



Variation in health beliefs across different types of cervical screening non-participants



Laura A.V. Marlow^{a,*}, Rebecca A. Ferrer^b, Amanda J. Chorley^a, Jessica B. Haddrell^a, Jo Waller^a

^a Cancer Communication and Screening Group, Department of Behavioural Science and Health, UCL, Gower Street, London WC1E 6BT, United Kingdom

^b Basic Biobehavioral and Psychological Sciences Branch, Behavioral Research Program, Division of Cancer Control and Population Sciences, National Cancer Institute, Rockville, MD, United States

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ABSTRACT

Understanding factors associated with different types of cancer screening non-participation will help with the development of more targeted approaches for improving informed uptake. This study explored patterns of general health beliefs and behaviour, and cancer-specific beliefs across different types of cervical screening non-participants using the Precaution Adoption Process Model (PAPM). A population-representative sample of women in Britain completed a home-based survey in 2016. Women classified as non-participants ($n = 839$) completed additional questions about health beliefs.

Some general health beliefs and behaviours, as well as cancer-specific beliefs, were associated with particular types of non-participation. For example, those who scored higher on fatalism were more likely to be unaware of screening ($OR = 1.74$, $95\%CI: 1.45-2.08$) or unengaged with screening ($OR = 1.57$, $CI: 1.11-2.21$). Women with greater deliberative risk perceptions were less likely to be unengaged with screening ($OR = 0.74$, $CI: 0.25-0.99$) and less likely to have decided against screening ($OR = 0.71$, $CI: 0.59-0.86$). Women who had seen a general practitioner in the last 12 months were less likely to be unaware ($OR = 0.49$, $CI: 0.35-0.69$), and those reporting cancer information avoidance were more likely to be unengaged with screening ($OR = 2.25$, $CI: 1.15-4.39$). Not wanting to know whether one has cancer was the only factor associated with all types of non-participation.

Interventions to raise awareness of screening should include messages that address fatalistic and negative beliefs about cancer. Interventions for women who have decided not to be screened could usefully include messages to ensure the risk of cervical cancer and the relevance and benefits of screening are well communicated.

1. Introduction

Cancer screening involves testing for higher risk of asymptomatic early stage cancer or precancerous lesions, which can then be diagnosed and treated before cancer develops. Population-based screening for colorectal, breast, and cervical cancer, along with oral cancer screening for at-risk groups, is recommended by the World Health Organization (WHO, 2013). Key to the success of all cancer screening is participation of the asymptomatic, healthy individual, but uptake of cancer screening is considered sub-optimal across different cancers and different delivery systems (NHS Digital, 2016; von Wagner et al., 2011; White et al., 2017).

Interventions to improve overall uptake of cancer screening have had limited success (Everett et al., 2011; Wardle et al., 2016) and support has been growing for a move from 'one-size-fits-all' interventions to more tailored or targeted approaches (Kreuter and Wray, 2003;

Myers et al., 2007; Sohl and Moyer, 2007). There has also been a shift in focus towards improving informed choice in cancer screening, ensuring that individuals have a good understanding of the risks and benefits before deciding about participation (Entwistle et al., 2008). Historically, most models of health behaviour (Ajzen and Fishbein, 1980; Maddux and Rogers, 1983; Rosenstock, 1966) have suggested a single set of variables could predict whether a person participates in a health behaviour (Weinstein, 1988). While these models seem to do a good job at predicting how those who are aware of a health threat form a decision about a related behaviour, they offer less insight into the processes involved for those who are unaware of the threat or those who need to translate their intentions into action (Weinstein et al., 2008). Consequently, Weinstein proposed the Precaution Adoption Process Model (PAPM) (Weinstein, 1988) as a way of highlighting different stages of participation (or non-participation) in a health behaviour. The PAPM describes how for any 'hazard' there will be several 'stages' through

* Corresponding author.

E-mail address: l.marlow@ucl.ac.uk (L.A.V. Marlow).

Box 1

1. 'In the UK, women who are aged between 25 and 64 are invited to participate in the NHS cervical screening program' followed by 'Have you ever heard of cervical screening, also known as the smear test or Pap test?' This was accompanied by a photograph of a woman being screened
(Response options: yes/no/don't know)
2. [Those who responded yes to Q1] 'Have you ever had a cervical screening test?'
(Response options: yes/know/don't know)
3. [Those who responded yes to Q2] 'When was the last time you had a cervical screening test?'
(Response options: within the last 3 years/3–5 years ago/longer than 5 years ago/don't know).
4. [Those who responded yes to Q1] 'Do you intend to go when next invited?'
(Response options: yes/no/don't know + 'I've never thought about it' as an additional response for those who had not been screened before)

which people move before participating in a behaviour to reduce that hazard. They may be unaware (stage 1: unaware), following which they may remain unengaged (stage 2: unengaged). There may then be a period that includes being undecided about whether to participate (stage 3: undecided), before forming an intention or plan (stage 5: decided to act), and then translating this into behaviour (stage 6: acting). A decision not to act can also be made (stage 4: decided not to act). For ongoing behaviours there is also a stage relating to whether the behaviour is being continued (stage 7: maintained). Weinstein proposed that there are qualitative differences between people at different stages and suggested that understanding the variables relevant to each stage could contribute to the design of more effective interventions. Initially developed to explain radon testing behaviour, the PAPM has since been applied to a range of behaviours including osteoporosis prevention and smoking cessation (reviewed here (Weinstein et al., 2008)), and more recently to cancer screening (Costanza et al., 2005; Ferrer et al., 2011; Hester et al., 2015; Marlow et al., 2017).

The PAPM is well suited to cancer screening behaviour because it draws together a range of empirical findings, including the fact that many people who are eligible for screening are unaware or unengaged (Robb et al., 2010) and that there is a significant gap between intention to be screened and participation in screening (Sheeran, 2002). It also allows a dedicated space for those who have made a choice not to participate and therefore works well with the move towards encouraging informed choice in the context of cancer screening (Entwistle et al., 2008). While the term 'stage' is used to highlight the phases people move through, the PAPM differs from earlier stage models (e.g. Prochaska and Velicer, 1997) by accepting that there is no set duration for each 'stage' and that people may skip stages or may move back into earlier stages. These assumptions work well within the cancer screening context, where the behaviour is repeated every few years, and movement between 'stages' before, after and between screening rounds (backwards and forwards) may occur. This provision allows for decisions about participation to change throughout the period over which an individual is eligible for screening. For a more detailed description of how each stage might be applied to cancer screening behaviour see Marlow et al. (2017).

A basic premise of the PAPM is that there are common barriers among people in the same stage and that barriers differ between stages. A number of studies have found support for this in the context of colorectal cancer screening. For example, social cognition variables (perceived risk, worry and regret) are better at explaining intention to be screened, whereas factors relating to life difficulty are better at predicting whether this intention was translated into action (Power et al., 2008). More specifically, those who are unaware or unengaged with colorectal cancer screening are less likely to have seen a health professional recently and have poorer self-rated health (Costanza et al., 2005). Moreover, the unaware are more fatalistic (Costanza et al., 2005), the unengaged are less worried and report lower perceived risk (Costanza et al., 2005; Ferrer et al., 2011), and those who have decided

to be screened have higher self-efficacy scores and a greater correlation between risk perceptions and worry (Hester et al., 2015). These studies suggest that the PAPM provides a useful framework for considering different types of non-participant at colorectal screening and understanding differences in health beliefs between types of non-participant. The PAPM has not been applied to cervical screening before and therefore in the current study we further the application of the PAPM to cervical screening and i) explore the pattern of health beliefs across types of non-participant and ii) consider the contribution that different general health beliefs and behaviours, and cancer-specific beliefs, can make in explaining an individual's non-participant type. Since this survey was cross-sectional we have described different 'types' of non-participant, rather than referring to stages. We did not form any hypotheses since no studies had explored differences between PAPM stages in the context of cervical screening or in a country outside of the US with free universal healthcare.

2. Methods

2.1. Participants

In the UK, women aged 25–64 years receive invitations for cervical screening every 3 or 5 years. We commissioned six waves of data collection among screening-eligible women across Great Britain in January/February 2016. Fieldwork was outsourced to a market research agency (TNS) as part of an omnibus survey (i.e. where data are collected during one interview on behalf of multiple clients). Stratified random location sampling was used to select sampling points across Britain. Interviewers knocked on doors at properties in each location, inviting people to take part. Three doors were left between each interview. At each location, quotas were set for employment status and presence of children in the household. Response rates are not recorded by the market research agency. Ethical approval was granted by the UCL Research Ethics Committee (ref: 7585/001).

Data were collected using face-to-face computer-assisted personal interviews (CAPI). A series of four questions assessed awareness of screening, past screening behaviour and future intention to be screened (Box 1). Women were classified into one of six stages of participation (based on Weinstein (Weinstein, 1988)). A detailed explanation of these questions and a flow-diagram indicating how women were allocated to each PAPM stage is available elsewhere (see Fig. 2 of Marlow et al., 2017). The present article focuses on differences in health perceptions among women who were classified as cervical screening non-participants. Women who were up-to-date with screening and intended to re-attend were not asked questions about their health perceptions and were excluded from these analyses. The decision not to include questions about health beliefs for all women was cost-based. Findings relating to socio-demographic differences between the non-participant types have been published elsewhere (Marlow et al., 2017).

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