COMMUNITY ENGAGEMENT STRATEGIES
FOR RAISING AWARENESS OF
CANCER PREVENTION AND EARLY DETECTION
AMONGST THOSE MOST IN NEED

Australia and New Zealand

March 2013
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1. Introduction

a) My Winston Churchill Memorial Trust Fellowship

The Winston Churchill Memorial Trust (WCMT) annually awards travelling fellowship grants, providing people with the opportunity to travel overseas and learn from professionals and projects in their line of work. The purpose is to bring knowledge and ideas home in order to set up new or enhance existing programs, which benefit communities and individuals in the UK. I submitted an application under the Health category and was fortunate to be accepted for the 2012 fellowship scheme. My travelling grant enabled me to spend five weeks across Australia and New Zealand during November and December 2012, where I researched methods of engaging communities with information about reducing cancer risk and spotting cancer early.

Experts estimate that around 4 in 10 cases of cancer in the UK could be prevented by changes to lifestyle, i.e. not smoking, maintaining a healthy body weight, eating a balanced diet, keeping active, cutting back on alcohol and being safe in the sun. In addition, knowing what's normal for your body and reporting any unusual or persistent changes to a doctor early, can help cancer to be diagnosed earlier and can often mean treatment is more successful.

I have worked for the charity Cancer Research UK since January 2009 and during that time I have been involved in a variety of activities designed to increase public awareness of the lifestyle changes that can help to reduce cancer risk, and why it's important to spot cancer early and go for screening when invited. Most recently I have managed Cancer Research UK's Cancer Awareness Roadshow programme which consists of four regionally-based roadshow units that visit towns and communities for eight months of the year, sharing free information with the public on cancer prevention and detection. Each unit is staffed by professional nurses who can talk to people about cancer and signpost to local health services in the area. The Roadshow targets low income communities where cancer outcomes tend to be poorer. Since launching in 2006, the Roadshow has seen over 300,000 visitors in more than 200 towns and cities across the UK. More information about the Roadshow can be found here: www.cancerawarenessroadshow.org.uk

For my fellowship, I wanted to research the activities used by other cancer charities and not-for-profit health organisations, for sharing cancer information with communities and individuals who are most at risk of developing or dying from cancer. One of Cancer Research UK's key goals, is to tackle cancer in low income communities where incidence tends to be higher and survival rates lower. Similar inequalities exist in Australia and New Zealand whereby the cancer outcomes of indigenous groups are in stark contrast to the non-indigenous population. I was therefore particularly interested in finding out more about the specific methods being used to engage these audiences with information to reduce cancer risk, and how these efforts were being sustained in communities.

Part of what makes the Cancer Awareness Roadshow so effective in tackling cancer inequalities in the UK, is the opportunistic access which the units provide for people who may not have sought information otherwise. However, given the nature of the landscape and rurality of many parts of New Zealand and Australia, I was aware that Roadshows aren't as common a model as they are in the UK. Therefore, while I had initially planned to focus my research on other examples of Roadshow-based models, I extended my project proposal to review a number of additional strategies for accessing hard-to-reach communities.

For the main part of my trip I met with health promotion and community education professionals from cancer charities in both Australia and New Zealand. I also met with representatives from other organisations such as cancer networks, public health agencies, screening providers and government health services. This included shadowing people in their roles, visiting the staff/teams on the ground and sitting in on meetings and cross-organisation forums.

In this report I have tried to consolidate the key learnings and insights gained from my five week trip. I hope to be able to use these findings to inform my future work, and that my report will be of interest to those working in a health community engagement capacity in the UK.
b) Aims and Objectives

My project application initially focussed on exploring how Roadshows were being used overseas to deliver health awareness information to communities, and the methods used to sustain efforts in the areas visited.

Improving sustainability of information provision and creating a sound knowledge base in the heart of communities has been a key area of interest for both me and my colleagues in the UK. As such, upon being shortlisted for my fellowship I submitted a revised proposal that would also allow me to spend time reviewing alternative methods for engaging communities with cancer awareness messages, in addition to programs involving Roadshows.

A couple of key areas I wanted to explore involved the use of volunteers and health workers as conveyers of information locally. By training others to share cancer awareness information either within their existing line of work, or through volunteering their time, we hope to overcome some of the limitations of the Roadshow and be able to increase the reach of information even further. I therefore wanted to use the opportunity provided by my fellowship to also learn from organisations who were already adopting these methods as part of their community engagement strategies.

In summary, the core aim of my fellowship was to:

Investigate effective community-based programs aimed at improving awareness of cancer prevention and early detection amongst groups with poorer cancer outcomes

Wider objectives included:

- Reviewing other examples of Roadshow-based activities that promote healthy living and finding cancer early
- Investigating alternative methods for providing cancer awareness information to hard-to-reach groups, to include training programs for health and other community workers, and the use of volunteers
- Learning more about how to link in with other community health engagement efforts in order to maximise wider impact
- Looking at ways of developing relationships with, and relevant information for, new audiences
- Providing recommendations for Cancer Research UK’s health community engagement strategy

Me with the Highbury Social Club set up by Chrissy Paul, Māori Cancer Navigator, Palmerston North, New Zealand
c) Itinerary

My five week trip consisted of three weeks in Australia, and two weeks in New Zealand. Below is a top-line summary of the organisations I visited and who I was hosted by. In each case, I was introduced to various members of the teams involved in cancer awareness projects, and was fortunate enough to sit in on several cross-organisational meetings which increased my network of contacts. A full list of the teams and forums I met with, can be found in the Acknowledgements.

<table>
<thead>
<tr>
<th>Australia</th>
<th>Cancer Council of New South Wales (CCNSW), Sydney</th>
<th>Kathy Chapman, Health Strategies Division Director</th>
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<tbody>
<tr>
<td><strong>New South Wales (NSW)</strong></td>
<td>Cancer Council of New South Wales, Hunter Region Office</td>
<td>Shayne O'Connell, Regional Manager Dana Buzinec, Community Programme Manager</td>
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<td><strong>Western Australia (WA)</strong></td>
<td>Cancer Council of Western Australia (CCWA), Perth</td>
<td>Dr Emma Croager, Education Services Manager Libby Foster, Regional Education Officer</td>
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<td>Western Australia Cervical Cancer Prevention Programme (WACCPP), Perth</td>
<td>Debbie Hanlin, Health Promotion and Education Coordinator</td>
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<td>BreastScreen WA, Perth</td>
<td>Karen Semmens, Health Promotion Coordinator Leanne Pilkington, Indigenous Program Officer</td>
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<td>Diabetes WA, Perth</td>
<td>Deanne Dymock, Community Relations Asha Singh, Senior Health Promotion Officer for Aboriginal Health</td>
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<td>WA Cancer and Palliative Care Network, Perth</td>
<td>Helen Walker, Programme Manager Violet Platt, Director of Nursing</td>
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<td><strong>New Zealand</strong></td>
<td>Cancer Society of New Zealand (CSNZ), National Office, Wellington</td>
<td>Dr Jan Pearson, National Health Promotion Manager</td>
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<td>Cancer Society of New Zealand, Wellington Division</td>
<td>Raewyn Sutton, Regional Health Promotion Manager</td>
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<td>Health Promotion Agency, Wellington</td>
<td>Dave Gibbs, Marketing &amp; Health Promotion Advisor</td>
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<td>Cancer Society of New Zealand, Canterbury Division, Christchurch</td>
<td>Martin Witt, Regional Health Promotion Manager</td>
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<td>Cancer Society of New Zealand, Auckland Division</td>
<td>Beth Jenkinson, Regional Health Promotion Manager Jacqui Fill, Volunteering Manager</td>
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<td>BreastScreen Aotearoa, Auckland</td>
<td>Maree Pierce, Programme Manager Claire Norris, Senior Analyst</td>
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<td>Bowel Screening Pilot, Waitemata District Health Board (DHB), Auckland</td>
<td>Gaye Tozer, Project Manager Elizabeth Brown, Community Awareness Raising Coordinator</td>
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<td>Waikato DHB, Hamilton</td>
<td>Rawiri Blundell, Equity Manager</td>
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<td></td>
<td>Māori Cancer Navigators, Midcentral DHB, Palmerston North</td>
<td>Chrissy Paul, Cancer &amp; Health Promotion Coordinator</td>
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2. Overview of cancer in Australia and New Zealand

a) The Cancer Landscape in Australia and New Zealand

Cancer is a major cause of illness in both Australia and New Zealand. Latest stats show that over 124,000 new cases of cancer are diagnosed a year in Australia, and almost 21,000 cases are diagnosed in New Zealand. In both countries, as in the UK, cancer incidence is increasing along with the ageing population. The most commonly diagnosed cancers in each country are prostate, bowel and breast cancer (prostate being the most commonly diagnosed cancer in men, and breast cancer in women). Lung cancer is the most common cause of cancer death, followed by prostate/breast, then bowel. Cancer survival rates have significantly increased in the last few decades in both Australia and New Zealand, just as they have in the UK. However, cancer remains as the leading cause of death for men and women in both countries, accounting for around 30% of all deaths overall.

The Australian Department of Health administers many of the Australian Government’s cancer control activities including programs aimed at improving cancer prevention and early detection, such as BreastScreen Australia, the National Cervical Screening and National Bowel Cancer Screening programs. State and territory government departments and agencies are then responsible for service delivery in their area. In New Zealand, the Ministry of Health will implement national programmes e.g. cancer screening services, and oversees 21 District Health Boards (DHBs) across the country. The DHBs are responsible for planning and funding cancer services in the area, as well as funding local Primary Health Organisations who focus on community health. Four Regional Cancer Networks also exist to ensure a collaborative approach to cancer service planning and delivery.

Healthcare in Australia is provided free or at a subsidised rate under the Medicare insurance scheme which provides access to primary care treatment by GP’s, practice nurses and a number of other therapeutic and diagnostic services. The system in New Zealand is a mix of public and private healthcare, meaning individuals will often have to pay a fee when seeking any sort of primary health care.

b) Cancer Inequalities

In the UK there are significant inequalities in cancer incidence, mortality and survival. The risk of being diagnosed with certain cancers is greater among the most deprived families and communities and, for most types of cancer, survival rates for the most deprived patients are worse. Social and health inequalities are leading to thousands of cancer cases in the UK being diagnosed at a late stage when the chances of successful treatment are lower, meaning the survival gap between the most affluent and deprived groups is widening. There are also ‘harder to reach’ groups where we see differences in cancer outcomes – men for instance are more likely to develop and die from cancer, and some ethnic groups are more likely to develop certain cancer types than the white population. It’s hard to pin down the exact reasons for the different statistics of these groups, but lifestyle factors, delays in diagnosis and failure to take part in screening, can all contribute to poorer cancer outcomes.

Similar contrasts in cancer outcomes exist in Australia and New Zealand also. Mortality rates for all cancer types combined, are higher for Australians living in lower socioeconomic areas, and for those living in remote areas. In addition, Aboriginal Australians, while less likely to have some types of cancer than other Australians, are significantly more likely to have cancers that have a poor prognosis, and have a higher mortality rate from cancer overall. In New Zealand, a gap in cancer incidence and mortality can be seen between high and low income groups, but this is less marked than the gaps by ethnicity across all cancers. In 2009, the incidence of cancer for Māori was almost 23% higher than the non-Māori population. And while the number of cancer deaths has reduced in both Māori and non-Māori in the last 10 years, cancer mortality amongst Māori is still 73% higher than in non-Māori.

But why do these differences exist? It is often the case that indigenous people present with cancer at a much later stage than non-indigenous groups; meaning successful treatment is more challenging. Further to this, risk factors associated with cancer are far more prominent amongst these groups, for example, more than 50% of Aboriginal Australians smoke compared to 23% of non-Aboriginal Australians, and similarly in New Zealand, the smoking rate amongst Māori is 40% compared to 19% for the non-Māori population. There is therefore a need to address the connection between health and cancer, as well as the importance of early detection.
Access to treatment can also vary considerably, with non-indigenous groups being less likely to receive treatment at all. In both Australia and New Zealand, the remoteness of some areas means that accessing cancer services becomes dependable on that person's ability to travel to the nearest treatment centre which tend to be in the cities. Furthermore, people's perception and understanding of cancer can have an impact on the uptake of services. For instance, fear of cancer can play a large part in deterring individuals from seeking help, regardless of their ethnicity. Some people may also affiliate a cancer diagnosis with a mark of shame or humiliation, and therefore choose not to bring this upon their families. Being aware and appreciative of such cultural differences is essential for anyone wishing to engage these audiences.

It is important that different beliefs, levels of cancer knowledge and capacity to access information and services, are considered as part of any strategy aimed at reducing the impact of cancer amongst those groups who are currently most at risk.

3. Findings

a) Summary of Approach

The following pages explain my observations and some of the conclusions drawn from my fellowship experience. In each example, my understanding has derived from informal discussions (or as I was told, 'having a yarn') with those involved in either the delivery or strategic coordination of such activities. Speaking with teams and individuals from various parts of the organisations I met with, helped me to appreciate the wider applications of some of the projects I have outlined.

You will notice that a number of the examples I refer to, regard activities that raise awareness of specific lifestyle factors to help reduce cancer risk, rather than cancer awareness as a whole. While the agenda for the Cancer Awareness Roadshow is to share information around all areas of prevention, early detection and screening, I found that the cancer charities I met with during my fellowship tended to focus their activities on single lifestyle factors at a time, and their teams were split accordingly to deal with each area – predominantly skin cancer prevention, tobacco, and nutrition and exercise. I was told that one of the reasons for this was that it can be easier to enforce positive messaging when you move the focus away from cancer.

Another thing to note is the organisational structures of the charities I met with. Both the Cancer Council in Australia and Cancer Society of New Zealand are split out into divisions who each set their own health agendas. In Australia, the Cancer Council Australia is the national charity, with separate charities operating in each state. The Cancer Society of New Zealand has a national office as well as six regional divisions throughout the country. In both countries, the separate charities that operate at a state or regional level, will raise their own funds and set their own health strategies based on the local need.

I have grouped together the key activities observed and discussed during my fellowship, into the following:

- Other Roadshow Activity
- Regionally Based Staff and Community Links
- Volunteering
- Educating Local Health Workers
- Culturally Relevant Training and Programme Development
- Working with Other Community-Based Organisations
- Providing Grants
- Everyone Getting Out and About
b) Key Activity Examples

**OTHER ROADSHOW ACTIVITY**

Firstly, here are a few examples of programmes that use (or used to use) mobile units to access communities, much like the Cancer Awareness Roadshow in the UK.

I spent time with BreastScreen Aotearoa in New Zealand and BreastScreen WA in Perth who are responsible for delivering breast cancer screening services to eligible women. Both services use mobile mammogram units similar to the UK. BreastScreen WA go to great lengths to ensure that women in the most remote areas can understand and take up breast screening. At present, their mammography units can only drive on tarmac, making many communities in the outback inaccessible. This means women from these communities, mostly Aboriginal women, must travel to the nearest town which can be up to 800km away. BreastScreen WA will pay to hire buses in order to transport the women to these towns, and will also provide meals depending on the length of time the women will be away from home. It can be the case that even after weeks of planning, the roads into the communities may be closed at a moment’s notice for cultural reasons e.g. observing the death of an elder (known as ‘Sorry Time’). At these times, no outsider will be able to access the communities, even if they have just driven all the way from Perth! Aboriginal liaison staff from BreastScreen WA will visit ahead of the mammography units to inform and educate the women of the community and the local health services, as to the importance of taking up screening. Recently, this has included the development of an Aboriginal specific presentation that talks about what breast cancer is, screening, treatment, support and common myths. It takes two years for the mammogram units to visit 100 rural towns, so if an appointment is missed, that person will likely not see the van again for another four years (unless they happen to see it when in another town, in which case the units accept walk-ins). But overall, Western Australia has seen an increase in the uptake of breast cancer screening amongst Aboriginal women in recent years.

I believe the pre-visit education sessions delivered by BreastScreen WA, are a key contributing factor to encouraging uptake amongst hard to reach groups. Similar measures have been adopted by BreastScreen Aotearoa in New Zealand. Manukau County, a district of Auckland, has one of the highest populations of low-income families and ethnically diverse groups in the country (over 50% non-European). The BreastScreen team working in this area will visit community settings such as churches and large workplaces e.g. mail sorting houses, to help raise awareness of the importance of breast screening ahead of the mammography unit visits. This is helping to achieve several 1000 new enrolments a year.

The research I conducted during my fellowship application revealed that the Cancer Council New South Wales (CCNSW) used to run a mobile unit in 2009 that was very similar to the UK Cancer Awareness Roadshow. The aim of the CCNSW unit had been to take information and cancer support to people who didn’t have access to services locally, as well as increasing the visibility of the CCNSW brand in rural areas. While the unit managed to visit a large number of rural towns, this proved quite challenging to organise, and the staff on board found it difficult to be away from home for several weeks at a time. It was also difficult to predict footfall in places, and they found themselves in a number of very quiet locations which did not prove...
economically viable in the long run. Unfortunately, the CCNSW unit stopped running after just a year. I think this example shows that successful Roadshow-based programs depend on employing the right staff from the local area who are able to advise on where and how to engage with local audiences.

In recent years, the CCNSW have instead set up Cancer Information Centres. These centres are based in 14 hospitals across New South Wales, and are stocked with information resources for cancer patients and their families. Each centre is staffed by trained volunteers (more on this in the 'Volunteering' section on page 11). Regional CCNSW program coordinators have worked closely with the 14 hospitals to negotiate space, IT support and signage for the Centres. While not a mobile Roadshow, I think this example is worth mentioning as it shows the importance of partnership working in order to create settings which allow local people to access cancer information.

The Cancer Information Centre at the Calvary Mater Hospital, Newcastle, New South Wales

Although not part of my original itinerary, whilst in Western Australia I came across the Freo Street Doctor. Based in Fremantle, this is a mobile health service for disadvantaged and homeless people that provides access to primary health care. Staffed by GP’s and nurses, the service provides over 2000 consultations annually. Over 20% of patients visiting the Freo Street Doctor identify as homeless and nearly 45% of patients self-identify as Aboriginal and/or Torres Strait Islander. As well as health information, patients to the mobile clinic can receive treatments including immunisations, cervical smears and specialist referrals. The Cancer Awareness Roadshow in the UK does not provide any such treatments or diagnoses, so I found it interesting that this service was able to work with local GP’s in order to provide an alternative source of health care for these groups.

The Freo Street Doctor, Fremantle, Western Australia
The relatively few encounters I have of Roadshow-related programs, shows that this kind of delivery may be more unique to the UK where the density and diversity of the population, in addition to the ease of getting from A to B, allows for higher levels of face-to-face engagement when using a Roadshow format.

REGIONALLY BASED STAFF AND COMMUNITY LINKS

Local knowledge and understanding can allow organisations to tap into the needs of a community, in order to make information and services most relevant and accessible to the people in the area. Being based locally means you can act on new opportunities that arise e.g. speaking at an event. And, through building and maintaining relationships with other health workers in the community, you may be able to partner on health initiatives that allow you to reach new audiences. In any case, the key is to have health staff or representatives based at a local level.

The Education Services team at Cancer Council Western Australia (CCWA) includes six Regional Education Officers (REOs) who are each based in different parts of the state (at time of writing: Broome, Geraldton, Midland, Bunbury, Albany and Kalgoorlie). All have health backgrounds, mostly in nursing or nutrition. The REOs each work with local stakeholders and agencies to promote healthy lifestyle choices and to improve early detection in their areas. They will also work to promote CCWA state-wide initiatives in their region. For Example, the Find Cancer Early campaign relied on the REOs to display campaign resources in community settings e.g. posters in public toilets, organise local forums for the public to learn about the campaign, and create local media opportunities by recruiting people to share their story.

I took part in the REO's monthly teleconference as part of my visit. Activities recently delivered included: healthy eating talks and cooking classes for parents at childcare centres and migrant centres, working with local Aboriginal health workers to deliver smoking cessation talks, delivering a skin cancer prevention presentation to pharmacy staff, promoting an upcoming visit from the BreastScreen WA mammogram unit, speaking to schools about becoming SunSmart accredited, and attending cross-organisational forums. It is reasonable for approaches in each region to vary, given the differences in local demographic and availability of stakeholder networks. The Pilbarra region for example has a large transient mining community which presents certain challenges for engagement. The Kimberley region and Kalgoorlie have large Aboriginal populations, and the Great Southern includes towns with diverse migrant groups as well as a high number of retirees. But it's obviously important that all activities are aligned with organisational priorities. As such, the REOs will complete a monthly reporting template that provides feedback on the community events they have delivered/supported.

The REOs are in a great position to work closely with public health staff working in the local area so that efforts can be combined where possible. My visit to the Great Southern region of WA where I met REO Libby Foster, included meetings with staff from local leisure centres, sport clubs, and community centres which gave me a sense of the kinds of networks Libby is in contact with and the events she will be invited to share cancer awareness information. Most useful, was a meeting with the Great Southern Population Health Network - a forum for discussing upcoming health promotion events and campaigns happening in the local area. The meeting included representatives from sexual health projects, the local Aboriginal health service, mental health service, and healthy schools coordinators. I believe everyone left with very full calendars of events and learned of many new opportunities for promoting their work to target audiences in the region.
I was fortunate enough to be part of similar forums of representatives and whilst in Perth with the CCWA, I met the Aboriginal Womens Reference Group. Facilitated by Leanne Pilkington, the Indigenous Programme Officer from BreastScreen WA, the Group aims to improve screening rates among Aboriginal women for both breast and cervical cancer. Members include the Aboriginal Programme Officer from the WA Cervical Cancer Prevention Programme (WACCPP), staff from local Aboriginal health services and women's cancer support groups. Meeting quarterly either face-to-face or via teleconference, they work together to improve communication between screening programmes and Aboriginal communities across the state. I also attended the Smokefree forum for Wellington and Waiarapa with staff from the Wellington Division of the New Zealand Cancer Society. Again, this was a good example of networking and sharing ideas between representatives from various organisations, including the Heart Foundation NZ, QUIT, the Health Promotion Agency and Otago University.

At the Cancer Council New South Wales, Community Programme Coordinators based across the state are responsible for building relations with community groups such as schools, Aboriginal organisations, local businesses and councils, in order to identify needs for cancer education and support. It's essentially a meet-and-greet role whereby coordinators will ask community representatives how the CCNSW can help the people in their area, and will look to address the need either by delivering an existing CCNSW health program if the fit is right (or a slightly adapted version), or developing a new activity. An example is in the Laperouse suburb of Sydney, where, having met with Aboriginal elders and arranged workshops to discuss how cancer has affected local families, the CCNSW supported the community to set up an fruit and veg co-op to provide discounted groceries. The programme was run by local Aboriginal men who would pack up the produce and deliver to families. However, capacity is a problem and CCNSW can't set up new activities for every community in the state. As such, they focus on building resource and understanding within those communities in order to give them the ability to set up activities themselves, or to advocate on issues that affect them. I asked whether encouraging communities to adopt their own cancer awareness activities rather than rolling out core programs, led to a move away from organisational priorities. While this strategy does mean that several different activities may be happening across the state at any one time, each proposal will be reviewed on a case by case basis to ensure they are in line with wider objectives, and successful activities can then be replicated in other areas which is less resource intensive for the CCNSW team to manage.

I think these examples demonstrate the fundamental importance of both understanding a community's needs in order to make the best approach, and having a presence in the area in order to build trust from locals and knowledge of opportunities for effectively engaging them with cancer information.

VOLUNTEERING

As mentioned in the Aims and Objectives, using volunteers to support programs to share health information locally, is an area of interest for me having been involved in starting a health volunteering pilot for the Cancer Awareness Roadshow in 2012. I was particularly keen to question organisations working with volunteers, whether they were concerned about any reputational risks that could result from involving non-professional staff in health promotion activities, and how they were managing this risk.

A large area where volunteers appeared particularly invaluable, was around advocacy. While this falls slightly outside of my fellowship remit, it is worth mentioning the fantastic work being done by a large number of volunteers to help influence the public health agenda in both Australia and New Zealand. For example, my visit to New South Wales in 2012 came shortly after the Government had announced a move to establishing Smokefree outdoor areas for parks, sports venues and outside dining establishments. The Cancer Council NSW largely accredited this achievement to their networks of volunteer advocates across the state who kicked things off by lobbying their local politicians. Similarly, the health promotion agenda at the Auckland Cancer Society involved recruiting and training volunteers to campaign on tobacco control issues such as plain packaging and Smokefree public spaces. In March 2013 (whilst writing this report!), the New Zealand Government announced that they would be introducing plain packaging laws in 2014.

Moving back onto health community engagement activities, I discovered a number of examples where volunteers were helping to both share and sustain the provision of health information in local communities. However, the prevalence of volunteer involvement for health purposes certainly varied, and I felt there was a higher abundance of volunteer-led projects in urban areas such as Sydney and Auckland, as opposed to areas with a wider rural spread, such as Western Australia and the South Island of New Zealand. The volunteer strategy at Cancer Council NSW has led to them working with around 18,000 volunteers.
Volunteers are also heavily involved in Cancer Council NSW initiatives aimed at improving awareness of skin cancer prevention and keeping a healthy diet. In 2012, CCNSW had a target to increase the proportion of SunSmart accredited primary schools in the state to 40% (from 15%). Previous evaluation had shown that engaging directly with school principals was the best way to encourage participation, but this would prove tricky to achieve with over 2500 schools in the state. To combat this problem, the SunSmart ‘blitz’ saw regional staff and the SunSmart team recruit and train local volunteers to visit and contact local schools as a way of influencing decision-makers. An online toolkit was developed to help volunteers which included lists of unaccredited schools to target and pre-written presentations about how to be SunSmart. Volunteers would typically stay on for about 10 weeks and visit up to 30 schools in that time. It proved to be a successful way of engaging with schools, with the proportion of accreditations jumping to 46% in 2012. The face-to-face communication provided by the volunteers was highlighted as a key success factor, with many schools pleased with the commitment demonstrated by the volunteers to beating cancer in their community.

Cancer Council NSW developed the Eat it to Beat it program to increase the consumption of fruit and vegetables among parents with primary school-aged children (5-12). The program was piloted in the Hunter region of NSW between 2008 and 2011 and is now being rolled out in other parts of the state. A component of the program called Fruit and Veg Sense saw community peer educators deliver short education sessions for local parents. Peer educators included health and welfare professionals, dietetic students, and also lay volunteers from the community. After an initial interview and agreeing to commit to delivering at least one session within the first two months of training, the volunteers would then attend a five hour training session. Following that, they would be invited back to do a competency assessment which involved presenting a portion of the Fruit and Veg Sense presentation to other trainees who would give feedback. After successful training, CCNSW would put the peer educators in touch with schools who had expressed interest in the program, to arrange a session. The sessions themselves would cover things like: what is a serving assessing current fruit and veg intake, menu planning and budgeting tips. The focus of these sessions was on improving health and diet, as opposed to cancer. At the end of each session the peer educators would complete a self-assessment form which asks things like ‘did you explain what an adequate size fruit portion is?’. These questions correlated to the feedback surveys that the parents complete, allowing CCNSW to spot any irregularities in the session delivery. During the pilot, 128 peer educators were trained, who then went on to deliver 100 free Fruit and Veg Sense sessions in schools. In addition, 35 “taster” talks of 25 mins were provided to parents at school assemblies and Transition to School events (held at nurseries), reaching more than 1,000 parents. Pre and post evaluation showed that the Fruit & Veg Sense intervention did help to increase fruit and veg servings by half a portion a day (compared to control group). While this might be a demonstration of the successful use of peer educators to help deliver a community intervention, sustaining the interest of the 128 trained educators did prove challenging with only 12 of these remaining active educators today. Moving forward, the program will focus efforts on recruiting a small number of high quality volunteers in each region.

Another key role is being played by community volunteers in New South Wales, by staffing the Cancer Information Centres within hospitals. Open Monday-Friday 9am-5pm, volunteers will cover different shifts throughout the week which is organised by the Volunteer Coordinator for that region. The volunteers are there to listen and signpost people to the information they want. As part of their training they sign an agreement to say they will not give any direct advice. I met a volunteer named Jim from the Cancer Information Centre at the Mater Hospital in Newcastle, NSW. I asked Jim what one thing he tries to get across to people who come into the Information Centre, but he rightly pointed out that it’s not up to him to push information, it depends entirely on what the visitor wants. Jim would provide leaflets, look up things on the CCNSW website for people, and give out the Cancer Information helpline number. The CCNSW are currently looking to extend the role of some volunteers to set up temporary Cancer Information Centres in local pharmacies for a couple of days a week.
The Wellington Division of the Cancer Society New Zealand, also showed how lay members of the community are being involved in efforts to promote cancer risk reduction and early detection. Similarly to CCNSW, Wellington volunteers take on a number of roles from driving people to GP appointments, to helping newly diagnosed cancer patients to orientate themselves around the local hospital. They are also being used to support a mens health project. Get the Tools is a website set up by the Cancer Society and Mental Health Foundation of NZ, to provide health and well-being information and support for Kiwi men: www.getthetools.org.nz

Through one of its corporate supporters (Mitre 10, a hardware store chain), a workplace cancer awareness scheme was set up where volunteers from the company could be trained as Get the Tools facilitators, and deliver a 30 minute presentation to colleagues over lunch about mens health. The main function of volunteers was to signpost male colleagues to the Get the Tools website. The program coordinator, Steve Kenny, is now looking to extend this model to train community champions as Get the Tools facilitators also. Volunteers will be recruited who already have good community links e.g. local sports team captains, and the main requirement will be that they are passionate about mens health. A one day training session for volunteers would be delivered by health professionals and CSNZ staff which would include scenario based discussions (based on actual events), presentation skills, guidance on dealing with difficult questions, and an introduction to the resources available on the Get the Tools website. Once trained, volunteers will buddy-up with local CSNZ staff or more experienced volunteers, in order to get used to delivering the presentations in public. Volunteers will then be responsible for finding opportunities in their local community to deliver talks to target audiences e.g. Rotary Clubs.

It's fair to recognise that working with volunteers can require a certain level of planning and monitoring which can be very time consuming unless you have dedicated staff resource. For this reason, it's of no real surprise that I didn't observe a consistent use of volunteers across all my fellowship meetings. But, there are benefits when you consider the additional reach that volunteers can provide, particularly when you have networks of 18,000+. It was widely acknowledged that it's fair to consider a degree of reputational risk when using volunteers to share health information, especially if they don't have any prior professional experience in this area. The main feedback I received around this was to acknowledge the level of risk you're willing to accept as part of the volunteer process, and manage this by recruiting the right people and putting stringent training in place.

**EDUCATING LOCAL HEALTH WORKERS**

While having regionally based staff can help organisations to fulfil local opportunities which can generate engagement with target audiences, it may not be possible to sustain these efforts if, for example, requests become too plentiful, or staff move on. Training others in the area to be able to share information about cancer prevention and early detection, can help increase reach, and create a larger ‘pool’ of contacts to support health engagement activities. I've highlighted above how capacity and local understanding can be increased by training volunteers, but I also came across many examples where people who already work in a health promotion capacity, are being up-skilled in order to discuss cancer more readily as part of their existing roles. This is a particularly interesting area given that Cancer Research UK started a training
programme for community-based health workers called *Talk Cancer*, which aims to equip staff with the knowledge, skills and confidence to talk to people about cancer within their day-to-day roles. *Talk Cancer* attendees have so far included health trainers, smoking cessation advisors, healthy lifestyle coordinators, pharmacists and nurses. An area of growth for this programme, is to look at ways in which the workshops can be adapted for different audiences so that they are professionally and culturally relevant.

Whilst in the Great Southern with Libby Foster, REO for Cancer Council WA, I was able to sit in on a short training session about skin cancer prevention for local staff at the Chemmart pharmacy, Albany. Training pharmacy staff is an interesting strategic area given the access that pharmacists have to people within the community, and the tendency of some to speak to pharmacists instead of/prior to consulting a doctor. By up skilling pharmacists, they can be more confident and accurate when talking to customers about cancer prevention, detection and screening. Libby has spent time contacting pharmacies in her region to arrange short presentations (typically about an hour in the evening, just after closing hours) covering a range of topics including smoking cessation, *Find Cancer Early* (part of a larger CCWA campaign), and skin cancer prevention. For the session I attended, 12 pharmacy staff were present which included trained pharmacist and counter staff. I questioned whether the training was meant for non-professional staff – the approach was to give consistent information to all attendees, but to leave the pharmacy manager to decide on the level of detail that non-professional staff could go into with customers before referring on. The one hour session included a short presentation, interactive quizzes, handing out information packs and pre and post surveys. CCWA resources were also provided for the pharmacy to display, and Libby would come back in 6-8 weeks to do a follow up evaluation. The training appeared to be well received by all staff and a number of questions were asked around the need for vitamin D supplements and the meaning of UV index, which apparently were typical questions asked by pharmacy customers. The fact that pharmacy staff who hadn't been working that day actually came in that evening for the training, shows a commitment to providing customers with accurate information. Post evaluation of the smoking cessation presentations (six weeks after) has shown an increase in the confidence of pharmacy staff to discuss smoking and cancer with customers.

By offering training programmes that are accredited to provide trainees with CPD points (Continued Professional Development), this can provide an extra incentive for attendance. The Wellington Division of the Cancer Society have been running Cancer Update Sessions for 12 years. These information events are held over one week of the year, each time focussing on a different cancer topic and involving a variety of forums and speakers. The most recent event in 2012 focussed on cancer prevention, while previous events have included topics such as survivorship, supportive care and site specific cancers. The events target health professionals (GP’s, practise nurses) and community health workers to equip them with up to date information to use in their roles, but there are also components that allow the public to hear from cancer experts. The format includes a series of public seminars held for local clinicians within the Wellington area, a professional education seminar led by an expert speaker (the session in 2012 had 95 health professionals attend), as well as a short workshop for Cancer Society volunteers and the public (in 2012 this session was called *meet the practitioner*). The professional education seminar component is normally held on a Saturday.
and carries CPD accreditation. There is a cost of $80 to attend the education seminar, but everything else is free. The events normally receive local corporate sponsorship. Survey feedback from attendees has been positive year-on-year.

In Perth too, Cancer Council WA offer a variety of educational opportunities to GPs, practice nurses and other health workers which includes on and offline CPD accredited training modules (two members of CCWA staff have been on courses to become CPD accredited trainers), occupational resources such as GP decision making cards for treatment options, and training seminars. Seminars are held over a day and include several guest speakers. Similar to the Cancer Society events described above, each seminar has a different area of focus which means several attendees come to multiple events. BreastScreen WA have also run four accredited primary care training sessions over the last eight years, which have involved speakers from breast cancer support services, as well as oncologists, radiologists, and survivors. Stories from survivors are particularly well received.

The WA Cancer and Palliative Care Network, part of the Department of Health, has a state-wide team of 26 nurse coordinators who, in 2012, ran over 220 training sessions for health workers about cancer patient care. These sessions were marketed with support from the Regional Education Officers at the Cancer Council WA. The Network also arranges for Health Professionals from Perth, which is the main provider of oncology services in WA, to visit their counterparts in other parts of the state where they can learn about the challenges for primary care in rural areas, and share their own experiences.

The lifestyle risk factors for cancer also contribute to the risk of developing type 2 diabetes, as such, health engagement efforts for both diseases can be coordinated. For this reason, I also spent some time with Diabetes WA and found out about their work engaging Aboriginal health workers using ‘Felt Man’ – a large visual display of the body with felt organs used to demonstrate the causes and effects of diabetes. Diabetes WA trainers will use it when training health workers, and will leave with them afterwards (for free) so that health workers can also run their own educational sessions in their communities. Evaluation follow-up has shown a positive reaction to using this resource. Having training Aboriginal educators present in communities has also helped to increase the number of Aboriginal people who have registered with the NDSS in these areas (the National Diabetes Service Scheme, which provides diabetes-related products at subsidised prices and provides information and support services to people with diabetes). However, a key challenge is the high turnover of health staff in rural areas.

Sharing knowledge and experience with people who are already working with key groups in a health capacity, can help to ensure that the provision of cancer information is as accurate as possible. If step one is to train health workers to share cancer information with the public as part of their existing roles, step two is to equip such health workers to deliver their own training sessions to both the public, and their peers. This provides a further solution to increasing capacity and sustainability of information provision within a community, but does require time investment to set-up, monitor and evaluate.

CULTURALLY RELEVANT TRAINING AND PROGRAMME DEVELOPMENT

At Cancer Research UK, the Cancer Awareness Roadshow and Talk Cancer trainers are often invited into culturally diverse settings. Targeting approaches to fit these settings, is something we are often asked about. While this may not always be viable within certain resource constraints, information about cancer prevention and early detection can be made more engaging when cultural beliefs and values are acknowledged as part of the delivery.

I was really interested in a programme developed by the Cancer Society of New Zealand which is not only a good example of train-the-trainer, but also a good demonstration of the importance of involving ‘consumers’ in planning stages in order to make the content and delivery as relevant as possible to their needs.

*Kia Ora e ti Iwi* is delivered by and for Māori as an adapted version of an established cancer support programme called Living Well. Living Well was set up by the Cancer Council Victoria, Australia, for those coping with cancer, those who have completed their cancer treatment, and their partners, family, or friends. It aimed to increase knowledge and understanding of cancer and its treatment, encourage discussion of common concerns and coping mechanisms. It is a free programme run by specially trained programme facilitators and is usually conducted in small groups for two hours/week over six weeks. However, while the programme had been adopted in New Zealand, Māori were not attending. One criticism was that while
**Living Well** was intended for families of cancer patients also, Māori have much wider families, or 'whanau', so getting them all to come for six consecutive sessions wasn't feasible. Certain cultural activities were also missing, for example, including prayer and song at the beginning of training sessions, and providing a meal (sharing food is considered important for sharing thought). A Māori Advisor on the **Living Well** working group, advised that the programme model was sound, but with some changes to content, delivery and resources, Māori would benefit from attending. So after an update, a pilot programme for Māori was set up in 2010 at a Marae (Māori community meeting place) in Kokiri, Wellington, and delivered by trained Māori facilitators. The pilot still consisted of weekly session of two hours over six weeks. Participants were those currently living with cancer or extended whanau who had experienced cancer in their life, and some Māori health workers.

Evaluation of the pilot (focus groups with attendees and facilitators, and post-session surveys), showed that participants found the sessions informative and helpful. Attendees learned how to access cancer information and questions to ask the doctor, they liked the homely atmosphere of the sessions and felt that being with other Māori in the Marae meant they could share stories comfortably. Some reported that the experience was uplifting and healing, having never before had the opportunity to talk openly about cancer. Facilitators fed back on the importance of using Māori trainers and 'Te reo' (Māori language), where possible. Following a further review of the content and language of the programme, Māori health providers around New Zealand were then given the opportunity to submit an expression of interest to run a pilot programme themselves. Three providers were selected in Whangarei, New Plymouth and Palmerston North, and each sent 2-3 facilitators for training in Wellington. The trained facilitators then went on to deliver their own training sessions to 27 people across these three areas, and received similar positive feedback to the Kokiri pilot. At this point, the programme was renamed **Kia Ora e te iwi**.

I was told that there are very few training programmes specifically for Māori health workers in New Zealand. As a result, the CSNZ have been overwhelmed with applications to take part in **Kia Ora e te iwi** facilitator training. There are currently 50 trained **Kia Ora e te iwi** facilitators across the country. The contacts I met in Hamilton and Palmerston North as part of my fellowship, were both trained facilitators themselves, and remarked on what a fantastic programme it is. Facilitators come from District Health Boards, Māori health providers and screening programmes. They tend to be community nurses, case workers, cancer support coordinators and other health workers. The main requirement is that they are Māori and work with people affected by cancer. Facilitator training is now led by one of the original facilitators from the pilot – CSNZ feel it's important to have the training carried out by someone with facilitation experience and a knowledge of cancer, moreso than it needing to be a qualified health professional.

Of the 50 trained facilitators, 12 have delivered sessions in their areas, but only two of them followed the six sessions/week format - the rest have done one day sessions. CSNZ allow facilitators to deliver the programme in whatever way fits their local community, and guidelines on programme modification have been developed to assist. For example, one facilitator held a session in a cemetery where they discussed Māori ancestors who they had lost their lives to cancer and how this may have been prevented through lifestyle changes. While facilitators may miss out sections of the programme content, supporting resources such as DVDs have been developed to ensure that everyone goes home with the correct information. The reach of information spread is certainly impressive, with people reportedly sharing what they learn from the sessions with up to 150 of their whanau. It is clear this is a popular programme that is building capacity in Māori communities to share information about cancer.

One of the things that prompted me to contact the Cancer Council Western Australia, was hearing about a cancer education scheme for Aboriginal Health Workers in WA, set up by Dr Emma Croager. Following an external review that identified a need to increase knowledge of cancer and cancer services amongst Aboriginal health professionals in WA, the CCWA developed a week-long course that included presentations, interactive sessions and visits to local cancer treatment centres. The overall aim was to increase knowledge and awareness of the resources and services available to support Aboriginal people affected by cancer. Where possible, the course content was delivered by Aboriginal speakers and the content was designed to be culturally relevant, acknowledging areas such as traditional bush medicine, and customs such as *mens and womens business* (where women/men are excluded from discussing certain issues with each other). The course pilot evaluated well showing a significant increase in participants' knowledge in areas such as cancer treatment and screening. However, more needed to be done in order to sustain knowledge, which highlighted the need for continued training. Between 2008-2011, 73 Aboriginal Health Professionals attended courses, including GPs, nurses and Aboriginal Liaison Officers. It is free for attendees – course funding comes from Cancer Council WA and the WA Cancer and Palliative care Network. I met some Aboriginal Health workers as part of the Aboriginal Women’s Reference group who had attended the course – they said it had been very beneficial to their roles, especially being able to visit their local treatment
centres. The CCWA ran a further two courses in 2012 and there continues to be a high demand for places.

The Aboriginal Health Promotion team at Diabetes WA have developed a number of programmes aimed at Aboriginal children. Firstly, the Desert feet tour project was created in 2008 to provide educational music workshops and concerts throughout the Kimberley and Pilbara regions of Western Australia. The project targets Aboriginal children and young people (aged 4-14) in rural and remote communities where risk of type 2 diabetes is higher, using music to inspire them to stay in school and pursue their dreams. As part of the music workshops, the Desert feet crew assist local children to write, perform and record songs that relay healthy messages. The project is funded by the Office for Aboriginal and Torres Strait Islander Health, and is still touring communities. Another project, Strong Culture: A Road to Good Health aims to support Aboriginal teachers and community health workers to engage Aboriginal school-children in diabetes prevention by using local knowledge and traditions to motivate students. Trialled in the town of Northam, just outside Perth it started with two Aboriginal elders who wanted to use their Aboriginal knowledge and practices, especially around bush tucker, as a foundation for discussing healthy eating with younger generations. Diabetes WA worked with them to implement this, and supported the elders to deliver training over a six week period. By observing and participating in cultural experiences, students were encouraged to make informed choices about their health. Following this pilot, Diabetes WA developed a training manual and DVD that demonstrated the process used in Northam, so that staff in other communities could set-up similar projects. The manual is split into six modules, each of which include activity ideas for bringing healthy lifestyle messages to life through art, dance and sport. Overall, the program is designed to meet the needs of Aboriginal students by drawing on knowledge and recommendations of their elders and their community. Elders set the direction of the project, but it is the inclusion of the extended community that make this program authentic and motivating for students.

The Cancer Council New South Wales are currently leading the Aboriginal Patterns of Cancer Care (APOCC) study, the largest study to date of cancer care for Australian Aboriginal people. The CCNSW is working with Aboriginal communities to identify factors affecting the diagnosis and treatment of cancer for Aboriginal people, and to find appropriate avenues for improvement in their cancer care. Findings so far typically show that Aboriginal people want more education on cancer, particularly for their children, and for Aboriginal beliefs to be appreciated by healthcare staff in hospitals.

Developing tailor made programmes for different groups and communities may not always be possible, but understanding local values and factoring in the interests of such communities, can help to build trust and recognition.

Me with Rangimahora Reddy and a service user from the Rauawaawa Kaumātua Charitable Trust, a Māori Health Service for people aged 55+. Hamilton, New Zealand
WORKING WITH OTHER COMMUNITY-BASED ORGANISATIONS

In addition to schemes that up-skill health workers who already come into contact with people in need of cancer information, there also appear to be opportunities for working with other types of staff who have access to people who are most at risk of developing or dying from cancer. In particular, social workers, drug and alcohol counsellors, employment officers and mental health workers. It is often very challenging to reach these groups and to make cancer prevention information a priority, as such, why not work with organisations who already work in these areas as a way of being able to share cancer information with people who are unlikely to seek information themselves.

This idea is being adopted by the Cancer Council New South Wales. As an extension of Eat it to Beat it, a pilot nutrition scheme was set up in a deprived part of Western Sydney in partnership with Brighter Futures - a government funded early intervention service for children, and their families. CCNSW developed a short Eat it to Beat it training session which was delivered at 14 Brighter Futures’ parenting workshops. Unlike the main Eat it to Beat it program which uses volunteer facilitators to deliver training to parents, these sessions were delivered by trained dieticians and CCNSW staff as it was felt the environment and disengaged audience may prove too challenging for volunteers. Evaluation of the sessions showed that the attending parents enjoying the light-hearted nature of the information, and Brighter Futures appreciated the input from CCNSW staff. Despite their challenging circumstances, the attendees found the overall message about eating healthily to be very positive, especially as it focussed on improving the lives of their children.

Moving forward, it would be ideal for CCNSW to be able to train Bright Futures case workers to share nutrition information themselves, as they come into contact with people who may need this information every day. However, this is proving quite challenging given the demand on the case workers’ time, and they prefer to have someone from the CCNSW there as an expert voice on the subject. It may be an idea that is revisited. Perhaps by stripping back the messages and making them easier to learn and share, this could encourage more case workers to take on the role of educating their clients about lifestyle and cancer.

Both the Cancer Council NSW and WA, have tobacco programmes aimed at educating health workers and other community-based workers with the skills needed to lead brief smoking cessation interventions. In NSW, Tackling Tobacco, partners with social and community service organisations to encourage case workers to talk to their clients about stopping smoking. These organisations include mental health services, alcohol support services, job training centres and homeless shelters – typically services who are able to see groups/individuals on a regular basis so they can continually support people’s efforts to quit smoking. Specific activities delivered by CCNSW staff, include: presentations about the links between smoking and cancer, free one-day training courses to enable case workers to support their clients to quit smoking, and financial support to help organisations to run their own smoking-cessation projects. The one day training sessions cover the problems caused by smoking to health as well as financially and socially, guidance on how to talk about it with clients, signposting information and resources. Over 1,000 case workers have taken part so far, and evaluation shows that confidence on talking about the effects of smoking, increases amongst training participants. An important part of the training is to de-normalise smoking in settings e.g. reminding case workers not to smoke themselves around their clients which can become part of their regular meetings. I asked the Tackling Tobacco team how they approached these organisation and encouraged them to make smoking cessation a priority in the first place – simple answer, providing financial support! Small grants of around $250 can help attract attention and remove possible barriers e.g. the cost of sending case workers to a training session can be covered. Demonstrating the relevance of tobacco training within their roles, and providing statistics for smoking in their area and the impact, can also help. The Fresh Start program at Cancer Council WA, also includes training options for community-based workers to be equipped with the skills to for providing smoking cessation advice to their clients, as well as more in-depth two-day training options that allow community staff to be trained up as Fresh Start facilitators themselves.

The Wellington Division of the New Zealand Cancer Society have an Understanding Cancer program to up-skill Māori health workers with information about what is cancer, commons myths, and lifestyle and cancer. Recently, other community-based workers have been invited to attend the training also, after discussing the need with the department for Health and Social services. This training is two-fold – education for the case workers themselves, and giving them the skills and confidence to share information with their clients too. Trainees are also given information about health services to signpost their clients too. Around 20 community workers have been trained so far.

New Zealand began a pilot bowel screening program in 2011. The pilot is being run by Waitemata District Health Board in Auckland, as part of a four year test to see whether bowel screening should be introduced throughout New Zealand (as it has been in the UK, and Australia). This is the first invitation-based screening
program in New Zealand, as such education has been required to make those who are eligible aware of the service in the Waitemata area, particularly in the case of Māori, Pacific Islanders and Asian people who have a higher mortality rate from bowel cancer. The Community Awareness Coordinator for the pilot has targeted education sessions at these groups, but also does a lot of presentations to people who work with the eligible bowel screening age group (50–74) e.g. Age Concern staff and support groups for Parkinson’s.

Finally, the Canterbury Division of the New Zealand Cancer Society have a strategy to influence the local environment following the Christchurch earthquake in 2011, and are currently speaking to the local council about the inclusion of SunSmart spaces and smokefree areas as part of the city’s rebuild.

Because cancer affects so many people, it makes sense to work closely with organisations who are able to access groups and communities where the cancer inequalities gap is widest, so we can therefore make the largest impact in the battle to reduce cancer incidence and increase the chances of survival through early detection.

PROVIDING GRANTS

It struck me as an odd concept at first – the idea of a charity or not-for-profit organisation paying other organisations or offering financial incentives to set-up and deliver activities aimed at reducing cancer risk and increasing early diagnosis. Why would these groups/organisations not be paying a knowledgeable cancer charity to do this for them? The simple answer it seems, is that the lists of priorities for other organisations and people working in the community, is often so long that they may need financial support and encouragement to raise cancer up the agenda. I heard of several projects during my fellowship whereby small grants were being used as a way of encouraging cancer awareness strategies in the community.

For the Kia Ora e ti iwi program described previously, the Cancer Society of New Zealand have made a small budget available to support those interested in becoming facilitators to attend training, and to also help them to go on and deliver their own sessions afterwards. Grants of up to $4000 can be used to pay for their transport and other costs for attending training, or to cover costs associated with holding their own Kia Ora e ti iwi sessions afterwards e.g. catering, room hire. Most sessions cost less to deliver, especially as Marae tend to offer the space for free, and some facilitators are able to deliver programmes within their existing work time, whereas others do it out of hours and require overtime. The grants are given up front and the facilitator should send back a report after the sessions are complete to explain how the money was used. While there is a certain level of risk with giving the money up-front, the regional CSNZ divisions have a good idea of what is going on locally, so if they know a grant is not being used, they ask for it back. The main aim of offering this financial support is to circumvent the risk of facilitators failing to deliver any sessions of their own, after the CSNZ invests time in training them. The Kia Ora e ti iwi program manager believes that many of the facilitators who have successfully delivered their own sessions, may not have done so without this financial support.

The Cancer Smart team at Cancer Council Western Australia, have recently trialled a Bowel Cancer Community Education Grants programme. Now that the Bowel screening programme in Australia has been extended to include people aged 60 (as well as those aged 50, 55 and 65), the CCWA were looking for new ways to raise awareness of bowel cancer and the importance of taking up screening if eligible. The Bowel Cancer Education Grants were set-up to provide community groups with small grants of $150 to assist them to hold a bowel cancer education event. The events aim to provide community members with information about bowel cancer prevention, identification of symptoms, screening and treatment. The grants can be used by community groups with members who are over 50 years of age, Aboriginal and Torres Strait Islander groups, culturally and linguistically diverse groups and health agencies. In 2011, 27 grants were applied for out of 1000 invitations. Those who applied for the grants could use the money to pay for catering (which had to be healthy as per CCWA guidelines, no alcohol), venue hire or fun activities e.g. inviting along a fitness instructor to run an exercise class after the education session. Where possible a CCWA speaker would attend the events, but all grant recipients were sent a pre-written CCWA presentation, resources and DVD's to support the information delivery. Grants were only made available to the group after they held their event – to receive the cheque, a completed feedback form had to be sent to CCWA, along with a tax receipt of costs. The program is currently under view following a poor uptake of grant invitations in 2012. Current thoughts are that the size of the grant may not be a big enough incentive for community groups.
The Western Australia Cervical Cancer Prevention Program, also offer funds of up to $10K to community health services to enable them to run initiatives. For example, an Aboriginal health service in the town of Newman in the Pilbara region of WA, received a grant to run an awareness campaign fronted by a local Aboriginal celebrity. They saw an increase in the uptake of cervical smears during cervical cancer awareness month, compared to same period in previous year.

Possibly the most intriguing use of grants, is in New South Wales where the Cancer Council NSW are offering grants to local councils as part of their efforts to create 'cancer smart communities' across the state. The CCNSW Alive and Well scheme aims to encourage local councils to develop and implement initiatives to help reduce the impact of cancer in their community. Grants from the CCNSW serve as incentives to get the councils thinking about the need for cancer prevention in their area. It also provides a platform for the CCNSW to build relationships with councils, as well as allowing the councils to benefit from the knowledge and expertise of CCNSW. Successful grant applications from councils must be for activities that target: tobacco use, healthy eating and exercise, sun protection, or improving access to health services. In 2011/12, 40 councils applied for grants (out of 152 in NSW), and seven councils were selected based on the potential impact their initiatives would make for cancer prevention and support in their areas. A total of $100K was provided to these seven councils, with individual amounts ranging from $5-20K. Grants were used for a range of activities, including:

- **Auburn City Council** - Awarded a $13,002 grant to undertake an initiative focused on reducing tobacco-related harm across the community, with a particular focus on culturally and linguistically diverse backgrounds, including Chinese and Arabic speaking communities. The initiative included implementing a smokefree policy, quit smoking workshops and community worker training.

- **Bombala Council** - Awarded a $6,180 grant to undertake an initiative focused on supporting healthy eating and active living across the community. The initiative included setting up a community garden, installing a sun shelter and holding a healthy community event.

- **Kiama Municipal Council** - Awarded a $14,000 grant to undertake an initiative focussed on improving sun protection across the community. The initiative included education and awareness raising activities about skin cancer prevention, with a particular focus on council employees, community gardeners and sporting clubs.

- **Hawkesbury City Council** - Awarded a $20,000 grant to undertake an initiative focused on improving access to health services by expanding Peppercorn Community Transport. The initiative included developing a volunteer driver program to increase community transport services for cancer patients.

Following the use of the grants, each council must submit their own evaluation report (CCNSW provide a list of points to consider in writing their evaluation). There's a moderate risk that councils might not do exactly as they say they will do with their grants, or the activity may end up costing less than the grant total, in which case the report should explain why. It took a while to receive the reports for the 2011/12 program, but they have provided some great case studies and demonstrable examples of what can be achieved when working together with councils. Evaluation has however, highlighted the need for CCNSW to be more involved in the development of the councils’ activities. Moving forward, CCNSW are looking at how they can better influence the use of the grants so that council initiatives can link in with CCNSW organisational objectives. For instance, for grants that focus on sun protection activities, the CCNSW will look to advise on the current priorities for sun protection in NSW, and how to target the messages appropriately. In any case, a positive result from the program has been the creation of good relationships with councils, which in the long term may assist the CCNSW to become more involved in consultation issues and decisions to help improve the health and wellbeing of people in these areas.

I was certainly surprised at the prominence of grants-based activities I encountered during my fellowship. But, I can see how this approach can serve to attract the attention of key partners in the fight to reduce cancer incidence and increase survival i.e. organisations who have access to inequality groups, and councils who make the decisions for the local area. If a charity supporter were to ever question this use of money, I believe the relatively small amounts combined with the impact that the activities could have, will make for a justifiable expense.
EVERYONE GETTING OUT AND ABOUT

Finally, it may sound obvious, but the simple act of getting out into the community as often as possible, is a great way to increase the reach of information about cancer, as well as engagement with what you can offer as an organisation.

The Cancer Council WA expect all staff to be able to deliver short talks in the community about cancer in general, prevention, screening and early detection, common cancers affecting men and women, what can be done to reduce the risk of cancer, and the work of the CCWA. Such talks are available to community groups, sporting clubs, childcare and parent groups and primary schools for free. A fee of $330 applies for workplaces, $110 for secondary schools and $220 for tertiary education institutions. Sessions vary from 30 mins-2hrs, and a minimum group of 15 is required. As part of their Find Cancer Early campaign, over 100 presentations were delivered by CCWA staff to more than 3,400 people.

Sometimes, using staff to deliver local talks is more preferable to using volunteers. Despite the additional capacity that volunteers can provide, their recruitment, training and management can be very time consuming. For this reason, organisations such as Diabetes WA also encourage their staff to respond to presentation requests. This includes ‘Yarn Up’ sessions for Aboriginal and Torres Strait Islander audiences within community settings. These sessions aim to increase knowledge and understanding of diabetes, and let the community know how to access resources and where to go for further information.

And the opinion from the team at BreastScreen WA is, ‘Every opportunity we get to have a presence at, we go to’.

Acting on opportunities to talk to target audiences about cancer prevention and early detection, should always be a priority. Availability of speakers and appropriateness of the settings need to be considered, but encouraging staff to go out into the community can help them stay connected to the importance of a cause.
4. Recommendations and Concluding Remarks

All in all, it was an incredibly busy five weeks and I feel I learned a lot - more than I could possibly write about in one document without it becoming very, very long! For this reason I hope that my fellowship contacts who read this report will forgive any omissions. What began as a mission to find out how Roadshows can be used to convey health information in other parts of the world, evolved into a wider appreciation of the diverse strategies being adopted by other not-for-profit organisations to help reduce the burden of cancer amongst those most at risk.

The Cancer Awareness Roadshow has changed a lot over the last seven years, but what has remained consistent is the focus on visiting the heart of communities and offering potentially life-saving information to those who need it most. Having seen the challenges posed by the geography of New Zealand and Australia in particular, I think that one of the elements that allows the Roadshow to be effective in the UK environment, is the ability to travel easily to a number densely populated areas where we can guarantee (most of the time!) that we will have a good level of exposure to our target audience. I think the unfortunate outcome of the Cancer Council New South Wales Roadshow, also showcases how important it is to employ locally-based Roadshow staff who can build a rapport with local audiences, and are best placed to understand the information needs and service availability in the area.

Whether an organisation has access to a Roadshow-type vehicle or not, it's vital to have a local staff presence, or good links with local representatives who can convey cancer information on your behalf. These individuals are best placed to speak to the public directly, and can put a face to your organisation which helps to increase trust and recognition of the commitment to reducing the impact of cancer in a community. Based on the observations from my fellowship, I believe this can be achieved, to a degree, by:

- Providing existing staff with a stronger remit to raise awareness of cancer prevention and early detection at a local level, by e.g. incorporating health promotion responsibilities into the role profiles of staff who already work locally, or making it mandatory for all staff to be involved in at least one community-based health activity throughout the year
- Building a pool of trained volunteers who can respond to local requests for cancer information, and help maintain relationships with local groups e.g. schools
- Training other professionals who are already community based and readily access key groups as part of their existing roles e.g. health workers, pharmacists and social care workers

Recruiting and training volunteers to support cancer awareness efforts was something I came across frequently during my fellowship, particularly in the larger cities I visited. There are some obvious challenges in getting volunteer programmes up and running successfully, but I am pleased that Cancer Research UK has already started to make steps in this direction and I am completely encouraged by the examples I have seen in Australia and New Zealand where volunteers have been involved in health activities. As I was told by Ditre Tamatea, General Manager for Māori health at Waikato DHB, New Zealand:

“There’s something powerful about ordinary people taking on the role of creating change in their community. Cultural shift won’t come from doctors, it comes from the community within”

Training other health workers to be more confident and knowledgeable when discussing cancer, is an area that Cancer Research UK's Talk Cancer programme is already addressing. Extending this programme to train other community-based staff, such as social workers and employment officers, could allow a greater level of access to target audiences, but incentives may need to be put in place to establish cancer prevention and early detection as a priority to discuss with clients. I think the examples of cancer charities in Australia and New Zealand who have used financial grants are particularly interesting, especially as a means of encouraging community workers to become training facilitators themselves after attending train-the-trainer courses.

Finally, the power of what can be achieved by starting small, should not be overlooked. For example, delivering a presentation about skin cancer prevention to a handful of pharmacy staff at a local pharmacy, could pave the way to a larger training opportunity with a pharmacy chain. Rather than trying to implement large education-based programmes straight away, why not approach local organisations or community settings, ask what they need and try something out - if the activity is successful it can be used to demonstrate what can be achieved in other areas, or on a larger scale with a bit more investment.

Overall, I feel that my fellowship experience has further justified the importance of face-to-face engagement strategies when working with hard-to-reach groups and communities, whether this is via Roadshows, or other means.
5. Acknowledgements

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6. References

Cancer Research UK – [www.cruk.org](http://www.cruk.org)
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