



Cervical cancer screening: meeting the needs of minority ethnic women

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Abstract Understanding of the uptake of cervical screening among women from minority ethnic groups, and how acceptable they find the process, still requires some considerable progress. This paper attempts to review the material available, identify the issues and discuss ways in which progress might be made in future.

Mortality from cervical cancer is higher among women born in the Caribbean Commonwealth than the standardised rate for women living in England and Wales. By contrast, mortality among women born in the Indian subcontinent and African Commonwealth is comparatively lower. Data about the incidence of cervical cancer among minority ethnic women are in short supply and some research findings are contradictory. For instance, Asian women may have either higher or lower rates of cervical cancer than the rest of the female population. Clearly further work is needed to establish whether Asian or other minority populations are high risk groups and why. There is also a need to assess trends regularly to see what impact migration has on incidence and mortality rates.

Recent publication by the Health Education Authority of the results of its survey of health and lifestyles among black and minority ethnic groups in England provided welcome information about their uptake of cervical screening. Rates differ considerably between the different minority groups surveyed and the challenge now is to use all this information to inform the process of developing an approach to increasing uptake that is culturally appropriate.

The literature on minority ethnic women's experience of cervical cancer screening is not distinguished by being plentiful. Whilst much research has been done into the uptake of breast screening among women from minority ethnic groups and how acceptable they find the process, our understanding of the corresponding position for cervical screening is still fairly elementary.

All women aged between 20 and 64 are invited for cervical screening, usually at their GP's surgery, mostly every three years but in some districts every five years. Screening aims to reduce the incidence of, and therefore mortality from, cervical cancer; and consists of a simple procedure in which a small sample of cells is scraped from the cervix. The content of this smear is then analysed at a laboratory, after which stage a woman will either be given a normal result or referred for further investigation. This takes the form of repeating the smear or carrying out a colposcopic examination of the cervix. Then, depending on the diagnosis, the woman is either kept under regular surveillance or treated. Survival is much higher in women who are diagnosed and treated at an early stage. By treating lesions detected through smear tests at a pre-cancerous stage, invasive cervical cancer can actually be prevented, although it is uncertain whether all early lesions progress to become more serious.

In examining the issues relating to minority ethnic women and cervical screening, it is important firstly to establish that there are in fact real issues concerning these populations. There are two areas of interest: the incidence of cervical cancer among minority ethnic women and their uptake of screening. National data on incidence of cervical cancer by ethnic group are limited as cancer registries do not routinely record ethnic origin; however the Department of Health has published data on mortality¹ (see Figure 1). These show that women born in the Caribbean have raised mortality from cervical cancer compared with the standardised mortality ratio for England and Wales. By contrast, the mortality of women born in the Indian subcontinent and African Commonwealth is significantly lower. It is important, however, to recognise the possibility that rates of mortality from cervical cancer among women born outside the UK may differ from those among women of different ethnic origins born in the UK.

Research has provided some data on the incidence of cervical cancer among minority ethnic women. However, the findings are not consistent. For instance, rates among Asian women have been reported as both higher^{2,3} and lower⁴ than among non-Asian women. The possible reasons for this variation may include differences in the methods used to define the Asian population, and the small numbers of cases on which studies are based. A useful surrogate measure for incidence is data from the country of

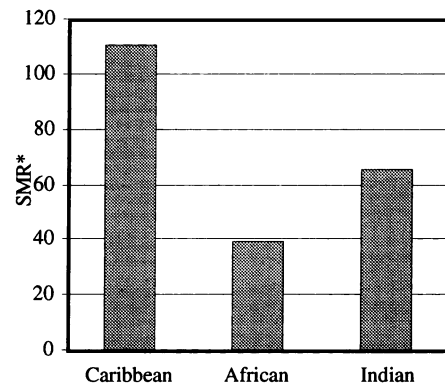


Figure 1 Mortality from cervical cancer for women born in the Caribbean Commonwealth, African Commonwealth and Indian subcontinent (ages 20-69) England and Wales, 1979-83. *Standardised Mortality Ratios; England & Wales = 100. Source: Department of Health 1993.

origin, as the expected incidence among the migrant population should be similar, at least in the first generation. There is some variation in world-wide incidence rates of cervical cancer, with most cases occurring in developing countries where it is the commonest female cancer. Very high incidence rates are recorded in Latin America, China and the Caribbean⁵ and incidence is also high in some Asian countries including India.¹ The lowest rates in the world are found among Jewish Israeli women. Research has shown that among later generations patterns of cancer are more similar to those in the indigenous population, and that this needs to be considered in conjunction with other changes such as increasing longevity. There is a need to monitor these trends, and also perhaps make minority ethnic populations aware that cervical cancer may be a problem in second and subsequent generations. Better data are clearly needed, possibly from the recording of place of birth and/or ethnic origin on cancer registers. In the meantime we must be aware of the possibility that Asian women, and indeed women from other minority ethnic groups, are at high risk of developing cervical cancer.

Incidence reflects a combination of environmental and genetic factors which may act variably on different ethnic groups. Risk factors involved in the onset of cervical cancer are many and may act directly or indirectly. These include sexual behaviour, parity and age at first pregnancy, method of contraception used, occupation and social class and smoking. In its recent survey of health and lifestyles among black and minority ethnic groups in England,⁶ the Health Education Authority analysed smoking behaviour. Table I shows that women from the African and

Caribbean Commonwealths are less likely than indigenous women to smoke, except in the 16-29 age group where there is now little difference. Women from the Asian subcontinent are far less likely to smoke than other women except older Bangladeshi women, who are still less likely to smoke than the indigenous female population.

Table I Current regular smokers

	All women %	Aged 16-29 %	Aged 30-49 %	Aged 50-74 %
UK population	27	31	29	21
African-Caribbean	17	30	17	5
Indian	1	1	1	2
Pakistani	2	2	2	2
Bangladeshi	5	2	4	12

Source: Health Education Authority 1994.

For sample size and other details of the survey design and response, refer to the survey report.

Table II Proportion of women reporting ever having been screened for cervical cancer

	All women %	Aged 16-29 %	Aged 30-49 %	Aged 50-74 %
UK population	60	48	73	56
African-Caribbean	54	45	57	63
Indian	37	25	51	27
Pakistani	32	23	44	28
Bangladeshi	28	23	38	18

Source: Health Education Authority 1994

There is clearly a need, when planning cervical screening services locally, to consider in detail the profile of the local population in terms of the risk factors identified above and ensure that initiatives to promote uptake are informed by this. Turning to uptake of screening, the success of the NHS Cervical Screening Programme (NHSCSP) depends on women's uptake and acceptance of the service that is offered to them locally. Although, overall across the country the proportion of women accepting invitations for cervical screening is on target, in some areas especially in the inner cities - uptake rates are still too low. There is currently no routine ethnic monitoring of women attending for screening and the need for this in future is clearly an issue that requires discussion. In the absence of national data we are able only to use local research studies as a guide. Alternatively we might take raw uptake data by district health authority or screening programme, and assess the extent to which low uptake might correlate with a high proportion of minority ethnic women in the population. However, it cannot be valid simply to deduce that ethnicity is the main variable at play; studies have suggested that socio-economic status is as important if not more so.^{7,8} For instance, class has been cited as a factor in smoking, and this may or may not interact with ethnicity, as might be the case for any other risk factors. The health needs of minority ethnic populations and their socio-economic status are two examples of inequalities in health, and when the two coincide an individual woman may find herself at a real disadvantage.

To summarise some of the relevant research, few studies have precisely quantified differences in uptake among UK populations. Uptake has been shown to be lower among Asian women, with women often unaware of the existence and importance of cervical screening services.⁹ Socio-economic factors may be involved: in another study Asians were not found to be disadvantaged in their

uptake of cervical screening compared with women from the same socio-economic group.⁷ In view of the shortage of research evidence, we welcomed the newly available information published by the HEA.⁶ The HEA survey found that the proportion of women reporting ever having been screened for cancer of the cervix differed significantly between ethnic groups:

There are two interesting points to note. Firstly, the overall figure of 60% is lower than the 83% uptake figure most recently reported by the NHSCSP,¹⁰ and lower still than the 68% average uptake during the last five years. Secondly, it contrasts with the proportion of women reporting ever having had a cervical smear test (Table III).

Table III Proportion of women reporting ever having had a cervical smear test

	All women %	Aged 16-29 %	Aged 30-49 %	Aged 50-74 %
UK population	85	71	97	82
African-Caribbean	87	77	98	87
Indian	70	57	83	62
Pakistani	54	38	69	64
Bangladeshi	40	30	57	29

Source: Health Education Authority 1994.

Table IV Reasons for not having a smear test

		%
Don't feel I need to	UK population	28
	African-Caribbean	37
	Indian	16
	Pakistani	13
	Bangladeshi	12
Never been told/recommended to	UK population	24
	African-Caribbean	11
	Indian	22
	Pakistani	33
	Bangladeshi	18
Don't know what smear test is	UK population	1
	African-Caribbean	1
	Indian	13
	Pakistani	15
	Bangladeshi	34
Too busy/never got round to it	UK population	13
	African-Caribbean	10
	Indian	11
	Pakistani	2
	Bangladeshi	6
Never been sexually active	UK population	11
	African-Caribbean	19
	Indian	6
	Pakistani	7
	Bangladeshi	6
Embarrassment	UK population	5
	African-Caribbean	1
	Indian	5
	Pakistani	5
	Bangladeshi	3
Scared	UK population	5
	African-Caribbean	2
	Indian	5
	Pakistani	2
	Bangladeshi	<0.5

Base: All women who have never had a smear test.

Source: HEA survey.

The overall figure here of 85% is comfortably close to the 83% reported by the screening programme. The implication must be that not all women understand that the purpose of the cervical smear test is to screen for cancer. Slightly more African Caribbean women report ever having had a cervical smear test than the UK population average, with lower rates among Asian women - a finding consistent with the limited research that has been done to date.

A major factor that has been cited as affecting uptake is inaccuracy of the address details held on the lists used to invite eligible women for screening, which are compiled from general practitioners' lists. The evidence from the HEA study is that 99% of all women claim to be registered with a GP, and almost 100% of all African Caribbean, Indian, Pakistani and Bangladeshi women. This highlights the need for all women to be aware of the importance of keeping their general practice aware of their current address.

Three main factors have been identified which we believe predict attendance for breast screening. There is no reason to expect these to be different for cervical screening:

1. attitudes and beliefs about screening
2. perceived benefits of the effectiveness of screening
3. the significance of support from family, friends and the community.

Literature has identified a lack of understanding about health services as a specific problem for ethnic minority groups: e.g. the principle of screening apparently well women for the early detection of disease.¹¹ Data from the HEA survey clearly show that some women do not understand the purpose of screening, do not perceive a need to attend, or identify some impediment to attending (see Table IV).

Different ethnic groups report different types of reason for not having a smear test. The HEA also looked at encouragement of women by health professionals to have a smear test (see Table V).

Table V Health professional suggested having a smear test in last 12 months (self-reported data)

	All women %	Aged 16-29 %	Aged 30-49 %	Aged 50-74 %
UK population	36	40	41	28
African-Caribbean	39	48	34	31
Indian	43	38	52	32
Pakistani	25	25	26	23
Bangladeshi	22	20	23	21

Source: Health Education Authority 1994.

The answer, therefore, to the original question: "Does the black and ethnic minority population represent a high risk group?" - is "maybe". We know, for example, that it is especially important for Afro-Caribbean women to have regular cervical smears, but require further data to inform action in respect of Asian women and women from other minority ethnic groups. Aided by the framework provided by the *Health of the Nation* target,

To reduce the incidence of invasive cervical cancer by at least 20% by the year 2000, from 15 per 100,000 in 1986 to no more than 12 per 100,000.

the NHSCSP is beginning to formulate its strategy to promote uptake of cervical screening among minority ethnic women and

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acceptability of the service they receive once they decide actually to attend. It is necessary to analyse the screening process step by step, from identifying target populations right through to the moment at which a woman is given a definitive diagnosis, to identify potential problem spots and action to resolve them. We need to look at whether access to cervical screening services is straightforward, whether the amount and type of health information given is appropriate, and whether the quality of care a woman receives is satisfactory. We feel that it is necessary to increase uptake of screening among women from all ethnic backgrounds, especially those who live in inner cities. However, to ensure that health promotion strategies have an equal chance of encouraging all such women to attend, materials publicising and explaining the programme must be available in a format that is racially and culturally appropriate, and translated into a more accessible language if necessary. Accessibility of the ethnic population is a problem for health promotion professionals; however this is not simply a question for the NHSCSP.

For breast screening, the NHS Breast Screening Programme and Department of Health have funded the production of a range of health promotion resources for use with women from minority ethnic groups. These range from leaflets and videos to a training pack for use by community health educators. They have proved popular and common sense suggested that an early project for the new national coordination team for the NHSCSP might be to arrange for similar materials to be produced on cervical screening. We are currently evaluating the need for these, and look forward to receiving the results of Cancerlink's Department of Health-funded review of the resources available to minority ethnic women about cervical screening. We are looking also at the idea of an NHSCSP-funded research project, conference or workshop resulting in a training pack similar to the one already in use within the breast screening programme. A conference or workshop would provide a forum for the NHS and charities to review progress so far and discuss the way forward on uptake and acceptability issues. We need also to clarify our basic "messages" about cervical screening, to support the work of health promotion specialists, primary care teams and smear takers.

In the meantime we are keen to receive any information about studies evaluating the impact of strategies devised to promote the uptake of cervical screening among women from minority ethnic communities. Above all, there is a need to avoid duplication of research and effort at national and local level, and ensure that research is commissioned where it is lacking and reflected in policy once clear results have been found.

In conclusion, minority ethnic women currently in the screening age group may be at greater risk of cervical cancer. However, until we have better information, methods are needed to increase screening uptake for all women. More research is needed into acceptability issues and the user perspective, and work needs to continue to promote an effective approach through the purchasing process, with strategies properly evaluated.

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