'Connecting tracks': exploring the roles of an Aboriginal women's cancer support network

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What is known about this topic

- Aboriginal Australians have higher rates of preventable cancers than other Australians; they also experience delayed diagnoses and poorer outcomes.
- Peer-support groups are beneficial to cancer patients.
- Cultural and logistical barriers, and communication issues impede engagement of Aboriginal Australians with mainstream cancer support services.

What this paper adds

- This peer-support network combined characteristics of a 'cultural broker' and a 'cancer navigator', addressing Aboriginal women's complex health and social needs.
- Despite its successes, the network's sustainability was threatened by unresolved tensions between Aboriginal and mainstream perspectives.
- Different perspectives need to be addressed in order to build effective partnerships between service providers and Aboriginal communities; adopting an intercultural approach may provide a way forward.

Abstract

Aboriginal Australians are at higher risk of developing certain types of cancer and, once diagnosed, they have poorer outcomes than their non-Aboriginal counterparts. Lower access to cancer screening programmes, deficiencies in treatment and cultural barriers contribute to poor outcomes. Additional logistical factors affecting those living in rural areas compound these barriers. Cancer support groups have positive effects on people affected by cancer; however, there is limited evidence on peer-support programmes for Aboriginal cancer patients in Australia. This paper explores the roles played by an Aboriginal women's cancer support network operating in a regional town in Western Australia. Data were collected through semi-structured interviews with 24 participants including Aboriginal and mainstream healthcare service providers, and network members and clients. Interviews were audiotaped and transcribed verbatim. Transcripts were subjected to inductive thematic analysis. Connecting and linking people and services was perceived as the main role of the network. This role had four distinct domains: (i) facilitating access to cancer services; (ii) fostering social interaction; (iii) providing a culturally safe space; and (iv) building relationships with other agencies. Other network roles included providing emotional and practical support, delivering health education and facilitating engagement in cancer screening initiatives. Despite the network's achievements, unresolved tensions around role definition negatively impacted on the working relationship between the network and mainstream service providers, and posed a threat to the network's sustainability. Different perspectives need to be acknowledged and addressed in order to build strong, effective partnerships between service providers and Aboriginal communities. Valuing and honouring the Aboriginal approaches and expertise, and adopting an intercultural approach are suggested as necessary to the way forward.

Keywords: Aboriginal Australians, cancer services, health disparities, regional and remote health, support groups

When I was introduced to the group I just felt like I wanted to cry because this was like a saviour. Like I could talk to them. If I was too sick and I couldn't clean, they would come and do that too. (Aboriginal woman)

Introduction

The incidence of cancer in Australia has increased in the last 20 years (AIHW, 2012) and, similar to other high-income countries (Clegg *et al.* 2002, Robson *et al.* 2006, Ahmed & Shahid 2012), the burden of disease is not evenly distributed among the population (AIHW, 2012). Until recently, cancer had not been considered as a priority health issue for Aboriginal Australians (Condon *et al.* 2003), as the attention was focused on other diseases such as diabetes and heart disease; however, it is now the second leading cause of death in this population (ABS, 2012). Aboriginal Australians have higher age-standardised rates of cancer, are more likely to be diagnosed with largely preventable cancers, are diagnosed at a later stage, and, once diagnosed, have poorer outcomes than other Australians (Cunnigham *et al.* 2008, AIHW, 2013). These inequalities are consistent with data for Indigenous populations in New Zealand (Robson *et al.* 2006), Canada (Ahmed & Shahid 2012) and the United States (Clegg *et al.* 2002).

Lower access to screening programmes and deficiencies in treatment contribute to poor cancer outcomes among Aboriginal Australians (AIHW, 2013); however, these factors do not fully explain the survival disadvantage, suggesting that other factors are at play (Cunnigham *et al.* 2008). Cultural barriers affecting care-seeking behaviour among Aboriginal Australians include fatalism, shame, preference for traditional healing (Shahid *et al.* 2009a) and the belief that cancer is contagious or payback for wrong-doing (McGrath & Holewa 2006). In addition, low health literacy in relation to cancer (Treloar *et al.* 2013) and communication issues with cancer service providers (Shahid *et al.* 2009b, 2013) further impede engagement of Aboriginal cancer patients in mainstream services.

Compounding the barriers to cancer services experienced by Aboriginal people, in Australia, regional areas experience deficiencies in cancer service availability, including oncology services, nursing and allied health, and multidisciplinary care (Underhill *et al.* 2009). Rural cancer patients have different patterns of care (Heathcote & Armstrong 2007) and lower survival rates than their urban counterparts (Coory *et al.* 2013). These issues are salient for Aboriginal cancer patients, given that approximately two-thirds of the Aboriginal population live in regional and remote areas (ABS 2011).

Logistical issues relating to transport and accommodation, displacement from family and lack of a culturally safe environment may lead to Aboriginal patients declining or discontinuing treatment (Shahid *et al.* 2011, Willis *et al.* 2011). Furthermore, evidence suggests that follow-up services for patients returning to their communities may be deficient (Shahid *et al.* 2011), although a study investigating the use of community services among Aboriginal cancer patients conducted in Queensland did not find significant differences between rural and urban participants (Bernardes *et al.* 2012).

Peer support is one type of supportive care service for cancer patients (Campbell *et al.* 2004); it is characterised by the provision of assistance or encouragement 'by an individual considered equal' (Dennis 2003, p. 323), and can be provided through multiple modes of interaction in diverse settings, and incorporate a variety of roles (Dennis 2003). Peer-support programmes for people with cancer provide benefits to participants, including receiving emotional and practical support (Hoey *et al.* 2008, Macvean *et al.* 2008), providing a sense of community, and facilitating positive relationships with family and friends (Ussher *et al.* 2006).

Despite this evidence, research conducted in Canada suggests that mainstream support groups may not meet the needs of Aboriginal cancer patients (Poudrier & Thomas Mac-Lean 2009), and, in Australia, evidence shows that Aboriginal cancer patients are not accessing mainstream support groups (Shahid *et al.* 2008). It is widely acknowledged that culturally safe initiatives need to be developed for Aboriginal cancer patients to engage with supportive care services, and although Aboriginal peer-mentoring programmes for the prevention of chronic disease have been developed and successfully implemented (Paasse & Adams 2011), there is scarce evidence on Aboriginal-specific cancer peer-support programmes in Australia (Shahid *et al.* 2008). Only one paper reporting preliminary descriptive results on the evaluation of an Aboriginal cancer peer-support group was found in the literature (Finn *et al.* 2008). Here, we present results from an in-depth analysis using qualitative data from the same study (Finn *et al.* 2008).

Methods

This research was part of a study investigating cancer experiences, attitudes and beliefs among Aboriginal Australians. Ethics approval was obtained from the Western Australian Aboriginal Health Ethics Committee and Curtin University Human Research Ethics Committee.

The network

The Aboriginal women's cancer support network (the network) operated in a regional town located approximately 400 km from Perth, Western Australia. At the time of initial data collection (Finn *et al.* 2008), the network had been operating for approximately 9 months, consisted of a paid part-time co-ordinator and 10 peer volunteers, and held fortnightly meetings at a community-based venue. The network had provided support to an estimated 50 women affected by cancer, including women undergoing cancer treatment, cancer survivors and carers.

Sample and data collection

The sample was recruited among key informants from Aboriginal and mainstream health service providers operating in the region, and from network members and clients. Data were collected through individual and group interviews conducted in 2008, and participants were invited to share their views on the role and effectiveness of the network. The sample and data collection process are described elsewhere (Finn *et al.* 2008).

Data analysis

Interviews were audio-recorded and transcribed verbatim. Transcripts were subjected to thematic analysis; participants' views were compared, and contrasting views and opinions were identified. The data analysis process broadly followed the following steps: immersion in the data, coding, creating categories and identifying themes (Green *et al.* 2007). Coding and analysis were performed by the main author and subjected to member checking and validation throughout the data analysis process. Data analysis started by reading the transcripts twice prior to commencing the coding. An inductive approach was adopted to develop a list of largely descriptive coding categories (e.g. 'access to services', 'confidentiality' and 'cultural barriers'); this list was reviewed by the research team and refined periodically as transcripts were coded. Initial coding of transcript segments involved multiple coding. This was followed by a second level of coding which involved exploring relationships between the codes and the identification of descriptive and analytical themes (e.g. 'structured vs. fluid', 'linking and connecting').

NVivo 10 (QSR International 2014) was used to manage the data and assist analysis; in particular, the 'Model' feature was used to visually map connections between coding categories (Bazeley & Jackson 2013). Using NVivo facilitated collaboration between research team members and enhanced rigour by adding transparency to the data analysis process (Siccama & Penna 2008). Furthermore, rigour was enhanced through team member checking, coding validation and peer debriefing (Morse *et al.* 2002).
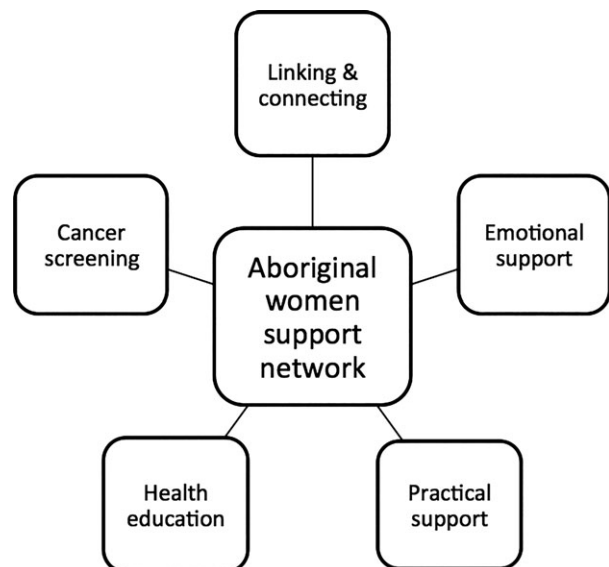
Findings

A total of 24 participants (female, *n* = 22; male, *n* = 2) took part in the study. The sample included Aboriginal workers and representatives from Aboriginal healthcare service providers (*n* = 3), representatives from mainstream cancer services and agencies (*n* = 8), network members (volunteers and co-ordinator) (*n* = 6), network clients (*n* = 4) and potential clients (*n* = 3). The results are illustrated with quotes; these are contextualised by the use of the interview identifier and the stakeholder group represented (ASP: Aboriginal Service Provider; MSP: Mainstream Service Provider; NM: Network Member; NC: Network Client).
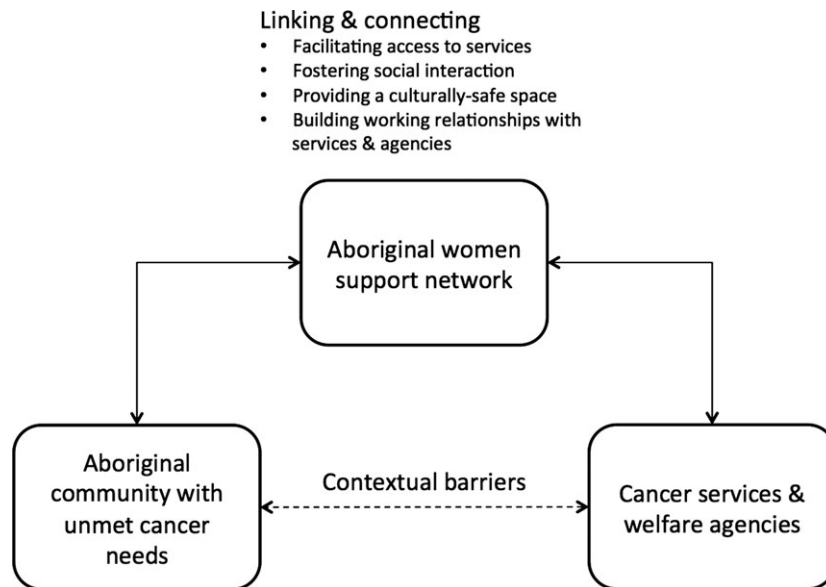
Participants' accounts showed that the network played multiple roles in the community. These roles are shown in Figure 1 and are discussed separately.

Linking and connecting people and services

Connecting and linking people and services was widely perceived as one of the main roles of the network. As seen in Figure 2, this role could be divided into four domains: (i) facilitating access to services; (ii) fostering social interaction; (iii) providing a culturally safe space; and (iv) building working relationships with services and agencies.

Figure 1 Roles played by the network in the community.

Linking & connecting
• Facilitating access to services
• Fostering social interaction
• Providing a culturally-safe space
• Building working relationships with services & agencies

Aboriginal women support network

Aboriginal community with unmet cancer needs

Contextual barriers

Cancer services & welfare agencies

Figure 2 The network as a 'cultural bridge' between cancer services and Aboriginal families.

Facilitating access to services
Service providers and network members viewed the network as playing an important role in facilitating access to mainstream services for Aboriginal women. This was consistent with their perception that the purpose of the network was not to duplicate services or 'reinvent the wheel', but, rather, to facilitate connections and linkages with existing services. Thus, the role of the network was described as 'connecting tracks' or 'opening doors'; one participant vividly described the network as an 'octopus extending its feelers', adding:

You know, we are all working together and we are not double-doing this or double-doing that. We are actually putting our feelers out. (14, NM)

The network had successfully linked women with a number of services, including mainstream and Aboriginal medical services, not-for-profit organisations such as the Cancer Council Western Australia (CCWA), home-care support service providers, welfare agencies and hospital social work departments. Service providers described specific ways in which this linkage to services had happened, for example facilitating access to financial support available through CCWA, and facilitating the reimbursement of travelling expenses through a national scheme providing financial assistance to country patients. One participant explained:

Now people will know through that group that there is some – it is pretty minimal, but there is some – financial assistance when you are undergoing cancer treatment. So, you know, you can get your power bill paid or something

like that. So it was something that people weren't accessing before. [. . .] So to me that is really important. (08, MSP)

The network had also referred women to counselling services, and had successfully established linkages for women accessing treatment services in Perth.

There were some reports of miscommunication between the network and the local service providers, which had resulted in duplication of work, and one MSP thought that the network's involvement had probably 'complicated some patients' journeys'. However, these incidents were largely attributed to the network 'finding its feet'.

Fostering social interaction
The network also played an important role in connecting women within the community, fostering social interaction. The network's fortnightly meetings provided a safe place, where women could escape from their daily routine:

[they] can come and get away from it all and yarn and talk and laugh and joke and whatever, but that is their place of escape. (12, NM)

The meetings were described as 'welcoming', 'friendly' and 'relaxing' by clients. The women reported enjoying the laid-back atmosphere; they described how they felt that 'everybody was your friend', and spoke of the comfort provided by sharing their stories. The use of humour featured strongly in women's accounts; they spoke of telling jokes and 'cracking up laughing'. One client reflected:

Aboriginal people like to sit down and have a yarn and a chat about things and, like, when we had that meeting here it was just all light-hearted. It was serious, but we just made jokes and giggled and laughed. (18, NC)

Providing a culturally safe space
Furthermore, the network was seen as a 'cultural broker', providing a culturally safe space for Aboriginal patients to engage with existing health services. MSPs saw this cultural brokerage as one of the most important ways in which the network could contribute to improving the health and well-being of Aboriginal women in the community, as they all acknowledge that, despite some improvements, Aboriginal clients were still not accessing mainstream cancer screening and support services. Providing support in a culturally safe environment was perceived as one of the main strengths of the network, and this was seen as having great potential to implement culturally appropriate health education and promotion initiatives, as one MSP commented:

Aboriginal people can say things to Aboriginal people that we can't, and often things that aren't easy to say, like 'get off your butt and get that lump checked out'. Like, no other white person could ever say that. (08, MSP)

Building working relationships
The network played an important role in building working relationships with existing services and agencies. It was widely acknowledged that solid working relationships between all stakeholders had to be established and nurtured, and 'respect' and 'trust' were seen as building blocks to establishing these relationships. However, there was some evidence to suggest that relationship building was still a work in progress; one MSP commented:

You have to have got to the point of having that relationship, and that comes from having professional respect for each other and trust. (06, MSP)

Participants shared the view that all stakeholders needed to work collaboratively and efficiently, especially given the complex health and social needs of Aboriginal cancer patients. However, a perceived lack of engagement from MSPs was seen as a sustainability issue by network members. One participant expressed her frustration as she explained that service providers had stopped attending the network meetings:

They just have to pop in for 5 minutes, have a cup of tea, 'hello, how are you?' While they are here we introduce them, 'look, if you need to go and see this lady, this is what she does; this is what she does'. They are there, because it has to work both ways. It is all right for us to say that we are linking up the community with the service providers, but the service providers also have to be willing to come and link up with us. (12, NM)

Emotional support
The network provided emotional support to women at the network's fortnightly meetings. Women got comfort from talking with other women who had experienced cancer themselves; one service provider vividly described the importance of this first-hand experience:

They know the pain. They know what happens on the first day of the chemotherapy, they know what radiation does. They have lived it, they have breathed it. They have smelt the smell of chemo, they know it stinks. They have shared those tears, those pains. (01, ASP)

Furthermore, this support was provided by Aboriginal women who were known and respected in the local community. It was widely agreed that the key to the network's success was the fact that it was run by Aboriginal women. MSPs acknowledged that the mainstream support groups available in the community did not meet the needs of Aboriginal clients, while network clients explained that talking to Aboriginal women made them feel more comfortable. One client said that 'knowing our culture, our way of life' made all the difference, while another explained:

I just think we have got this different way of feeling for one another. We can be open and that with one another. Within yourself you feel like you can talk to them about it and you feel a big sigh of relief. (20, NC)

The network meetings were unstructured, allowing women to join in and feel the comfort of being with other Aboriginal women. Participants who had attended meetings described how clients slowly began to share their stories and opened up about their experiences. One woman described the network as 'the best thing that [had] ever happened' to her family, while another spoke of feeling 'strengthened' from sharing stories with other women.

The meetings provided a safe space for women to show their emotions outside the family environment; this was seen as an essential part of the healing aspect of the meetings, as at home women were expected to be strong for the family. One woman explained:

Because if the kids were there, 'Oh, no, mum's the rock'. They depend on you. Everybody depends on you and looks up to you. You can fix everything. You keep your stiff upper lip. But with a group like that you can show your emotion because it is not your family, and that is a big difference, a very big difference. (21, NC)

Humour was cited often by Aboriginal participants, and it was evident that it was used to diffuse fear and stress; this was perceived to be intrinsic to Aboriginal women, as one participant explained:

Aboriginal women have a sense of humour that is just about everything else. They can laugh in the face of their illness and sicknesses and stuff like that. (12, NM)

Similarly, another participant said:

A lot of [women] just prefer you to be joking and things like that, because they say, 'well, you know what? That was a good therapy. I had a really good laugh and I let off all my steam' […] So it is kind of a therapy. It is not counselling, but it is a therapy thing. (14, NM)

The quote above is illuminating as it describes the support provided as 'a kind of a therapy'. Later, this participant explained that if the underlying issue was 'a little bit deeper', they would refer the client to a counsellor. Despite this, two MSPs who were directly involved in supporting cancer patients felt uncomfortable about the network providing emotional support. One of them explained:

Peers that are employed as volunteers through the Cancer Council go through peer-support training and they are facilitated by group leaders and they have that debriefing opportunity, so that they know that it is not about their opinion, it is about their feeling and their experience and how they can positively assist somebody to understand that journey. But they certainly need to be aware too that they are not giving advice. And I am not saying that that is what happens, but this is the danger of any peer sort of support. It actually needs strong support and facilitation. It is not just a matter of having willing people and passion-driven people, and particularly when some of those passion-driven people have their own issues that they maybe haven't dealt with. (03, MSP)

Similarly, the other MSP said that her understanding of peer support and group facilitation was 'obviously very different to what the group is doing'. This participant raised concerns about the lack of guidelines, which in her view could lead to breaches of confidentiality, adding:

It is not that I don't agree with the service or how it is running the group or whatever, but I feel really uncomfortable and threatened, you know. (11, MSP)

Practical support

Referred to as its 'behind the scenes' work, the network provided practical support to women in the community. Network members provided home support services including cleaning, gardening, cooking and washing. One MSP explained that she thought this practical support would be the main focus of the network:

My vision of the group was for absolutely practical support, you know, having Indigenous people care for Indigenous people so that they feel comfortable with them coming to their homes and helping them mop up and clean up, and make big pots of stew, and taking them shopping and accessing food vouchers, you know, just really practical support which is what the Cancer Council do as well, but they have never had an Indigenous sort of focus. (03, MSP)

In contrast, another MSP who was involved in delivering this type of support to cancer patients in the community expressed that they had 'no issues' delivering practical support services to Indigenous clients. Similarly, another participant thought that there was no need to 'reinvent the wheel' and it was more important to link Indigenous women with existing services. However, one network member pointed out that some women preferred a service delivered by Aboriginal people, adding: 'if they want us, we are not going to say no'.

Network members also drove women to their medical appointments, and this was particularly valued by service providers, who recognised lack of transportation as a major barrier to accessing services. The network also arranged school runs and provided respite to mothers by assisting with children. Practical support extended to buying furniture and cleaning products, and generally providing assistance when needed, as one participant explained:

When someone gets sick and that sick person is sleeping on a mattress on the floor and that floor is cold and winter is coming and there are a few things missing, we can provide that, and it is only those basic things that will make such a difference to that family. (12, NM)

Similarly, one client recalled the assistance she had received:

I was financially broken in January. I had absolutely no money and it was my daughter's birthday and […] [they] made a cake and they made sandwiches, and they brought a chicken and salad, and put on this little birthday party and bought presents for my daughter. (19, NC)

Aboriginal participants felt strongly that this practical support made a difference to women's quality of life and to their families. However, some concerns were raised about sustainability and liability issues. One MSP spoke of her concern about potential liability issues should a volunteer be injured or involved in a car accident while performing their volunteer work. One network member touched on this issue when she spoke of having stopped driving a client's children to school because her insurance did not

cover this. Referring to a conversation she had had with the network co-ordinator, another MSP commented:

I am saying to [the network co-ordinator], 'you can't call them carers. They have to be caring supporters. They can't go in and do things. They can't spend their money on these people. They might be able to accompany them to their appointments. They might be able to give them a lift. They might be able to go into the home and just be there as a companion and then also feed it back to someone who can do something about it, which is your co-ordinator role'. So there are limitations. (09, MSP)

Health education

The network was seen as having a role in the community educating women and their families, especially dispelling myths around cancer and providing information on community support services. Aboriginal participants felt strongly about this education role, and believed that through raising awareness, women would be empowered to confront their fears and go to the doctor. One representative from an Aboriginal service provider explained how by talking about cancer, this information would 'filter out' and the community would realise that cancer 'is not a death sentence'. Through this education role, the network played a proactive part in health promotion and early intervention, rather than only supporting cancer patients in times of crisis or at the end of their journey:

It is not a matter of just supporting for treatment. We want to support before treatment is even required. The education, going and having early intervention, that's what our group is all about as well [...] It is not just about making the last months comfortable for them. It is all about education. (12, NM)

Network members also spoke of linking in with existing health promotion and education initiatives and programmes, and using social events as culturally appropriate learning opportunities.

Cancer screening

Finally, the network facilitated access to cancer screening services, encouraging women to engage with existing breast cancer and cervical screening initiatives. Participants noted that cancer screening figures in the region had remained stable over recent years and were not showing signs of improvement. It was widely perceived that the network could play an important role in raising those figures, and MSPs thought that the network would enable mainstream cancer screening services to extend their reach to Aboriginal women in the community.

All service providers believed that the network could play an important role demystifying cancer screening, and addressing fears and cultural barriers. Aboriginal women spoke of the shame associated with nakedness and exposing 'private parts', and the network was credited with helping women overcome their embarrassment and their fears. Network members were actively involved in encouraging women to have their regular mammograms and pap smears, driving them to their appointments when needed; one NM explained their hands-on approach:

We go 'You are due for that. Come, come on! You are not getting away from us!' [...] If someone doesn't want to go along by themselves, we go along with them. (14, NM)

Discussion

Operating in a regional setting, the network played multiple roles supporting Aboriginal women affected by cancer and their families. The network combined characteristics of peer-support programmes – insofar as it was run by women who had experienced cancer and it provided emotional and informational support (Hoey *et al.* 2008) – and 'community navigators' (Henderson & Kendall 2014) or 'cancer navigators' (Whop *et al.* 2012) – insofar as the network provided instrumental and practical support to its clients, and engaged in culturally safe health promotion and education initiatives in the community.

Linking and connecting people and services was widely perceived as the main role of the network. Somewhat in contrast with findings from Shahid *et al.* (2009b), MSPs demonstrated some understanding of the life circumstances of Aboriginal patients, and readily acknowledged that the current mainstream care model failed to address the complex health and psychosocial needs of Aboriginal cancer patients and their families. Measuring the unmet supportive care needs among Aboriginal people with cancer is paramount to providing supportive care (Garvey *et al.* 2012). Overall, the network was perceived as bridging the gap in cancer service delivery, acting as a 'cultural broker' (Jezewski 1990) by providing a culturally safe space for women to engage with cancer services and with health promotion and screening initiatives. The network also fostered social interaction, and, consistent with findings from Poudrier and Thomas Mac-Lean (2009), Aboriginal women found comfort in relating to shared cultural and upbringing experiences within the network. Furthermore, by linking women with and bridging the information gap about available services, the

network addressed potential perceptions of disparity, thus reaffirming the symbolic value of access to health services (Gould *et al.* 2009).

The network also provided emotional support, and although clients spoke positively of their experiences, some MSPs had concerns relating to the unstructured way in which this support was provided. This highlighted a tension between two opposing perspectives, with Aboriginal stakeholders valuing cultural appropriateness and safety over structure, and MSPs prioritising clinical safety over other considerations. The perspective of some MSPs in this study may be regarded as paternalistic, as it fails to acknowledge and value Aboriginal expertise and ways of working, despite the network succeeding in areas and with clients where MSP acknowledged previous lack of engagement.

The network had been actively engaged in grassroots health promotion and education initiatives, and in doing so, it had addressed the 'silence about cancer' existing among Aboriginal communities (Treloar *et al.* 2013). Consistent with findings from Willis *et al.* (2011), embedding health education and screening initiatives as part of social events was seen as culturally appropriate by Aboriginal stakeholders, and MSPs acknowledged that the network provided a culturally safe space for women to engage with screening and educational initiatives.

Finally, the network provided practical and financial support to its members. Consistent with findings from a community navigator model implemented in Queensland among migrant communities (Henderson & Kendall 2014), flexibility and adaptability were essential characteristics of the network's grassroots approach to practical support delivery; however, MSPs raised issues of risk management and professional boundaries. In addition, the network was based on a volunteer model, and issues of out-of-pocket expenses incurred, availability of volunteers and supervision were also raised, which are consistent with other evidence on volunteer support programmes for people with cancer (Macvean *et al.* 2008).

A perceived lack of role definition and operational guidelines were perceived as sustainability issues by MSPs. These unresolved issues had led to some MSPs not referring clients to the network, and some questioned the network's ability to support their clients until such issues were resolved. Aboriginal stakeholders, on the other hand, cited lack of support from mainstream services and funding as the main sustainability issues. This disconnect was a reflection of a broader tension between flexibility and structure, which is consistent with findings from Henderson and Kendall (2014). Fluidity and flexibility character-

ised the operations of the network. This finding is consistent with other evidence on culturally appropriate Indigenous peer-support groups (Paasse & Adams 2011); however, it was found to be a source of conflict in this study, as MSPs thought that a more structured approach would be required for the network to be sustainable.

A limitation of our study is that interviews were conducted when the network had been operating for less than a year and was still establishing itself in the community. Also, data were collected in one specific regional setting, and thus, our findings may not be transferable to our cultural and geographical locations. Despite these limitations, the strength of this study lies in providing a rare, comprehensive description of the multilayered roles played by a community-led Indigenous-specific cancer support group.

There is ample evidence on the health benefits of peer-support programmes for people with cancer (Campbell *et al.* 2004, Hoey *et al.* 2008), and this paper described how a community-led, grassroots initiative successfully delivered culturally safe and appropriate support to women with cancer in a regional community. Although MSPs valued Aboriginal leadership in developing and running this network, they were also critical of some of the key features which contributed to its success. It became apparent that for initiatives such as this to be effective and sustainable, adequate ongoing funding and resources need to be mobilised to support Aboriginal leadership and the sustainability of the model. Furthermore, any tensions between different perspectives on service delivery between Aboriginal organisations and communities and mainstream cancer service providers must be addressed and resolved, building trusting relationships over time (Taylor & Thompson 2011). Valuing and honouring Aboriginal approaches and expertise, and adopting an intercultural approach where neither culture dominates (Haynes *et al.* 2014) provide a way forward.

Conflict of interest

The authors declare that they have no conflict of interest.

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