The acceptability and feasibility of lay-health led interventions for the prevention and early detection of cancer

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Background

Lay-health led interventions

• Non-professionals (no formal education) trained to deliver health messages (Witmer et al., 1995)
• ‘...indigenous to his/her community and consents to be a link between community members and the service delivery team’ (Eng, Parker & Harlan, 1997)
• Many terms used to describe this; we have used Lay Health Worker (LHW)
• Systematic review and meta-analysis showed effectiveness at increasing odds of cancer screening uptake: OR 1.90 CI 1.60-2.26 (Bellhouse et al., 2017)
• Limited research in field of cancer symptom detection (Smit et al., 2016) and lifestyle related risk is an important consideration for using this approach
Aim and objectives

Aim
To explore the acceptability and feasibility of lay health-led interventions with a focus on cancer prevention and early detection in the UK

Objectives
i. Assess the feasibility and acceptability of creating a LHW role to deliver health promotion interventions
ii. Identify what type of health promotion interventions potential LHWs would be willing to undertake
iii. Identify potential LHW’s expectations and training needs
Methods

Design
Qualitative: audio-recorded focus groups and semi-structured interviews

Participants
Purposive sampling (approx. $n=50$) to recruit from 5 groups:

1. Completed cancer treatment
2. Friends/family of cancer patients
3. Cancer hospital volunteers
4. Cancer charity volunteers
5. Members of the public

Analysis
Thematic analysis using framework matrices (Braun & Clarke, 2006)
Results

Sample
41 participants: 8 focus groups, 14 interviews

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<tr>
<th>Participant characteristic</th>
<th>Range or N</th>
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<tbody>
<tr>
<td>Age</td>
<td>23-84 years</td>
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<tr>
<td>Gender</td>
<td>27 (65.9%) female</td>
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<tr>
<td>Ethnicity</td>
<td>31 (81.6%) White British, 5.3% Bangladeshi</td>
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<td>Employment status</td>
<td>19 (47.5%) in employment, 14 (35%) retired</td>
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<td>Marital status</td>
<td>23 (56.15%) married, 7 (17.07%) single, never married</td>
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# Findings

<table>
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<th>SUB-THEME</th>
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| 1. Scope of the role | - Topic of focus  
- Potential roles |
| 2. Defining LHWs | - Setting and audience  
- Modality  
- LHW Characteristics  
- Training and support |
| 3. Clearly defined boundaries | - Liability  
- Limitations of the role |
1. Scope of the role

**Topic of focus**
Preference for screening or early detection:

“...you’re talking about something concrete and you are offering somebody something helpful there”  FG7 post-treatment, female

Main barrier of healthy lifestyles = potential to induce guilt:

“...people could feel very guilty if their [relative] died of a cancer which was potentially preventable”  I4 friends/family, male
1. Scope of the role

Focus of role
Overcoming barriers (screening):

"...the best thing is to try and find out what’s preventing them from attending [screening]...it might be a chaotic lifestyle...transport...fear of the test, or some fear that they have about coming for whatever they have to come for that can be explained and then they can be put at ease about the situation, so sometimes it’s maybe lack of knowledge or ignorance about what it actually entailed and why it’s actually being done." I12 charity volunteer, female

Education (early detection):

“I think education is massive...‘I’m worried that that might be a symptom of cancer.’ Why shouldn’t the patient say that to a doctor? I think the more information that a patient has got, the better really.” FG7 public, male
2. Defining the LHW role

Setting
Community-based:

“I think schools are open to it provided someone goes out to them. I don’t think enough schools get people in those sort of roles coming to them and telling them, ‘We’re willing to talk to you about health issues.’” FG5 post-treatment, female3

And linked to primary care:

“…I would feel far happier and able to do that sort of job or role if I knew the medical practices knew I was there and maybe I could contact them or they could contact me…I would love to see a relationship with the local practices.” I1 friends/family, male
2. Defining the LHW role

**Audience**

Shared characteristics between LHW and intervention participant (e.g. community, gender, ethnicity, culture):

“...the ambassador will have a knowledge of that particular area. He will be able, or she will be able to apply that knowledge of that area to resonate with those residents.” FG2 post-treatment, male

“...trying to get them to go for a cervical smear test, I think it would be received better coming from a woman” FG7 public, female
2. Defining the LHW role

Modality

Majority preference for face-to-face interactions (especially treatment):

“I always think face to face or telephone is...I’ve found this is better. You’re talking to a real person then...online, you haven’t got that personal touch about it. You can hear people’s reactions on the telephone and I’m sure you know yourself, cancer is the worst thing...”

I3 post-treatment, male

Although charity and public groups okay with online:

“You could have it [videos on a website] from each different angle, like you could have it from a normal person who’s gone and done it [screening] and reasons why they’ve done it and their experience and the nurse telling you what would happen...”

FG7 public, female
2. Defining the LHW role

**LHW specifications**
LHW should have positive personality characteristics including empathy:

“Just: confident, outgoing, chatty, approachable, friendly; all those words.”

I5 charity volunteer, female

LHW should have personal experience of cancer (treatment + friends/family):

"I think it probably gives you that little bit of something extra perhaps, that people might be more inspired to listen to you because you have had a cancer and think, well, they perhaps know what they're talking about because of that..."  FG5 post-treatment, female1
2. Defining the LHW role

Training and support
Difficult to envisage but all thought there should be some level of training (communication skills and knowledge):

"...if they've got that training to back them up, they can really support themselves. They feel confident in their answers, and they feel like they can actually give people the right answers"

FG6 family/friends, female2

There should be on-going support from professionals:

"If there is [sic] also more medical issues then maybe it might be that there needs to be a nurse specialist or somebody to be able to deal with more medical orientated issues."

I7 post-treatment, female
3. Clearly defined boundaries

Liability
There should be a safety net built in to the role:

“...if you say something wrong then somebody's going to claim compensation. It shouldn't fall on you, because we have got to have a safety net. Because if you don't have a safety net, you can't do things like that...you're working with people's lives”  FG3 public, female

Limits of the role
The role should be clearly defined, particularly for treatment & friends/family:

"...knowing where the limits of that particular role are, so you don't start diagnosing and things."  I11 family/friends, male
Conclusions

• Role worthwhile to develop with focus on screening or early detection; healthy lifestyles had too many barriers in our participant sample
• Role must have a clearly defined remit with on-going support after structured training
• No particular differences across the groups except treatment feeling most strongly that the LHW should have had cancer experience
• Should be community-based and LHW part of the local community
• Future research required to develop intervention and training programme
Thank you, any questions?

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