

Wise Up To Cancer Bradford

*Improving cancer prevention and early diagnosis
for South Asian women in Bradford.*



This report has been produced by the University of Bradford, June 24th 2019. Authored by the University project team: Nisa Almas, Dr Mel Cooper, Zaynab Nejadhamzeeigilani, Dr Daisy Payne, Professor Marcus Rattray, School of Pharmacy & Medical Sciences and Faculty of Health Studies, University of Bradford on behalf of the whole project team.

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2 Summary

Awareness of cancer signs and symptoms and attendance for breast, cervical and bowel screening is generally lower in women from black and minority ethnic (BAME) groups. BAME women face specific barriers to accessing cancer screening including the procedure, emotional and practical barriers and this project adapted a complex intervention, entitled 'Wise Up To Cancer' to use with South Asian women who are the majority BAME population in Bradford. The overall aim of the project was to increase the prevention and early diagnosis of cancer in South Asian women aged 25-74 in Bradford.

One arm of the intervention included two GP medical practices in Bradford (Avicenna and The Ridge) with lower than target screening rates who sent text messages and made phone calls in English or other languages to women who were overdue breast, cervical and bowel screening. Over a six-month period, 1,928 women received this intervention. From the GP intervention 403 women who were previously overdue a cancer screening (290 cervical, 32 breast, 81 bowel), completed their screening within the study period. Both GP practices experienced an increase in cervical screening with Avicenna having excellent increase in uptake of bowel screening, compared to the Ridge, but neither having major increases in breast screening uptake. As a result of the success, Avicenna have already made texts part of their cancer screening routine service.

Wise Up To Cancer consisted of a baseline questionnaire, delivered in community settings by trained Community Health Champions and Pharmacy Health Champions, who were mainly peers. These included 10 community pharmacies, schools, community and faith groups. The questionnaire stimulated a 'health chat' focusing on setting goals for a healthier lifestyle, recognising signs and symptoms of cancer and encourage attendance of cancer screening programmes.

Over a fourteen-month period, a total of 1,375 women were reached through the questionnaire intervention. The baseline questionnaire was most successful in community pharmacy settings where 985 women completed the baseline questionnaire. In community sessions, 282 women completed the questionnaire, with a further 108 participating in group discussions but not agreeing to fill out the questionnaire.

The questionnaires revealed a low level of health literacy, with a third of all women not recognising any sign or symptom of cancer, with no symptom of cancer being recognised by more than a third. There was no clear relationship between knowledge of cancer signs and symptoms and age or country of birth, though non-UK born and older women generally had lower health literacy. The intervention was successful in improving health literacy with nearly all women reporting they had learned about this through the intervention, would be more likely to attend screening and would visit their GP if they had signs and symptoms that they had learned may be associated with cancer.

Over half the participants set at least one lifestyle goal to reduce cancer risks including

exercise, healthy eating and weight management. The goals of being more physically active and eating a healthier diet were twice as popular as weighing yourself and working towards a healthy weight. Women were more likely to set these goals following the intervention in pharmacy settings compared to community settings. In both community and pharmacy settings, women were successfully signposted to external services for weight management or exercise, with the intervention in pharmacies resulting in over 60% of women being signposted.

Over 90% of women who stated they were overdue cancer screening set attending for screening as a goal. However, in the community, only half of these participants said they would undertake bowel screening, with more work needed to explore how the barriers to undertaking bowel screening can be better addressed. Barriers to not booking a screening appointment or visiting a GP about symptoms included health perceptions, lifestyle, difficulties in accessing medical services and concerns or fears about the procedure.

In addition, 109 women participated in follow up telephone questionnaires after six weeks to review their goals and attendance for cancer screening. Around 75% of those completing the follow up questionnaire reporting success in making progress towards the goals of increasing physical exercise (57 women, 78%), changing eating habits (66 women, 89%), achieving a healthy weight or weighing themselves (33 women, 66%). Of the 24 women who had set the goal to speak to their GP about signs of symptoms of cancer, 37% (9) had done so. Of the 27 women who set a goal to complete cervical, breast or bowel screening 67% (18) had done so (15 cervical, 2 breast, 1 bowel).

Community pharmacies were highly successful in delivering the intervention through training staff. In other community settings where we wished to talk with women we found it took more time than expected to identify, approach, access and then establish a trusting relationship with the different organisations which South Asian women access regularly.

Health Champions as peers were beneficial for the participants due to shared cultural and language backgrounds enabling communication and rapport building. Health Champions also reported the benefit for themselves personally in terms of knowledge gain to share with family and friends, increased confidence and many discussed how the project could lead to other opportunities including further education.

A longer project would have been beneficial to increase the number of women completing the intervention in community settings. Most Health Champions and community workers felt the project was worthwhile and wanted to continue the intervention past the project end.

3 Background

There is a local and national imperative to reduce the incidence and diagnose cancer earlier in the general population (Department of Health, 2013, NHS England, 2014, Independent Cancer Taskforce, 2016). Routine screening is a vital public health programme that reduces morbidity and mortality from cancer by ensuring early detection and prompt initiation of treatment. There are 8.4 cases of breast cancer diagnosed per 1,000 women screened, 3.4 cases of cervical cancer diagnosed in every 10,000 women screened and 2 cases of bowel cancer diagnosed in every 1,000 people screened. Since early detection of cancer leads to improved survival rates (Hawkes, 2019, Office for National Statistics, 2019), improving screening rates at local level, particularly in populations which are traditionally hard to reach has a direct benefit in saving lives.

In Black, Asian and Minority Ethnic (BAME) communities, awareness of cancer signs and symptoms is generally low (Robb et al., 2009) and BAME women are less likely to access breast and cervical screening than white women (Forbes et al., 2011, Marlow et al., 2015). South Asian communities make up the largest BAME group in the UK (Office for National Statistics, 2011) and South Asian women have a low uptake of cancer screening and higher rates of morbidity and mortality from breast and cervical cancers than other populations, being more likely to present late for health care when the disease is advanced (Anderson de Cuevas et al., 2018). Therefore, it is important to refine public health interventions to address this health inequality.

There is a wealth of evidence that South Asian women face many barriers to accessing breast and cervical cancer screening. They may lack knowledge of cancer and how to reduce their risk of developing cancer (Forbes et al., 2011, Marlow et al., 2015). They may also lack understanding of the idea of preventative health care, the importance of screening and how to access it, which can be exacerbated by language barriers (Crawford et al., 2016, Anderson de Cuevas et al., 2018). In addition, cancer can be stigmatised by the community and deter women from attending screening (Crawford et al., 2016, Anderson de Cuevas et al., 2018). There can also be practical barriers such as transport, family responsibilities and being required to seek guidance from a male or elder prior to accessing health care (Crawford et al., 2016, Anderson de Cuevas et al., 2018). Psychological barriers also exist such as embarrassment or the fear of a male health professional undertaking the screening or being frightened to attend a GP surgery or clinic alone (Crawford et al., 2016, Anderson de Cuevas et al., 2018).

In order to facilitate South Asian women adopting a healthy lifestyle and attending cancer screening, successful public health interventions need to understand the barriers and seek to address them. A recent scoping review has found that peer support interventions have been used successfully with BAME women in a wide range of contexts and matching the woman's ethnic and cultural background to the peer can convey a powerful message leading to healthy choices and behaviour change in the woman (Payne et al., unpublished)

and therefore could effectively be included when refining public health interventions for BAME women.

Yorkshire Cancer Research, who were successfully awarded funding by the Department of Digital Culture Media and Sport 'Tampon Tax' funding, partnered with the University of Bradford to undertake the Bradford Wise Up To Cancer study, targeting South Asian women where in the Metropolitan District, 26.6% of the population are Asian or Asian British (Office for National Statistics, 2011). We worked in partnership with two GP practices: The Ridge Medical Practice (Little Horton area), and Avicenna Medical Practice (Bradford Moor area), and Community Pharmacy West Yorkshire who recruited 10 community pharmacies (see acknowledgements). These partners were chosen in the geographical locations to reflect the higher South Asian populations in inner city Bradford. For example, the Bradford Moor ward has an Asian/Asian British population of 77.2% and the Little Horton ward, 57.7%. Cancer screening rates are below the national average in both CCGs serving the Bradford community as can be seen in table 1.1. Screening uptake rates are broadly in line with the patient demographic. The areas with high South Asian populations have the lowest screening uptake rates and are also areas of socio-economic deprivation and poor health outcomes in general.

Table 1.1 – Cancer screening uptake rate in Bradford

	National rate	Bradford City CCG	Bradford Districts CCG	The Avicenna Medical Practice	The Ridge Medical Practice
<i>Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %)</i>	72.1	50.4	68.4	55.7	62.7
<i>Females, 50-70, screened for breast cancer within 6 months of invitation</i>	71.7	47.1	67.5	10.0	61.4
<i>Females, 25-64, attending cervical screening within target period (3.5 or 5.5 year coverage, %)</i>	71.7	61.2	72.3	57.0	63.4
<i>Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %)</i>	59.6	37.9	56.8	38.1	46.0
<i>Persons, 60-74, screened for bowel cancer within 6 months of invitation (Uptake, %)</i>	57.7	34.9	55.2	35.4	44.7

Public Health England Fingertips Data, 2017/18. Data from fingertips.phe.org.uk 1/6/2019. The Avicenna Medical Practice is within Bradford City CCG, The Ridge Medical Practice is within Bradford Districts CCG.

This report builds on the interim evaluation and discusses the final outcomes of this fourteen month Bradford Wise Up To Cancer project, targeting South Asian women.

4 Aims and Objectives

The project had the following aims and objectives:

Aims

- To reduce inequalities and improve cancer outcomes in South Asian women in Bradford (age 25-74)
- To increase the prevention and early diagnosis of cancer in South Asian women in Bradford

Objectives

- To decrease behaviours associated with cancer risk (e.g. poor diet/ low levels of exercise)
- To increase awareness of cancer signs and symptoms
- To increase the number of South Asian women taking part in the cancer screening programmes
- To increase signposting to other services e.g. weight management programmes to improve general health

An additional aim of the project team was to use the evaluation to suggest service improvements which will lead to sustained increases in uptake of screening services, following longer term evaluation of the project.

5 Methodology

The project aimed to reach 3,000 South Asian women and ran over 14 months (April 2018-June 2019). There were two arms to the study, a GP intervention and a community/pharmacy setting intervention. Both qualitative and quantitative methods were used to collect data to evaluate the project.

Ethical approval was received from the NHS Research Ethics Committee reference 235627 prior to any evaluation being undertaken. Confidentiality and anonymity were maintained to ensure participants could not be recognised.

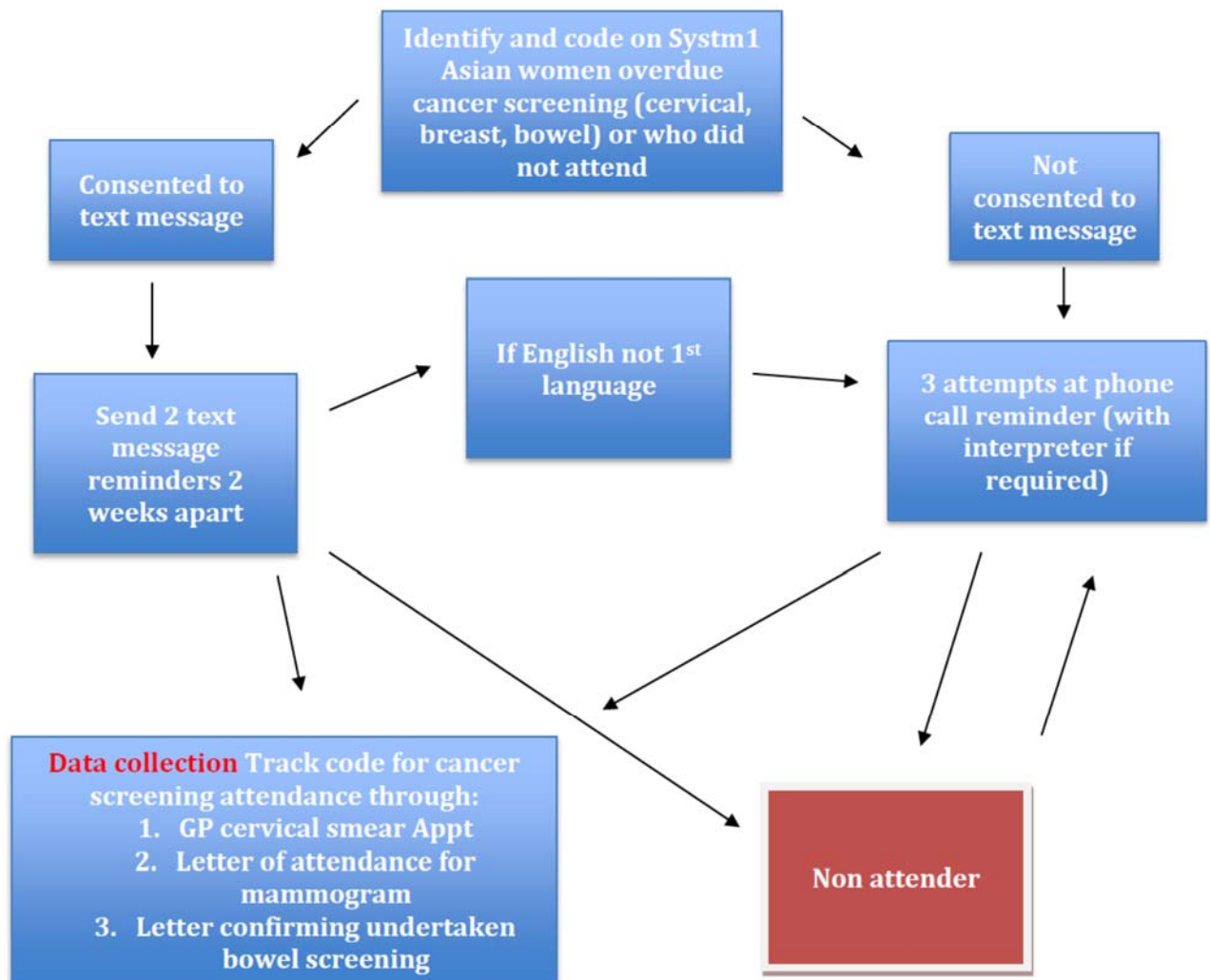
5.1 The GP intervention

The standard practice for inviting women to cervical screening is the use of appointment letters sent through the post. Breast screening invitations come from the service provider, in this region Pennine Breast Screening Service. For Bowel Screening, patients receive a letter from the Bowel Screening Service with a bowel screening test kit. GPs signpost patients to breast and bowel screening services. GPs receive reports about who had not attended screening.

The Ridge Medical Practice and The Avicenna Medical Practices undertook text messaging reminders targeting South Asian women who were overdue bowel, breast and cervical cancer screening. If the woman had not consented to receive text messages or her preferred language was not English then phone calls in her preferred language were undertaken as an alternative (see below). Two weeks later, a reminder text message was sent. The text messages encouraged women to ring the practice for more information and for support in booking or signposting to screening. The phone call offered the facility to book cervical screening appointments; signpost to breast screening; and either order a bowel screening replacement kit (only in one of the GP practices) or signpost to the bowel screening hub to order a replacement kit.

Women included in the intervention were coded and tracked to assess attendance at cancer screening. Quantitative data was collected from GP practices in the form of aggregated data from SystmOne, sent to the research team by via the GP practices.

**Bradford BME women 'Wise up to Cancer' project
Phase 1 intervention A: The Ridge and Avicenna GPs**



Other interventions to support increasing screening uptake

1. A whole staff approach

- All staff will be trained in the importance of screening, barriers and how to encourage attendance
- The project aims, progress and impact will be effectively communicated to staff
- Pop-up alerts on GP's, health professionals and admin staff systems will be set up to prompt opportunistic conversations (around, importance, barriers and how to attend).

2. GP health champions/ reception staff role will include

- Help with phone calls where possible to make appointments and request bowel screening kit
- Brief/opportunistic conversations about screening (importance, barriers and how to attend)
- Appointments available for cervical smears on the day
- Promote the project and update displays

5.2 Community and Community pharmacy intervention

In community settings, including pharmacies, the intervention comprised a baseline questionnaire which facilitated 'chats about health'. The chat aimed to encourage awareness of and uptake of healthy lifestyles, raise awareness of cancer signs and symptoms, and encourage attendance of routine screening for bowel, breast, and cervical pathology. The baseline questionnaire was adapted from the West Leeds and Wakefield pilot (Seims et al., 2018; Woodward et al 2018). Women had the option to be referred for extra support such as weight management services or to Community Health Champions for additional peer support, since current advice is that healthy diet and bodyweight helps prevent cancer incidence (Brown et al., 2015). The questionnaires and selected information leaflets are presented in the appendices.

With consent from participants, a follow-up questionnaire was also utilised a minimum of six weeks later to discuss progress towards making healthy lifestyle changes and attending screening appointments. This was undertaken by phone by members of the University-based research team and Urdu speaking volunteers.

Pharmacy data were supplied securely and anonymously to the University team via Community Pharmacy West Yorkshire, using PharmOutcomes software. Quantitative data and free text comments were extracted from handwritten questionnaires from the community arm of the study, from both baseline and follow up questionnaires. Data was cleansed and analysed using Statistical Package for Social Sciences (SPSS).

Qualitative data collection included focus groups and individual interviews with stakeholders to explore the impact of the intervention engaging a South Asian community of women in more depth. Data were hand recorded or audio recorded and transcribed verbatim. In depth interviews were conducted with ten Pharmacy Health Champions, five Community Health Champions, four workers in the community-based organisations (including school and faith) and five participants accessed through the community. We note at the time of writing we have not finished the full analysis of the qualitative data, and these will be disseminated as part of academic outputs at a later date.

Key findings from the project are presented below with direct quotes from the data to illuminate the findings where relevant.

6 Results from General Medical Practice intervention

The standard practice for inviting women to cervical and breast screening is the use of appointment letters sent through the post, with GPs receiving reports about who had not attended screening. Bowel screening involved women being sent a bowel screening kit in the post, to obtain faecal specimens and then re-post. Neither GP practice had previously routinely used texts or phone calls to proactively follow up missed appointments or bowel screening.

The project design required the two GP practices to identify South Asian women of an appropriate age-range who had overdue screening appointments, through coding on SystmOne. The practices identified whether eligible women had English as their first language, and also whether or not they had consented to receive text messages. Both practices received payment from the project funds in order to provide time for the staff making the calls, and also to provide data reports. Women were coded within the medical practices throughout the study period, and women moved, so the number of women who received intervention during the study was different to the original numbers identified as being eligible for intervention before the study commenced.

Both of the GP practices who were partners in the project had lower than average screening rates for all cancer screenings in line with the regional data (Table 1) including significant numbers of eligible South Asian women overdue cervical, breast and bowel screening (Table 6.1). The two practices are of different sizes. In August 2018, shortly before the study commenced, Avicenna Medical Practice had 374 South Asian women overdue screening and The Ridge having 1,522 South Asian women overdue screening.

Table 6.1. Numbers of South Asian women overdue screening in two Bradford GP practices.

	Cervical screening overdue	Breast screening overdue	Bowel screening overdue	All overdue screens
Aug-18	846	792	379	2017
May-19	680	742	299	1721

Data from two practices participating in the study have been combined to show numbers of South Asian women overdue screening derived from GP practice records at baseline (before study commenced) and 3 months after the last text/phone call intervention. Note the practice populations change, so it is not possible to directly derive improvement data from these figures, even though the numbers of people with overdue screenings have been reduced overall.

During the study, both practices set up processes to remind women who had not attended their screening appointments. Texts were sent to women who consented to text messages and phone calls were attempted for women for whom English was not their first language or did not consent to texts. At The Avicenna Medical Practice, the calls were mostly made by one of a team of five practice nurses, and mostly in English. At The Ridge Medical Practice,

the calls were made either by a specially trained member of the administrative staff fluent in Urdu or by one of the Lead GPs, who speaks Urdu.

Both practices adopted a whole team approach, led at Avicenna by a patient engagement lead, to raise awareness and increase engagement of the screening services available and to reduce anxiety and stigma of the procedures with women. Both practices exhibited material about the project, and staff wore project t-shirts through the six months of the intervention period (September 2018 to February 2019).

Both practices valued the involvement in the study and working with the project partners, including Yorkshire Cancer Research to increase awareness of cancer screening and signs and symptoms to improve the health and wellbeing of their patients.

'[We] took time to explain the procedures to women, for example showing them a speculum.' (Practice manager, The Avicenna Medical Practice)

Both practices were highly successful in initiating and delivering the intervention, reaching 1,928 women in total (Table 6.2). The Avicenna Medical Practice carried out 574 interventions, and the Ridge 1,354. Table 6.3 provides a breakdown of the screening uptake for women who received the intervention by practice and screening test.

Table 6.2. Numbers of South Asian women overdue screening in two Bradford GP practices who received a text or phone intervention during the study period.

	Cervical	Breast	Bowel	Total
Received intervention via text only	739	672	236	1,647
Received intervention via phone call following text (did not have English as first language)	127	78	76	281
Total	866	750	312	1,928

Data from reports from GP practices: data from both practices is combined.

Table 6.3. Numbers of South Asian women overdue screening in 2 Bradford GP practices who completed screening appointments following text or phone intervention

	Cervical screening appointments completed	Breast screening appointments completed	Bowel screening test completed	Total screening appointments completed
Avicenna	156	13	35	204
Ridge	134	19	46	199
Total	290	32	81	403

Practice data from SystmOne records (screenings completed and notified to practice from overdue groups by end May 2019).

403 women of the 1,928 who received the intervention completed cervical, breast or bowel screens by May 2019, an intervention success rate of 21% overall. There was no detection of malignancy in for any of the completed screenings with test results returned to the practice.

The data shows that the intervention was most successful in eliciting booking and completion of cervical appointments, where 290 screenings from the 866 women who received the intervention (33%) were completed, with a similar success rate in each practice.

The intervention was less successful in both practices in eliciting breast screening appointment booking and subsequent screening, with 32 women from 750 who received the intervention (4%) completing their screenings.

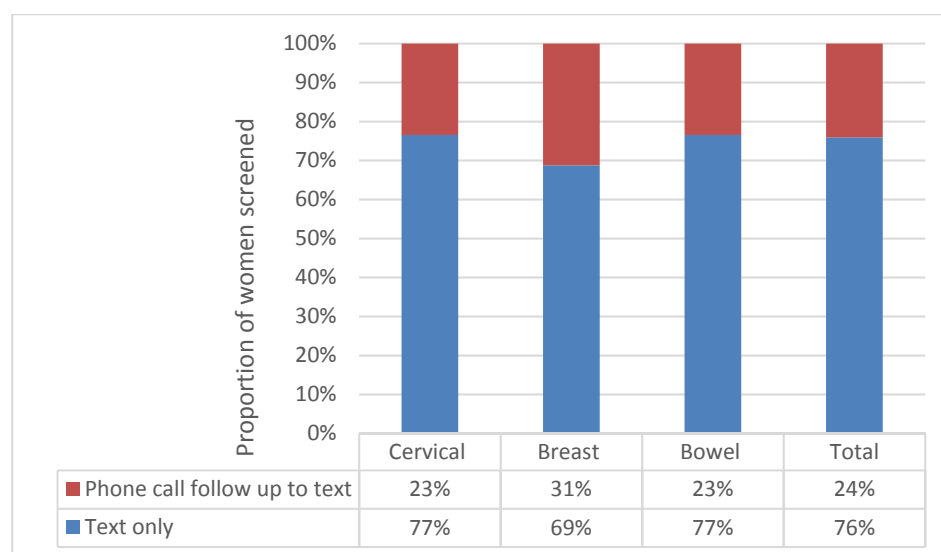
The intervention had a major impact on bowel screening. Overall 81 screenings were completed from 312 women who received the intervention (26%). For this screen there were profoundly different outcomes within the two medical practices. At Avicenna, 54% of women who received the intervention completed bowel screening (35 screenings from 65 interventions) whereas at the Ridge, 19% of interventions resulted in completed bowel screening (46 screenings from 247 interventions).

Both practices reported an increase in their screening rates. For example the Ridge carried out an analysis that showed 82 women for whom English was the preferred language and received a text message attended cervical screening compared to 6 women in the previous year from a similar group of eligible women with the same characteristics who did not receive a text message.

6.1 Were phone calls more effective than texts to support screening completion?

Figure 6.1 shows that the majority of the screenings (76% in total) were as a result of texts, with just under a quarter (24%) resulting from phone calls. Since only 14% of the women who received the intervention received a phone call (Table 6.2), the data suggests that phone calls are over 70% more successful than texts alone to support uptake and completion of cancer screening.

Figure 6.1. Relative proportion of screening completions from the two interventions – text only, text & Phone call



290 women completed cervical screening, 32 women completed breast screening, 81 women completed bowel screening. Proportions of screening completions with phone call follow up to text or text only are shown.

To gain more insight into whether phone calls were more effective than text messages we calculated the success rate for each type of intervention: the number of screenings completed from the number of interventions made (Table 6.4). Nearly one in five women completed screening following text and around 1 in 3 non-English language preferring women completing screening following a phone call as a result of the intervention. The data suggests that, overall, phone calls are more effective than texts, though we note that since texts and phone calls were aimed to target different subpopulations (English and non-English language preferring) than the text only group, further studies would be required to develop full practice recommendations.

Table 6.4. Relative Success rates of text and phone intervention in resulting in completed screening.

	Cervical	Breast	Bowel	Total
Text	30%	3%	26%	19%
Phone call follow up to text	54%	13%	25%	35%

Data shows the percentage of screenings completed out of the number of women who received the type of intervention shown in Table 6.2.

6.2 Discussion and Conclusions

6.2.1 Effect on screening improvement

Altogether the data shows that the use of texts and phone calls following texts is a simple and effective measure to support completion of cervical and bowel screening. Since the interventions were specifically targeted to women who had missed appointments or not completed screening, the interventions appear to have been highly successful since these women are unlikely to have done so without this intervention.

The study suggests that simple measures such as texts and phone calls are effective in increasing uptake and attendance of screening.

‘199 women have attended screening out of 1354 contacted which is almost 15%. We set a target of 10% so this is great!!’ (GP, The Ridge)

Whilst we are confident that screening uptake rates have increased, we note that the full data for complete analysis of the impact of the intervention in GP practices will not be available until late 2020 when public health data covering the period (2019/20) is made available and comparison groups are included to exclude other factors beyond the intervention as the cause of the effects seen. These aspects were not part of the original study design and will be disseminated in due course as part of an academic publication.

We note that while highly successful in producing improvements, there remain 79% of women altogether who did not complete cancer screening following intervention. This demonstrates that while the interventions have promise, additional interventions and refinements are required to reach satisfactory uptake of screening services amongst South Asian women.

For cervical screening, texts were highly effective in increasing screening appointment booking and completion, with phone calls even more effective in women whose preferred language is not English. Here there is a direct connection between the GP and the service. The text (or phone call) is from the GP surgery where the procedure is carried out. With

phone calls, the appointments can be booked in discussion with the women, for example to choose a convenient time.

Phone calls appeared to be more effective than texts for breast screening appointment booking and completion, but there was a much lower success rate for this screening compared to cervical and bowel screening. At the time of writing we do not know the reasons why breast screening improvement was less successful, but we note that, currently, GP surgeries can only signpost women to breast screening and cannot book appointments on their behalf or provide the service.

We noted differences in success in increasing bowel screening completions between the two practices, with Avicenna achieving more screenings than The Ridge with close to a threefold greater success rate in relation to the number of screenings achieved per intervention compared to the Ridge. There were differences in practice: the Avicenna practice, which made a higher proportion of phone calls (in relation to their patient numbers) for bowel screening. In addition, Avicenna supported patients to order test kits, with their consent, that in some cases involved making a phone call on their behalf. The Ridge followed current practice guidelines signposting patients to order their own kits.

'The intervention appears to have had little effect on bowel screening, but we did put the onus on the patient to order the tests themselves.' (GP, The Ridge)

'[Involvement in the study] changed us from being reactive to proactive, our screening rates have increased so now we are exceeding the national benchmark in some areas' (Practice Manager, Avicenna)

The data suggests that GP practices provision of additional support to patients to order test kits can be effective in increasing test uptake. The Ridge commented that to do this routinely for patients would be too time consuming to adopt as part of routine practice. For example, the need to dedicate staff time to phone the Bowel Screening service on behalf of patients. The information flow between GPs and bowel screening service made it difficult for GPs to track whether patients who had received kits had used them correctly and/or sent them off, making it slow to identify those patients who require a reminder. These points suggest areas for future service improvement.

6.2.2 Practice implications

Both practices regard that the existing system for completing screening based on postal letters does not work well for their patients who do not speak English as a first language, with the letters being unread ignored or not understood. GP surgeries cannot currently (formally) order kits for bowel testing for women, nor book appointments directly for breast screening services. For breast and bowel screening practices commented on the complexities of the interaction with the external services, in relation to booking appointment and also GPs receiving information about whether or not a patient has attended a screening appointment or have not ordered or returned a bowel test kit.

As a result of participation in the study, Avicenna have already made a service change and made texts part of their routine service. In addition, both GP practices are also considering making phone calls to encourage screening uptake a routine part of their practice, with the Ridge planning to use Health Care Assistant time, and Avicenna preferring the use of Nurses time. Both practices noted the additional benefits of 'proactive' phone calls which can help support the uptake of other services and allow a wider conversation about self-management and health promotion.

However, there are financial barriers to providing clinical sessions for phone calls, which are a significant issue for both practices. We note that, since cervical screening is funded as part of the GP contract, increase in cervical screening rates (but currently not breast or bowel screening) can partially offset GP practice investment into dedicating staff time for calling. Neither practice regarded language to be a significant barrier in the phone calls they made, with the majority of phone calls being made in English. Increases in breast screening uptakes were less than the increases in bowel and cervical screening uptake. In addition, there remain a significant number of women who did not respond to texts or phone calls by booking an appointment. This shows that there are additional barriers, whether within GP surgeries or within the community of South Asian women that require further consideration.

Within GP surgeries barriers include the investment required (increased workload) to take extra steps such as making phone calls combined with the complexities of coding and tracking patients to support routine screening and bespoke follow up interventions for missed appointments. The dissociation of breast and bowel screening services from the practice environments, the lag in data return and lack of additional funding to enhance uptake of breast and bowel screening services are also potential challenges to service improvement that have been identified through interviews with GPs and practice staff.

The barriers are not only within GP surgeries however, and the data suggests that even with enhancing the communications in the way done during the study period, nearly 80% of women overdue screening will still not complete their screening promptly. Women who receive invitations to screening services ignore them in large numbers, do not attend appointments or, for bowel screening order or return test kits. Therefore, understanding these issues from women's perspectives is essential to improve screening uptake, and this was addressed through the community and community pharmacy intervention.

7 Community and community pharmacy intervention and the Health Champion model for peer support

7.1 Developing the questionnaire and project resources

The original 'Wise Up To Cancer' public health intervention targeted the all ethnicities within disadvantaged populations in West Leeds and Wakefield district rather than a specific ethnic group. We needed to adapt it for use with our target BAME population (the majority BAME population in Bradford) South Asian women aged between 25-74 whose families originated from India, Pakistan, Nepal or Bangladesh. We therefore convened a service user group of women representing the target population to work on how the intervention should be adapted to meet the needs of this population and help address potential barriers accessing cancer screening.

The original Wise Up To Cancer baseline questionnaire included questions about lifestyle and we considered how they would apply to the target population with respect to age, gender, cultural background and religion. For example, how questions about physical activity consider women's cultural needs such as the ability to undertake activities in traditional dress, 'women only' exercise opportunities, age relevant suggestions and the importance of considering women's roles in the community.

'The women don't have transport to go to the gym, if they are middle age they can go to the gym or community centre. Those that couldn't go to the gym can go to the park or walk, they can do housework' (Community Health Champion 1)

'Women were reluctant to want to participate in exercise due to age, felt household chores were enough for exercising' (Community Health Champion 2)

When discussing aspects of diet, we needed to consider the different food groups in the context of a South Asian meal and developed simple easy read leaflets with pictures to supplement the conversation.

The resources used within the project facilitated learning for the participants but also the champions. This included the baseline questionnaires, learning about cancer signs and symptoms and the cancer screening services available. The leaflets were simple and the use of pictures was invaluable with some participants. Examples of leaflets, as well as the questionnaires are found in the appendices.

7.2 Health Champion recruitment and training

Both Pharmacy and Community Health Champions received training before undertaking the role. Community Health Champions were DBS checked.

Pharmacies who submitted an expression of interest, were assessed by Community Pharmacy West Yorkshire (CPWY) to ensure they fitted the inclusion criteria and were recruited to the study. Within the 10 selected pharmacies, staff attended a two-hour training event. The session was attended by 35 pharmacy staff (41 including host and speakers). Each participating community pharmacy sent their nominated Lead and designated Pharmacy Health Champions to the event (a requirement of the service was that each pharmacy made a commitment that at least two members of staff would be trained for the service). The training included a background to the project, the aims and objectives and expectations of the Pharmacy Health Champions. Attendees had the opportunity to practice using the questionnaire. The training was followed up by CPWY, and members of the University team, with individual visits to the pharmacies. CPWY delivered additional one to one training where required, for example when new champions were recruited. On a scale of 1 to 10, we found that 90% of participants scored 9 or 10 out of 10 when asked how satisfied they were with the training event, indicating that the training was well received.

Women of the same peer group as the target population were trained as Community Health Champions to deliver the questionnaires. Training was ongoing as new volunteers were recruited throughout the project. Training was similar to the training provided to Pharmacy Health Champions, covering the questionnaires and content. In addition, Community Health Champions received training about confidentiality and relationship boundaries with the participants, data protection (GDPR), consent, safeguarding and lone working. They also had access to ongoing training and development on health-related issues relevant to South Asian women which led to many champions extending their understanding and networks within the community.

We also launched a social media campaign, with Bradford West MP, Naz Shah speaking at the launch. The product launched was a video (<https://vimeo.com/300671577>) to be disseminated via social media e.g. Instagram and Twitter to encourage women who use social media to volunteer as a Community Health Champion and/or to book an appointment for a health chat with a volunteer. Eight of the 25 volunteers did so via the form on the website.

7.3 Health Champions as peers

For both community and community pharmacy contexts, Health Champions were usually of similar ethnic backgrounds as the women. In the community, shared ethnic background and the ability to speak additional South Asian languages was taken into account when recruiting Community Health Champions. Matching ethnicities appeared a beneficial process in the community, enabling women of shared backgrounds to build rapport. Pharmacy Health Champions of the same ethnic background found this beneficial on a

number of levels. Women believed that being able to communicate in their preferred language helped build a rapport and increase the information revealed during a chat:

'Yeah, I think it did make them feel a bit more comfortable because I know with some of the women English was harder, they knew how to speak a little bit but they weren't comfortable speaking English, so having somebody that you can speak your own language to, it makes you open up a bit more and it makes them talk a bit more than they usually would and they don't give you answers that they think you want to hear, they'll give you actual answers' (Pharmacy Health Champion 1)

Being a peer and sharing personal experiences also appeared to help overcome the stigma and taboo of discussing cancer:

'I had a woman, she was quite freaked out because as soon as you hear the word cancer that's like "God, I think I'm going to, I shouldn't be having this conversation", so you have to tell them like it's fine, if it makes you feel better I'll give you a little bit of story of what my family members went through' (Pharmacy Health Champion 3)

Although being a peer was perceived as positive, age differences could be a barrier that needed addressing where older women were approached by a younger Health Champion:

'...maybe because they see a young face they're thinking, right, why is this young lady asking me these questions, but again it was reassuring them, look it's for health purposes, we're not being nosy' (Pharmacy Health Champion 2)

For our Community Health Champions being a peer was felt to be positive. For example, Community Health Champion 2 was asked if she felt being a peer influenced the women asking for help:

'Yeah, I think because she was able to speak the same language that really helped and she felt comfortable in disclosing that and thought that that information was confidential, it wasn't going to kind of go elsewhere unless needed and stuff. Whereas I think if that was somebody with a different ethnicity she probably wouldn't have felt that way.' (Community Champion 2).

7.4 Benefits of participation for the Health Champions

Several of the Pharmacy and Community Health Champions expressed a positive impact on their own health and wellbeing as a result of taking part in the project. Social confidence was repeatedly cited as a significant area of development which had boosted their self-esteem. For those from the community, there was a clear relationship between the Health Champion role and reduced anxiety at the prospect of attending interviews and appointments where they had no existing rapport with the person they were expected to talk to. The project has also inspired them to think beyond the roles that had been suggested to them and for some the prospect of further education has also become an option.

'I think I learnt as well how important this is: a better lifestyle, eating habits, walking, exercise and I have more confidence in talking to people and new people, so it's new things for me....I got confident to speaking with person you totally don't know, what their name or where they are from, what they are doing so you can go and talk with them confidentially, get their attention and have a chat with them' (Community Health Champion 4)

'It's been really good, it's been my pleasure to work with you...I really enjoyed it, its increased my confidence and made me feel good that I am doing something for the community. I want to do more, a lot more' (Community Health Champion 5)

8 Results from the pharmacy and community-based intervention

8.1 Baseline questionnaire and follow up questionnaire completion rates in pharmacy and community settings

A total of 1,267 women completed the baseline questionnaire, 985 in the pharmacy setting and 282 in the community setting, with an additional 108 women participating in group discussions covering the questionnaire questions, but not filling out the questionnaire. Some women in the community setting who filled out the questionnaire did not complete all of the questions. Data from the baseline questionnaires is presented below, following some evaluation of the work in both settings.

Whilst not part of the DCMS proposal, we note that 54 women (30 from the community, 24 in the pharmacies) requested additional support from a Community Health Champion.

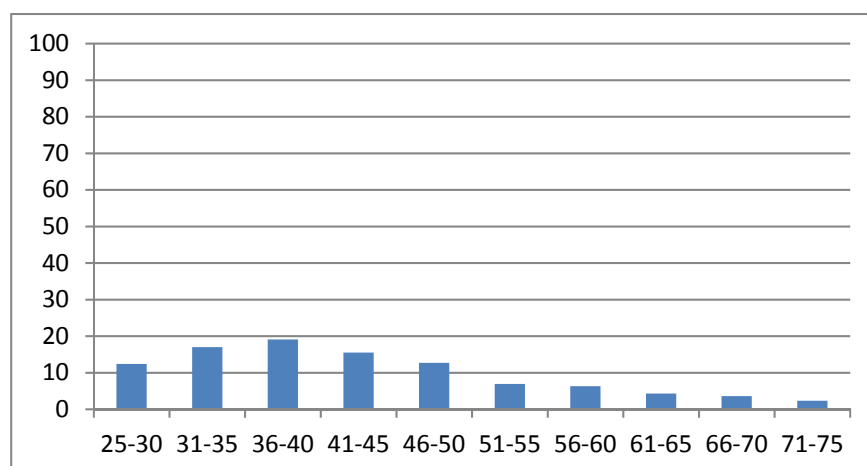
In total, 271 women who completed the baseline questionnaire consented to take part in the telephone follow-up, 228 from the pharmacies and 43 in the community. Altogether 109 participants completed the follow-up questionnaire, the results of which are presented in section 8.10.

8.2 Baseline Demographics

8.2.1 Participant age

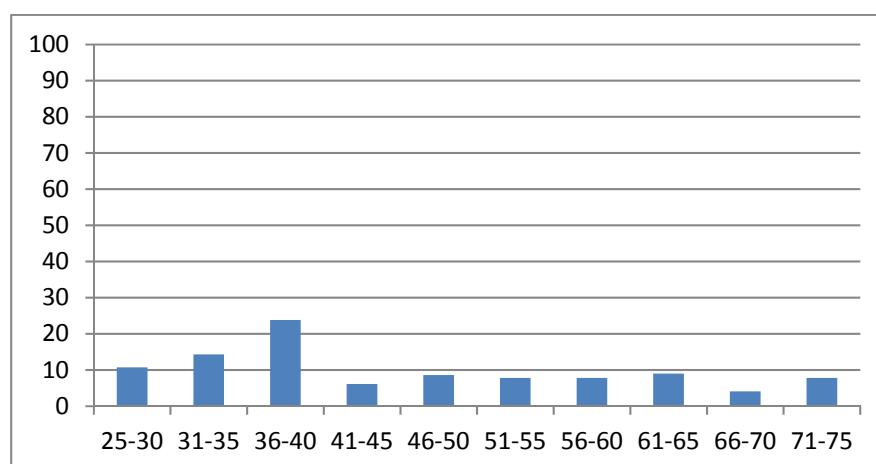
Women aged between 25-74 were eligible to take part in the study. Figures 8.1 and 8.2 show the age ranges of women who completed the baseline questionnaire in pharmacy and community settings respectively. In both groups, the most common age group of participants was 36-40. This age group represented just under 20% in the community pharmacy setting, and just over 20% in the community setting. Participation was lower for women aged 51 and over, although the community setting was more successful than the community pharmacy setting at recruiting women in the older age groups. This partly reflects the types of community groups attended by Community Health Champions, for example some community centre groups were specifically for older women.

Figure 8.1: Ages of women completing the baseline questionnaire in a pharmacy setting



985 women completed this part of the questionnaire

Figure 8.2: Ages of women completing the baseline questionnaire in a community setting

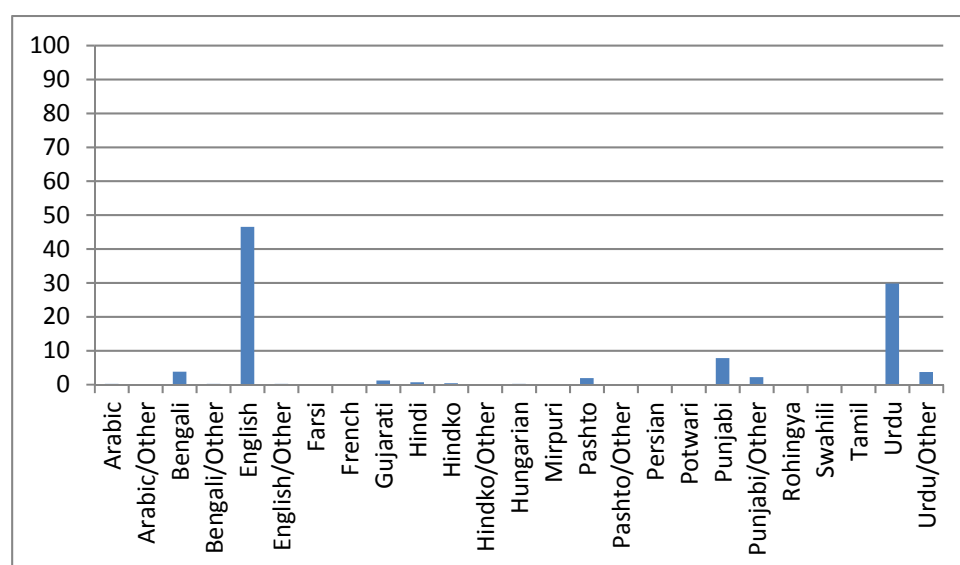


254 women completed this part of the questionnaire

8.2.2 Preferred spoken language

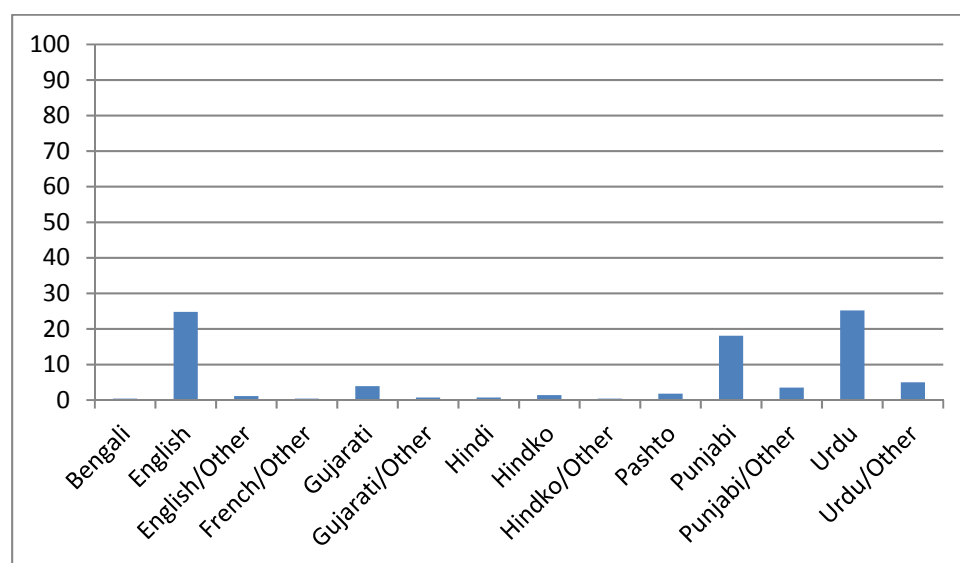
In the pharmacies, less than half (46%) of women preferred English as their spoken language when undertaking the intervention (Fig 8.3). In the community setting only 27% of women preferred English (Fig 8.4), which highlights the importance of community organisations providing an environment for non-English speaking women to meet and discuss issues including health. It also highlights potential language barriers if interpreters are not utilised effectively with this population. Urdu and Punjabi were the most common preferred languages after English.

Figure 8.3: Preferred language of participants in pharmacy setting



985 women completed this part of the questionnaire

Figure 8.4: Preferred language of participants in community setting



246 women completed this part of the questionnaire

8.3 Place of birth

Table 8.5 shows places of birth for women in community pharmacy and community settings, and demonstrates that in both groups, the majority were born in Pakistan, followed by the UK. Nearly 20% of women in both settings were born in other countries in the Middle East, Africa, Europe and South Asia (Other in Table 8.5).

In the community setting, fewer women were born in the UK, aligning with the data on their preferred language (see Figures 3 and 4), and the higher proportion of people in the older age groups.

Table 8.5: Place of birth of participants in pharmacy and community settings

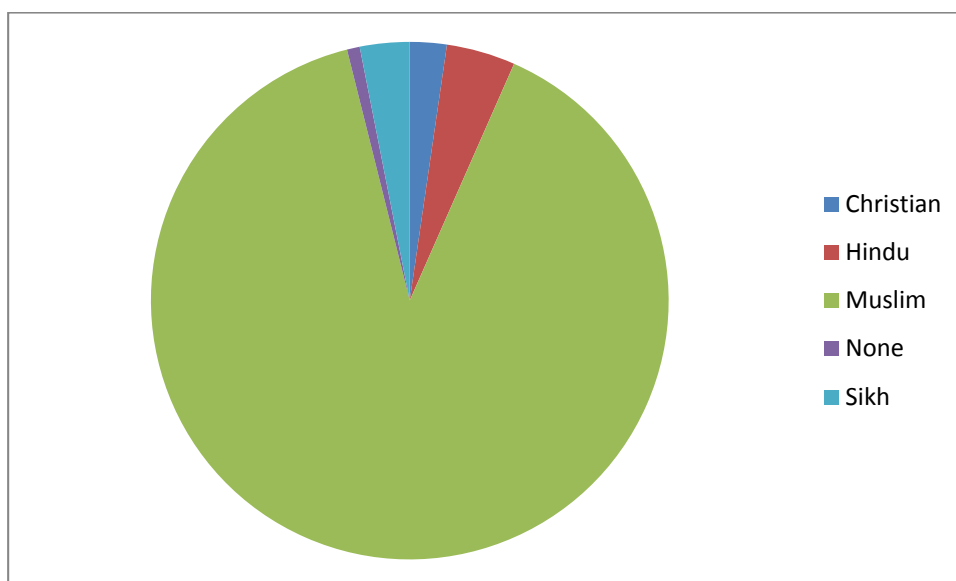
	Pakistan	UK	Bangladesh	India	Nepal	Other
Pharmacy	43%	32%	4%	4%	0%	18%
Community	47%	20%	0.7%	14%	0%	19%

841 women completed this part of the questionnaire in pharmacy, 240 in community.

8.3.1 Religion

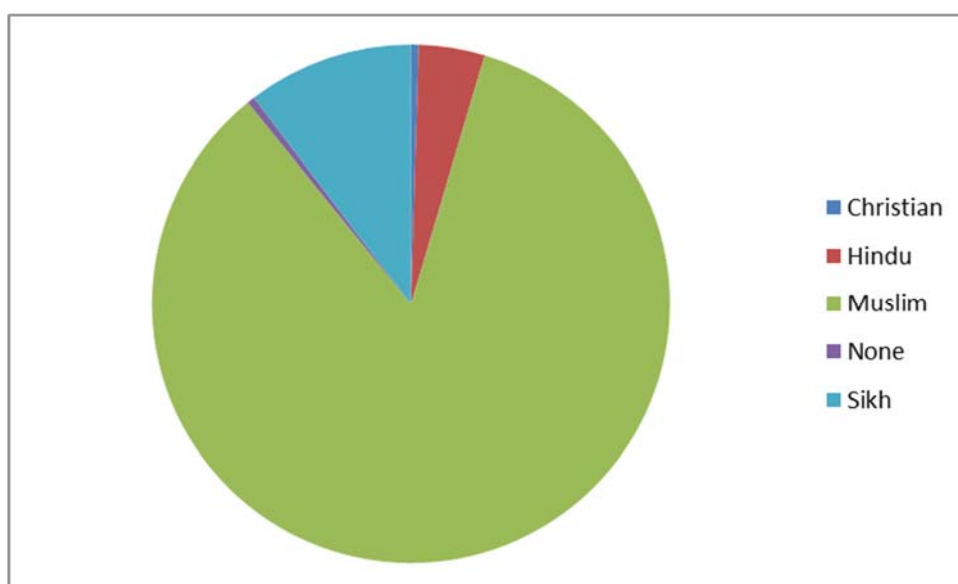
Figures 8.5 and 8.6 show most women in both settings are Muslim (89% in the community pharmacy setting and 72% in the community setting respectively). Hindu and Sikh are the two other most common religions among the participants interviewed in both settings.

Figure 8.5 Religion of participants in pharmacy setting



985 women completed this part of the questionnaire

Figure 8.6: Religion of participants in community setting



240 women completed this part of the questionnaire

8.4 Lifestyle factors

8.4.1 Alcohol consumption and tobacco use

A small minority of women reported consuming alcohol (Table 8.6) or tobacco products (Table 8.7), as expected from a South Asian, predominantly Muslim population. Of people who use or have used tobacco products (7.5% of the surveyed population), 68% use cigarettes, 15% chewing tobacco 11% snuff (Naswar) and 8% Shisha. Due to the low numbers of people consuming alcohol or tobacco products in the survey it was not possible to carry out a meaningful analysis of the relationship between knowledge about cancer signs or symptoms or lifestyle changes.

Table 8.6: Weekly alcohol consumption

	Pharmacy	Community
1-7 units	4%	1%
8-14 units	1%	0%
14+ units	0%	0%
None	95%	66%
Not answered	0%	33%

985 women completed this part of the questionnaire in the pharmacy, 188 in the community

Table 8.7: Use of tobacco products

	Pharmacy	Community
No, never have	88%	69%
No, I've quit	5%	3%
Yes, but not every day	2%	0%
Yes, every day	5%	1%
No response	0%	27%

985 women completed this part of the questionnaire in pharmacy, 206 in community

8.4.2 Exercise and Diet

Less than half of women exercised at the nationally recommended level of 30 minutes, at least 5 times per week, with a greater proportion of women in community settings having more exercise than those found in pharmacy settings (Table 8.8).

Table 8.8: Exercise frequency (per week)

	Pharmacy	Community
0-4 days	61%	53%
5+ days	39%	47%

906 women completed this part of the questionnaire in pharmacy, 162 in community

Over 80% of community pharmacy participants and 70% of community participants do not meet the UK guidance to eat least five portions of fruit and vegetables per day (Public Health England, 2018) (Table 8.9). However over 90% of participants in both settings were within the dietary recommendations for healthy eating of red meat (consuming less than 4 70g portions per week) (Table 8.10). 52% of women in community pharmacy setting and 46% of women in community settings appeared to meet guidelines for wholegrain consumption, defined as 30g per day (Figure 8.7) which we defined as 7 portions per week. We noted a significant proportion of women who reported they ate no wholegrains (13% in the community and 4% in the pharmacy cohort).

Table 8.9: Fruit and vegetable consumption

Daily fruit and vegetable consumption (portions)	Pharmacy	Community
0-4	81%	71%
5+	19%	29%

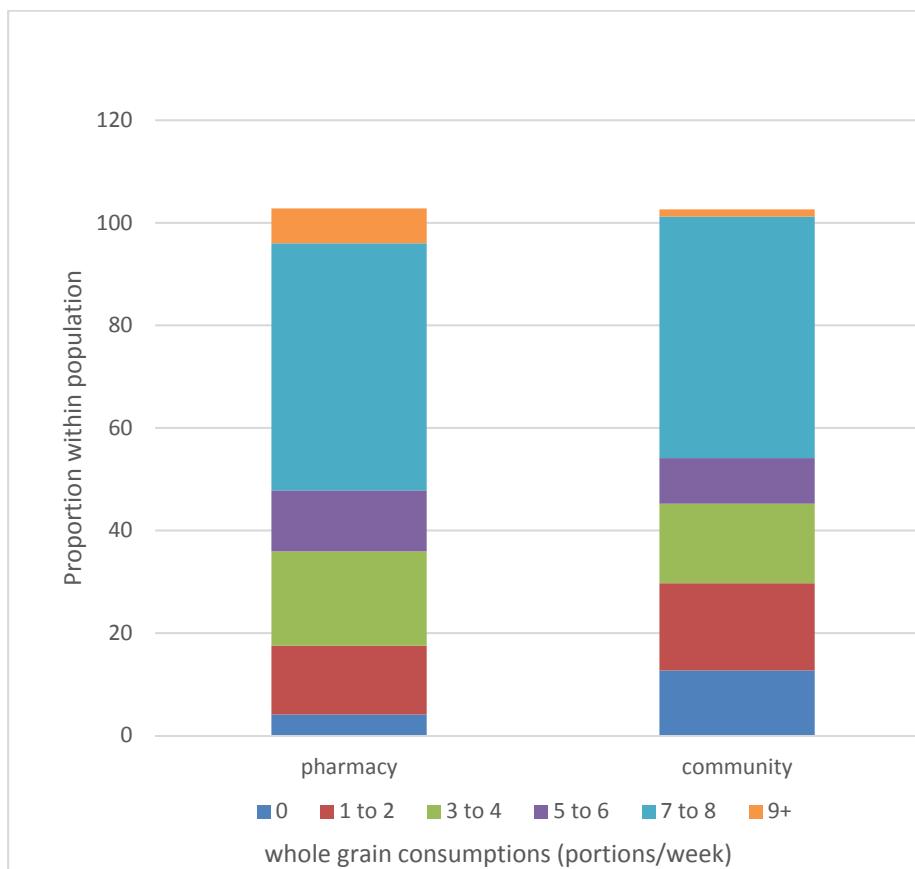
985 women completed this part of the questionnaire in pharmacy, 212 in community

Table 8.10: Weekly red meat consumption

Weekly red meat consumption (portions)	Pharmacy	Community
0-3	91%	92%
4+	9%	8%

985 women completed this part of the questionnaire in pharmacy, 213 in community

Figure 8.7: Weekly Wholegrain consumption



985 women completed this part of the questionnaire in pharmacy, 212 in community

Women responded positively to information about diet and healthy eating during the conversations, many making lifestyle changes part of their health goals (see below).

We found that there was a difference between perceptions of healthier daily food, and hospitality food where there were expectations to prepare food in a certain way that can include unhealthy ingredients

‘...when I was talking about diet and there was food about, the women would laugh and say we prepare our food at home and keep it healthy but when we come out, it can be deep fried and full of sugar, we have Asian snacks, sweets and cakes....Wedding food was another example cited by women as being unhealthy, but tasty nonetheless’. (Community Health Champion 3)

Since hospitality foods are embedded within the culture of the communities, it is important to reflect this in the context of discussions with women about diet and unhealthy food examples.

8.5 Body weight perception

In Bradford, obesity is a significant public health issue, with 68% of adults reported to be obese, with national statistics showing that 56% of Asian adults are overweight Gov.UK (2018). In this survey, whilst objective measures of weight or BMI were not undertaken, just under half of the participants in community pharmacy or community settings regarded themselves as having a healthy weight, the same proportion regarded themselves as having an unhealthy weight, and just over one in ten women were unsure (Table 8.11).

Table 8.11: Healthy Weight perception

Are you a Healthy weight?	Pharmacy	Community
Yes	46%	44%
Not sure	13%	11%
No	42%	45%

985 women completed this part of the questionnaire in pharmacy, 214 in community

8.6 Self-reported cancer screening status

Women were asked about their cancer screening status. Excluding women who were ineligible (age range), women reported a higher than expected uptake of screening services in relation to the known screening rates in the areas of the study, and the data from GP practices. For cervical and breast screening in both community and pharmacy settings, between 73-83% of women reported being up-to-date, while for bowel screening nearly half of women in community pharmacy settings and 74% of women in community settings reported they had undertaken the screening (Table 8.12). While it is possible that the women surveyed did not represent the typical population within the area, it is also possible that this discrepancy relates to the barriers inherent in the low level of screening, for example some women not having sufficient knowledge about the tests themselves to be able to answer the question accurately.

Table 8.12 Self-reported data on whether up to date with cancer screening

	Cervical attendance		Breast attendance		Bowel screen	
	Pharmacy (917 eligible)	Community (202 eligible)	Pharmacy (221 eligible)	Community (80 eligible)	Pharmacy (118 eligible)	Community (43 eligible)
No	14%	24%	14%	19%	33%	26%
Not sure	3%	3%	4%	1%	18%	0%
Yes	83%	73%	81%	80%	49%	74%

8.7 Women's awareness of cancer signs and symptoms

Women were surveyed on their knowledge of cancer signs and symptoms. In the community setting women were more likely than women in the community pharmacy settings to be aware of one or more signs or symptoms of cancer, and less likely to say that they did not know of any (Table 8.13). In general, the knowledge of all the possible cancer signs and symptoms were low in both settings (Table 8.14), but particularly the community pharmacy setting. This included some of the more commonly known signs and symptoms- pain, bleeding and weight loss, with none of the symptoms being recognised by a third of women or more.

Table 8.13: Awareness of cancer signs and symptoms in pharmacy and community settings

	Pharmacy	Community
Don't know	34%	10%
Awareness of 1 symptom or more	66%	90%

985 women completed this part of the questionnaire in pharmacy, 255 in community

Table 8.14: Knowledge of specific cancer signs and symptoms in pharmacy and community settings

Cancer sign/symptom	Pharmacy	Community
Pain	32%	24%
Bleeding	27%	18%
Weight loss	20%	22%
Tiredness/fatigue	16%	22%
Loss of appetite	11%	14%
Feeling weak	10%	12%
Nausea/sickness	9%	15%
Cough/hoarseness	9%	11%
Change in bowel/bladder habits	9%	13%
Generally unwell	8%	12%
Difficulty swallowing	4%	9%
Sore that does not heal	4%	9%
Bruising	3%	9%
Blurred vision	3%	7%
Nothing	3%	6%

985 women completed this part of the questionnaire in pharmacy, 255 in community

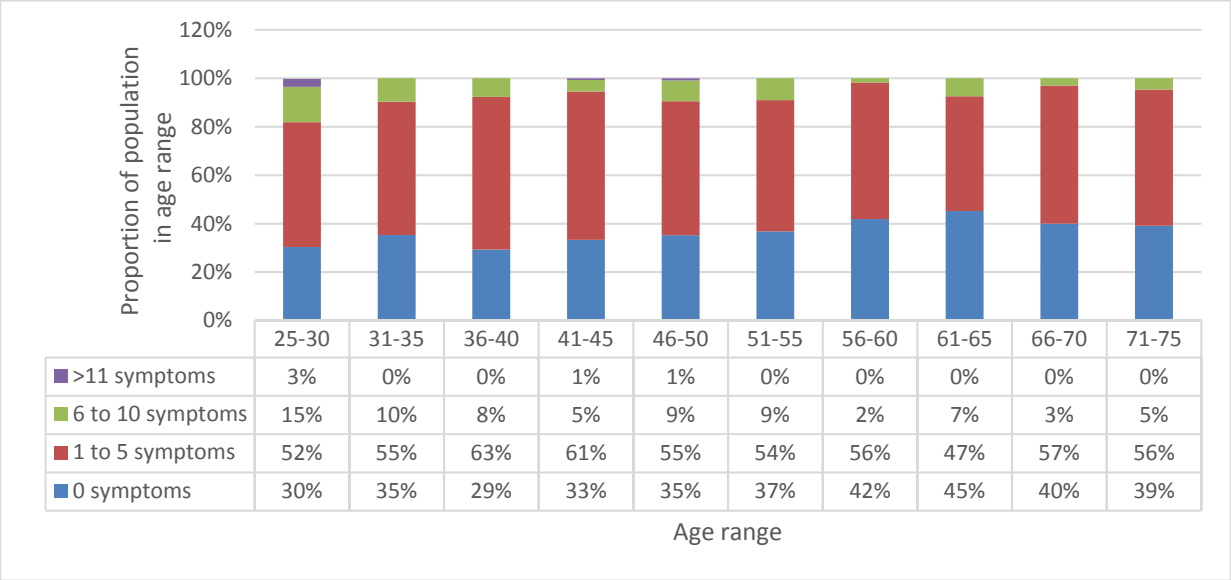
Whilst further analysis is necessary from the qualitative data this data shows that symptom awareness is very poor amongst the South Asian women surveyed. Comparing the community and pharmacy settings the data also suggests that engagement in community settings can be supportive of developing knowledge about health and wellbeing, including cancer signs and symptoms.

Further analysis was carried out to determine whether or not the knowledge of symptoms was related to age (Figure 8.8, Figure 8.9). The data shows that irrespective of age very few women were aware of all of the potential cancer signs and symptoms. In the community pharmacy setting, younger women had slightly more knowledge of symptoms than women in the older age ranges. In the community setting, knowledge was more evenly distributed amongst the age groups, with a higher proportion of older women with a good knowledge of many of the signs and symptoms of cancer than found in the women visiting community pharmacies. In the community group there is also a smaller proportion of women with no knowledge at all of cancer signs.

We also looked to see whether the place of birth was a factor in knowledge of cancer signs and symptoms, analysing the data by whether women were born in the UK or outside the UK (Table 8.15). In both community and pharmacy settings, women born outside the UK were more likely than women born in the UK to have no knowledge of cancer signs and

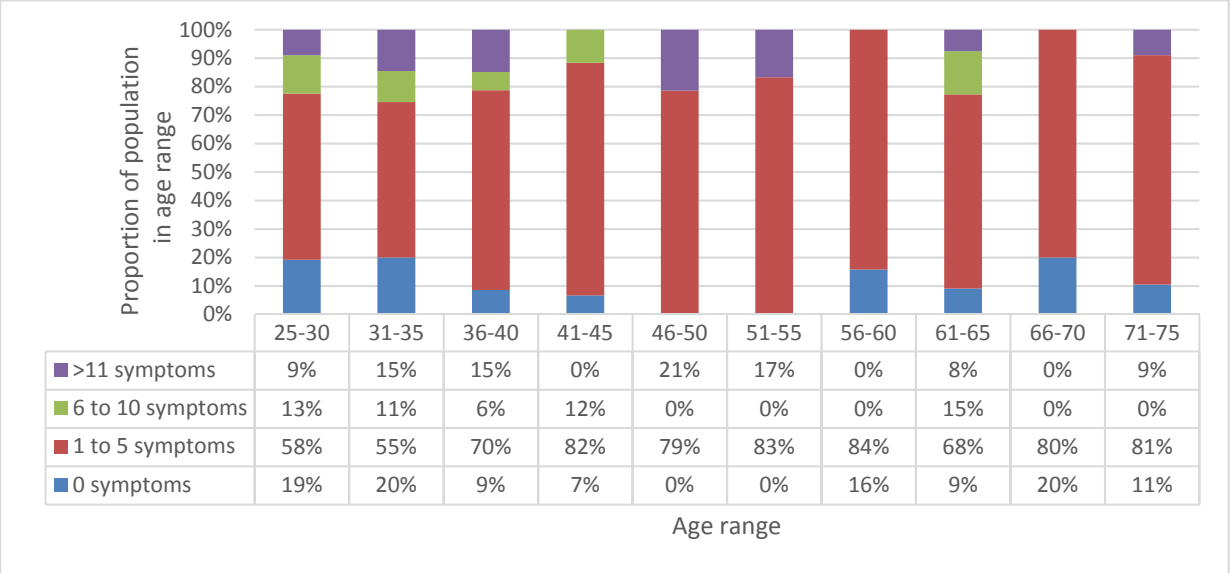
symptoms, with women born outside the UK who were seen in community settings having more knowledge of cancer signs and symptoms than women visiting pharmacies.

Figure 8.8: Total Number of symptoms recognised in pharmacy settings by age



985 women completed this part of the questionnaire

Figure 8.9: Total Number of symptoms recognised in community settings by age



254 women completed this part of the questionnaire

Table 8.15: Total number of symptoms recognised in pharmacy and community settings by country of birth

	Pharmacy		Community	
	Born in UK	Not born in UK	Born in UK	Not born in UK
No symptoms known	21%	40%	7%	12%
1 to 5 symptoms known	64%	54%	75%	69%
6 to 10 symptoms known	13%	5%	9%	6%
>11 symptoms known	2%	0%	9%	13%

985 women completed this part of the questionnaire in pharmacy, 240 in community

Overall the data confirms a very low knowledge base of women in the community before the intervention, especially amongst women not born in the UK. This is likely to be a significant factor in relation to the awareness of the importance of cancer screening. This data strongly suggests that educational interventions, e.g. in community pharmacy or community settings, may be an effective route to sustaining increases in awareness that could be predicted to lead to increased uptake of health services, including cancer screening. It also suggests that engagement in community groups is somewhat supportive of improving awareness of health.

The lack of knowledge, and the possibility of interventions to improve knowledge and awareness was commented on by one of the Pharmacy Health Champions who participated in the project:

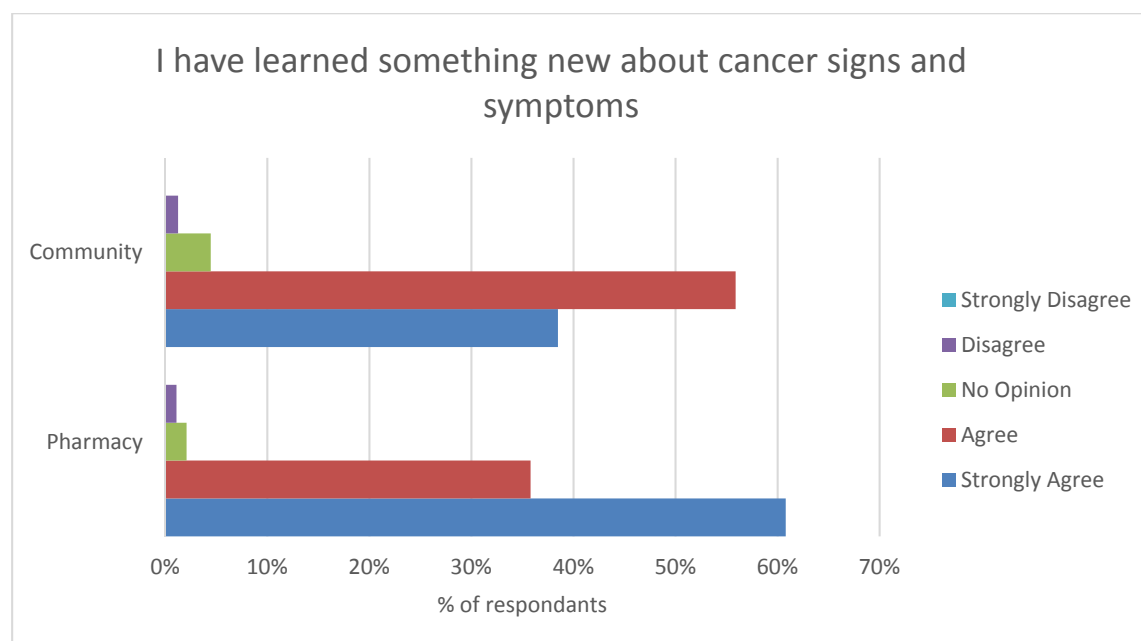
‘...when we did ask them, you know, what do you think are the signs and symptoms, a lot of them didn’t have that much awareness, and it was not shocking, but it was, I suppose that when we said, oh you know, look, these could be the signs, that it did sort of open the eyes and make them say, oh right, okay, so again it’s building up their awareness, but I wasn’t shocked, but I was just sort of, I thought they might know, okay, weight loss, but a lot of them didn’t have much idea’ (Pharmacy Health Champion 2)

Following the intervention, women were asked if they had learned something new about cancer signs and symptoms from the ‘health chat’. The majority of women (94% in community settings, 97% in pharmacy settings) agreed or strongly agreed that they had learned something new about the signs and symptoms of cancer (Figure 8.10). This demonstrates that the intervention had been highly effective in raising awareness and knowledge of cancer signs and symptoms amongst the participants. The increased awareness was commented on by one of the Pharmacy Health Champions

‘I think it’s been absolutely brilliant. It has, I honestly say this, there have been many patients from different backgrounds that have sat with me and didn’t have any idea

of any of the signs and symptoms, if any of the screenings were available, how they could access the screenings, where they would take place. I think if anything the women that I did speak to went away with that vital information and it was all for it, and obviously it's thank you to the project and you guys for promoting that.'
(Pharmacy Health Champion 3)

Figure 8.10: Effect of intervention on learning about cancer signs and symptoms



985 women completed this part of the questionnaire in pharmacy, 247 in community

8.8 Setting lifestyle goals

Over half of women set at least one lifestyle goal following the intervention. The most common goals set by participants in both the pharmacy and community settings related to increasing physical activity levels and eating a healthier diet (Table 8.16). Women interviewed in the pharmacy setting were more likely to set goals than those in the community setting. The goals be more physically active and eat a healthier diet were at least twice as likely to be set as the goals weigh myself and work towards a healthy weight.

Table 8.16 Lifestyle goals

Goal setting (% of people setting lifestyle goals)	Pharmacy	Community
Be more physically active	60% (n= 595)	50% (n=127)
Eat a healthier diet	67% (n = 660)	50% (n=128)
Weigh myself	31% (n = 309)	26% (n=65)
Work towards achieving a healthy weight	33% (n = 326)	18% (n = 46)

The majority of participants in both settings who regard themselves as not being a healthy weight set the goal towards achieving a healthier weight (Table 8.17). The intervention in the community setting appeared to be more successful than the pharmacy intervention in encouraging participants to set this behavioural goal. This data also demonstrates that approximately one in five women who, in the questionnaire, regarded themselves as being a healthy weight, set goals to achieve a healthy weight.

Table 8.17 Relationship between perceived weight and goal setting to healthy weight.

	Am I a healthy weight?					
	Yes		Not sure		No	
	Pharmacy	Community	Pharmacy	Community	Pharmacy	Community
Set goal to work towards achieving a healthy weight?	18%	18%	41%	9%	53%	72%
Didn't Set goal to work towards achieving a healthy weight?	82%	82%	59%	91%	47%	28%

985 women completed this part of the questionnaire in pharmacy, 214 in community

The self-reported intake of fruit and vegetables, i.e. an indicator of a healthy diet did not alter whether women set goals to achieve a healthy weight (Table 8.18).

Table 8.18 Relationship between fruit and vegetable consumption and goal setting to healthy weight.

	Fruit and vegetable consumption (portions/day)	
	0-4	5+
Set goal to achieve healthy weight	32%	37%
Did not set goal to achieve a healthy weight	68%	63%

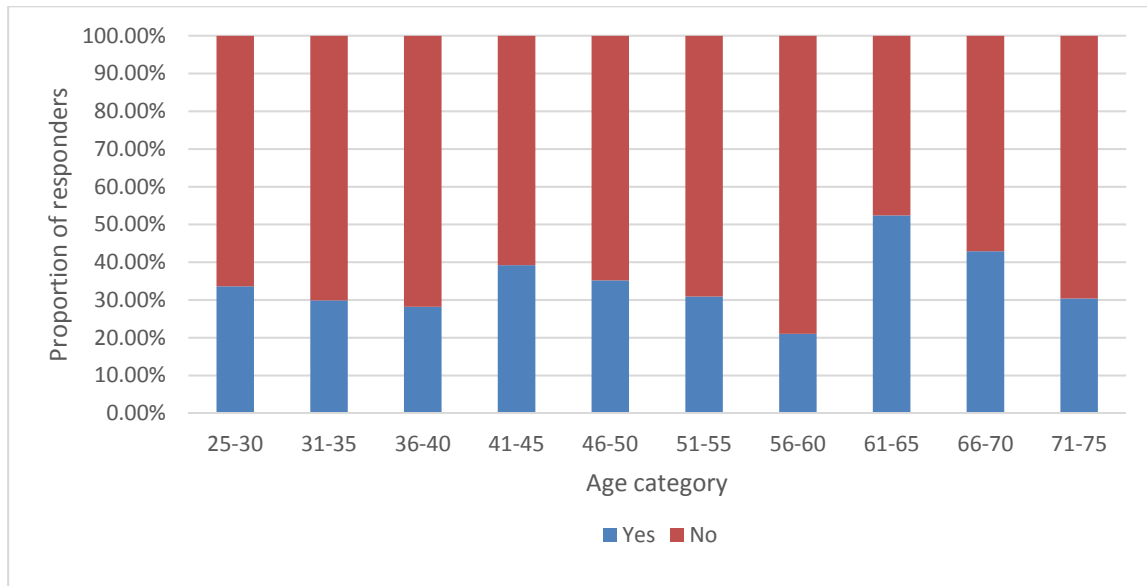
985 women completed this part of the questionnaire in pharmacy, 212 in community

We also tested whether this goal setting was influenced by age (Figures 8.11, 8.12). While in the community setting older women (56+) had a tendency to set this goal less than younger women, there were no major differences between age groups.

We also looked at whether age was a factor in setting goals for increasing physical activity (Figures 8.13, 8.14), eating a healthy diet (Figures 8.15, 8.16) and weighing yourself (Figures

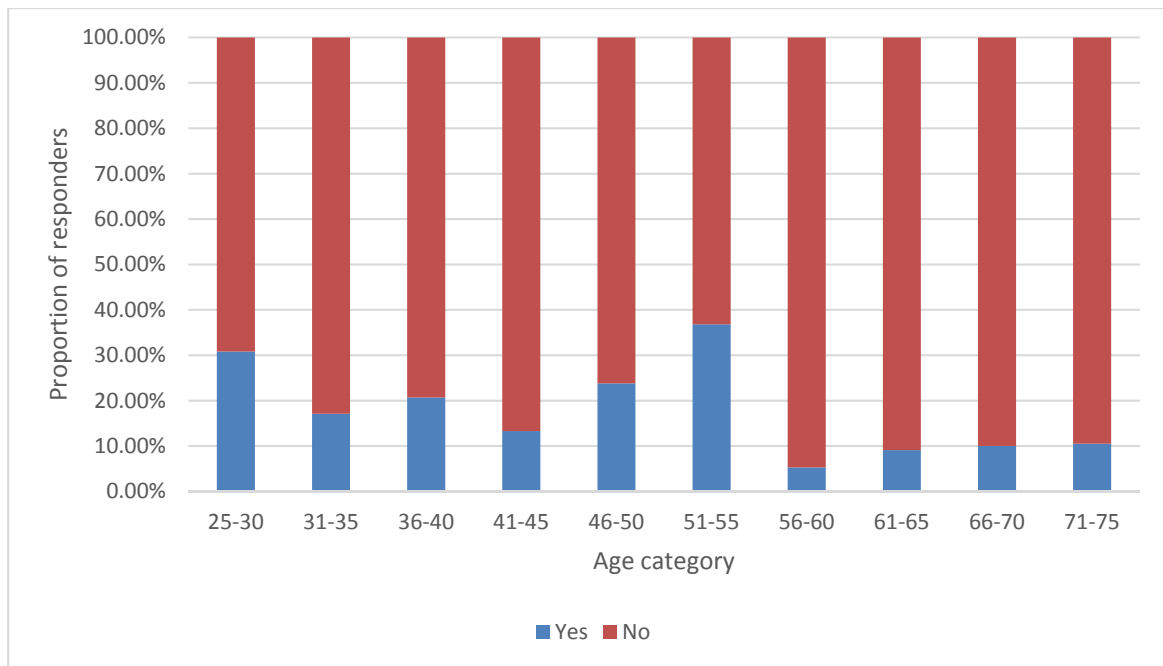
8.17, 8.18). There were no major age differences in goal setting, noting that there was a trend in the goal of 'weighing yourself', with the popularity of this goal increasing in line with age, more popular among the older age groups and a trend that younger women set goals to have a healthy diet.

Figure 8.11 Relationship between age and goal setting to healthy weight in pharmacy participants



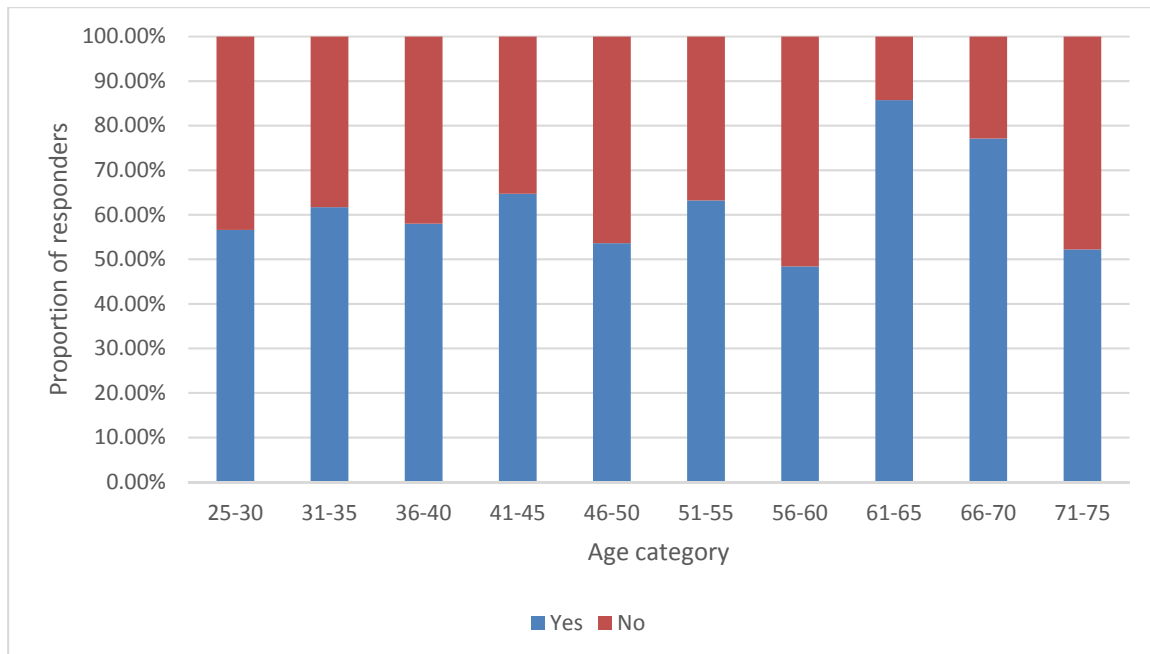
985 women completed this part of the questionnaire

Figure 8.12 Relationship between age and goal setting to healthy weight in community participants



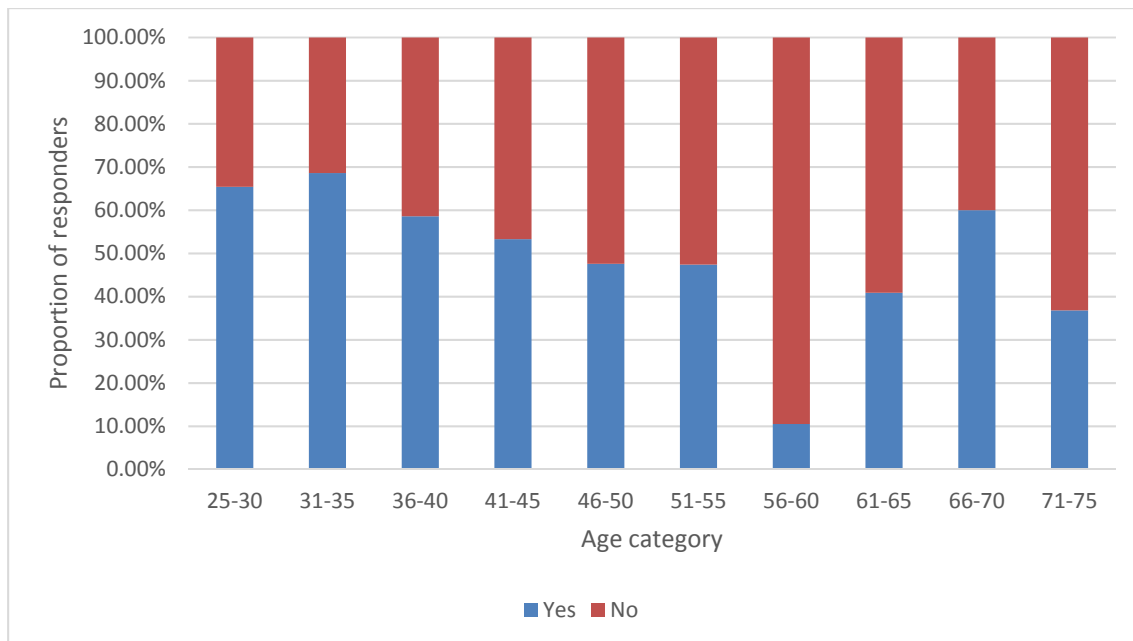
254 women completed this part of the questionnaire

Figure 8.13 Relationship between age and goal setting to increase physical activity in pharmacy participants



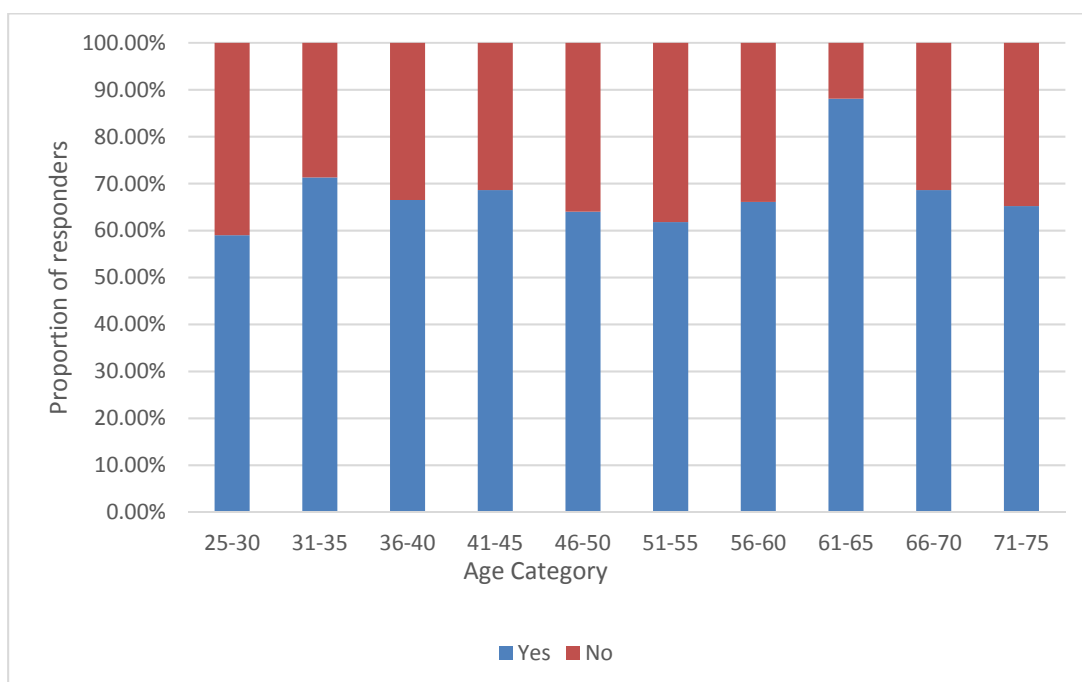
985 women completed this part of the questionnaire

Figure 8.14 Relationship between age and goal setting to increase physical activity in community participants



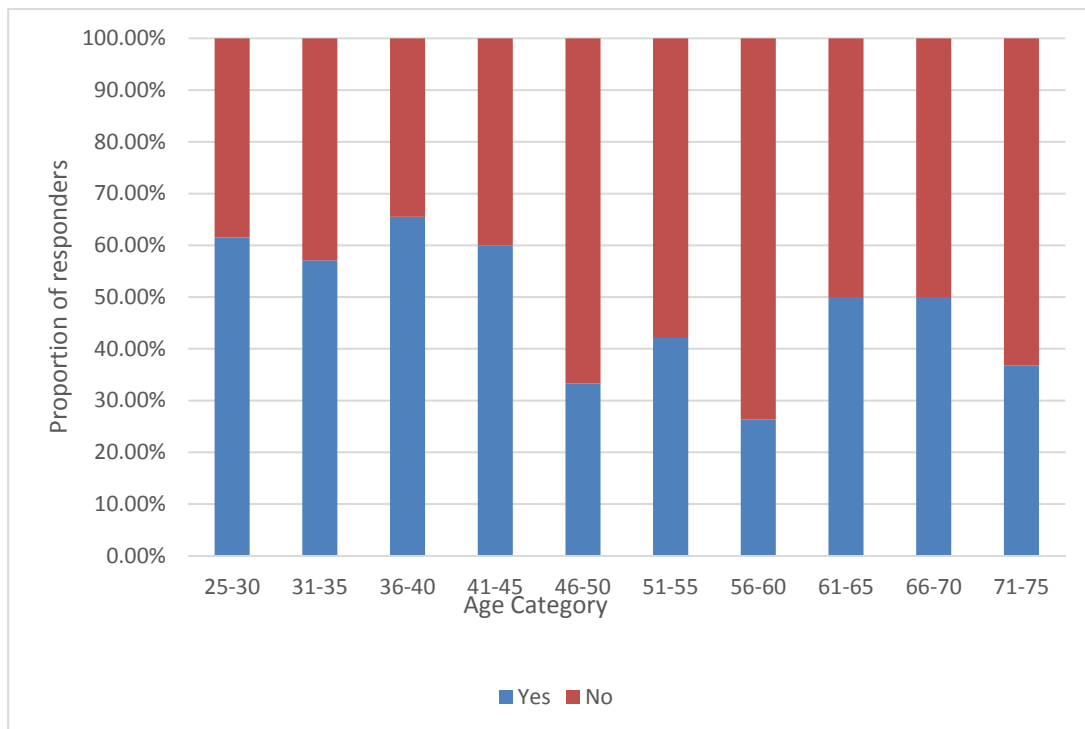
254 women completed this part of the questionnaire in pharmacy

Figure 8.15 Relationship between age and goal setting to eat a healthier diet in pharmacy participants



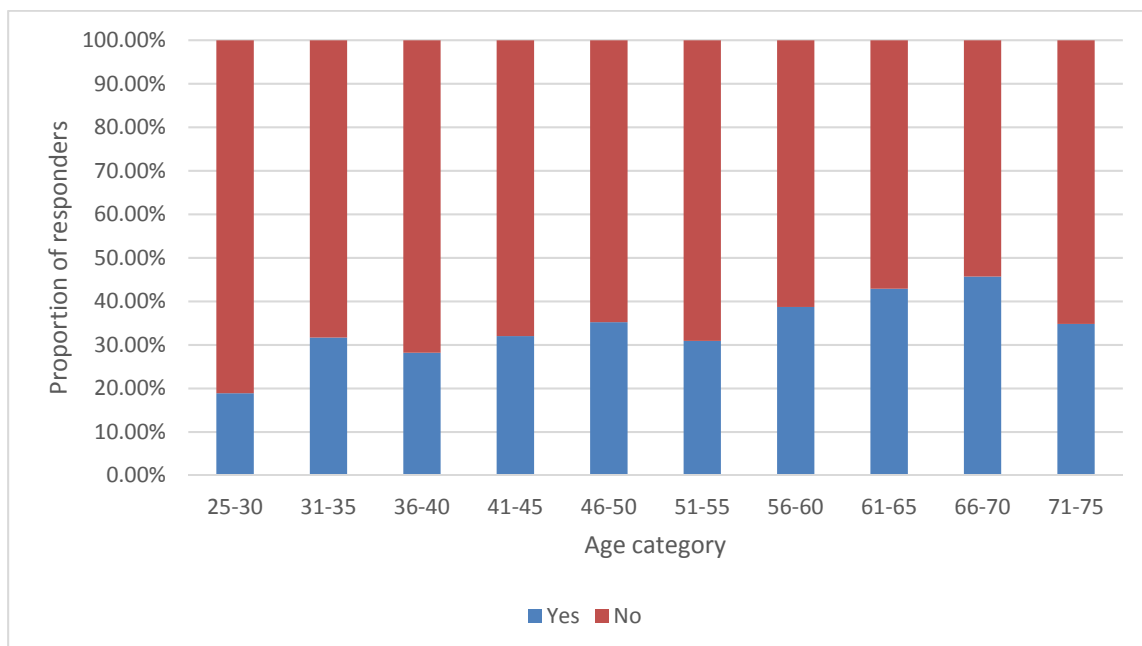
985 women completed this part of the questionnaire in pharmacy

Figure 8.16 Relationship between age and goal setting to eat a healthier diet in community participants



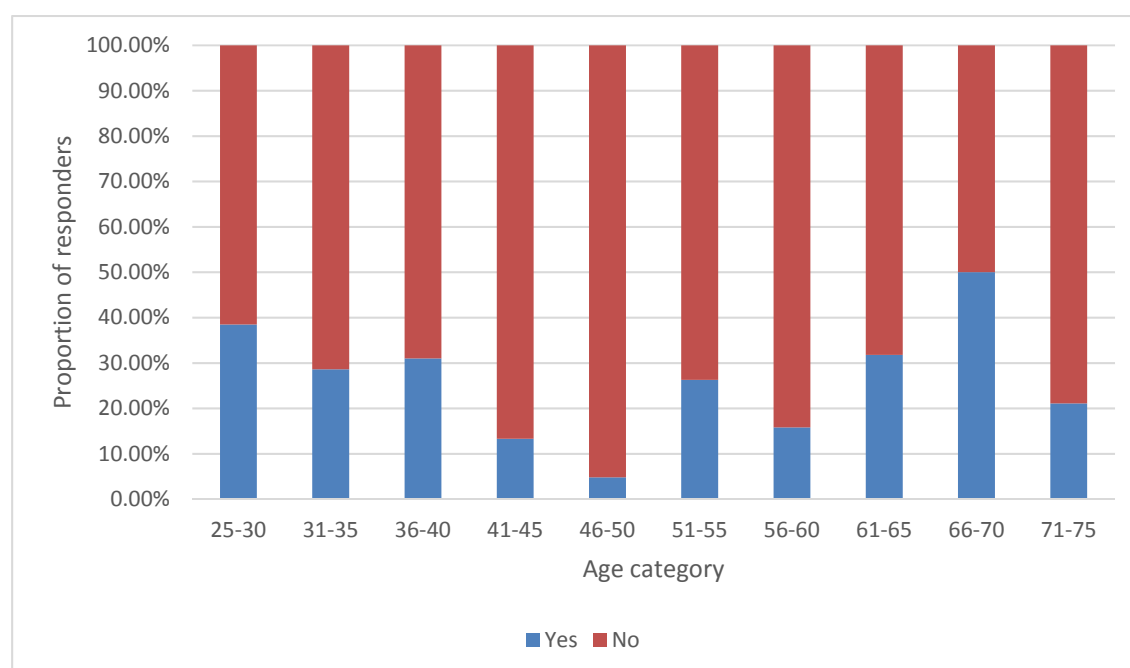
254 women completed this part of the questionnaire in community

Figure 8.17 Relationship between age and goal setting to weigh yourself in pharmacy participants



985 women completed this part of the questionnaire in pharmacy

Figure 8.18 Relationship between age and goal setting to weigh yourself in community participants



254 women completed this part of the questionnaire in community

The relationship between country of birth and goal setting to achieve healthy weight, increase physical activity, exercise more and weigh yourself was tested (Tables 8.19-8.22). There were no important differences found, the proportion of women setting these goals setting was similar for women born within or outside the UK.

Table 8.19. Relationship between country of birth and goal setting to achieve healthy weight

	Pharmacy		Community	
	Born in UK (n = 313)	Not born in UK (n = 528)	Born in UK (n = 55)	Not born in UK (n =185)
Set goal to achieve healthy weight	32%	31%	25%	17%
Did not set goal to achieve a healthy weight	68%	69%	75%	83%

Number of women in each group shown in brackets

Table 8.20. Relationship between country of birth and goal setting to increase physical activity

	Pharmacy		Community	
	Born in UK (n = 313)	Not born in UK (n =528)	Born in UK (n =55)	Not born in UK (n =185)
Set goal to increase physical activity	56%	60%	56%	50%
Did not set goal to increase physical activity	44%	40%	44%	50%

Number of women in each group shown in brackets

Table 8.21 Relationship between country of birth and goal setting to eat a healthier diet

	Pharmacy		Community	
	Born in UK (n = 313)	Not born in UK (n = 528)	Born in UK (n = 55)	Not born in UK (n = 185)
Set goal to eat a healthier diet	66%	66%	47%	53%
Did not set goal to eat a healthier diet	35%	35%	53%	47%

Number of women in each group shown in brackets

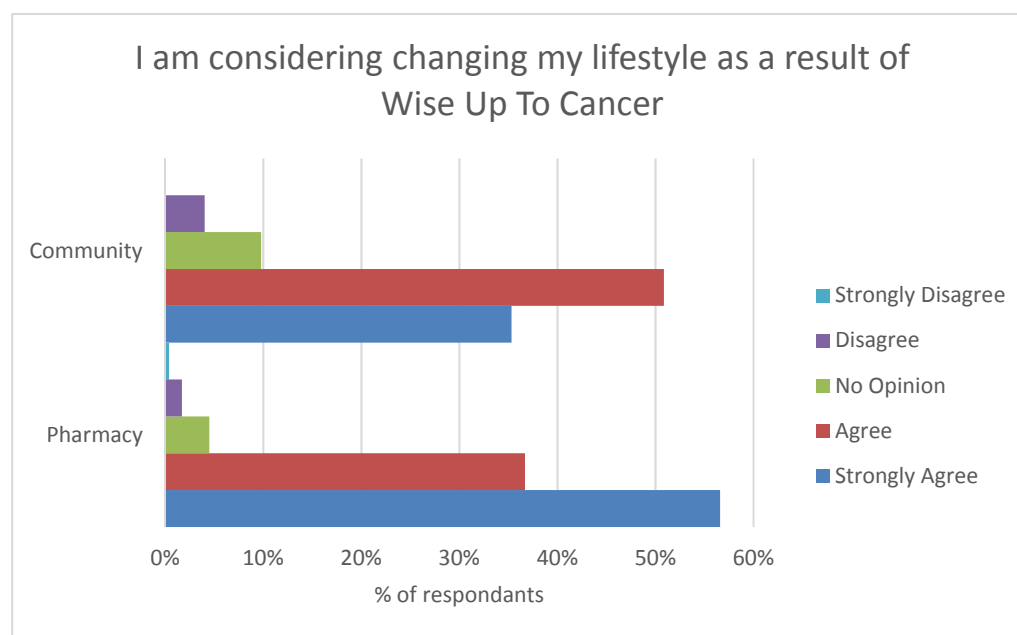
Table 8.22 Relationship between country of birth and goal setting to weigh yourself

	Pharmacy		Community	
	Born in UK (n =313)	Not born in UK (n = 528)	Born in UK (n = 55)	Not born in UK (n =185)
Set goal to weigh myself	30%	34%	22%	29%
Did not set goal to weigh myself	70%	66%	78%	71%

Number of women in each group shown in brackets

When women were asked, at the end of the survey following the health chat, whether they were considering to change their lifestyle as a result of the Wise Up To Cancer intervention. The vast majority of women interviewed in community settings (86%) and pharmacy settings (94%) agreed or strongly agreed (Figure 8.19). This demonstrates that the intervention has been highly successful in supporting an intention to change.

Figure 8.19 Intention to change lifestyle as a result of participation in survey



995 women completed this part of the questionnaire in pharmacy, 246 in community

In the free text part of the survey, women were asked to state if they were setting any additional goals following the health chat that included discussions about healthy lifestyles (e.g. diet, weight management and exercise). A number of women set goals (Table 8.23). The free text answers suggest good health literacy amongst this group of women in the goals set. In general, the personal goal setting in pharmacy and community interviews were similar, and included goals about diet and weight management, exercise and health and wellbeing (many relating to mental health).

The intervention prompted some women (1 in the pharmacy and 3 in the community) to take action relating to health issues not directly related to weight, showing that a 'health chat', here focussed on cancer prevention, can support uptake of health services. In the community setting there were a number of goals set relating to other significant issues for women including harassment, disability and the desire to engage with educational programmes. This illustrates the holistic nature of the intervention carried out in the community settings, where women wished to engage with Health Champions about a range of issues which affected them in addition to the main purpose of the survey.

Table 8.23 Additional goal setting by women

	Pharmacy	Community
Diet & Weight management	<i>Eat more healthily</i> <i>Eat a smaller breakfast</i>	<i>Healthy eating</i> <i>Drink more water</i>

	<i>Reduce snacks</i> <i>Improve digestive system</i> <i>Drink more water</i> <i>Cut down on sugar in tea</i> <i>Decrease salt intake</i> <i>Eat more wholemeal/wholegrain foods</i> <i>Increase fruit and veg intake</i> <i>Eat more grilled food</i> <i>Eat less fried food</i> <i>Reduce cholesterol</i> <i>Put less oil in food</i> <i>Lose weight</i> <i>Increase weight</i> <i>Eat smaller portion size</i> <i>Control diabetes/improve blood sugar</i>	<i>Less sugary food</i> <i>Eat more fruit and more fibre</i> <i>Eat food on time</i> <i>Reduce carbs</i> <i>Lose weight</i> <i>Eat small portions</i> <i>Control diabetes</i>
Exercise	<i>Walk more</i> <i>Increase exercise/join gym/attend classes</i>	<i>Increase exercise</i> <i>Walk more</i> <i>Improving fitness/energy level</i> <i>See health trainer</i>
Health & Wellbeing (mental health)	<i>Reduce stress</i> <i>Keep healthy and happy</i> <i>Feel happier/less depressed</i> <i>Be more positive and then I'll be more motivated</i> <i>Travel more</i> <i>Get out more (participant is a full time carer)</i>	<i>Reduce stress</i> <i>Think positive</i> <i>Support with mental health/wellbeing</i> <i>Improve sleeping pattern</i> <i>Work on confidence</i>
Medical unrelated to weight/diet or mental health	<i>Take regular thyroid medication</i>	<i>Speak to GP about results</i> <i>See GP/counsellors about skin problem</i> <i>See nurse</i>
Social & Educational		<i>Study English to aid communication about health</i> <i>Study (medical field)</i> <i>Harassment/Hate Crime/Victim support</i> <i>Contact disability service</i>
Other	<i>Making plans for after new year</i>	<i>Time management</i>

8.9 Smoking Cessation

Seventy four women interviewed in the pharmacy setting used tobacco products of whom 32 (43%) intended to cut down use of tobacco, and 12 (16%) stop altogether. 29 women (39%) of this group were signposted to smoking cessation services. For the women interviewed in the community setting, only 5 used tobacco products. 1 woman (20%)

intended to cut down smoking, none to stop altogether and none were referred to smoking cessation services.

8.10 Signposting to services by Health Champions

The questionnaire provided the opportunity for Health Champions to signpost participants to relevant local services including physical activity and healthy weight services. Over half of women who wanted to work towards achieving a healthy weight were referred to services that support a healthy lifestyle (Tables 8.24, 8.25). Pharmacy Health Champions were more likely than Community Health Champions to refer participants and we note that this included referral to healthy weight services, even if the women had not set goals towards healthy weight. Likewise, a high proportion of women who set a goal to increase physical activity were referred for physical activity services (39% community, 71% pharmacy). Pharmacy Health Champions were twice as likely to refer women compared to their community counterparts (Table 8.26).

Table 8.24. Relationship between goal setting to healthy weight and champion signposting to weight management services.

	Women who set goal to work towards a healthy weight		Women who did not set goal to work towards a healthy weight	
	Pharmacy (n =326)	Community (n = 46)	Pharmacy (n =659)	Community (n =209)
Signposted to weight management service	63%	54%	46%	22%
Not signposted to weight management service	37%	45%	54%	78%

Numbers of women meeting each criteria in brackets.

Table 8.25 Relationship between goal setting to healthy diet and champion signposting to weight management services.

	Women who set goal to eat a healthier diet		Women who did not set goal to eat a healthier diet	
	Pharmacy (n =660)	Community (n =128)	Pharmacy (n =325)	Community (n =127)
Signposted to weight management service	73%	40%	8%	15%
Not signposted to weight management service	27%	60%	92%	85%

Numbers of women meeting each criteria in brackets.

Table 8.26 Relationship between goal setting to physical activity and champion signposting to physical activity services

	Women who set goal to increase physical activity		Women who did not set goal to increase physical activity	
	Pharmacy (n =595)	Community (n =127)	Pharmacy (n =390)	Community (n =128)
Signposted to physical activity service?	71%	39%	8%	5%
Not signposted to physical activity service?	28%	60%	92%	95%

Numbers of women meeting each criteria in brackets.

Overall the data shows that the intervention was highly successful in signposting women to local services. Intervention in pharmacy settings was more effective in referring women to local services. Signposting to other appropriate services is common practice in many pharmacies. In addition, the Pharmacy Health Champions will be more familiar with having chats about ‘personal’ issues and may have a perception on what goals would be appropriate for women. This is illustrated by one of the Pharmacy Health Champions, who considered that some women’s perception of their health did not match the reality but influenced the goals they wanted to set:

‘I can’t tell you what to, and I mean I’ve seen some women and God bless them, they may not be healthy and they say “yeah, I’m healthy” and you don’t want to say “mm, no you’re not!” You don’t want to put them in that situation so you’re just like “right okay, even though you are healthy, how would you like to be a little bit more healthy?”’ (Pharmacy Health Champion 3)

8.11 Impact of community intervention on cancer screening and accessing GP services

Women were asked if they were familiar with and were currently experiencing any of the signs and symptoms of cancer. If they did have signs and symptoms, they were asked whether they had checked these with a GP or intended to. In pharmacy settings 21% of the 713 women who had experienced cancer signs or symptoms said they had signs checked, and 3% that they planned to. In community settings, 16% of the 155 women who had experienced cancer signs or symptoms said they had had cancer signs or symptoms checked, and 3% that they planned to. When asked about the reasons for not planning to visit the GP there were a range of responses (Table 8.27).

These responses are illustrative of the barriers to cancer screening among women. Some perceive they do not need to visit, and do not have symptoms. Some cannot make time to visit the GP as they are busy, some find it difficult to get an appointment or contacting their GP and some are concerned or fearful of examination, particularly the potential of being seen by a male doctor.

Table 8.27 Reasons given why women do not visit GP to have signs and symptoms of cancer checked.

Health perceptions:	<i>Didn't think it was serious</i>
	<i>Would go if there were symptoms</i>
Lifestyle:	<i>Been really busy (we spent some time working out time, activity, priorities and client suggested Friday was best and would book an appointment)'</i>
	<i>Busy lifestyle/vitamin D deficiency</i>
	<i>Forget about it</i>
Difficulties (actual or perceived) in accessing medical services	<i>Not getting appointment</i>
	<i>Doctor unresponsive</i>
	<i>It is hard to get an appointment and i have communication problems</i>
Concerns/fears about the procedure(s)	<i>It's a sensitive area, I can't go through the medical examination, I feel embarrassed</i>
	<i>Male Doctor</i>
	<i>Don't want to go, feels uncomfortable</i>

Women were also asked if they intended to make an appointment for cancer screening, if this was overdue. The vast majority of women asked this question (>90%) said that they would, except for bowel screening in the community setting where only just over half of the women said that they would (Table 8.28). This confirms there are likely to be particular barriers to bowel screening uptake, where rates are very low.

Table 8.28 Intention to make an appointment for cancer screening self-reported data

	Pharmacy (n =153)	Cervical Community (n =36)	Pharmacy (n =41)	Breast Community (n =16)	Pharmacy (n =61)	Bowel Community (n =11)
Yes	90%	86%	95%	82%	95%	56%
No	10%	14%	5%	18%	5%	44%

Numbers of women meeting each criteria in brackets.

When women who said they were not going to book a screening appointment were asked about their reasons for not wanting to do so, a range of responses were provided (Table 8.29).

Table 8.29 Reasons given by women for not booking a screening appointment

Health perceptions:	<p><i>Already been</i> <i>[I am] well, so not needed - it's normal so not needed</i> <i>She thinks she is fine</i> <i>Normal - don't feel need to</i> <i>has had a hysterectomy</i> <i>endometriosis</i> <i>Pregnant</i> <i>Will follow up with GP</i></p>
Lifestyle:	<p><i>family commitment no time</i> <i>'no time</i> <i>Time consuming - bowel. Interrupts with work because 3 days. Needs to be</i> <i>simple test.</i></p>
Difficulties (actual or perceived) in accessing medical services	<p><i>Getting appointment</i> <i>no transport</i> <i>has had womb removed patient has a disability and unable to walk</i> <i>Complex mental health, difficulty recalling info provided</i> <i>Not had an appointment</i> <i>waiting for invitation</i></p>
Concerns/fears about the procedure(s)	<p><i>not comfortable with the process</i> <i>embarrassment</i> <i>Embarrassed</i> <i>Embarrassed</i> <i>finds it uncomfortable</i> <i>physical barriers- too painful for her</i> <i>Being 'invasive'</i> <i>Bowel screening - dirty impact on ablution</i> <i>Painful, uncomfortable</i> <i>Tearful (?)</i> <i>Scare - insets and pain/thoughts. Suggested urine test would be better.</i> <i>Scared to know results</i></p>
Other	<p><i>not sure</i> <i>Just moved here from another country</i></p>

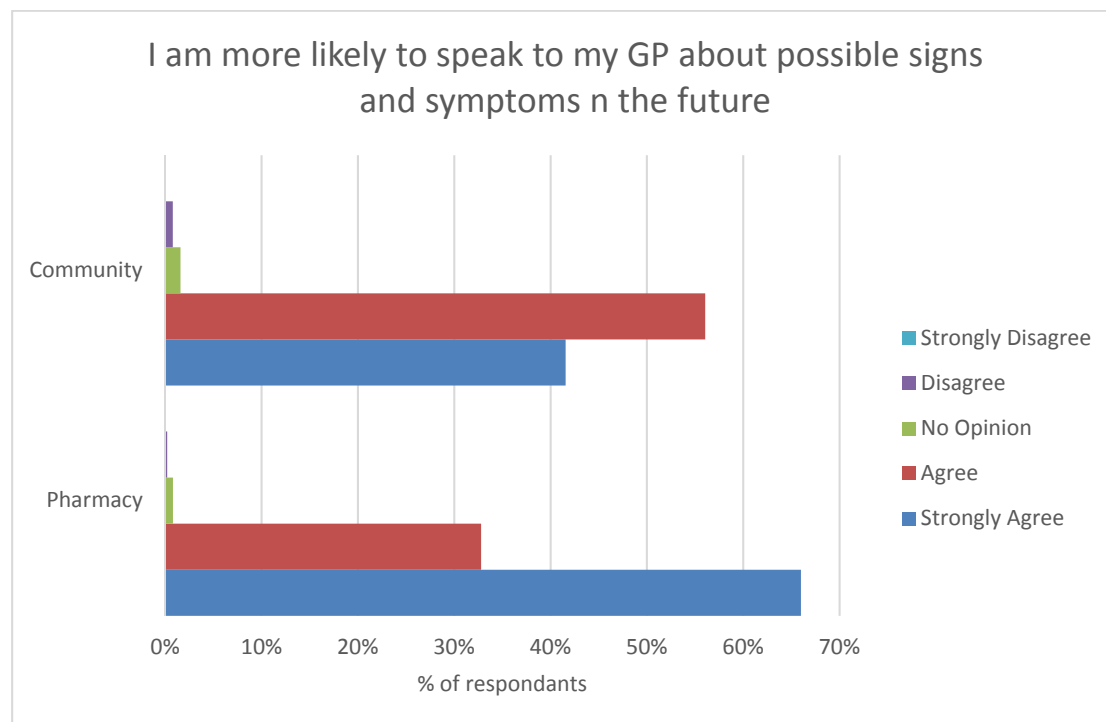
These were similar to those provided for not wishing to visit the GP to discuss cancer signs and symptoms. Some women's health perceptions were that they did not require screening because they were symptom free or that other medical issues meant they did not require screening. Others felt they were too busy to go or felt that the procedure would require taking time off work. Several cited difficulties in getting an appointment or getting to an appointment, including disability. Many respondents reported embarrassment or that the procedures would be painful or cause discomfort or that they were scared.

These statements from women sum up the key issues and lived experience of South Asian women in Bradford, confirming that there are a number of barriers to screening relating to health perceptions, lifestyle, difficulties in accessing medical services and concerns about the medical procedures.

Women were asked a series of questions at the end of the survey about intention to take actions following the discussions. Almost all (98%) of women in community setting and 99% of women in pharmacy setting agreed or strongly agreed that they would be more likely to speak to their GP about cancer signs and symptoms as a result of participating in the study (Figure 8.20). Likewise, 93% of women in the community and 96% of women in pharmacy settings agreeing or strongly agreeing that they are more likely to attend screening (Figure 8.21). Therefore, the intervention was highly beneficial in supporting an intention to change, with the hope that some of the barriers present, in particular to engage with GPs and health services were reduced.

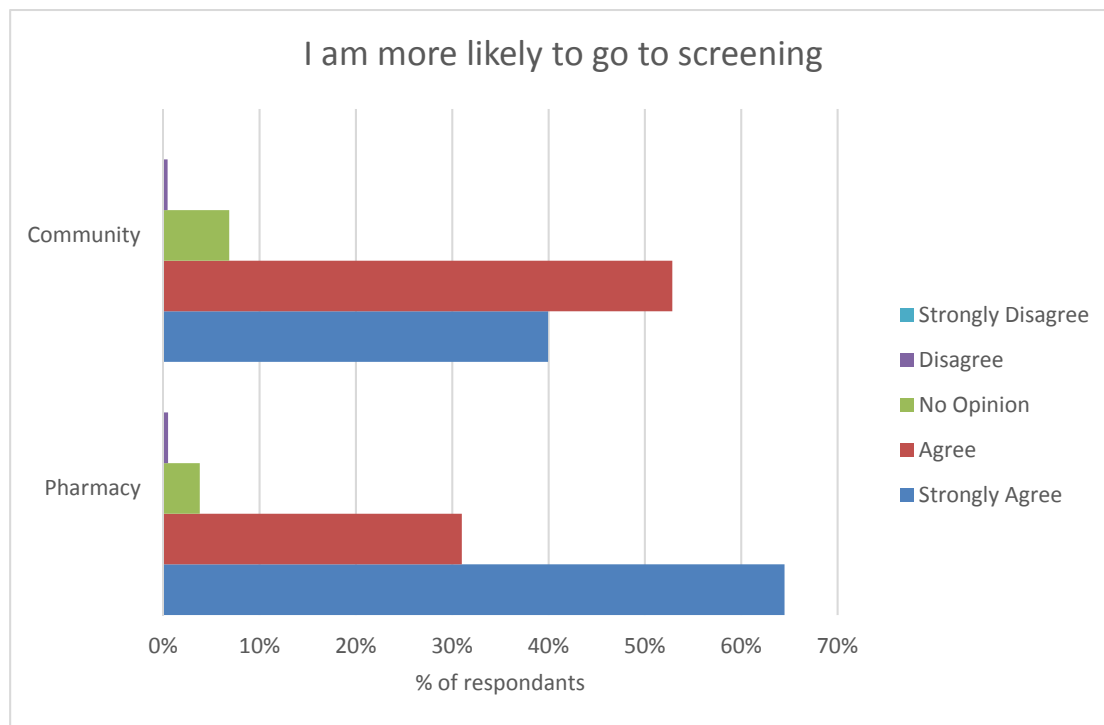
'I didn't know about bowel cancer, I didn't know there was screening and I didn't know how you would know if you had it or what you should do.' (Community Participant)

Figure 8.20 Likelihood to speak to GP about cancer signs and symptoms as a result of the intervention.



985 women completed this part of the questionnaire in pharmacy, 250 in community

Figure 8.21 Likelihood to attend screening as a result of the intervention.



985 women completed this part of the questionnaire in pharmacy, 248 in community

8.12 Follow up questionnaire

A total of 271 (228 in the pharmacy setting, and 43 in the community setting) women consented to participate in a short follow-up questionnaire, to check progress with goals they had set when completing the baseline questionnaire, and for us to obtain feedback on the intervention. These follow-ups were completed a minimum of 6 weeks after the initial baseline questionnaire, by a member of the research team, and by several volunteers who spoke a range of South Asian languages.

Of those who consented to take part, 109 were successfully contacted and completed the follow-up questionnaire. Three attempts were made to contact participants, after which they were removed from the list and not contacted again. Follow-up questionnaires were recorded in Excel, and the questionnaires were then shredded as they contained patient identifiable information.

8.12.1 Progress towards healthy lifestyle goals

Of the 74 participants who set a goal to change their eating habits, 66 said that they had done so since the intervention, and 18 said that they had not done so, with one saying she had recently had a baby and planned to attend slimming world. Participants were asked about what kinds of changes they had made, which included: eating fewer takeaways; increasing consumption of fruit and vegetables; fewer fizzy drinks; boiling and grilling food instead of frying it; reducing sugar and snacks; reducing portion sizes; eating fewer fatty foods. Of those who had not changed their eating habits, one said that this was due to

stomach problems and another said that she had recently had a baby and would be starting a diet soon.

Of the 73 participants who set a goal to increase their physical activity levels, 57 said that they had done so, and 18 said that they had not. Of those who had not increase their physical activity, two said it was hard to do so with childcare responsibilities and four mentioned physical and mental health problems as a barrier to increasing physical activity. Changes to physical activity levels included: more walking; exercising with children (e.g. in the park); going to the gym; swimming; using treadmills at home; accessing classes at a local community centre; doing physiotherapy.

Of the 50 participants who set a goal to either weigh themselves, or work towards achieving a health weight, 33 had done so and 17 had not. Of those who hadn't met this goal, one stated that thyroid problems had prevented her from doing so, one said that due to family issues she had not been focusing on herself, one said she would work on this after returning from her holiday. Several participants reported weight loss as a result of lifestyle changes, whilst one stated that she had (intentionally) gained weight to achieve a healthier weight.

Of the 5 participants followed up who used tobacco and had aimed to reduce their use of tobacco products, four had not. One participant said that she did not want to, and another said that she had had a lot going on including bereavement and had been smoking more. One participant had reduced her intake of paan as a result of the intervention.

Some participants reported on other goals they had set themselves. One said that, although she had set a goal to get out more, she was finding it difficult due to full-time caring responsibilities, and two stated that they had not worked towards their goals without giving a reason. One participant said that she had reduced her consumption of sugar and was no longer in the 'at-risk' category for diabetes.

Six participants provided general feedback on the lifestyle changes they had made following the intervention, and reported feeling happier, better, and more energetic.

8.12.2 Screening and symptom checking

Nine participants out of the 24 who set this goal said that they had spoken to a GP about signs or symptoms of cancer following the intervention. 67% of women (18/27) who had set a goal to complete a screening had done so. This consisted of 15 of the 20 women (75%) who set the goal of attending cervical screening. Two of the four women (50%) who set the goal of completing breast screening reported they had done so, and one out of the three women (33%) who set the goal of completing a bowel screening test, reported doing so. Two had not, but one said she had made an appointment with her GP. This demonstrates directly that the intervention had had a positive effect on women on taking up their screening.

Participants who had not completed screening following the intervention said this was due to: issues with booking at the GP surgery; going on holiday; and pregnancy.

8.12.3 Learning from Wise Up To Cancer

Participants were asked what they had learned as a result of the intervention, and their comments are synthesised below in Table 8.30.

Table 8.30 Learning from the intervention

Health lifestyle changes	<i>Importance of exercise – walking more and incorporating into socialising</i> <i>Importance of healthy eating and making changes to diet</i> <i>Factors associated with risks of obesity</i> <i>Attending healthy eating classes at a community centre</i> <i>Relationship between weight and other health problems</i> <i>Relationship between blood sugar and diabetes</i>
Awareness of cancer signs and symptoms	<i>Importance of getting signs and symptoms checked</i> <i>Importance of looking out for signs and symptoms of cancer</i> <i>Breast examination</i> <i>Importance of cancer screening</i> <i>Increased knowledge and awareness of cancer signs and symptoms</i>

In addition, one participant reported that following the intervention she had found a lump and gone to the GP to have this checked. Participants' learning from the intervention maps directly onto two of the key objectives of this project, to increase awareness of cancer signs and symptoms, and to decrease behaviours associated with cancer risk, by educating women about the relationship between a healthy lifestyle and cancer.

8.12.4 Feedback on the intervention

Feedback on the intervention was largely positive. Participants were asked about topics covered, advice and support given, the leaflets, the amount of time the questionnaire took and the venue. Their responses are given below in Table 8.31.

Table 8.31 Feedback on the intervention

	Topics covered (n =96)	Advice and support (n=96)	Leaflets (n=86)	Time (n = 88)	Venue (n=95)
Poor	1%	2%	0%	0%	1%
Fair	2%	5%	16%	11%	10%
Good	40%	46%	42%	59%	51%
Very Good	57%	46%	42%	30%	37%

The number of women completing each part of the survey are include in brackets

Participants were also asked if they wished to make any additional comments about the intervention, and these were positive. Participants were positive about the support they received during the intervention, and recognised the need for increasing awareness of cancer signs and symptoms amongst the South Asian community. One participant said that she did not like discussing cancer, one said that she had received insufficient information, and one said that she had struggled with the leaflet as she couldn't read and no one helped her to read it.

37 participants said that they told someone else about Yorkshire Cancer Research after taking part in the intervention; four said that they had visited the website; three said that they had signed up to received Yorkshire Cancer Research communications; 10 said that they had donated to Yorkshire Cancer Research; two said that they had participated in or organised fundraising activities for Yorkshire Cancer Research.

We note that the numbers of women consenting to participate in the follow-up are low, and this indicates that both Pharmacy Health Champions and Community Health Champions require more clarity on the purposes of the follow-up, and what can be provided in terms of additional peer support to see if this improves uptake. There are other possible factors including time constraints, confidence in speaking to new/unknown people and concerns about use of personal data. These are factors that can be addressed in the design of future projects.

We also note that given the length of time both Pharmacy Health Champions and Community Health Champions spend chatting to some of the participants, it is possible that that women already have gained the benefit of having peer support without needing additional referral.

9 Discussion about the Community Pharmacy intervention

The pharmacy intervention delivered in 10 community pharmacies was highly successful, reaching 985 women, close to the target number of 1000. Community pharmacies received a remuneration from project funds for each questionnaire completed. The results were recorded on PharmOutcomes and transmitted securely to the University-based team.

Pharmacies were well engaged with the project team via regular communications, including site visits from Community Pharmacy West Yorkshire and University staff. In addition, the team sent regular 'thankyou' letters. The encouragement to pharmacies that their work was appreciated and that they were meeting, and in some cases exceeding, their targets was appreciated. The value to the pharmacies of being able to do something to support their community featured strongly in the feedback.

The CEO of Community Pharmacy West Yorkshire provided feedback on the project. CPWY had learned from the original pilot project in the Wakefield area to refine approaches to recruitment of pharmacies and training of Pharmacy Health Champions as well as project delivery, and brought their expertise to the project. CPWY commented that they found the Bradford pharmacies easy to engage with and very willing to participate in the study on behalf of the project team, as part of their community-centred approaches.

Community pharmacies are well linked to the communities they serve where there are often relationships which are already established, with customers/patients being willing to engage in health conversations. In the pharmacies, factors influencing the success of the intervention included the participants being in an environment embedded in their local communities where health was the focus of conversations, as opposed to the community settings which were often social events. Consequently, women were happy to engage in the intervention with staff who they often had an existing rapport with, who they considered knowledgeable as health care professionals, in an environment where privacy could be maintained.

The enthusiasm for the project was evident in two of the pharmacies that created visual displays in the consultation room that related to the questionnaires and guided their delivery.

'I think pharmacies is one of the best places that you've actually chosen to promote this, I have to say, because it's more of clinical isn't it? It's more of we're attached to surgery doctors, we have that little bit of information and we can just be like "right, all you need to do is speak to a doctor, speak to a nurse", get that out there, any help that you need pop back and we can give you that, and obviously we have your contact number so we have that availability as well. And I think the other thing that was quite good was the follow-up.' (Pharmacy Health Champion 3)

Generally, the pharmacy environment was considered an appropriate location for the intervention, with a consultation room that could be used to chat to the women in private. However, if the consultation room was being used for another purpose, this could create difficulties finding a confidential space to implement the intervention. Pharmacy Health Champions felt that being identified as a healthcare professional, for example by wearing a work uniform, was beneficial to engaging women with the questionnaire and receiving advice:

'I think healthcare profession they, they listen to you more carefully, and they know then this person is guiding you right' (Pharmacy Health Champion 4)

9.1 Pharmacy Health Champions

The Pharmacy Health Champions we spoke to as part of the evaluation were positive about the project and thought it was valuable. The location of the pharmacies appeared beneficial to attracting the target population:

'...the pharmacy where I worked at was in, slap bang in the middle of a South Asian community, so nearly every woman that came in qualified [for the intervention]'
(Pharmacy Health Champion 1)

The data demonstrated enthusiasm from the pharmacy staff involved and an ongoing commitment to reach their targets:

'so we used to do it in the morning, have a bit of a team huddle and say, right, guys, we need to keep the Wise Up To Cancer as well, nominate one person to sort of get them in, and the other two would manage the workload there' (Pharmacy Health Champion 2)

The Pharmacy Health Champions also commented on the benefit of the interventions for themselves in terms of helping them to learn about healthy lifestyles and cancer which they could share with their family and friends.

'I gained some knowledge as well myself, and then obviously I was helping other women as well, which I found that some of the people they don't know much about anyway.' (Pharmacy Health Champion 4)

They also discussed how they incorporated national media campaigns into the chats to re-enforce the messages:

'...the anniversary of Jade Goody, there was that in the news as well, This Morning had the campaign on, Lorraine, so it was good to sort of add all that into it as well and say, look, you know, it's been advertised on TV, radio, the other one that's on TV as well.' (Pharmacy Health Champion 2)

Pharmacy Health Champions needed to fit the delivery of the intervention into their regular workload and found that some days of the week they couldn't prioritise the project due to competing priorities. However, overall they felt a sense of job satisfaction from undertaking the intervention and expanding their role:

'...showing that we don't just give medicines out, we also have so many other health promotion opportunities that we can help them with many things.' (Pharmacy Health Champion 1)

And also building relationships with the participants:

'Actually I think I built a really good relationship with the patients. You get the cuddles, you get, you know, I really appreciate this and you get the breakdown and you see another side to them and it's just more of we're here to help.' (Pharmacy Health 3)

The Pharmacy Health Champions stated that now that they had been part of the project they would incorporate what they have learnt, in conversations with women. Following the project, some Pharmacy Health Champions have also encountered questions from women, who have heard of the project through others, regarding cancer signs and symptoms:

'..when now people come in to ask these questions it's much easier for us as well because they've already been to the doctors or they're scared to go to the doctors so they'll come in and ask us. I don't know how it's happened but a lot of them are just coming in, I don't know if women have spoken to them and said we've been down there have had a word with them I don't know but a lot of women have come in and said you know I've got such and such a problem, I'm bleeding more than normal what do you think I should do? I don't want to go to the doctors, do you think it's my age? I do sometimes even use the form..' (Pharmacy Health Champion 6)

Surprisingly a number of Pharmacy Health Champions commented on how some women weren't aware of the screening services available to them and that they were free of charge.

'..a lot of the women didn't know that over 55 you can go and get your over 60 it is I think sorry your mammograms done. Not a lot of in our in my community knew, you could get that done, that service is in the hospital..' (Pharmacy Health Champion 6)

After completing the baseline questionnaires, Pharmacy Health Champions had the option (with the woman's consent) to refer her for extra peer support from a Community Health Champion. The criteria for referral was that the woman was overdue cancer screening and appeared demotivated. The intention was that the woman met with the Community Health Champion to discuss her barriers to attending screening and how they could be addressed. There was also the option to help make the phone call for an appointment and accompany

the woman to the appointment. A total of 24 pharmacy participants were referred for peer support from a Community Health Champion.

9.2 Conclusions

All pharmacies were successful in recording and transmitting data effectively using the PharmOutcomes system, but we note from the study that there is the potential for the pharmacies to do more to support screening with certain service changes. Firstly, it would be advantageous for pharmacists to have read and write access to patient record systems, so they could use conversations in the pharmacy, whether opportunistic or focussed, as in this case to code patient records to flag missed screenings or need for additional interventions (that could include a GP call). Secondly, it could be useful for health professionals in community pharmacies to support patients directly by, for example, requesting bowel test kits or booking clinic appointments.

Enhanced clinical services of this type if administered within community pharmacy would have to be funded appropriately as part of the pharmacy contract, and we believe this should be part of the NHS transformation agenda. There are significant advantages to public health in bringing a wider range of services within easy reach of people in the community, particularly health promotion. The difficulties (actual and/or perceived) in getting a GP appointment and the strain on GP services are well known, and community pharmacies are an underutilised resource with highly trained staff and availability and accessibility to patients. The advantage that many community pharmacies are embedded within their communities and staffed by peers is significant in relation to improving BAME women's access to health services. This study demonstrates that pharmacies are well positioned to deliver health promotion interventions at scale and record outcomes.

10 Discussion about the Community Intervention

A total of 247 women completed the baseline questionnaire in the community settings. In addition, in the community settings 108 women participated in group discussions addressing the key issues in the questionnaire but opted not to complete the full questionnaire. 18 women opted only to answer Question 33, which addresses future intentions, after the group discussion that had covered, in discussion, all the questions on the questionnaire.

Women who participated benefited from the health chats and learned about cancer screening, as demonstrated from the quantitative data above, and adopted life-style changes, visited their GP and attended screening appointments. The data illustrates the various barriers that women have in attending appointments, relating to health perceptions, lifestyle and fear/embarrassment. The data supports the concept that in-depth interventions that were carried out embedded in the community, mostly in group settings mediated by peers have the potential to produce sustained change. This is because they are un-rushed and have the potential to empower women to gain knowledge and control of their own health as well as to demystify and reduce anxiety about the screening procedures.

10.1 Locations for the intervention and associated challenges

The Community Health Champions found Community Centres helpful locations to deliver the intervention. For example, the community workers had an existing relationship with the women that attended the groups which was valuable in encouraging women to participate:

‘It was the Community Workers at the, like the Community Centres that I was at that were kind of more getting them to kind of be more involved’ (Community Health Champion 2)

Accessing women through schools was a successful strategy, with women often attending health classes as part of the school community engagement. We found women were comfortable in a safe environment surrounded by familiar peers.

‘The school is a safe and comfortable place where the parents can come and discuss anything, no one knows why they are coming to school and they also can meet other parents.....They are a close knit group and support one another, they also learn from each other’. (School worker)

‘Have sessions in school, have groups and we can help each other, have people that can speak the same language’ (Community Participant)

Approaching women on a one-to-one basis, in public, for example in parks was less successful. We found these women wanted to engage with exercise in this context, not wanting to stop to access a healthy lifestyle intervention.

'They have the time to run in the park and they don't want anyone to stop them and ask question, it's a waste of their time. They do have a certain time to run and go home. Everyone we asked made an excuse...They don't want to talk, they come to the park to run, they don't want to waste their time, they just want to run in the park and then go' (Community Health Champion 1)

However, the same Health Champion found a strategy to complete some questionnaires in the park:

'I was running with a lady because she wants to answer as well and she wants to walk as well so I was just running with her and filling the questionnaire'. (Community Health Champion 1)

We also found that approaching women outside shops was not appreciated:

'...when asked talking to women at shops, example Bombay stores the champion said" they are just interested in shopping, even they didn't come to us' (Community Health Champion 1)

However, approaching women on a one-to-one basis was considered successful and positive in the context of a faith organisation, who would like to continue to work with the project:

'One to one conversations were best because it allowed our members to speak in confidence and raise any concerns they had about themselves' (Faith organisation worker)

'It raised awareness, allowed our members to feel comfortable in talking about this. We would continue to carry on having champions.' (Faith Organisation worker)

It was not considered successful in the context of some community groups who preferred a group approach:

'No – we would not have gone to one to one sessions. (Group sessions) this was much better' (Community Participant)

In the community and school settings, the enthusiasm of the community organisation managers and workers influenced the success of the project. They facilitated the Community Health Champions to implement the intervention at the optimal time for that group and their pre-existing relationship with the participants, in a comfortable and safe environment helped build trust in the champions and the project, encouraging them to participate.

We experienced some difficulties connecting with religious establishments. Most mosques and madrassas have educational and health-related programmes but require appropriate

introductions to the community leaders who influence the prioritisation, selection and scheduling of activities, or recommend to women that they participate. Whilst we approached community faith leaders directly and through a variety of contacts including males within the community, we were unable to achieve, within the timeframe of the project, the level of referrals or hosting of group meetings that we had originally expected. Nevertheless, we successfully engaged with two mosques attached to community centres where women attended courses, events and activities. We also attended a Sikh temple on a number of occasions and successfully engaged with the women who attended there.

Despite the enthusiasm of the volunteers, and the perceived high value of the conversations in the community setting, which is reflected in the data on intention to make lifestyle changes and attend screening, the community intervention was less successful in reaching the number of women originally expected. Recruitment of Community Health Champions, DBS checking and training following granting of NHS ethical approval for the project took longer than expected, and a number of different approaches had to be tried. Some feedback was that the word cancer in the title of the project 'Wise Up To Cancer' may have detracted some women from participating in the Community intervention, related to stigma around the word cancer and the fear associated with this.

10.2 Group discussions

The most successful strategy to access women was to participate through local community groups such as ESOL (English as a Second Language) classes or creative art sessions. With the support of the Centre Managers, we successfully visited 18 different groups, some on a weekly basis.

'...if the projects are going to work in this sort of model I feel that is quite useful, that you have to work with the grassroots levels ... the people that are on the ground, that are working with them day-to-day' (Centre Manager 1)

We found that we needed to be flexible about how we delivered the intervention, with different groups wanting different levels of engagement. When undertaking the questionnaire on a one to one basis, we had to work quickly to ensure the woman maintained engagement until the end of the intervention. This was also because we were taking up their 'social/recreational time'. In a group setting, it was generally more relaxed, but the sessions were quite long.

Some groups were keen to talk about healthy lifestyle and cancer screening but did not wish to engage with the formal questionnaire. In some groups, women would answer just some of the questions while in others women completed the full questionnaire. The community intervention, like the pharmacy intervention, supported communication in a common language between people who share common backgrounds. There was more time to have a dialogue, so that the women's questions could be answered and concerns addressed.

Delivering the intervention in community groups was also encouraged by group leaders who saw benefit of the environment for women who regularly attend the group:

'I felt because the centre was quite trusted in by the community around the centre, so having the project here was beneficial, first we didn't have to go and tell them about the project, and build that trust up, the trust was already built...so they found it easier to talk, they quite openly talked, and they didn't feel, not to talk in a reserved manner.' (Community Centre Manager)

Health conversations in groups could help to overcome difficulties where words used in the intervention were not everyday terms in other languages (for example vagina and bowels).

'Having picture and examples were helpful because they can see the picture and we explained to them and they understand what I am saying and if they didn't understand they can ask me. Once they had the explanation they would get into it (the chat) and say we are doing good job' (Community Health Champion 2).

'Women who could not read or write could at least look at the pictures' (Community Health Champion 1)

Age was an important influence and when introducing the intervention in a group setting, we firstly targeted women who were perceived as more prominent, finding if they agreed to partake then the other women present tended to follow.

'Sometimes women are well known in the community, as teachers or sell something, somehow they know all the ladies, the ladies know...she says, ok we'll do this then the other few ladies that are quiet say ok that's fine we are fine with that...a few other ladies were shy before and they said to her go on you go first. Then we talked to that lady and then they said yes, that's fine, we want to do it as well, one by one' (Community Health Champion 5).

Younger, UK born, women were perceived to generally understand more about cancer and healthy lifestyle and their presence in group sessions was found to be helpful for the older women. Older women said they felt included in the discussion and learnt from the younger women by joining in the conversation without having pressure to ask (or answer) any direct questions.

'More older ladies want to know more about everything because things are going around and no one lets them know. They say, no one says anything to us, families don't have time to talk to us....the middle aged group started asking questions but...the elderly people just join in, they say ok let the (younger women) answer then' (Community Health Champion 1)

10.3 Integration with other activities in community centres

We found that within community groups, delivering the intervention following a planned activity for example ESOL or creative art classes was a successful strategy. In these settings, the group appeared receptive to a conversation about cancer and the discussions could be used as a way to practice speaking English. In addition, no one outside the session was aware of the content of the session apart from the attendees. For women who were required to make special arrangements, had time restrictions or were required to seek approval to attend appointments outside their family requirements, this was ideal as it was a routine part of their 'time out'. Resources such as a crèche were already in place ensuring women had the time and opportunity to engage. For some sessions, representatives of breast screening services were able to attend the group discussion.

The format allowed different strategies to be used to introduce the intervention, for example, integrating the discussion within creative arts, as can be seen from the questions posed and photographs (Figure 10.1):

Figure 10.1. Integrating discussions within Creative Arts.



Women participants responded to trigger questions during a creative session in a community centre: 1. Do you know what screening means? 2. What stops you from going? 3. What helps/will help?

10.4 Providing support and referrals; beyond health promotion

Many of the group sessions resulted in requests for follow-up support on issues including breast screening. The latter was successfully carried out by signposting the community centres to partner agencies such as breast screening services. The women who attended community groups found the attendance of the staff who run breast screening services invaluable. We believe that increased co-working with trained Community Health Champions will be invaluable for future work since peer Health Champions can support the services to help them tailor their delivery work in a way that is effective for women in the local communities, including translating. Staff from screening services reinforced the key

health messages through the use of leaflets with discreet pictures and props such as knitted and silicon breasts.

'...breast screening lady who came and showed us all about what to check, I didn't know you could get a lump under your nipple, I told us all about that and she used lots of things to show us, fake boobs and that was really good.' (Community Participant)

These referrals also helped to normalise traditionally taboo conversations about body parts, screening and cancer

'There are a bit of shyness because it's about their personal life...you can't use the words on a daily basis...they are familiar (the words) but you can't use them' (Community Health Champion 4)

We found Community Health Champions had longer conversations with women compared to Pharmacy Health Champions, with discussions that extended beyond the questionnaire delivery. We perceive this as a success factor. In the community setting, through the intervention and talking to a peer, many women revealed difficulties that related to their health and wellbeing that had they had not previously discussed including domestic issues, mental health, poverty and deprivation. The intervention facilitated these women to be signposted to essential support services to address their health and social needs, which were higher priorities for the women and needed to be addressed before the woman could consider the messages from the Wise Up To Cancer project. We noted that many women wanted to have wider discussions relating to their health and wellbeing as a whole.

'There was one lady in one session who wanted more assistance with her age and her pension issues....she said that her age on her passport was incorrect and because of that she was having to work, which meant that she couldn't apply for pension earlier' (Community Health Champion 2)

10.5 Use of volunteer champions – peer support

As highlighted in section 9.1, after completing the baseline questionnaires, the Pharmacy Health Champions had the option to refer women for extra peer support from a Community Health Champion. A total of 24 pharmacy participants were referred for peer support from a Community Health Champion. In reality this formal approach was not successful but it became clear through the duration of the project that the Community Health Champions being a peer had a positive influence on women. Women began to reveal personal issues such as domestic abuse, severe poverty and mental health problems that the champion could discuss and signpost the women to appropriate services. In addition, peer support led to women asking for help:

'she used tobacco or something and she is trying to quit it but it is, she's having it still but less than before she was taking it...I am trying that, to quit it but I'm just not taking that much but slowly, slowly I wanted to stop this.' (community health champion 1)

Community Health Champion 2 was asked if she felt being a peer influenced the woman asking for help:

'Yeah, I think because she was able to speak the same language that really helped and she felt comfortable in disclosing that and thought that that information was confidential, it wasn't going to kind of go elsewhere unless needed and stuff. Whereas I think if that was somebody with a different ethnicity she probably wouldn't have felt that way.' (community champion 2)

A model for delivering the intervention where volunteers are trained as Health Champions was considered beneficial to the volunteers. The Community (and Pharmacy) Health Champions reported an impact of the project on their skillset. This included increased knowledge, self-confidence, public speaking skills and helped to build their CV ready for paid work. The University of Bradford team offered support with job applications and CV writing with the Community Health Champions as part of the project:

'...we have a number of people who are wanting to build up their skills, build their confidence and possibly enter the employment market, this would be an opportunity for them to start off with something....I think that the volunteers that they have found it quite useful as well, so they find it's given them confidence, being able to talk to people that they don't know, and it's bringing them out of their comfort zones as well, because that's what we want, we want people to come out, be more confident, and be able to do things' (Centre Manager 1)

While a total of 25 Community Health Champions were trained for the role, due to the voluntary nature of the role, we discovered the champions often had limited time to undertake the intervention due to other commitments such as childcare and many women moved on to other roles. Whilst recruitment of champions continued throughout the project, the availability of volunteer time was one of the limitations to achieving the number of interviews originally planned. The study allowed us to test a number of strategies to recruit volunteers, with the development of a video infographic and application website, being particularly useful and appreciated by women who are connected to social media. For future projects, we will adopt this model from the outset.

10.6 Conclusions

Although we did not reach the number of women originally anticipated, we regard this part of the study as successful as it has yielded very useful and detailed information, particularly about the settings for health conversations, to develop approaches on how to make women's health improvement sustainable.

Our learning from the study is that the public events that worked in West Leeds community settings, for example, stalls at local festivals and shopping centres, were not successful for this group of women in the community setting. We learned it takes time to identify, approach, access and then establish a trusting relationship with the different organisations which South Asian women access regularly, in particular mosques and madrassas. In addition, the intervention questionnaire took longer to deliver in community settings as part of a wider health conversation and generally women preferred to talk in groups rather than have individual conversations focussed on the questionnaire. We also learned that many women did not want to engage with the questionnaire but were keen to learn about a healthy lifestyle and consequently, there was a large group of women who participated in the health intervention, but without supplying data through the questionnaire

The demonstrated that some women confided complex health and social issues such as poverty, poor mental health and domestic issues that needed to be addressed before they could consider engaging with the intervention. The Community Health Champion referred these women on to relevant external services to help address the issues. This suggests the need for a holistic approach to meeting the needs of vulnerable women in order that they can benefit from public health messages. Peer support from a Community Health Champion can be very effective to achieve this.

Our learning from the project is that to develop such a community takes time, and the engagement from a community champion volunteer coordinator is critical, to work with community organisations, secure locations for group conversations, train and mentor volunteers and to support data collection and evaluation. Even though the volunteers themselves are providing support for free, the coordinator salary is a necessary cost to maintaining the network. For this study, there was insufficient time to implement the intervention with the numbers originally anticipated. However, since we have developed many of the relationships, the possibility exists to extend the study to develop a sustainable peer-volunteer led scheme to continue to engage South Asian women with healthy living, including cancer screening.

We created a network of 25 community champions working in several settings, with the network taking time and effort to establish and develop to the stage it is now. By the time the project finished, we believe the network had not yet realised its full potential in terms of reach into the community or in terms of outcomes possible. Given time, we would expand the number of champions, broadening the impact of the project. An example is the success of the intervention in three Bradford schools, where it would be possible to broaden the project to schools across Bradford, as well as working with more faith groups. This in turn will increase the proportion of women who are more willing to improve their health, talk about cancer, engage in screening, and reduce the morbidity and mortality rates in women through reducing late diagnosis of cancers.

Although numbers of completed questionnaires were lower than anticipated in the community, this evaluation has indicated that many women are still benefiting from the intervention even if they do not complete the baseline questionnaire. Therefore it was decided to start documenting the numbers of women who are still having 'chats about health' but are not completing the questionnaire. Aside from issues relating to questionnaire length and translation, it may also be the case that some of the women approached are suspicious of being involved in a research project. This does not mean that they are not benefiting from the intervention but indicates that Community Health Champions might need to be creative in their approaches. Indeed, that fact that women are discussing complex social issues with Health Champions demonstrates the power of the peer in complex health even where women do not wish to complete the baseline questionnaire.

11 Feedback on the Questionnaire and leaflets– tailoring the intervention in future.

While the vast majority of the champions and participants were highly positive about the project and its outcomes, during the evaluation there were a number of suggestions made as to how a similar intervention could be adapted for the future to be more tailored to the South Asian female population.

Some Community and Pharmacy Health Champions suggested reducing the length of the questionnaire. It was felt that this would encourage more women to participate:

‘...there was a lot of paperwork going on, especially with South Asian women, like it felt like they were kind of afraid of the paperwork but they were willing to have a conversation, so perhaps like that side of things could, yeah, be looked at’
(Community Health Champion 2)

‘...there’d be some kind of repetition and you don’t want to, like okay, you start with the first page, it’s absolutely fine, you go off with the next page, you want all the health and the fitness to be on one page so you’re not wasting time with the next page, and you go on the next page and it’s pretty much the same as what’s been said on the second page. So it’s like “oh, you know, have you exercised?” or, um, I’m trying to recall it. (Pharmacy Health Champion 3)

The sections which involved explaining cancer screening and also asking women what they already know about the signs and symptoms of cancer was perceived to be an important part of the questionnaire:

‘...it would be better to have a shorter questionnaire focusing on the cancer screening part rather than goal setting etc. Sometimes people need to leave before the questionnaire is finished as it takes about 20 minutes.’ (Community Health Champion 1)

‘...final page that was on there with the signs and symptoms, what they know about it, and I did highlight to say that this is the most important part because I found during that questionnaire that was the section that I needed the most information from. So even though they told me two or three of the symptoms that they’ve experienced or what they know about them, I still took that time to read what they should have known...’ Pharmacy Health Champion 3)

The Community Health Champions felt that more interactions with the participants prior to introducing the baseline questionnaire may increase their engagement:

‘...visiting them a few times and get kind of recognised with them, as opposed to just going in and saying 'this is what I'm doing', just build that rapport with them initially and then go back in like let's say the third or fourth time. I know it's a lot more time-consuming but I think that's the only way to break the barrier with them’

(Community Health Champion 2)

To access women in the community settings, it was believed than continuing to build a relationship with the organisations that run groups and activities that women attend would increase the rate of completion of the questionnaire but also ensure that any issues that arise during the discussions are followed through to benefit the women:

‘...work with grassroot levels, organisations, that are already there, and it will just make the work a lot more easier, and also it is more joined up in a way, that you know, both organisations benefit, you get your message out, and you are able to talk to women and have open discussions, because sometimes you get information and you don't act on it, sometimes when you have a discussion and you think about and mull over the things that what people are saying to you, and then it's sort of, yeah, it makes an impact, because the whole point of having that information is to change some sort of thinking, change some sort of behaviour, and that's what needs to happen, rather than just information’ (Community Manager)

It was suggested that more thought needed to be given about the relevance of parts of the questionnaire with women from different age groups. An example was related to setting goals within the baseline questionnaire with older women:

‘Middle aged ladies don't need to achieve goals because they are already 60 or 70 years old.....Telling them about signs and symptoms and helping them understand that (Community Health Champion 4)

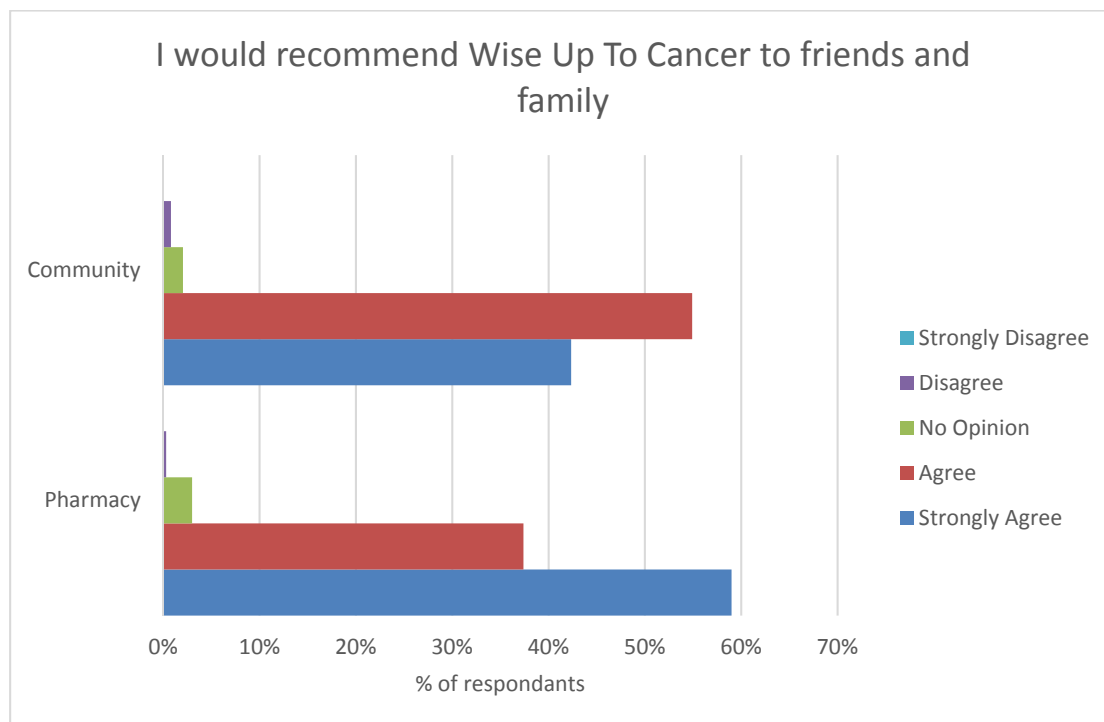
The leaflets were generally very well received. However, there was some negative feedback from some participants and champions who felt that they could be easier to read with larger text with key messages. For women who didn't read English, an audio version or the information on a mobile application could have been a useful alternative.

From feedback, we believe that both Community Health Champions and Pharmacy Health Champions would benefit from the use of visual aids to support their discussions, particularly when words or phrases are difficult to translate.

12 Participant feedback on the Wise Up To Cancer project and Yorkshire Cancer Research

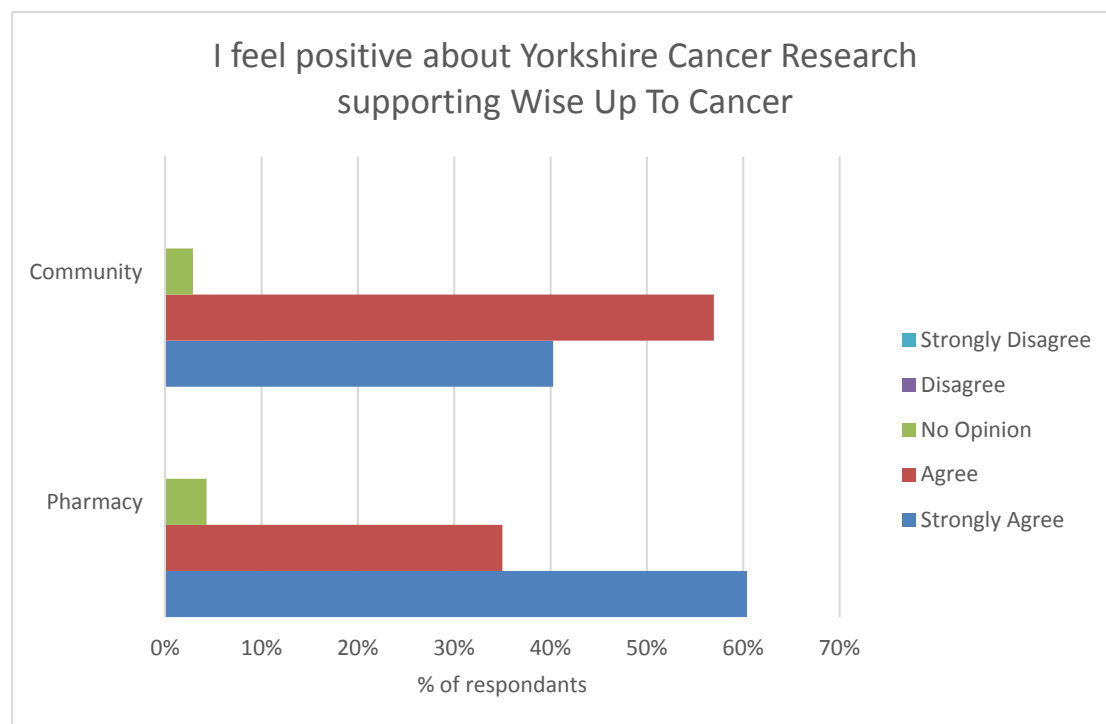
158 (16%) women in the pharmacy setting and 63 (22%) of women in the community setting had heard of Yorkshire Cancer Research before the day of the intervention. At the end of the health chat, women were asked if they would recommend Wise Up To Cancer project to friends and family, and on their perception about Yorkshire Cancer Research who oversaw the management of the project. The vast majority of women (97% community, 96% pharmacy) strongly agreed or agreed that they would recommend the project. Similarly, 97% of women in the community setting and 95% of women in the pharmacy setting agreed or strongly agreed that they felt positive about the role of Yorkshire Cancer Research (Figures 12.1, 12.2).

Figure 12.1 Recommendation of project



985 women completed this part of the questionnaire in pharmacy, 248 in community

Figure 12.2 Positive attitudes towards project



985 women completed this part of the questionnaire in pharmacy, 248 in community

We had been concerned during the project design that some women may consider the questionnaire and its delivery to be considered intrusive or raise anxieties. This data confirms that the intervention was well-received. We note that care was taken with the training of champions, as we were aware that it is both the questions and the people delivering it that are important in the intervention being effective.

The positive response by the participants was echoed by the community and Pharmacy Health Champions who valued their role in the project:

'No, I'd say definitely a really good project, really good, especially with all the campaigns backed with it, one of those things that you have to do just to get the word out there, you sort of watch the, you know, the cancer advertisements on TV and it is really saddening, but it is, the truth is nowadays cancer, every other person has got it, you know, back 20 years ago you'd very rarely hear, we especially when we were young, so and so had cancer, but now it's just become so common, and it's so sad, and the more awareness the better really, if you get it treated earlier then that's the best, yeah, yeah, but yeah, keep up the good work, definitely, thank you. (Pharmacy Health Champion 2)'

13 Dissemination of the project and wider community engagement

To ensure that South Asian women and the local community were informed of and engaged with the project and the opportunity to participate and input, we were active in disseminating the aims of the project, engaging with the community and community organisations as well as the media:

- The research advisory group which met bi-monthly with members from NHS England, Bradford Council, NHS Screening Services, Community Engagement Officer, Service Users, Health Visiting and Practice Nursing, Social Prescriber, Community Pharmacist
- Yorkshire Cancer Research website <https://yorkshirecancerresearch.org.uk/how-we-help/wise-up-to-cancer>
- Article in the Bradford newspaper- Telegraph and Argus <https://www.thetelegraphandargus.co.uk/news/16345264.cancer-scheme-expands-to-support-bradfords-south-asian-women/>
- Twitter account <https://twitter.com/wiseuptocancer1> The account, launched in September 2018 had 115 followers in June 2019

I love volunteering for @WiseUpToCancer1 ! Today I spoke to a Bangladeshi woman in Bengali to give her information on cervical cancer screening! She didn't realise how quick and easy it was. If you get your screening invite, make an appointment today. It only takes a few mins 😊

- Internal communications within the University to encourage South Asian women to volunteer as Health Champions <https://www.bradford.ac.uk/news/2018/wise-up-to-cancer.php>
- Official media launch in November 2018 with Local MP Naz Shah speaking along with Yorkshire Cancer Research, a local GP and a Pharmacy Health Champion and shown on BBC Look North <https://www.facebook.com/NazShahMP/posts/1971698423130653>



- Production of a website to raise awareness of the project (<http://wutc-bradford.org/>) that reached 213 users with 8 women volunteering as Community Health Champions.
- Production of a short video featuring women from the target background, that was disseminated via social media to encourage women to book an appointment with a Health Champion or volunteer: <https://vimeo.com/300671577>
- Radio interviews <https://www.sunriseradio.fm/news/local-news/yorkshire-cancer-research-launches-community-health-programme-for-south-asian-women/>
- Third sector Community Network and social media including Cnet Women's Health Network meeting



- Bradford Schools Online <https://bso.bradford.gov.uk/Schools/Home.aspx>
- Bradford interfaith centre, chaplaincy at Bradford Hospitals, Bradford Institute for Health Research, Various faith forums and faith based venues
- Consultation workshop and regular attendance at the Bradford BME screening subgroup

- Closing event at Community Works Bradford 3. This included presenting certificates to the Health Champions. See photos below including a Community Health Champion receiving her certificate.



14 Overall conclusions

The Bradford Wise Up To Cancer pilot project makes progress towards the need and national drive to engage hard to reach groups in screening services and provides a means of tackling health inequalities in South Asian women.

A total of 3,303 South Asian women have been reached through this project, 1,928 women via GP practices sending texts and phone calls, and 1,267 women who completed the baseline questionnaire in community settings or community pharmacy settings and 108 women who attended group educational sessions but did not fully complete the questionnaire. 109 women were followed up after the initial community intervention to complete a follow up questionnaire.

403 South Asian women who were previously overdue cancer screening (290 cervical, 32 breast, 81 bowel), completed screening within the study period as a result of this project, as measured through GP records. The GP intervention was effective in 21% of women, and was most successful for cervical screening.

Almost all (98%) of women in community setting and 99% of women in pharmacy setting agreed or strongly agreed that they would be more likely to speak to their GP about cancer signs and symptoms as a result of participating in the study. Of the 24 women within the follow up who had set the goal to speak to their GP about signs of symptoms of cancer, 37% (9) had done so. Of the 27 women who set a goal to complete cervical, breast or bowel screening 67% (18) had done so (15 cervical, 2 breast, 1 bowel).

The two GP practices took a holistic, practice-wide approaches and used texts and phone calls to greatly increase cervical screening uptake as well as producing smaller increases in uptake of breast and bowel screening. The use of text messaging and phone calls was a simple but effective intervention. The community pharmacies were well equipped to deliver the intervention and appreciated being part of supporting this community health initiative. In the community, voluntary organisations including community centres proved to be venues conducive to having detailed health chats with groups of women.

The community intervention delivered in community pharmacies and community settings through the use of Pharmacy Health Champions and Community Health Champions for the South Asian female community, demonstrated a positive impact on the number of women gaining knowledge of cancer signs and symptoms and the screening procedures, setting goals to improve their health to reduce their risk of developing and also committing to attend cancer screening.

The community surveys revealed low levels of health literacy, with over one third of women being unaware of the signs and symptoms associated with cancer, and none of the symptoms were recognised by more than one third of women. Following the intervention,

the majority of women (94% in community, 97% in pharmacy settings) agreed or strongly agreed that they had learned something new about cancer signs and symptoms.

Over half of women set at least one lifestyle goals that would reduce the risk of developing cancer, with many being referred to local services to support weight management, diet and exercise. The goals of being more physically active and eating a healthier diet were twice as popular as weighing yourself and working towards a healthy weight, with goal setting more likely to occur in community pharmacy settings compared to community settings. Around 90% of women agreed or strongly agreed that they were considering changing lifestyle changes following the health chats. In the follow up questionnaire 89% of women who had set a goal around healthy eating reported progress towards that goal, 78% of women who had set an exercise goal reported progress towards that goal and 66% of women who had set a goal to weigh themselves or work towards a healthy weight reported progress toward that goal.

The surveys revealed a number of barriers to visit a GP or attend cancer screening which included health perceptions, lifestyle barriers, difficulties in accessing medical services and concerns/fears about the procedures. Some participants were not aware that the services were free.

In a short period of time, we developed a community network of individuals and organisations and trained a cohort of pharmacy and community Health Champions and provided a sustainable and low-cost model to improving cancer screening and health outcomes in South Asian women. Peer support was effective in the community setting, with women appreciating having concepts around cancer explained in their own language within safe and familiar environments. These women are likely to attend screening again in the future. They can also help to address barriers to other women attending such as fear, pain or a male doctor undertaking the procedure.

We believe the increased awareness about healthy lifestyles, signs and symptoms of cancer and cancer screening will benefit others within the community through women speaking with other women in their family and local community.

‘...you can always have a chat with your family, let your next door neighbour know, have you been, just ask them, have you been for your smear test, you know, sort of things like that’ (Pharmacy Health Champion 2)

Further research and longer-term evaluation is needed to examine the medium and long term impacts of these interventions- on cancer rates and early diagnosis, including some economic evaluation to support adoption by NHS agencies. The full impact of the existing project will not be completely known for a period, due to the lag between uptake of screening services and reporting through NHS platforms, as well as the dissemination of the

academic arm of the study, which requires deeper analysis of the transcribed interviews and further evaluation.

15 Recommendations

In conclusion this project has worked out how a Wise Up To Cancer complex intervention can be used with a South Asian community of women. We believe that this learning is applied to South Asian communities of women in other areas of the UK and also the principles of our learning applied to other BAME communities of women who also have health inequalities and are less likely to attend cancer screening. The study strongly suggests that integrating some of the learning from the study into mainstream services would benefit South Asian and other BAME women through increasing health literacy and cancer screening uptake.

We recognise that more evidence of success, including economic evaluation of the potential benefits would be required to mainstream some or all of these proposals, and that some of the data required will not be available until 2020, and require academic outputs. The key service improvement priorities we suggest based on our findings to date are:

15.1 GP Practices

- Incorporation of texts into routine GP practice to maintain high uptake of cervical screening.
- Use of GP practice service time for proactive phone calls from GP practices to increase uptake of breast and bowel screening, with such services being carried out by trained health professionals (e.g. nurses, health-care assistants).
- That GP practices should order bowel screening kits for patients.
- That breast screening appointments should be booked on behalf of women from within GP practices.
- That the ways in which data flow between GP practices and breast and bowel screening services is reviewed, with consideration given of greater integration of services and coding to better support GPs to take a more proactive approach.
- That barriers to GP surgeries increasing breast and bowel screening be addressed through the consideration of financial incentivisation and the best location of such services.

15.2 Community pharmacy

- That cancer health promotion interventions, e.g. conversations about healthy living and cancer screening, developed from the intervention used here, be embedded as a routine part of community pharmacy practice to support person-centred and integrated health care.

- That community pharmacies are allowed read/write access to patient records so they can check screening status and directly flag the need for GP follow-up/phone call/text as a result of opportunistic or planned discussions within the healthcare setting.
- That consideration is given to developing processes where community pharmacies are able to book appointments on a patient's behalf for bowel and breast screening, without the need for referral to a GP.
- That the Pharmacy Contract and the Community Pharmacy Contractual Framework (CPCF) allow (and incentivise) community pharmacies to carry out health promotion activities/services, utilising the skills and knowledge of pharmacy teams to help people stay well in the community.
- That educational and training packages, such as those developed by Community Pharmacy West Yorkshire for pharmacy staff be further developed and rolled out nationally following further evaluation.

15.3 Community

- That the Bradford network of Community Health Champions is continued and expanded through partnership working and co-production to reach more locations, particularly mosques, madrassas and schools,
- The women who attended community groups found the attendance of the staff who run the breast screening services invaluable. We recommend that part of the role of NHS screening services is to visit similar faith/ community/ or school groups to demystify their service, explain the procedure and ensure women have a familiar face.
- That GP cervical screening staff and representatives from NHS bowel screening and breast screening services are included as part of community-based discussions, facilitated by Health Champions.
- That educational resources for use in community settings are further developed in relation to the feedback from community champions and participants, to deliver health promotion interventions in community settings.
- That more context-appropriate visual aids are produced to facilitate discussions, especially where English is not the first language, and where there are low levels of health literacy.

15.4 Future research priorities

- Continue the activities and the research evaluation in community settings (including community pharmacies) for a further 2 years. We note an extension of the study would also allow longitudinal follow up of the women in the original study to be able to assess the longer-term benefits of the original intervention.
- To facilitate the Community Health Champions to continue to support peers who benefit from their health conversations. In particular to work more closely with faith groups, based on the establishment of trust that has been achieved in the period of the study.

- Continue to run a complex intervention and collect evidence from women to support health service improvement so that services become more 'user friendly' and accessible, as well as to have a self-sustaining community of trained volunteers who can demystify cancer, the screening processes and reassure women about the nature of the tests.
- To develop further the pharmacy intervention by reducing the dependence on questionnaires and focus on the transmission of information between pharmacies and GPs.
- To gain better-linked data to assess how well the community intervention produces increases in screening uptake (this requires a different project design than was possible for this study).
- To carry out an economic evaluation using NHS principles and including a social return on investment model to measure the wider social and economic value of Wise Up To Cancer in terms of outcomes for the woman (improved health, reduced cancer risk and early diagnosis) her family and society as a whole.

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17 Appendices

Baseline questionnaire

Follow up questionnaire

Selection of Informational leaflets prepared to support the 'health chats'



Wise Up To Cancer Questionnaire

Location:

Person delivering questionnaire:

Date:

Please tick to confirm that you have gone through the information sheet with the woman ☐

ABOUT YOU

1. Is English your first spoken language?

☐ Yes ☐ No

2. If no, what is your preferred spoken language?

PROMPT Do not proceed if you cannot communicate effectively in a common language.

3. What languages can you read?

PROMPT If you don't have a leaflet in the same language that the woman reads, ask if someone can read the leaflet to her.

4. Have you heard of Wise Up To Cancer before?

☐ Yes ☐ No How?

PROMPT Do not proceed if the woman has completed this questionnaire before.

5. What is your postcode?

6. What is your date of birth?

7. Age

PROMPT Do not proceed any further if the woman is not aged 25-74 years.

8. Where were you born?

9. What is your religion?

☐ Muslim
☐ Hindu
☐ Sikh
☐ Buddhist

☐ Christian
☐ None
☐ Other, please state:

LIFESTYLE

EATING HABITS

PROMPT Provide explanations and examples to assist understanding where necessary. Please just include one number in the responses below.

10. In a typical week, how many times do you eat red meat (e.g. beef, lamb, pork) processed meat (e.g. bacon, ham, salami, corned beef and sausage) or kidneys, liver, offal and trotters?

11. In a typical week, how many times do you eat wholegrain/wholemeal pasta and rice, wholemeal flour in bread or chapatis, or cereal?

12. On a typical day, how many portions of fruit or vegetables do you eat?

PHYSICAL ACTIVITY

PROMPT Provide explanations and examples to assist understanding where necessary. Please just include one number in the response below.

13. In a typical week, how many days do you do a total of at least 30 minutes of exercise or physical activity which gets you slightly out of breath and sweaty (e.g. brisk walking, housework, gardening, swimming, attending a gym)?

WEIGHT

14. Do you think you are a healthy weight?

- ☐ Yes
☐ No
☐ Not sure

TOBACCO USE

PROMPT Provide explanations and examples to assist understanding where necessary.

15. Do you use tobacco products?

- ☐ Yes, every day ☐ Yes, but not every day ☐ No, I've quit ☐ No, never have

16. If yes, which tobacco products do you use?

- ☐ Cigarettes ☐ Chewing tobacco ☐ Shisha ☐ Snuff (naswar)

ALCOHOL CONSUMPTION

PROMPT Provide explanations and examples to assist understanding where necessary.

17. How many units of alcohol do you drink in a week?

- ☐ None ☐ 1-7 ☐ 8-14 ☐ More than 14

LIFESTYLE: FUTURE CHANGES

PROMPT Review the above lifestyle responses and discuss making changes to these lifestyle behaviours that may reduce their cancer risk. Suggest that they are better making one or two changes that are achievable rather than trying to set many goals.
Give the 'lower your cancer risk' leaflet for more information.

18. Is there anything you would like to change about the lifestyle factors we have discussed?

Eating Habits: ☐ Eat a healthier diet

Did you signpost the women to her local healthy eating group or service? ☐ Yes ☐ No

Physical activity: ☐ Be more physically active

Did you signpost the women to her local physical activity group or service? ☐ Yes ☐ No

Weight: ☐ Weigh myself ☐ Work towards achieving a healthy weight

Did you signpost the women to her local healthy eating and/or physical activity group or service? ☐ Yes ☐ No

PROMPT If you have access to the equipment, you can offer to weigh and measure the woman and calculate the woman's BMI using the BMI chart.
If not, please signpost her to where she can have her BMI checked.

Tobacco use: ☐ Cut down on tobacco use ☐ Stop tobacco use

Did you signpost the women to her local stop smoking service? ☐ Yes ☐ No

Alcohol: ☐ Cut down on my alcohol consumption ☐ Give up alcohol

Did you signpost the women to her local alcohol support group or service? ☐ Yes ☐ No

19. Is there anything else not covered already that you would like to set as a goal?

☐ Yes ☐ No

PROMPT If yes, please complete the boxes below. Can you signpost anywhere else?

Other lifestyle goals

1.

2.

Other lifestyle signposting

1.

2.

20. Please tick if the woman is already living a healthy lifestyle and does not need to set any goals ☐

PROMPT Give the woman positive encouragement for lifestyle factors she is already achieving and encourage her to continue.

CANCER AWARENESS

PROMPT This is an open question - **DO NOT** read out the options below or allow the individual to see the questionnaire but use these as a guide to record their responses.

21. What do you think are the early signs and symptoms of cancer?

- | | | |
|---|--|---|
| <input type="checkbox"/> Lump/swelling | <input type="checkbox"/> Sore that does not heal | <input type="checkbox"/> Loss of appetite |
| <input type="checkbox"/> Pain | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Blurred vision |
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Tiredness/fatigue | <input type="checkbox"/> Feeling weak |
| <input type="checkbox"/> Cough/hoarseness | <input type="checkbox"/> Nausea/sickness | <input type="checkbox"/> Nothing |
| <input type="checkbox"/> Change in bowel/bladder habits | <input type="checkbox"/> Generally unwell | <input type="checkbox"/> Don't know |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Bruising | <input type="checkbox"/> Other |

If **other** please state:

PROMPT Use the 'finding cancer early' leaflet to discuss cancer signs and symptoms, then record any signs and symptoms they have experienced in this section.

22. Have you recently experienced any of the following signs and symptoms?

- | | |
|--|--|
| <input type="checkbox"/> A lump or thickening in your breast or armpit | <input type="checkbox"/> A cough that has lasted for three weeks or more |
| <input type="checkbox"/> Changes to the skin of your breast | <input type="checkbox"/> Repeated chest infections |
| <input type="checkbox"/> Changes in the shape or size of your breast | <input type="checkbox"/> Breathlessness |
| <input type="checkbox"/> Nipple changes or discharge | <input type="checkbox"/> An ache or pain in your chest or shoulder that has lasted some time |
| <input type="checkbox"/> Bleeding from your vagina when you are not on your period or bleeding after the menopause | <input type="checkbox"/> Mouth ulcers that don't heal |
| <input type="checkbox"/> Discomfort or pain during sex | <input type="checkbox"/> Lumps in your mouth or neck that don't go away |
| <input type="checkbox"/> Blood in your poo or looser poo for three weeks or more | <input type="checkbox"/> White or red patches on your mouth or throat |
| <input type="checkbox"/> Weight loss for no obvious reason | <input type="checkbox"/> Bleeding or numbness in your mouth |
| <input type="checkbox"/> A pain or lump in your stomach | <input type="checkbox"/> Changes in your voice or speech problems |
| <input type="checkbox"/> Feeling more tired than usual for some time | <input type="checkbox"/> Pain or difficulty when swallowing |

GP/HEALTH PROFESSIONAL APPOINTMENT ABOUT SIGN OR SYMPTOM

PROMPT Reassure the woman that these symptoms do not mean she has cancer but it is important to get them checked out by her GP.

23. Have you spoken to your GP about these symptoms? ☐ Yes ☐ No

PROMPT Give the woman positive encouragement if she has already spoken to a GP.

24. If no, there is a chance that these signs and symptoms could be linked to cancer so we advise you to see your GP. Will you do that? ☐ Yes ☐ No

25. If no, why don't you plan to attend?

PROMPT If the woman does not know, ask if it is any of these: getting an appointment, embarrassment, time, other priorities, too busy, not necessary.

CANCER SCREENING

PROMPT Only ask questions where applicable to the woman's age. Leave blank if not applicable. Explain what the screening involves if she is not aware. If the woman says she has not been invited for screening, advise her to contact her GP surgery to find out why not.

26. What is the woman's age?

27. **Women aged 25 to 64 years only** - Did you attend the most recent cervical screening (smear) appointment you were invited to?

☐ Yes ☐ No ☐ Not sure ☐ Not been invited

28. **Women aged 50 to 70 years only** - Did you attend the most recent breast cancer screening (mammogram) appointment you were invited to?

☐ Yes ☐ No ☐ Not sure ☐ Not been invited

29. **Women aged 60 to 74 years only** - Did you complete and return the most recent bowel cancer screening test you were sent?

☐ Yes ☐ No ☐ Not sure ☐ Not received a test

PROMPT Give the woman positive encouragement for the screening programmes she is already attending and encourage her to continue to attend.

SCREENING: FUTURE CHANGES

PROMPT Discuss the importance of cancer screening and any barriers the woman has to attending screening. Only set goals if the woman is not already taking part in screening and where applicable to the woman's age. Use the 'finding cancer early' leaflet to help and give the woman this leaflet if you haven't already.

30. **As a result of this discussion, do you plan to do any of the following?**

Take steps to complete cervical screening (**Women aged 25 to 64 years only**)

☐ Yes ☐ No

Take steps to complete breast cancer screening (**Women aged 50 to 70 years**)

☐ Yes ☐ No

Take steps to complete bowel cancer screening (**Women aged 60 to 74 years only**)

☐ Yes ☐ No

31. **If you answered no to any of these questions, why don't you plan to complete?**

PROMPT If the woman does not know, ask if it was any of these: getting an appointment, embarrassment, time, other priorities, too busy, not necessary.

YOUR FEEDBACK

PROMPT If this wasn't covered earlier, briefly explain the work of Yorkshire Cancer Research

32. Had you heard of Yorkshire Cancer Research before today?

☐ Yes ☐ No

33. Thinking about your experience here today, how much do you agree or disagree with the following statements:

	Strongly agree	Agree	No opinion	Disagree	Strongly disagree
I am considering changing my lifestyle as a result of Wise Up To Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have learnt something new about cancer signs and symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am more likely to speak to my GP about possible signs and symptoms of cancer in the future	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am more likely to go to screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I would recommend Wise Up To Cancer to friends and family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel positive about Yorkshire Cancer Research funding Wise Up To Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

REFERRAL TO COMMUNITY HEALTH CHAMPION AND FOLLOW-UP RESEARCH

34. What is your family's country of origin?

☐ Pakistan ☐ India ☐ Nepal ☐ Bangladesh ☐ Other, please state

PROMPT If other - please do not proceed any further.

Referral to Community Health Champion:

PROMPT If the woman is not attending cancer screening, doesn't appear motivated to complete screening and is from Pakistan, Bangladesh, India, or Nepal, please use the information sheet to discuss a further meeting with a Community Health Champion.

If the woman agrees to being referred to a Community Health Champion, please provide her name and phone number below.

Name:

Phone number:

Please state preferred contact times (tick all suitable options):

☐ Weekday morning ☐ Weekday afternoon
☐ Weekday evening ☐ Weekends

Follow-up Research:

We would like to contact you for another chat to complete a follow-up questionnaire in 6 to 8 weeks so we can see how taking part in Wise Up To Cancer has helped you.

If you are happy to do this, please provide name and phone number below.

PROMPT Pharmacy only: Only ask the woman to take part in the follow-up if the woman is able to listen and speak on the phone in English.

Name:

Phone number:

Please state preferred contact times (tick all suitable options):

☐ Weekday morning ☐ Weekday afternoon
☐ Weekday evening ☐ Weekends



Leeds Beckett University, Yorkshire Cancer Research, Community Pharmacy West Yorkshire and Barca Leeds were involved in the development of the Wise Up To Cancer questionnaire for the Wise Up To Cancer pilot in Leeds and Wakefield, funded by Yorkshire Cancer Research.



Wise Up To Cancer Follow-Up Questionnaire

You recently completed a questionnaire with a Health Champion about lifestyle, cancer awareness and screening.

We would now like you to talk to the Health Champion again whilst she fills in a follow up questionnaire. We want to know if 'Wise Up To Cancer' has helped you. Your feedback is valuable to us because it will help us improve 'Wise Up To Cancer' in the future.

This is part of the research study 'Wise Up To Cancer'; improving lifestyle, cancer awareness and screening for South Asian women in Bradford.

What are the aims of this study?

- To encourage healthier lifestyles
- To increase awareness of signs and symptoms of cancer and attendance of cancer screening

Do I have to take part?

- No, but if you decide to take part in the study, this could help other South Asian women in Bradford live healthier lives.
- If you change your mind you can tell the Health Champion who will stop the questionnaire and remove your answers. If you change your mind about being involved with the other stages of the project, you can withdraw at any time in the next 2 months by contacting the independent research contact on the participant information sheet.

What will happen to my data?

- As before, we assure you we will maintain confidentiality and your data will remain anonymous.
- The data from this study will not be shared beyond the researchers. It will be stored in a locked cupboard or password protected computer area and will be destroyed/deleted once we have completed the study.
- Information from this study will only be used for research and **NOT** be shared with anyone else, including your GP if you provide your contact details.
- The findings from the study will form a research report and may be published. They may also be presented at meetings and conferences. We will not use any information where you could be recognised in these reports.

LIFESTYLE CHANGES

PROMPT Check goals summary. If a woman set a goal to make any lifestyle changes please ask the following questions. **Do not ask lifestyle questions if a goal wasn't previously set.**

EATING HABITS

1. Have you taken any action to change your diet since setting your goals?

☐ Yes

☐ No

If yes, please describe these changes. Have you contacted and attended any services to help you?

PHYSICAL ACTIVITY

2. Have you taken any action to increase your physical activity since setting your goals?

☐ Yes

☐ No

If yes, please describe these changes. Have you contacted and attended any services to help you?

WEIGHT

3. Have you taken any action to work towards a healthy weight since setting your goals?

☐ Yes

☐ No

If yes, please describe these changes. Have you contacted and attended any services to help you?

TOBACCO USE

4. Have you taken any action to reduce your tobacco use since setting your goals?

☐ Yes

☐ No

If yes, please describe these changes. Have you contacted and attended any services to help you?

ALCOHOL CONSUMPTION

5. Have you taken any action to reduce your alcohol consumption since setting your goals? ☐ Yes ☐ No

If yes, please describe these changes. Have you contacted and attended any services to help you?

OTHER LIFESTYLE GOALS

6. Have you taken any action on any other lifestyle goals you set? ☐ Yes ☐ No

If yes, please describe these changes. Have you contacted and attended any services to help you?

7. If you have made any lifestyle changes, have these affected the way you feel? If so, in what way?

PROMPT Only ask the next question if the woman has not made the lifestyle changes she set (check goals summary).

8. If you haven't made any lifestyle changes what has stopped you from doing so?

GP / OTHER HEALTH PROFESSIONAL APPOINTMENT

PROMPT Check goals summary. If a woman was experiencing signs and symptoms and a goal was set to speak to a GP/health professional please ask the following question. **Do not ask this question if a goal was not previously set.**

9. Since 'Wise Up To Cancer', did you speak to your GP (or other health professional) about any signs and symptoms you have that could possibly be linked to cancer? ☐ Yes ☐ No

10. If you have not spoken to your GP what stopped you from doing so?

PROMPT If the woman does not know, ask if it was any of these: getting an appointment, embarrassment, symptoms gone away, time, other priorities, too busy.

ATTENDING SCREENING

PROMPT Check goals summary. If a woman set a goal to complete screening please ask the following question. **Do not ask screening questions if a goal was not previously set.**

11. Since you set your goals, what have you done to complete the screening?

PROMPT If the woman does not know ask if she has read information, spoken to friends and family or GP, made an appointment, had the screening test. Only fill in the relevant boxes below.

CERVICAL SCREENING (SMEAR)

BREAST SCREENING (MAMMOGRAM)

BOWEL SCREENING

12. What were your experiences of attending the screening?

13. If you haven't attended your screening, please tell me what stopped you from doing so?

PROMPT If the woman does not know, ask if it was any of these: getting an appointment, embarrassment, time, other priorities, too busy, convenience of venue, cost of travel, not necessary.

YOUR FEEDBACK

14. What have you learnt as a result of taking part in 'Wise Up To Cancer'?

15. Please rate the following parts of 'Wise Up To Cancer' and share any comments you may have around what you liked or how you could make it better:

Feedback	Very good	Good	Fair	Poor	Very poor
Topics covered	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Advice and support given	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leaflets given	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Length of time taken	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Venue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

16. Do you have any other comments about 'Wise Up To Cancer'?

17. Since taking part in 'Wise Up To Cancer', have you done any of the following (tick all that apply):

- ☐ Told someone else about Yorkshire Cancer Research
- ☐ Visited the Yorkshire Cancer Research website
- ☐ Signed up to receive the Yorkshire Cancer Research communications
- ☐ Made a donation to Yorkshire Cancer Research
- ☐ Signed up to take part in a fundraising activity, for example a sponsored run
- ☐ Organised your own fundraising activity, for example a coffee morning or cake sale

FOLLOW-UP INTERVIEW

To be completed by Community Health Champions only

To find out about your experience of 'Wise Up To Cancer', we will be inviting a few people to take part in a short interview (lasting 20-30 minutes). This could be by phone, face to face or in a group. This will help us improve 'Wise Up To Cancer' in the future.

If you are happy to be approached to take part in this interview, please provide your name and a contact number.

Name:

Phone number:

Please state preferred contact times (tick all suitable options):

☐ Weekday morning ☐ Weekday afternoon ☐ Weekday evening ☐ Weekends



Leeds Beckett University developed the Wise Up To Cancer questionnaire/follow-up questionnaire in conjunction with Yorkshire Cancer Research, Barca Leeds and Community Pharmacy West Yorkshire for the Wise Up To Cancer pilot in Leeds and Wakefield, funded by Yorkshire Cancer Research.

NOW RECRUITING

Community Health Champion Volunteers

We provide sessions to improve lifestyle, cancer awareness and screening for South Asian women in Bradford aged 25 and above.



Be a healthy weight



Keep active



Eat well



Stop smoking



Drink less alcohol

You (What we are looking for)	The role (one to one and groups)	Our support (training, supervision and expenses)
<p>We are looking for:</p> <ul style="list-style-type: none"> • South Asian women who have an interest in health and social care. • If you have experience of screening (cervical, breast and bowel) this would be ideal however, it is not necessary. • Being fluent in a South Asian language (Urdu, Hindi, Bengali etc) would be great but not essential. 	<p>As a champion you will:</p> <ul style="list-style-type: none"> • Arrange and deliver one to one and group awareness sessions to improve lifestyles, cancer awareness and screening. • You may also support women to make appointments and attend screenings. • You may be working across BD3, BD7 & BD8 in a variety of community and health venues. 	<p>We will provide:</p> <ul style="list-style-type: none"> • Training certified by the University of Bradford which will include all the information and skills you need to run the sessions. • Regular monthly supervision to support you in your role. • Opportunities to network with other professionals and develop on both a personal and professional level. • Travel expenses.

**For more information contact Nisa or Daisy on 07867982062
or email communityhealthchampion@bradford.ac.uk**

Join our team to help spread information that will help South Asian women lower their risk of cancer, find cancer early and save lives.

Bradford South Asian women volunteers required

Do you want to help improve health of South Asian women in your local community?

‘Wise Up To Cancer’ is a new, exciting project in Bradford to help South Asian women lower their cancer risk and spot cancer early, so it can be more easily treated.

We are looking to recruit South Asian women volunteers to:

- Talk to women about cancer, fill in a questionnaire about healthy lifestyles, signs and symptoms of cancer and cancer screening
- Help women to make a cancer screening appointment and go along with them if they want you to

Volunteer expenses will be paid

For more information please contact:

Mel Cooper, University of Bradford

Email: M.Cooper2@bradford.ac.uk **Phone:** 07827 981927

In partnership with:

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In partnership with:

Come along for your
FREE chat about health
with a local Community Health Champion

Get advice and support on:

- Living a healthy lifestyle
- Being aware of the early signs and symptoms of cancer
- Cancer screening programmes available to you



Date:

Time:

Location:

In partnership with:

Come along for your
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**Speak to a member of the pharmacy
team for more information**

In partnership with:



www.ycr.org.uk/wiseuptocancer

Registered Charity 516898



Taking part in cancer screening can:

- Help find cancer early
- Make it easier to treat
- Help save lives



**Speak to your doctor or a health professional
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In partnership with:

Finding cancer early

Finding cancer at an early stage makes it easier to treat successfully and can help save lives.



You and your family can take the following steps to find cancer as early as possible:

Take part in cancer screening when you are invited

Look out for signs and symptoms and talk to your doctor about them



“My breast cancer was picked up through the routine breast screening, before I noticed any symptoms. Luckily it was caught early and has now been successfully treated. The women at the breast screening team were always so professional and respectful.

I can’t stress how important screening is and I would encourage other women to go. It saved my life.”

Abida



Take part in cancer screening

Screening can help find cancer early, even before you notice any symptoms.

There are 3 FREE cancer screening programmes available in England - Cervical, Breast and Bowel screening.

You will get an invite for your screening in the post when it's due. Make sure you are registered with a GP practice and they have your current address to receive the invite.

	Who is it for?	What does it involve?	How to arrange a screening if you have missed it or you have not been invited
Cervical screening	<ul style="list-style-type: none">• Women only• Aged 25 to 64 years• Completed every 3 years for 25 to 49 year olds and every 5 years for 50 to 64 year olds	Smear test to find early changes to cells in the cervix that could turn into cancer.	Contact your doctor to make an appointment
Breast cancer screening	<ul style="list-style-type: none">• Women only• Aged 50 to 70 years (47 to 73 in some areas)• Completed every 3 years	Mammogram to find breast cancers when they are too small to see or feel.	<ul style="list-style-type: none">• Contact your doctor to find out how to make an appointment• Make an appointment directly through contacting your local screening centre. Visit: www.nhs.uk/service-search
Bowel cancer screening	<ul style="list-style-type: none">• Men and women• Aged 60 to 74 years• Completed every 2 years	Home testing kit sent through the post to check for hidden blood in poo.	<ul style="list-style-type: none">• Contact your doctor to find out how to order a bowel screening kit• Order a kit directly by calling the Bowel Screening Hub Freephone helpline on 0800 707 60 60

It's important to keep going for screening during the time it's offered. Between screenings talk to your doctor straight away if you notice any signs or symptoms.

Most people who take part in their cancer screening will get a normal result. People who get an abnormal result will be asked to take part in further tests but this doesn't always mean you have cancer.

Breast screenings are always carried out by a female health professional. Normally, cervical screenings are carried out by a female practice nurse, but you can ask to make sure when you book your appointment.

Look out for signs and symptoms and talk to your doctor

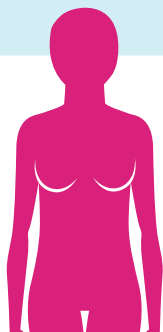
It is important to get to know your body and check yourself for any changes. Talk to your doctor straight away if you notice any of the signs and symptoms below or anything unusual for you.

Having these symptoms does not always mean you have cancer. It could be nothing serious, but it's worth getting them checked out.

Women can ask to talk to a female doctor or health professional about any signs and symptoms.

Breast cancer

- A lump or thickening in your breast or armpit
- Changes to the skin of your breast
- Changes in the shape or size of your breast
- Nipple changes or discharge

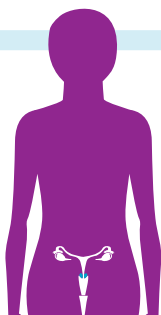


Checking your breasts

Look at and feel your breasts and get to know what is normal for you. Talk to your doctor if you spot any of these breast cancer signs and symptoms or anything unusual for you.

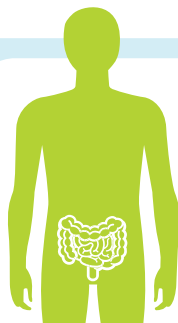
Cervical cancer

- Bleeding from the vagina when you are not on your period or bleeding after the menopause
- Discomfort or pain during sex



Bowel cancer

- Blood in your poo or looser poo for 3 weeks or more
- Weight loss for no obvious reason
- A pain or lump in your stomach
- Feeling more tired than usual for some time



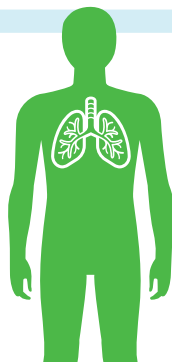
Mouth cancer

- Mouth ulcers that don't heal
- Lumps in your mouth or neck that don't go away
- White or red patches on your mouth or throat
- Bleeding or numbness in your mouth
- Changes in your voice or speech problems
- Pain or difficulty when swallowing



Lung cancer

- A cough that has lasted for 3 weeks or more
- Repeated chest infections
- Breathlessness
- An ache or pain in your chest or shoulder that has lasted some time



There are many other signs and symptoms of cancer.
For more information visit www.nhs.uk/conditions/cancer

Did you know?...

Around 9 in 10 women diagnosed with breast cancer at an early stage will survive for at least 5 years. When breast cancer is diagnosed at a late stage, only around 1 in 10 women will survive for the same length of time.

Looking out for signs and symptoms, talking to your doctor about them and taking part in cancer screening can help make sure cancer is found at an early stage. This makes it easier to treat successfully and can help save lives.

“We would encourage you to speak to your doctor if you have any concerns. They’ll be able to reassure you or arrange the appropriate further tests.

Getting yourself checked early and attending cancer screening can be life-saving. Put your health first.”

Dr Henna Anwar,
GP Registrar at The Ridge
Medical Practice



Further information and support

If you have any questions about signs and symptoms or any of the cancer screening programmes, talk to a doctor, pharmacist or health professional.

You can also visit www.nhs.uk/conditions/cancer for more information.

This leaflet has been produced as part of our Wise Up To Cancer programme. Please help us offer this programme across Yorkshire by supporting Yorkshire Cancer Research. You can make a one off donation or sign up to give monthly by visiting **www.ycr.org.uk/donate** You can also make a donation today by texting **YORKSHIRE** to **70007** to donate £3. Thank you.

Wise Up
To
Cancer


yorkshire cancer
research

Lower your cancer risk

Our risk of getting cancer depends on many things we don't have control over, such as our genes and age. But it is also influenced by lifestyle factors which we can change.



You and your family can take the following steps to lower your risk of cancer:



Be a healthy weight



Keep active



Eat well



Stop smoking



Drink less alcohol

"A few years ago, my doctor suggested I should lose weight and I realised it was time to make changes to my lifestyle.

I started going for walks in my neighbourhood and reduced how much sugar and fat I ate each day. It made me feel better, have more energy and the weight just fell off.

Now my family is more health conscious and I would recommend having a healthier lifestyle to everyone to reduce their risk of cancer."

Halima



Did you know?...

Many common cancers, including some bowel and breast cancers, could be prevented by being a healthy weight, keeping active and eating well.

Be a healthy weight

- Find out if you are a healthy weight by working out your **Body Mass Index (BMI)**. BMI uses your height and weight to find out what is a healthy weight for you.
- To work out your BMI go to www.nhs.uk/healthyweight or ask a health professional to work it out for you.
- Both being active and eating well can help achieve a healthy weight.



Keep active

- **Aim to be active for 30 minutes every day.** Whether this is in one go or small chunks, it all counts.
- Build activity into your everyday routines. Household jobs like cleaning and doing the gardening count too. Anything that raises your heart rate and gets you slightly out of breath helps.
- Try doing activities you enjoy and exercising with your family and friends.

Eat well



- **Eating less red meat** (beef, lamb, offal) and **avoiding processed meat** (bacon, sausages) can lower your risk of bowel cancer. Try swapping to chicken, fish, egg, dahl and pulses.



- **Eating more foods high in fibre** helps to keep your bowel healthy and can lower your risk of bowel cancer. High fibre foods include wholegrain bread, chapatis, rice, pasta and cereal.



- **Eating lots of fruit and vegetables** can help lower your risk of cancer. Fresh, frozen, dried, canned in water or fruit juices all count.

Stop smoking

Stopping smoking is the best thing you can do to improve your health and lower your risk of cancer.

Cigarettes including roll-ups, bidi or kreteks and shisha contain tobacco and can increase your risk of cancer.

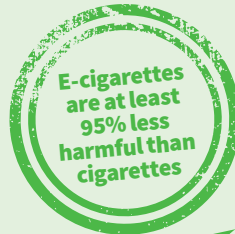


Chewing tobacco including betel quid, paan or gutkha and snuff (naswar) contain tobacco and can increase your risk of mouth and oesophageal cancers.



E-cigarettes

- If you are finding it difficult to stop smoking tobacco, switching to an e-cigarette is less harmful and can help you quit for good.
- E-cigarettes work by providing nicotine without the tobacco that causes smoking related cancers.



Drink less alcohol

There is no safe level of alcohol but sticking to the guidelines below can lower your risk of cancer and many other health conditions:

1. Drink less than 14 units of alcohol a week

14 units of alcohol is equivalent to:



2. Spread your units over 3 or more days

3. Have several alcohol free days

Try drinking less alcohol by:

- Having smaller measures of alcohol
- Having low-sugar soft drinks or water in between alcoholic drinks
- Diluting alcohol with a soft drink

Did you know?...

4 in 10 cancers could be prevented by living a healthy lifestyle.

Even simple, small changes to your everyday routines can make a difference to help lower your risk of cancer.

"I have Type 2 Diabetes and have worked hard over the last year to improve my condition. I've lost nearly 4 stone now by cutting out unhealthy snacks and going to the gym a few times a week.

I feel healthier, more energetic and happier in myself!

A healthy lifestyle can help prevent diseases such as cancer, diabetes and heart disease which are big issues in the South Asian community."

Dr Rehana Younis,
GP at The Ridge Medical Practice



Further information and support

If you have any questions about making changes to your lifestyle, talk to a doctor, pharmacist or health professional.

You can also get more information and search for local support services at www.nhs.uk/oneyou search for

- weight loss
- smoking
- moving
- drinking
- eating

This leaflet has been produced as part of our Wise Up To Cancer programme. Please help us offer this programme across Yorkshire by supporting Yorkshire Cancer Research. You can make a one off donation or sign up to give monthly by visiting www.ycr.org.uk/donate. You can also make a donation today by texting **YORKSHIRE** to **70007** to donate £3. Thank you.

