controlling oneself through self-monitoring and social support); observational learning (learning by viewing the rewards and consequences received by others as they perform a behavior); and self-efficacy (a person's ability to perform a specific behavior) (Glanz et al., 2008).

Social Cognitive Theory has been used to employ culturally specific interventions. In 2017, the American Journal of Health Behavior published a study titled the Utility of Social Cognitive Theory in Intervention Design for Promoting Physical Activity

among African American Women: A Qualitative Study. In the study, the authors used focus groups to examine how Social Cognitive Theory could be employed to develop an intervention. Focusing on the specific concepts of behavioral capability, outcome expectations, self-efficacy, self-regulation, and social support, the study found that Social Cognitive Theory was indeed effective in elucidating findings to develop a comprehensive intervention design (Joseph et al., 2017).

Intervention Design

Project Nana is a 10-year program, targeting 1000 senior women of color for a total of ten, 12-week intervention cohorts. For each year of the intervention, a cohort of 100 women will participate in the five-phase intervention (see Table 17.3) to be delivered over an implementation time of 12-weeks. The initial year of the intervention began with a pilot study July 1, 2018, and September 30, 2018, in Hampton Roads, Virginia.

The first education workshop for the pilot occurred at Sentara Virginia Beach General Hospital (see Fig. 17.2). The presenters included gynecologists, primary care providers, and community advocates who volunteered their time. Volunteer outreach coordinators recruited participants who were chosen as a result of indicating that it had been over two years since a gynecological exam occurred on the eligibility survey. This survey was conducted at local churches, senior living facilities, medical offices, and at community events.

Project Nana is divided into five phases:

Phase One: Education Intervention

In the first four weeks of the program, participants participated in an interactive education workshop. Using a combination of lecture style and interactive vignettes, participants were exposed to information about gynecological care and the need to continue well-women screenings. They also learned about the role of the primary care physician in their gynecological care and how gynecologists and primary care physicians work together. Participants were educated about risk factors, symptoms, and prevalence rates for gynecological cancers with an emphasis on ovarian, cervical, and uterine cancers. Participants also learned about issues related to sex including successful interventions to maintaining sexual activity and risk factors, symptoms, treatments, and prevalence rates for sexually transmitted infections with an emphasis on HIV and syphilis.

The plan was to have program clinicians to conduct lunch and learns with community women's health and primary care providers. Studies have linked the coaching of the use of checklists in patient examinations to the increase in quality of communication and information gathered. The result was improved patient satisfaction, knowledge, and health outcomes (Ferguson, 2012). The lunch and learn sessions are designed to teach better communication with patients and to examine the goals of the intervention, and to provide education on gynecological health considerations of postmenopausal women. In a study found in the American Cancer Society Journal,

Table 17.3 Project Nana intervention design

Intervention phase	Corresponding objective	Corresponding theory
Phase one: Education Intervention—Training for program participants, lunch and learns for physicians	Increase knowledge of the benefits of gynecological care for postmenopausal, black women, age 55 years and older, in Hampton Roads, Virginia, by 60% within 3 months from the start of the intervention	Theory of Planned Behavior
Phase two: Social Marketing Campaign—via Facebook, print, radio, television, Web site, dissemination of information of the health issue and the event	Reduce perceive barriers to seeking gynecological care for postmenopausal, black women, age 55 years and older, in Hampton Roads, Virginia, by 40% within 3 months from the start of the intervention	Theory of Planned Behavior
Phase three: Training Senior Community Workers—Senior women from the target audience who are active patients of a gynecologist	Increase self-efficacy to seek gynecological care among postmenopausal, black women, age 55 years and older in Hampton Roads, Virginia, by 20% over 2 years	Social Cognitive Theory
Phase four: Peer-to-Peer Engagement—Senior community workers follow up with participants to schedule GYN visits	Increase self-efficacy to seek gynecological care among postmenopausal, black women, age 55 years and older in Hampton Roads, Virginia, by 20% over 2 years. (Participants will support efforts to provide information on current gynecological issues such as risk of STIs, cancers, and need for routine pelvic exams by a gynecological care team to their peer groups.)	Social Cognitive Theory
Phase five: Take Your Nana to the Doctor Day—Program participants receive well-woman exams from participating gynecologists and their designees (PA's, NP's)	Increase the utilization of gynecologists for annual screenings among postmenopausal, black women, age 55 years and older in Hampton Roads, Virginia, by 20% over 2 years	Social Cognitive Theory

researchers found that communication training improves therapeutic humility, assists providers in compassionately engaging a patient, and the perception of authentic, active listening impacts the patient experience, reduces patient distress, and ultimately improves the quality of medical care (Chochinov, 2013). Therefore, the goal of provider engagement is to create a safe space for discussion on sexual activity and gynecological issues the patient may be having but historically not disclosed and

Fig. 17.2 Project Nana workshop

to have providers consider and promote routine annual gynecological exams with gynecologists with the target audience among their patient population.

Phase Two: Social Marketing Campaign

Upon completion of phase one, a six-week social marketing campaign consisting of print materials and social media was launched. The social marketing campaign served two purposes—to educate the community about the need for senior women to continue gynecological screenings and to direct people to participate in Take Your Nana to the Doctor activities. Print materials were distributed in the form of brochures and fliers to faith-based organizations, senior centers, aging advocacy agencies, and physician practices (see Fig. 17.3). Brochures and fliers provided information on Take Your Nana to the Doctor and directed readers to the Web site and social media sites for contact information on participating medical practices and additional resources.

Phase Three: Training Peer Support Advocates

Outreach coordinators recruited women from the target audience to participate in training to become Peer Support Advocates (PSA), or essentially, community outreach workers. In a study analyzing the effectiveness of peer coaching on physical activity of breast cancer patients, the authors found that peer-led interventions have the potential to positively impact health behaviors (Pinto et al., 2015). In the Project Nana intervention, women from the target audience who are active patients of a gynecologist and consistently receive well-women visits were invited to be trained. Thus, they had more of an impact in persuading their peers to schedule gynecological exams and to provide ongoing resource support for information such as insurance, available providers, transportation, etc. Over the course of a weekend, participants

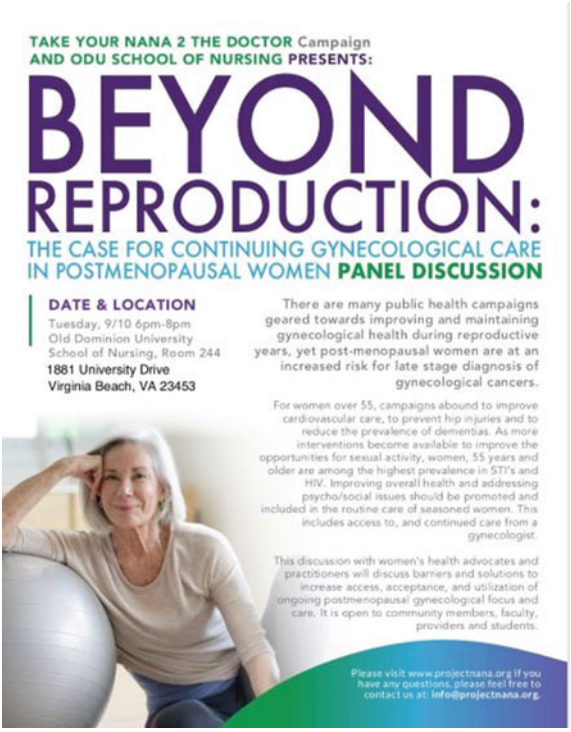


Fig. 17.3 Take Your Nana to the Doctor campaign flier

were educated on specific gynecological issues, how to engage others, and how to overcome objections.

Phase Four: Peer-to-Peer Engagement

The Peer Support Advocates are key in following up with the participants from the phase one education workshops in order to reinforce the education received and to get them to commit to schedule appointments with designated gynecologists during the Take Your Nana to the Doctor week. They conduct home visits and make phone calls to participants. The aim is to give the participants a sense of accountability to following through on scheduling medical appointments. A similar approach was applied to an outreach program to target and treat psychiatric illness in seniors. The study published in the Journal of the American Medical Association found that when using a model of care including trained community peers who conduct home visits and encounter patients on a daily basis as part of a treatment team to locate and speak with the target audience, there was a decrease in the levels of symptoms among psychiatric patients who lived in high risk neighborhood settings (Rabins, 2000). PSAs also provide initial engagement to any organization or group who may want additional information regarding senior women's health and Take Your Nana to the Doctor week.

Phase Five: Take Your Nana to the Doctor Week

This is a weeklong event where participants go to medical appointments for screening by participating gynecologists. Gynecologists use the step-by-step questionnaire and guide in order to acquire necessary medical and social history and to engage participants in conversations in more sensitive topics such as sexual activity/history. Gynecologists perform a well-woman visit, including pelvic examinations and any other physical exams that are deemed necessary.

Although the original intervention included a five-phase education and engagement intervention to be offered within a 12-week timeframe, due to scheduling issues and time constraints, the initial pilot consisted mainly of conducting surveys and presenting the education workshops. The Take Your Nana to the Doctor campaign was impacted due to hurricane and subsequent evacuations in the region. However, partnering physicians did note that some participants from the workshops did follow up and become patients.

Additionally, it was determined that there should be programming to support the medical visits in order to continue to make the community aware of the issues associated with senior women. Thus, in 2019, panel discussions and small groups were added to the offerings (see Fig. 17.4). In association with the partnership with Sentara Healthcare and Old Dominion University School of Nursing, the following activities are scheduled for 2020: a co-educational prostate/gynecological cancer awareness program and football tailgating event; panel discussion; community dinner; and a health expo to include women's health screenings.

Fig. 17.4 Project Nana panel discussion

Evaluation Design

Evaluations occurred after the pilot phase and will continue throughout the intervention. Using survey instruments that measure pre-intervention attitudes, perceived norms, perception of agency, and knowledge, the intervention program applied a variety of engagement opportunities to influence more positive attitudes with regards to going to the gynecologist. Project Nana employed the Theory of Planned Behavior to predict whether or not postmenopausal women of color, who do not consistently go to a gynecologist for well-woman visits, will schedule a gynecological exam as a result of the intervention. Participating in a cohort of women of similar demographics and psychographics, the program created new subjective norms that encouraged gynecological visits. The education workshop provided the opportunity to overcome perceived educational, cultural, and economic barriers to gynecological services.

Prior to the initial educational workshop, surveys were distributed to senior women participants to evaluate their attitudes about seeking gynecological care, a self-assessment of their knowledge of gynecological health, and their beliefs of the importance of gynecological health to their overall quality of life before they were introduced to the information. After the education workshop, participants were provided with a post-workshop survey with the same questions and included additional questions on their intent to participate in *Take Your Nana to the Doctor* week by scheduling a well-woman visit with participating gynecologists. The Social Cognitive Theory was applied to Project Nana throughout the intervention. Project Nana encouraged visits to the gynecologists by providing education on consequences and rewards and through testimonial accounts by postmenopausal women who either benefited from consistent gynecological visits and those who did not have gynecological screenings. Creating a cohort also allowed for social support among peers to have a sense of accountability to follow through on scheduling a gynecological visit by the end of the intervention.

In 2020, upon completion of the Take Your Nana to the Doctor Day week, a final survey is scheduled to determine how many of the participants scheduled and completed well-woman visits at the participating gynecologists. Focus groups divided between those participants who completed gynecological visits and those who did not are scheduled to further investigate the reasoning behind their respective decisions.

Method of Evaluation

The intervention is designed to increase the utilization of gynecological services in postmenopausal women, 55 years, and older. The program seeks to increase knowledge about the need for continued gynecological care and reduce barriers associated with attitudes and beliefs among the target audience. The evaluation should answer the following questions:

- *To what extent was there an increase in knowledge of the benefits of gynecological care for the target audience?*
- *To what extent was there a reduction in perceive barriers to seeking gynecological care for the target audience?*
- *To what extent was there an increase in positive attitudes toward seeking and continuing gynecological care for the target audience?*
- *To what extent was there an increase self-efficacy to seek gynecological care among target audience?*
- *To what extent was there an increase the utilization of gynecologists for annual screenings among target audience?*

The program intervention consists of a target audience who volunteer to participate in the program. There may be individuals who do not complete the entire intervention program. A new cohort will begin each year with cohort continuing to be monitored to evaluate program recommendations and adherence.

Results from Pilot Workshop

During the first education workshop in 2018, there was a total of 46 participants who answered preworkshop and post-workshop surveys. These participants attended as a result of the outreach to the faith community specifically. The 46 participants' knowledge about cancer items were summated at the pre- and post-workshop levels, and a paired samples *t*-test performed to determine whether knowledge of cancer levels increased after exposure to the workshop. A pair-wise deletion approach was used to remove missing values, such that comparisons were made based on participants that completed the survey pre- and post-intervention. The paired samples t-test was statistically significant, $t(31) = 6.57$, $p < 0.001$, indicating that there was a statistically significant difference in participants' knowledge at post-test compared to pretest. Specifically, participants' knowledge levels were higher after the workshop ($M = 206.72$, SD = 23.24) compared to before the workshop ($M = 178.31$, SD = 26.09). Specific sets of items were examined further to determine the areas in which knowledge increased from pre- to post-intervention. Questions related to cervical cancer were summated at the pre- and post-workshop levels to determine whether participants' knowledge of approaches to preventing cancer increased (see Table 17.4). A sample question asked the participant to indicate level of agreement for the following statement: For cervical cancer prevention, one has to be protected against sexually transmitted diseases. The paired samples t-test was not statistically significant, $t(31) = -0.41$, $p = 0.342$, indicating there was no statistically significant difference in participants' knowledge of how cancer can be prevented post-test compared to pretest. Therefore, participants' knowledge levels of prevention were similar before the workshop ($M = 12.69$, SD = 3.49) compared to after the workshop ($M = 12.34$, SD = 3.47).

Table 17.4 Results from initial pre- and post-workshop survey

Comments about the workshop							
	Strongly disagree	Disagree	Somewhat disagree	Neither disagree nor agree	Somewhat agree	Agree	Strongly agree
Prepared me to make informed decisions	0	1	0	0	0	8	21
	(0.00%)	(3.33%)	(0.00%)	(0.00%)	(0.00%)	(26.67%)	(70.00%)
Learned new information	0	0	0	1	0	8	21
	(0.00%)	(0.00%)	(0.00%)	(3.33%)	(0.00%)	(26.67%)	(70.00%)
Corrected about some information	0	2	0	2	1	10	15
	(0.00%)	(6.67%)	(0.00%)	(6.67%)	(3.33%)	(33.33%)	(50.00%)
Workshop was a valuable tool	0	0	0	0	0	6	24
	(0.00%)	(0.00%)	(0.00%)	(0.00%)	(0.00%)	(20.00%)	(80.00%)
Workshop changed my mind	0	2	0	5	1	7	14
	(0.00%)	(6.90%)	(0.00%)	(17.24%)	(3.49%)	(24.14%)	(48.29%)
Broader understanding of GYN impacts health	0	0	0	2	1	5	21
	(0.00%)	(0.00%)	(0.00%)	(6.90%)	(3.49%)	(17.24%)	(72.41%)
Broader understanding of GYN impacts quality of life	0	0	0	1	2	5	21
	(0.00%)	(0.00%)	(0.00%)	(3.49%)	(6.90%)	(17.24%)	(72.41%)
Adequate time for the information to be presented	0	0	4	0	1	8	16
	(0.00%)	(0.00%)	(13.79%)	(0.00%)	(3.49%)	(27.59%)	(55.17%)

However, questions related to risk factors of gynecological cancers were also summated at the pre- and post-workshop levels to determine whether participants' knowledge of cancer risks increased as a result of the workshop. Sample questions asked to the participant to indicate level of agreement for the following three statements:

1. *Being pregnant at an older age is risk factors for cancer of the uterus.*
2. *Getting pregnant three or more times starting at an early age is a risk factor for cervical cancer.*
3. *There are noticeable symptoms for ovarian cancer.*

The paired samples *t*-test was statistically significant, $t(31) = 4.82$, $p < 0.001$, indicating there was a statistically significant difference in participants' knowledge of cancer risks at the post-test level compared to the pretest level. Specifically, participants' knowledge of cancer risks increased after the workshop ($M = 85.34$, SD = 10.55) compared to before the workshop ($M = 75.44$, SD = 9.92).

Discussion

Project Nana is an innovative approach to increasing the lives of some of our most valuable resources in our community—our senior women. The pilot program compressed the schedule for the actual intervention. This provided mixed results. For those women who consistently get medical care, there were not too many barriers to convincing them to get a gynecological exam providing they attend the education workshops and have reinforcing support via their primary physicians, social networks, and the senior community interventionists. Conducting preworkshop surveys also allowed the participants to query the presenters regarding further discussion to items addressed in the survey.

Once the workshops were conducted and the participants encouraged to schedule medical visits, access became a major unanticipated barrier. Via frustrated phone calls and emails from program participants, it was revealed that in the Hampton Roads region of Virginia, there were few gynecologists who would accept Medicare or Medicaid as a form of insurance. This was an unexpected issue that arose for our patients for whom Medicare was the primary insurance and for our participants in the lower economic bracket who only had Sate sponsored insurance. Through off the record conversations with practice managers of the major gynecological practices in the area, it was revealed that the difference in reimbursement was the reason for this disparity. Thus, the participants who had private insurance had a wider selection of gynecological practices than those who did not have private insurance. Those who did not either asked for a suggestion for provider who accepted Medicare/Medicaid, opted to go to their primary care provider, or continued to not seek gynecological care.

The pilot phase also had a limited budget request. In order to increase donations and successful bids for funding, Project Nana must demonstrate success in increasing awareness and new patients to schedule visits. With an increase in budget, the opportunity to train more Peer Support Advocates and provide more workshops also increases. More community outreach workers enable the ability to train for a variety of community interventions that are under-resourced with regards to human capital. Additional training of PSAs will allow Project Nana to not only staff more workshops and conduct more outreach for gynecological awareness, it will also allow Project Nana to expand its scope and serve as a clearinghouse and pipeline to train advocates to engage in grassroots community organizing and outreach. Awareness and maintaining gynecological health may have a secondary outcome in decreasing comorbidities, which may in fact allow participants, who are now healthier to become

more productive by learning new tools as PSAs and becoming engaged in community activities. Organizations that need volunteers will have a trained group of people to assist.

Women who experience success in the program through early detection of a disease have been effective in proving that the intervention works. This means that there must be available gynecologists who provide good experiences for the senior women. First, the program must be able to recruit a substantial number of gynecologists who will open their schedules for this one-week campaign blitz. Excitement will increase by seeing groups of participants in medical practices simultaneously. An increase in patient acquisition will be a good outcome especially for those physicians who need to increase their patient panels. However, as mentioned earlier, the access to gynecology services for those with Medicare and Medicaid needs to be addressed. One solution that is integrated into the 2020 program is to provide more information to and about women's health nurse practitioners. This is an initiative in collaboration with Old Dominion University's School of Nursing.

Some religious organizations may be more conservative and may not be open to discuss gynecological health, let alone issues of sexuality pertaining to senior members of their congregations. However, given the opportunity to discuss these issues during the recruitment process, program representatives have been able to highlight the opportunity to improve overall health which may result in increased productivity within their houses of worship.

With proper buy-in by key stakeholders in the community, Project Nana does have potential for success. With suggestions and modifications that will come from the activities and study evaluations, the program can be improved to help ensure its ongoing sustainability.

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