WOMEN’S PERSPECTIVE ON THE ACCESSIBILITY TO CERVICAL CANCER SCREENING: A REVIEW

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ABSTRACT

Women’s health behaviour pertaining to cervical cancer screening is a complex inter- and intra-relationship between concerns on health matters and other internal and external influences. Women’s decision to seek preventive health care such as cervical cancer screening is being made complicated by women’s status in the society. This review looks into women’s perspectives in seven areas of influences namely, knowledge; psychosocial; gender roles and norms; accessibility; beliefs, attitudes and perceptions; health services; and, language and communication. These influences are interlinked with each other and they function simultaneously. This review also showed that knowledge alone is inadequate to enable women to seek cervical cancer screening. Other factors interplay to hinder women from attending screening.

Keywords: women’s perspective, gender roles, cervical cancer screening, Pap smear test, decision making

1.0 Introduction

The Pap smear test, as a screening mode for cervical cancer, has been recommended as a population based screening method for the early detection of cervical cancer. The uniqueness of the Pap smear test among other cancer screening test is its ability to detect cervical cancer at a precancerous stage, and therefore, early intervention can be carried out to prevent its progress to cancer (World Health Organisation (WHO), 2006). Despite the important benefits of the Pap smear test in early detection of cervical cancer and reduction of morbidity and mortality, not all women acknowledge these benefits or accept the test. Numerous studies have shown the differential impact of external as well as internal influence on an individual’s decision. These influences can either facilitate or prevent a person from carrying out a decision to participate in cervical cancer screening following any information they received (Ackerson, Pohl, & Low, 2008).

Cervical cancer screening programme as a whole has a wide range of coverage rates across countries worldwide. In general, developed countries have higher rates of more than 80%,
compared to developing countries whose rate can be as low as 1% (Gakidou, Nordhagen, & Obermeyer, 2008). The success of a cervical cancer screening programme depends on two large aspects: the provider and the client. The provider aspect consists of not only the primary, secondary and tertiary levels of providers, but also the policy makers. In addition, a well-planned organisation as well as adequate resources and skilled manpower are required to ensure an effective programme and high coverage rates (WHO, 2006).

Nevertheless, several studies have shown that women’s decision to attend cervical cancer screening is influenced by a number of factors which are interlinked with each other. These factors range from personal factors, cultural factors, to institutional factors. Most of these factors are modifiable either at the individual level or at higher policy maker level. The following paragraphs discuss the literature on these factors.

2.0 Influencing factors on decision regarding the Pap smear test

2.1 Knowledge

In any decision, a person needs to be aware of the existence of an issue which needs a decision to be made. Similarly, for the Pap smear test, a woman needs to be made aware that the test exists. Information about cervical cancer screening is seen as an important factor for women’s decision-making. Women who did not go for the Pap smear test gave the reason that they were totally ignorant about the existence of cervical cancer screening (Institute for Public Health (IPH), 2008). Studies which asked on motivational factors found that among the factors were recommendations by physicians, family, neighbours and friends (Pelcastre-Villafuerte, Tirado-Gómez, Mohar-Betancourt, & López-Cervantes, 2007), and also recommendations by other users (Abdullah, Students, & Leung, 2001). Abdullah et al. (2001) also found that not only recommendation, but support from family and friends played a role in motivating women. Other sources of information such as the media and pamphlets were also found to provide awareness to women.

Different sources of information provided different types of information. A study among Chinese Hong Kong women, for instance, found that the majority of them received information on screening services from relatives and friends (59%) and the source of information on health knowledge was from the newspapers and magazines (63%). Unexpectedly, health care workers and hospital staff were not the main source of information on screening and health information in this study (Abdullah et al., 2001).

Ironically, women who had had the Pap smear test did not necessarily do it out of consciousness of the benefits, but rather due to other reasons such as recommended by physicians or as part of a routine health examination. Hence, some women who had the test done did not know that it was a procedure for cervical cancer screening (Markovic, Kesimal, Topic, & Matejic, 2005). Several studies showed that a recommendation by a physician played an important role in motivating women to attend screening (Ackerson, 2010; Lovell, Kearns, & Friesen, 2007). It was perceived to be adequate for the women to know that the test is beneficial for their health (Ackerson et al., 2008). Physicians were viewed as the experts and hence, following their advice was felt to be the right decision (Haas & Sainsbury, 2006)
Nonetheless, some studies found that women felt they should be in control of their own health and thus, should take the responsibility to search for information on cervical cancer screening on their own (Smith, French, & Barry, 2003). These women did not trust their doctors and preferred to search for information independently. Other studies however, found that women played the passive role of receiver of information and failed to enquire further. They felt that the physicians would tell them if there was anything which they needed to know (Ackerson & Preston, 2009; Markovic et al., 2005).

Therefore, there were instances whereby information given by health personnel concerning cervical cancer or cervical cancer screening was perceived to be inadequate by women. Not having further information about the Pap smear test was the commonest reason given by women in the Malaysian National Health Morbidity Survey for eluding the test (IPH, 2008). Certain aspects of information are important to women, other than knowing the benefits and importance of Pap smear. Women in a number of studies expressed that they wanted to have the Pap smear test but could not have it because they did not know the location of the facilities providing the screening services (IPH, 2008; Wong, Wong, Low, Khoo, & Shuib, 2009). In addition, not knowing the frequency of screening was reported by women as a barrier to screening (Oon et al., 2010). The indications for Pap smear were not apparently clear to some women as well. Thus, women who were not currently sexually active did not attend screening (Watkins, Gabali, Winkleby, Gaona, & Lebaron, 2002).

Another aspect which has an impact on women’s decision is the misconceptions about cervical cancer screening. Though cervical cancer screening is an established screening test whereby its benefits are well established, the choice to have a screening done is not the prerogative of physicians. Increasing advocacy for informed decision-making has shifted the decision to individuals. However, informed decision-making is not without its problems. Communication between health care providers and women plays a vital role in women’s knowledge about screening. A study by Denberg, Wong, and Beattie (2005) showed that whilst physicians and patients shared the same terminology of cancer, screening and prevention, they did not share the same meaning. Cancer was seen as a terminal disease and not preventable, and screening was only done when symptoms occur. Women who failed to attend screening were also found to misunderstand the Pap smear test as a diagnostic test rather than a screening test (Bessler, Aung, & Jolly, 2007).

The ignorance about the Pap smear test was multifactorial. Markovic et al. (2005) looked further into this issue. The lack of information about cervical cancer screening within education on women’s health issues was traced back to school days whereby preventive health care was not a focus of discussion. This inadequacy was further accentuated by cultural taboo on the subject concerning sexual and reproductive health in the family and community. Even seeing a women seeking reproductive health treatment would trigger negative perception in the community. In addition, the media was also not a significant source of information on women’s health due to inadequacy of the relevant information as well as inaffordability to purchase media resources. The lack of sharing of experience on screening with family members or acquaintances was found to be a gender-related barrier in a study by Pelcastre-Villafuerte et al. (2007). Hence, due to the taboo of discussing reproductive matters, women did not know of other family members’ experience with regards to the Pap smear test or cervical cancer. Discussing on matters pertaining to the cervix (and breast) was also found to be taboo among Korean American women (Lee, Tripp-Reimer, Miller, Sadler, & Lee, 2007).
Nonetheless, having the knowledge about the Pap smear test does not necessarily motivate women to attend screening. These women believed that they were in control of their health and their bodies. They felt that their health care practices such as healthy lifestyle and safe sexual activities were adequate to prevent them from diseases and that screening was unnecessary (Blomberg, Ternestedt, Tömberg, & Tishelman, 2008). On the other hand, women had also expressed their being in control of their body by attending screening as a measure of taking care of their health (Lovell et al., 2007). These different concepts of being in control were pointed out by Corones and Hardy (2009). Hence, the gender-based expectation that women are compliant to health promotion strategies can be misleading.

Different aspects of knowledge were studied in relation to cervical cancer screening and the Pap smear test. A study in rural Mexico for example, asked if the women knew the Pap smear test was a screening measure for cancer and that it involved the cervix (Watkins et al., 2002). Although almost all of the women (94%) knew both the purpose of the Pap smear test and the correct anatomic location, 34% of the women never had a Pap smear test, and only 48% of them had received a Pap smear test within the last two years. Chee, Rashidah, Shamsuddin, and Intan (2003) tested knowledge using a true or false answer to the question “The Pap smear test is a test to identify cervical cancer”. Answering correctly was significantly related to having the Pap smear test within the last three years. Having the knowledge about the risk factors of cervical cancer was also found to be significantly associated with having a Pap test among respondents in Turkey (Uysal & Birsel, 2009). A study among women attending emergency department in the United States found that having the knowledge concerning screening services was significantly related to having a Pap smear test and breast cancer screening (Merchant, Gee, Bock, Becker, & Clark, 2007). There were also studies which showed that knowledge did not have a significant relationship with the practice of Pap smear. A study by Yu, Kim, Chen, and Brintnall (2001) for instance, asked about knowledge on cancer warning signs or symptoms and this was found to be not significantly related to the Pap smear test.

2.2 Psychosocial factors

The Pap smear examination involves exposure of women’s private parts to health personnel. The intimacy of this procedure was not acceptable by women and was reported to be one of the common barriers to screening. For instance, a study among low income women in rural Mexico, Watkins et al. (2002) found the most frequent reason for not obtaining or for delaying a Pap smear test was anxiety regarding physical privacy (50% of respondents). This is described as an embarrassment about having one’s body viewed by a man, which also includes aspects of shame and is manifested as anxiety regarding one’s body. The area of the body which is being examined involves the intimate body parts which are expressed as related to sexuality and extremely private (Blomberg et al., 2008). The feeling of embarrassment and anxiety over compromising their modesty was also echoed by women in the study by Agurto, Bishop, Sanchez, Betancourt, and Robles (2004), Oscarsson, Benzien, and Wijma (2008), Wong, Wong, Low, Khoo, and Shuib (2006), and Al-Naggar & Chen (2012). Conversely, women who did not feel that the examination was embarrassing did not feel that it was a problem to attend screening (Taylor et al., 2002).

These feelings of anxiety and unacceptability of the pelvic examination were reported to be closely related to cultural values of a community. The private parts were considered sacred...
and associated with sexual intimacy. Thus, this area of the body can only be viewed by their husbands (Lovell et al., 2007). Gender norms dictate the value of women and their body and has triggered the issue of being embarrassed and shy of having one’s body examined by health personnel. In addition, gender stereotyping of gender-appropriate behaviour of femininity and female passivity as being shy, timid and reserved might explain women’s shyness of having their body being examined (Corones & Hardy, 2009). Hence, anxiety over privacy is expressed by rural as well as non-rural women (Abdullah et al., 2001). In addition, husbands also share the same perception of embarrassment of having their wives’ body being exposed to others, even in the noble act of medical examination (Pelcastre-Villafuerte et al., 2007). The specific aspects of being embarrassed are not only related to the fact of one’s privacy being exposed to others, but also from personal factors. Such personal factors are like negative bodily image which includes being obese (Ferrante, Chen, Crabtree, & Wartenberg, 2007), overweight, disfigured (Adolfsson, Gravenik, & Paulson, 2012) and disabled (Wei, Findley, & Sambamoorthi, 2006).

Another psychological barrier regarding the Pap smear test is the anticipation of pain. Women expressed their fear that the procedure would be painful (Al-Naggar & Chen, 2012; Bessler et al., 2007; Forss et al., 2001). In addition, a study by Hunter (2005) reported that women associated the speculum as an instrument of extraction in their confusion with other gynaecological procedures such as vaginal hysterectomy. Previous experiences of domestic violence and sexual abuse also contributed to the anticipation of pain (Ackerson, 2010; Adolfsson et al., 2012).

Women also expressed their fear of an abnormal result (Bessler et al., 2007; IPH, 2008; Oscarsson et al., 2008). In a study by Drew and Schoenberg (2011), women’s basis for this fear was because of the changes in their lives and the changes they would have to make if faced with cancer. They also feared the effects of treatment and were apprehensive over the possibility of a recurrence during the period of remission. These thoughts made them feel that it was better if they did not know their health status. In a study by Pelcastre-Villafuerte et al. (2007), women feared losing their identity as a wife and mother. The women in this study perceived that without a womb and the ability to have children, a woman is useless. In addition, women felt that being submissive to men meant that men must have sexual intercourse. Thus men will seek elsewhere if they are not satisfied with the wives. If the women are confirmed to have cancer, they fear abandonment by their husbands. The respondents also believed that a woman’s role is to provide pleasure to her partner at her own expense. Other anticipated feelings women had over the Pap smear examination were discomfort (Oscarsson et al., 2008) and unpleasantness (Ackerson, 2010).

Women coped with their feelings of embarrassment by going to a health care provider who was familiar to them. A study by Blomberg et al., (2008) showed that women expressed their preference for physicians, not necessarily gynaecologists, whom they have been visiting regularly. They felt that they had a trusting relationship with their regular providers. This was important to them because of the intimacy of the procedure. Others preferred to see a female rather than a male health care provider (Ackerson, 2010; Lovell et al., 2007). In addition, Lovell et al. (2007) reported that women of older age felt comfortable with the screening examination. These women associated this with their several experiences with obstetric and gynaecological examinations for childbirth and gynaecological problems. Hence, they have become accustomed to having their bodies exposed during medical examinations.
As a result of women’s feeling of embarrassment of the Pap smear examination, devices were developed to reduce the need for women to expose their genitals to smear takers. Self-administered devices, such as the Kato device, were found to be more acceptable by women as they do not need to expose themselves to other people (Sanchaisuriya et al., 2004). More recently, a tampon-like device was developed to enable women to collect HPV and perform the test at their own home. However, the benefit of this test is still doubtful because of lack of professional advice (McCartney, 2010).

2.3 Gender roles and norms

In many households, women in paid employment are still expected to fulfil their domestic roles such as household chores and child care. This dual burden on women has the same impact on Pap smear screening attendance as in other reproductive and general health care seeking practices. Women were too occupied with their roles and responsibilities to make time for a screening test (Adolfsson et al., 2012; Wong et al., 2006). Compared to their gender roles, screening was not a priority. This situation was made worse when their home, workplace and the clinic were in different areas. This incurred lost time and money for the journey (Oscarsson et al., 2008). Furthermore, they face difficulties in their workplace when the administrators are men who would scarcely allow them time to go to a health clinic without any symptoms of a disease (Markovic et al., 2005).

Women as health carers in many communities often subordinated their health needs to other members in the household. Hence, if there were family members who needed care at home, the woman’s role would be prioritised above her health needs (Adolfsson et al., 2012; Markovic et al., 2005; Pelcastre-Villafuerte et al., 2007).

In some cultures, husbands are not involved in matters pertaining to women’s health. In relation to reproductive health, women’s confidante and companion were the women elders such as mothers and paternal aunts, as well as peers (Mutyaba, Faxelid, Mirembe, & Weiderpass, 2007). Lack of male involvement was reported as a barrier to attend screening as men controls the financial resource and women’s access to health facility. Women were reluctant to disclose their gynaecological symptoms as they would be accused of promiscuity and this could threaten their marriage. Hence, women did not seek for husbands’ support even when they were diagnosed to have cervical cancer (Pelcastre-Villafuerte et al., 2007). Husbands’ encouragement was mentioned as an important motivating factor for women to attend screening (Keshavarz, Simbar, & Ramezankhani, 2011).

2.4 Accessibility

Accessibility to health care provider was problematic to women in certain localities. One of the problems faced was irregular presence of doctors (Leach & Schoenberg, 2007; Markovic et al., 2005). This was attributed to the shortage of doctors in the area. Health facilities which were located far from women’s residence made it difficult for women to have access, and especially so when the operating hours were inconsistent (Agurto et al., 2004; Watkins et al., 2002). Another issue concerning accessibility is the scarcity and inconsistency of public transportation, which can be a problem for women to attend clinics (IPH, 2008). These geographical barriers, including bad roads, further impede women from going for screening especially when preventive health care was not a priority (Leach & Schoenberg, 2007).
Prevoius studies found differences in cervical cancer screening behaviours between women with regular source of health care and those without such resource. This is shown in studies which found that women who had a regular physician were more likely to ever have a Pap smear test (Seow, Huang, & Straughan, 2000; Wang, Sheppard, Schwartz, Liang, & Mandelblatt, 2011). Women with regular source of care also had higher odds of having a Pap smear test in the last three years and within the past one year (Owusu et al., 2005). However, a study in New York City showed that though missing the Pap smear test only was not significantly related to having a personal doctor, missing both breast and cervical cancer screening was found to be more common among those who did not have a personal doctor compared to those who did (Nash, Chan, Horowitz, & Vlahov, 2007). Women also had preferences for specialists rather than nurses for the Pap smear test (Abdullah et al., 2001). In addition, Lee, Seow, Ling, and Lee (2002) found that women were more likely to visit a general practitioner or a gynaecologist than a government polyclinic.

Other than having a regular physician, access to health care was also studied using variables such as recent contact with health service. A study in Malaysia found a close association between Pap smear screening and having had a medical examination within the last five years (Chee et al., 2003). Similarly, a study in Singapore also found that women were more likely to have a Pap smear test as a self-initiated screening test or part of a regular health check-up (Lee et al., 2002). Having more number of visits to physicians was also linked to an increased likelihood of having a Pap smear test (Goel et al., 2003; Østbye et al., 2003).

In some countries, the Pap smear test is more readily available for women who used the maternal and child health services or family planning services as the Pap smear screening is advocated through these services. Thus, some studies have included pregnancy related and contraceptive related variables. For example, the study in Malaysia by Chee et al. (2003) identified that a woman having at least one young child aged 6 years or younger as having had recent contact with postnatal care, and is currently using either contraceptive pill or intra-uterine device (IUD) to reflect contact with family planning services. This study found that having had the Pap smear test within the last three years was significantly higher among women with young children. However, being currently pregnant was not significantly related to the Pap smear test. A study by Watkins et al. (2002) found that women who had delivered children were significantly more likely to have received a Pap smear test.

Financial constraint of those living in poverty further limits women’s decision to attend screening. Although screening is provided free by the government in many countries, women still have to consider the indirect costs of going to the health facility. These include expenses during travelling to the clinic which is often located far from the rural area they are residing (Leach & Schoenberg, 2007). This is in addition to the indirect cost of lost hours spent on travelling to and waiting in the clinic. This would involve sacrificing their productive working hours which impinge on their income. In the absence of symptoms, these sacrifices seem futile (Markovic et al., 2005). In addition, women need to also consider returns to clinic for results, further diagnostic procedures and treatments if the results were positive of cancer (Tsu & Levin, 2008). Other charges include unofficial charges and bribery (Mutyaba et al., 2007). In the absence of adequate facilities in a nearby public health clinic, women would need to attend or sometimes would be referred to expensive private clinics for screening (Keshavarz et al., 2011). Hence, women usually sacrifice their health needs in view of other priorities in the family. The intersection of gender bias and poverty further complicates women’s decision and accessibility to attend screening. Other than that, within certain households, men’s health...
care take priority over women’s health care, especially when there are competing needs of resources (Tsu & Levin, 2008). In patriarchal societies, the subordinate position of a woman, specifically a wife, in a household, denied a woman from access to and control over monetary needs (Agurto et al., 2004). Women are also reluctant to discuss sexual problems with their husbands as they (wives) would be accused of causing the disease. Thus, women had to inform of having other diseases if they need the money to go for screening (Mutyaba et al., 2007).

Women have to visit clinic several times for screening and screening follow-ups because of the stepwise approach to management of cervical lesions which includes screening and diagnosing, followed by confirmation with colposcopy and biopsy, and finally treatment. This approach had posed problems with compliance of women who have difficulty in attending clinic due to geographical and logistics restrictions (Denny & Sankaranarayanan, 2006). Hence, screening with visual inspection techniques such as visual inspection with acetic acid (VIA) or with Lugol’s iodine (VILI) is recommended and was found to improve compliance and prevent women from losing to follow-up. These two methods apply a one visit ‘screen and treat’ strategy whereby treatment with either cryotherapy or loop electrosurgical excision procedure (LEEP) is carried out immediately for pre-cancerous lesions detected on screening during the same visit (Cuzick et al., 2008). This simple procedure with a single-visit approach has been found to be more acceptable to women and was also cost-effective especially for low-income countries (Cronjé, 2004).

Power relation between a husband and a wife also dictates whether a woman could have access to health care. A woman would not be able to attend health facility if the husband does not consent (Agurto et al., 2004; IPH, 2008), or even if the woman thinks her husband does not allow her to (Wong et al., 2006). Usually, husbands did not allow wives to attend if the provider was a male. In certain societies, women have to abide to the cultural practices in accessing health care. In a study by Nikièma, Haddad, and Potvin (2008), husbands have the responsibility to protect and provide for their wives and a woman must conform to the code of conduct of a dutiful wife to be able to obtain resources for treatment. Even then, the decision whether to seek modern healthcare or traditional is the prerogative of the husband alone or his natal family. And the woman cannot seek healthcare without her husband’s consent, even if she has the resources to do so. If a husband declines his wife’s health expenses, the wife can first turn to the husband’s family, followed by her own family. Thus, not every health problem is eligible for household resources. From this study, it can be seen that women’s access to health care is a complex one. This will seem to be more complicated if the woman is seeking preventive health care, at a time when she is well and capable of carrying out routine household chores.

2.5 Beliefs, attitudes and perceptions

One of the aspects about making decision concerning the Pap smear test is that the decision is made when one is well, as opposed to decisions on choice of treatment which are made when a person is ill. A woman needs to foresee the effects if she were to be ill and the need to prevent it from happening. Therefore, women’s beliefs, perceptions and values are important in influencing their decision to have a Pap smear test. Cognitive appraisal such as perceiving that prevention is better than cure, and having higher risk of cancer were factors which motivate women to have a Pap smear test (Abdullah et al., 2001; Ackerson et al., 2008). On the other hand, studies on the barriers to Pap smear test showed that women who perceived
they were of low risk of cervical cancer (Pelcastre-Villafuerte et al., 2007) did not attend screening.

Other beliefs and perceptions which were found to be significantly associated were the belief that the Pap smear test can prevent and detect cervical cancer (Taylor et al., 2002), or can evaluate general health status of the body (Ackerson et al., 2008;). Hence, women who believed that cervical cancer could not be prevented (Agurto et al., 2004) or that they would get the disease if they were screened (Wong et al., 2006), did not attend Pap smear screening.

Many women associate the Pap smear test as a diagnostic test rather than a screening test. Thus, women only seek screening when they have symptoms which they perceived to be due to a reproductive health problem such as abnormal vaginal discharge or abnormal menstrual bleeding (Markovic et al., 2005). Cultural belief on health management was found to be a factor to women’s health seeking behaviour (Hunter, 2005). It was not that women did not understand the seriousness of cervical cancer. Rather their own experiences of witnessing relatives and friends suffer the disease was far more enriching than the biomedical model of cancer. The cultural beliefs include traditional beliefs of disease and the use herbal medicine as a first line treatment. Formal health care provider was only consulted when the disease has worsened (Mutyaba et al., 2007).

The absence of a preventive attitude towards one’s health was reported as a barrier to screening (Pelcastre-Villafuerte et al., 2007). Thus, women felt they did not need the test because they did not have any gynaecological symptoms such as pain or discharge (Bessler et al., 2007; Watkins et al., 2002), or that they were not ill (Hoque, Hoque, & Kader, 2008). However, women who had a preventive attitude towards their health were hindered from going for screening as a result of previous negative experiences. These women had the experience of being chastised or humiliated during previous preventive health care visit(s) which consequently, strengthened their reason for not attending screening (Leach & Schoenberg, 2007). They deferred going to the clinic until they could not tolerate the symptoms of pain and other symptoms which incapacitated their daily routine. Furthermore, physicians’ lack of emphasis on preventive care enhanced women’s perception that they only need to attend Pap smear when they have symptoms. These women were turned away by physicians when they previously attended the clinic for a gynaecological check-up (Markovic et al., 2005). Hence, women’s health seeking behaviour is shaped by not only cultural practices, but also by health care providers’ attitude and practices.

Nevertheless, women who believed in the need and importance of the Pap smear test may not attend screening due to other reasons. These women were faced with several constraints in their life such as financial and employment (Drew & Schoenberg, 2011). The uncertainty of the test result, be it false-positive or false-negative, was of concerned to the women as they would have to return for another test. This would affect the limited resources they have, as well as their psychological well-being. Hence, women with these concerns were more likely to express their submission to fatalism as a last resort (Drew & Schoenberg, 2011; Hunter, 2005). On the other hand, women who were concerned over the accuracy of the test results in a study by Smith et al. (2003) suggested yearly screening to ensure that an abnormal result is not missed.

Previous studies have found that attending cervical cancer screening was also associated with other positive health behaviours such as doing physical exercise (Abdullah, Aziz, & Su,
Health Promoting Lifestyle Profile scale has been used in studies to look at six healthy lifestyle behaviour: self-actualization, health responsibility, exercise, nutrition, interpersonal support, and stress management, and their relationship with other health variables. These studies have shown significant relationship between healthy lifestyle behaviour with cervical cancer screening practices (Oran, Can, Senuzun, & Aylaz, 2008). These studies showed that women who undertook cervical cancer screening were also involved with other healthy lifestyle practices. This supports the notion that women who have a preventive health care attitude will readily decide on screening if recommended by, for instance, a health care provider. Women with these preventive attitude perceived screening as one of their regular health check-ups (Forss et al., 2001).

2.6 Health services

Previous experiences with health services play a significant role in motivating (or otherwise) women to have a Pap smear test. The experience can be either directly or indirectly related to the test. Women who experienced unpleasant treatment by health personnel during visits to health centres were more likely to report non-attendance to screening. These visits were for various health problems, not confined to preventive health care. These women expressed their unpleasant encounters as uncaring management such as not informed who will be treating them, not knowing whether the treatment will be comprehensive, very brief consultation period and long waiting time (Abdullah et al., 2001; Agurto et al., 2004; Markovic et al., 2005). Women attributed the long waiting times in Markovic et al.’s (2005) study to poor staff discipline and inadequate staffing. In addition, women criticised ill-mannered health staff which hindered them from preventive health care (Abdullah et al., 2001; Agurto et al., 2004; Nguyen, McPhee, Nguyen, Lam, & Mock, 2002). Women, especially those of low income in rural areas, felt they were humiliated and disrespected during their visits for various preventive health care (Leach & Schoenberg, 2007), including for Pap smear screening (Blomberg et al., 2008). These negative experiences affected women’s decision to go for the Pap smear screening. As a result of the various offensive accounts, women expressed preference for private health care which were perceived to be more caring and attentive to their problems (Adolfsson et al., 2012). Nonetheless, the high fees can be a hindrance to some low income women (Markovic et al., 2005).

Returning for another screening was associated with previous experience with the Pap smear procedure. Past experience with screening is important in determining the prospect of another screening. Negative experiences such as feeling of coldness of the speculum, unskilled health personnel or negative consequences of the test such as pain or bleeding hindered a woman from returning for future screening (Ackerson et al., 2008; Agurto et al., 2004). Conversely, a positive experience motivated women to return for repeated screening. This was found in Ackerson’s (2010) study whereby women who felt that health personnel were caring and attentive attended screening regularly.

Women did not only judge the attitude and performance of health care providers, but they also critised the physical environment and efficiency of services. The physical environment was described as crowded (Markovic et al., 2005), unclean (Mutyaba et al., 2007), and uncomfortable (Adolfsson et al., 2012). Screening facilities in health clinics perceived to be of poor quality, hindered women from attending preventive care. These incompetent services include poor management of results such as long turnaround time (Adolfsson et al., 2012;
Aguirto et al., 2004), lost results, results delivered to the wrong person (Aguirto et al., 2004), inadequate supplies and facilities, and lack of privacy (Mutyaba et al., 2007).

2.7 Language and communication

In English speaking countries, fluency in spoken English is of concern to ensure that the messages and education on cancer screening are understood by the population. Therefore, studies among immigrants and minorities have included variables concerned with the English language usage and fluency and understanding of health materials. For example, the study by Yu et al. (2001) which asked about spoken English fluency among Chinese Americans showed that women with moderate to good English fluency were twice more likely to have a Pap smear test compared to those who reported poor fluency. The importance of language in effective communication is supported by studies which showed that women preferred health care providers who spoke their native language (Dohan & Levintova, 2007; Lovell et al., 2007). Language was also found to be closely linked with cultural practice. The study by Dohan & Levintova for instance, found that Russian-speaking emigrants in San Francisco expected the physicians to be more compassionate and less technical. In addition, they also expected the physician to avoid disclosure of cancer to patients. These language and cultural problems were reported as barriers to cancer care. Language barriers had led to the feeling of mistrust of the healthcare provider (Aguirto et al., 2004) and fear of attending clinic for screening (Dohan & Levintova, 2007).

Communication does not involve only verbal interaction but also written messages. Previous studies investigated the effects of letters sent to invite women to attend cervical cancer screening. There were mixed responses from women who received these letters. Some studies showed positive effects of the invitation letters in which women were motivated to attend screening (Adolfsson et al., 2012; Forss et al., 2001). On the other hand, women in a study by Blomberg et al. (2008) felt offended by the invitation letters. In addition, there were women who felt unsure whether the invitation was meant for them (Adolfsson et al., 2012). These results showed that written invitation could be misunderstood by women.

Some studies have also looked at communication in relation to cervical cancer screening. A study in Belgrade for instance, found that women who had conversations about cervical cancer and who were more exposed to the media about the prevention of cervical cancer were more likely to have attended cervical cancer screening (Matejic, Vukovic, Pekmezovic, Kesic, & Markovic, 2011).

3.0 Conclusion

The reasons and factors which hinder women from or motivate women to participate in screening do not function in isolation. The factors are interlinked with each other and they function simultaneously. Furthermore, many of the reasons women gave showed that their non-attendance was not a denial of the benefits of screening. Neither was it a purposeful decision to not attend screening. But rather, they felt discouraged and hindered from attending due to various influencing factors. This view is supported by Adolfsson et al. (2012) which found that women who did not attend screening did not consciously reject the test. Rather, there were several reasons which discouraged them from attending.
References


